The New Age of Aging: Promise and Peril in the Changing World

W. June Simmons, CEO
Partners in Care Foundation

HASC Conference on Aging

October 15, 2013

Partners in Care
Who We Are

Partners in Care is a transforming presence, an innovator and an advocate to **shape the future of health care**

We address **social and environmental determinants of health to broaden the impact of medicine**

We have a two-fold approach, creating and using evidence-based models for: **provider/system practice change and enhanced patient self-management**

Changing the shape of health care
through new community partnerships
and innovations

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From Volume to Value

- Infrastructures and reimbursement are transforming
- The roles of hospitals, physicians and payers are blurring
- Major consolidation – unpredictable future
- The role of the community agency is growing
- New broader partnerships are essential

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Massive Change Calls for Strategic Focus & Collaboration

- Times of Transformation – disruptive levels of change
- Even *positive* change is disruptive at this level of intensity and scale
- Moving everyone's cheese at once!
- But the positive impact is so delightful
- Worth the pressures and extra work!

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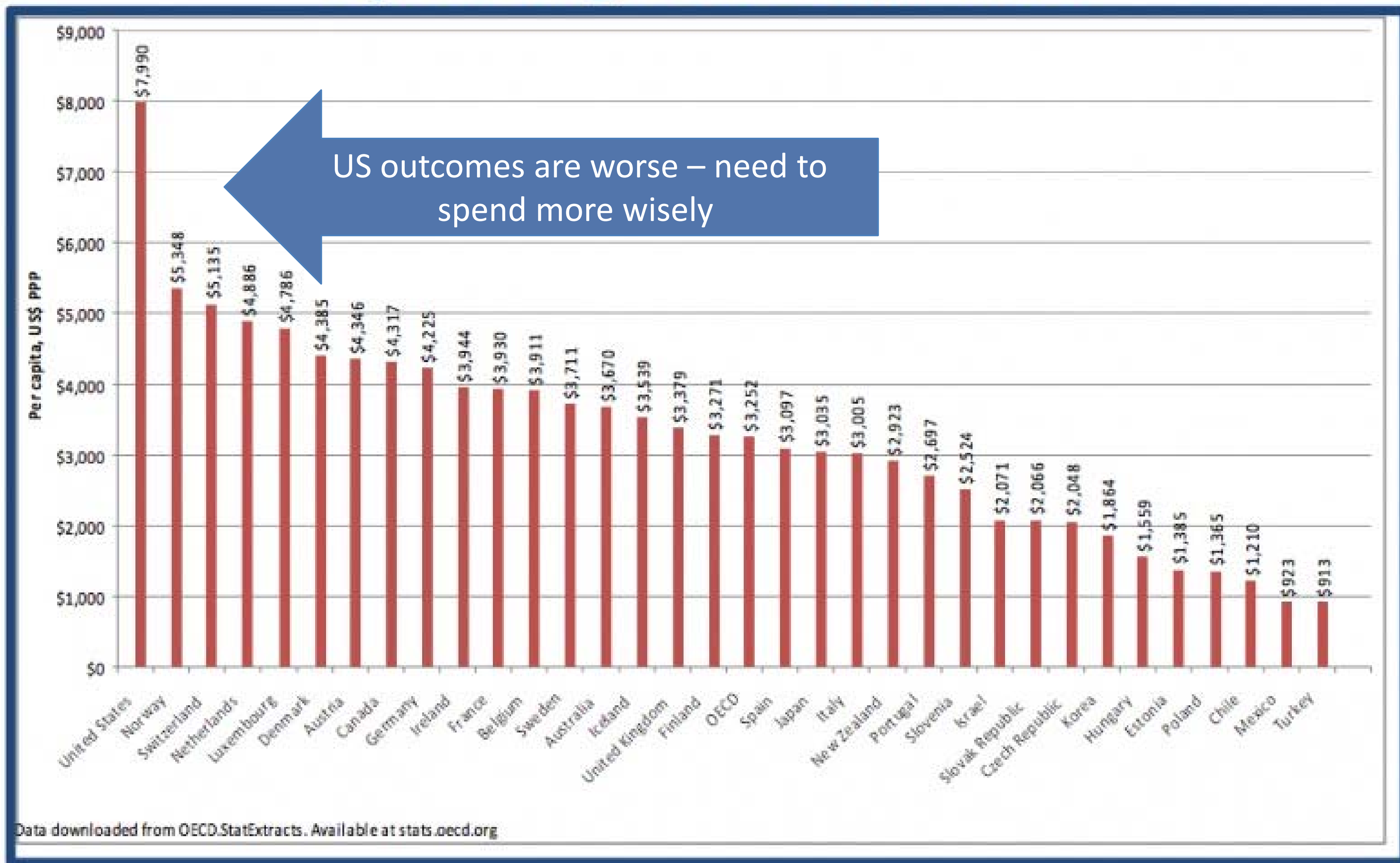
Spending on health care



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RWJF Survey of 1,000 PCPs

- 86% said "unmet social needs are leading directly to worse health" & it is as important to address these factors as medical conditions.
- 80% were "not confident in their capacity to address their patients' social needs."
- 76% wish that the healthcare system would cover the costs associated with connecting patients to services that meet their health-related social needs.
- 1 of 7 prescriptions would be for social supports, e.g., fitness programs, nutritious food, transportation assistance.

Health Care's BLIND SIDE - The Overlooked Connection between Social Needs and Good Health, Robert Wood Johnson Foundation, December 2011, http://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2011/rwjf71795

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Bringing medicine, patients and community-based services together.

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Time to do something about them

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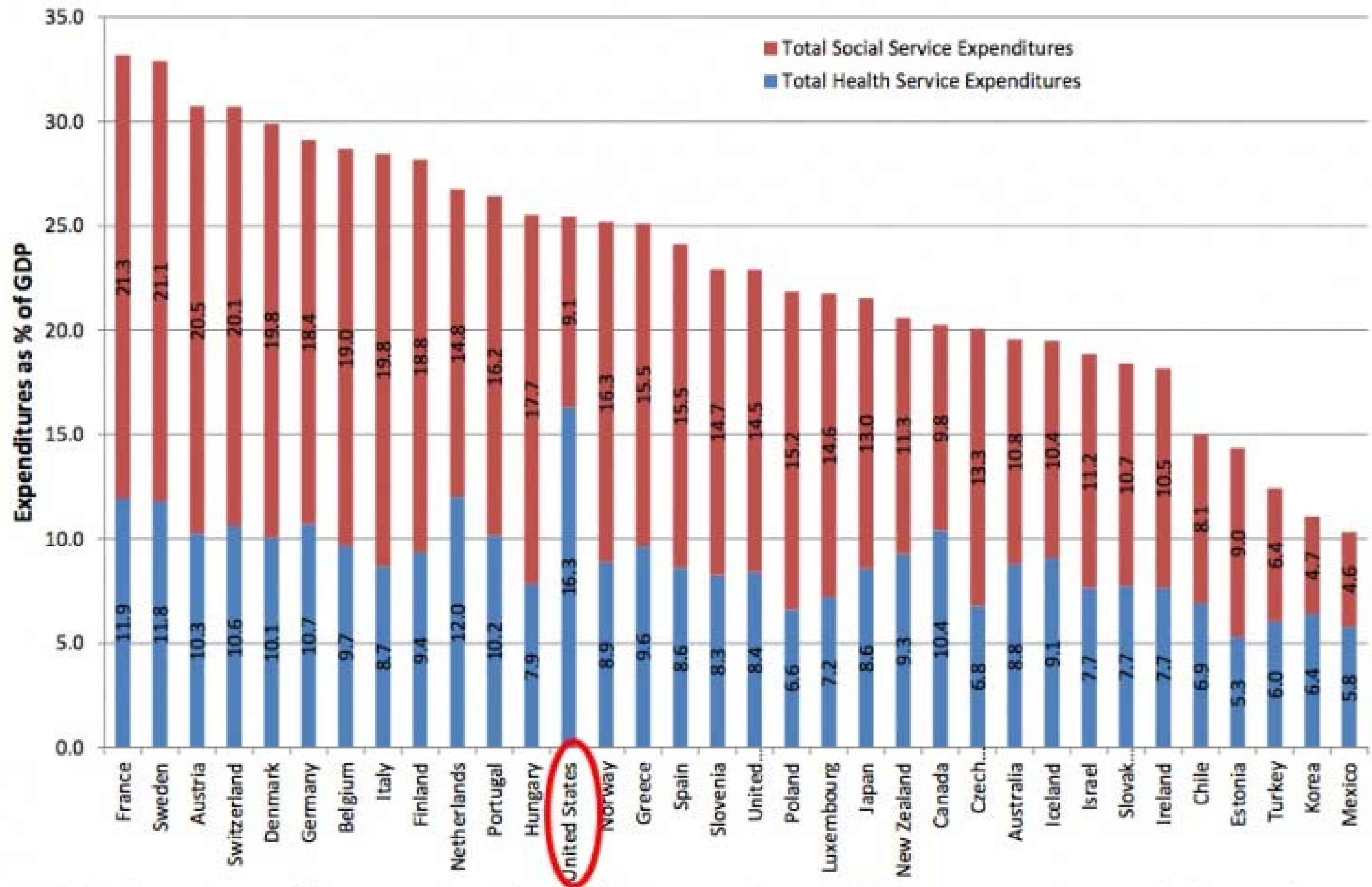
Total health care investment in US is *less*



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

Health Care + Social Services = Better Health, Lower Costs

- Address social determinants of health
  - Personal choices in everyday life
  - Isolation, Family structure/issues, caregiver needs
  - Environment – home safety, neighborhood
  - Economics – affordability, access
- Social Service Agencies Have Advantages
  - Time to probe, trust, different authority
  - Cultural/linguistic competence
  - Lower cost staff & infrastructure
  - High impact evidence-based programs

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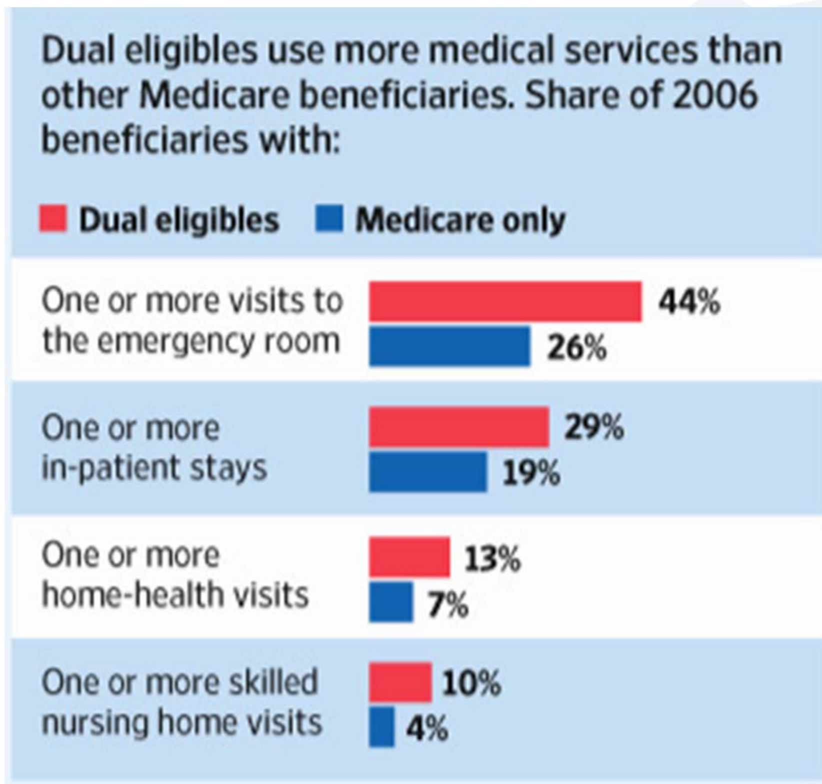
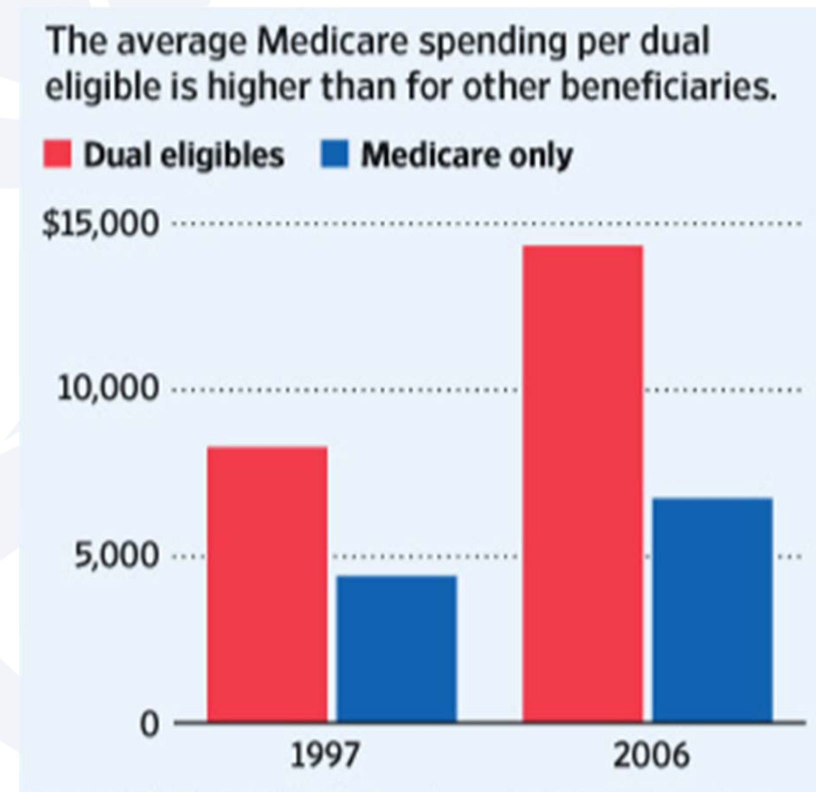
Dual Eligibles – The Ultimate Case Study:

Age + Poverty = Worse Health, Higher Cost





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

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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	Average cost to Medicare	Average cost to Medicaid
6.7 days	**$7,846**	**$321**

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

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

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How can we accomplish these goals?

Comprehensive, person-centered, coordinated healthcare and social services!

The goal: population health management

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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
- Care system integration with community health resources

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

Center for Medicare & Medicaid INNOVATION

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New Roles for the Medical System

- Person-Centered Care –Attention to Quality of Life
- Risk Stratification – Active Screening & Targeting
- Continual Monitoring for "trigger events" that could change a risk category
- Seamless, comprehensive care system: Build integrated care with local health-related social service providers ~~(HIPAA lawyers)~~
- Build comprehensive partnerships with community providers as part of the delivery system for population health

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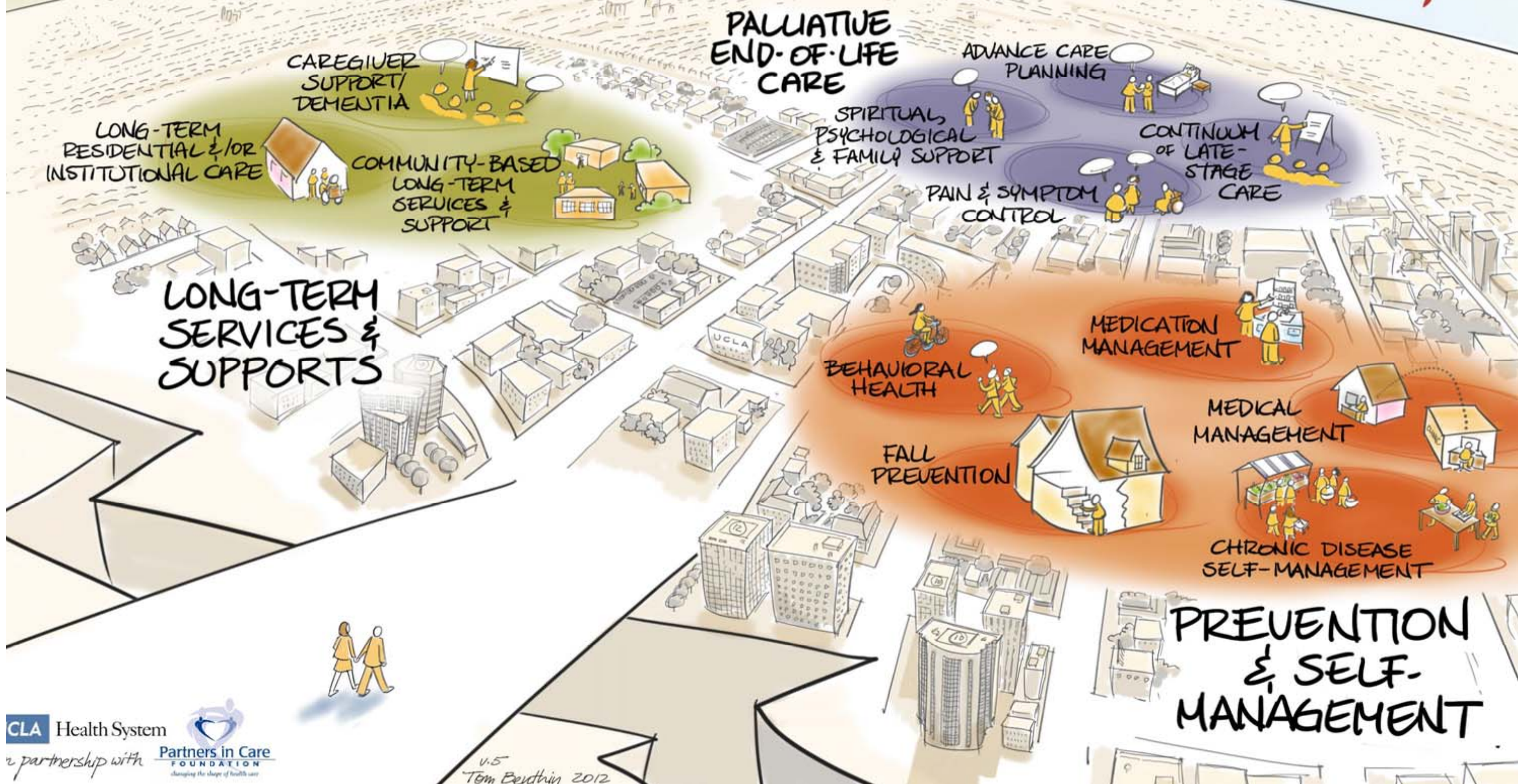
Welcome to
UCLA's VISION for PARTNERSHIP with COMMUNITY SERVICES

HEALTHY & INDEPENDENT



The Business Case for Partnership

- Care Coordination is now a required and essential benefit in Medicare Advantage
- Standards are beginning to emerge from State, Federal and National Accreditation Agencies
  - National Committee for Quality Assurance (NCQA) has issued DRAFT *Structure and Process Measures for Integrated Care of People with Dual Eligibility for Medicare and Medicaid*
- Non-medical services can improve health outcomes at lower cost – chronic conditions and function

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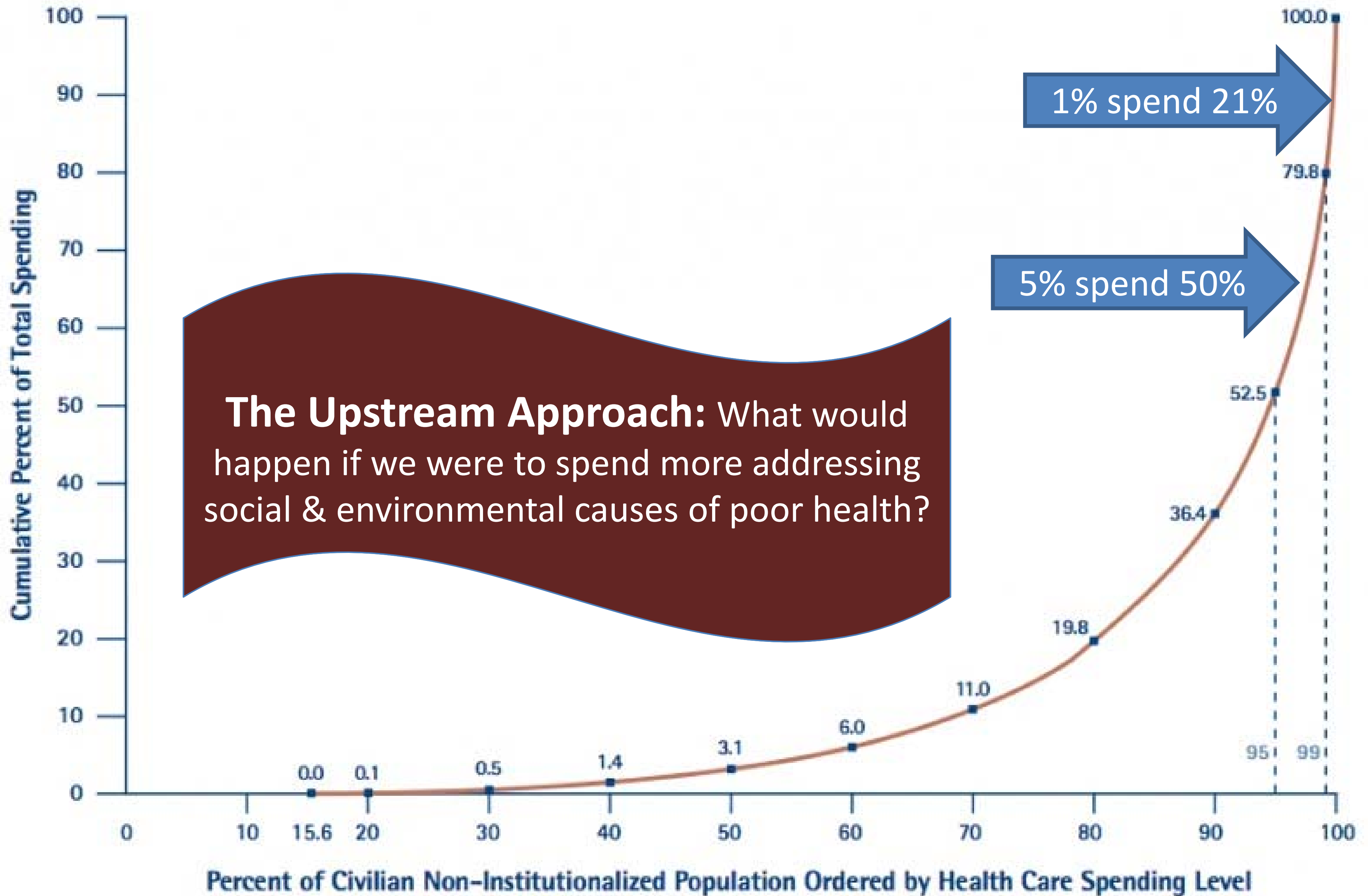
FIGURE 3. DISTRIBUTION OF HEALTH CARE SPENDING, 2008
Cumulative Percent of Total Spending
100
90
80
70
60
50
40
30
20
10
0
1% spend 21%
5% spend 50%
The Upstream Approach: What would happen if we were to spend more addressing social & environmental causes of poor health?
100.0
79.8
52.5
36.4
19.8
11.0
6.0
3.1
1.4
0.5
0.1
0.0
95
99
0
10
15.6
20
30
40
50
60
70
80
90
100
Percent of Civilian Non-Institutionalized Population Ordered by Health Care Spending Level

Targeting is Key to Cost-Effectiveness

- Social determinants often invisible to medicine
- *Innovations require investment* to build better outcomes and decrease costs
- Community partners help identify where these investments will have greatest impact:
  - Population health management – prevention
  - Managing progression of chronic conditions & function
  - Medications management
  - Reducing admissions/readmissions & SNF
  - Late life care – palliative/hospice

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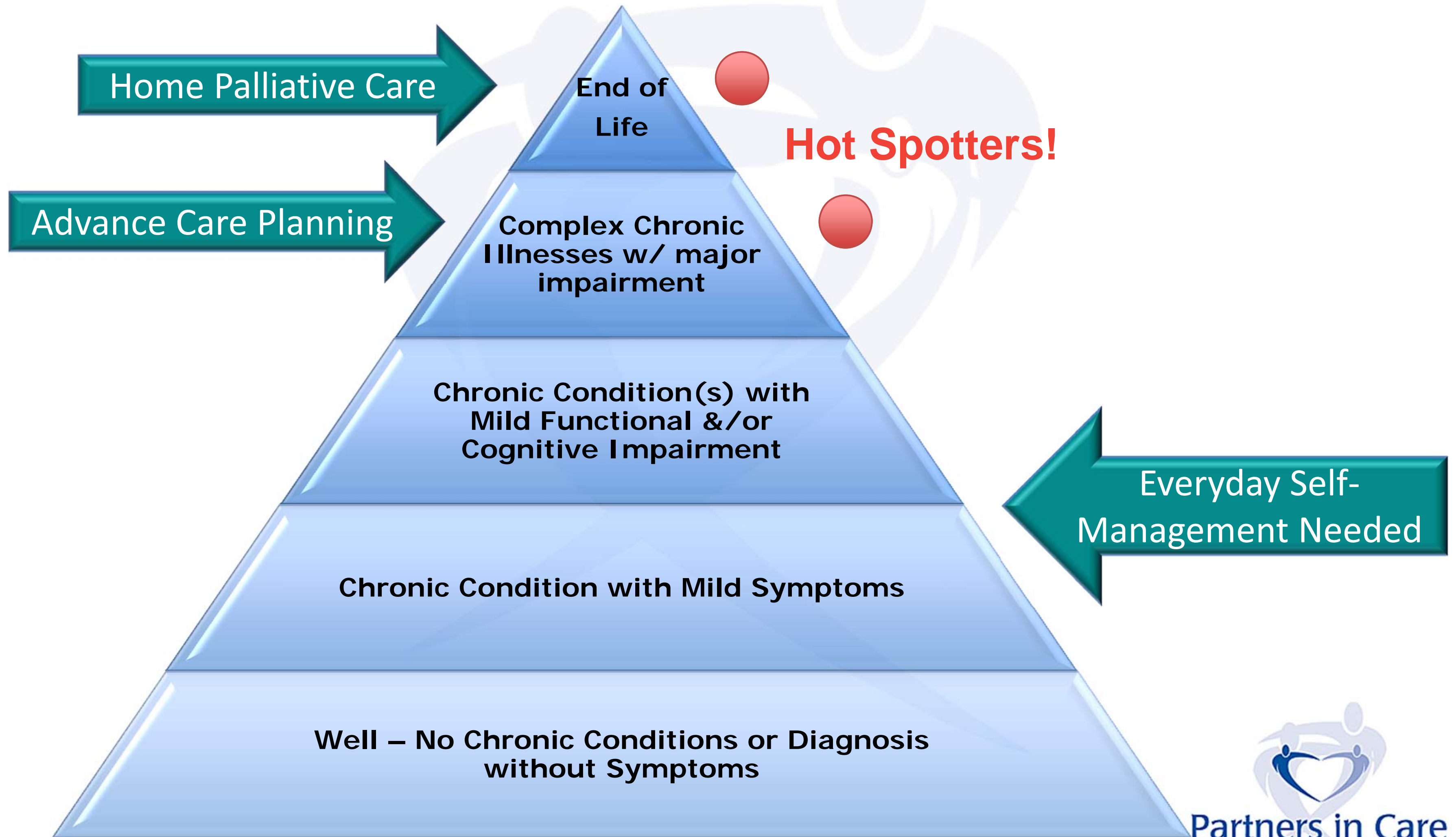
Active Patient Population Management



Why integrate delivery of medical, behavioral health, and long-term services and supports?

- Coordination leads to improved continuity and access to care and benefits
- Community based alternatives maximize an individual's ability to remain in their home and community and saves on institutional care
- Preserve and enhance the ability for consumers to self-direct and receive high quality care
- Improved member health and satisfaction with care
  - Posted ratings, penalties and incentives, retention

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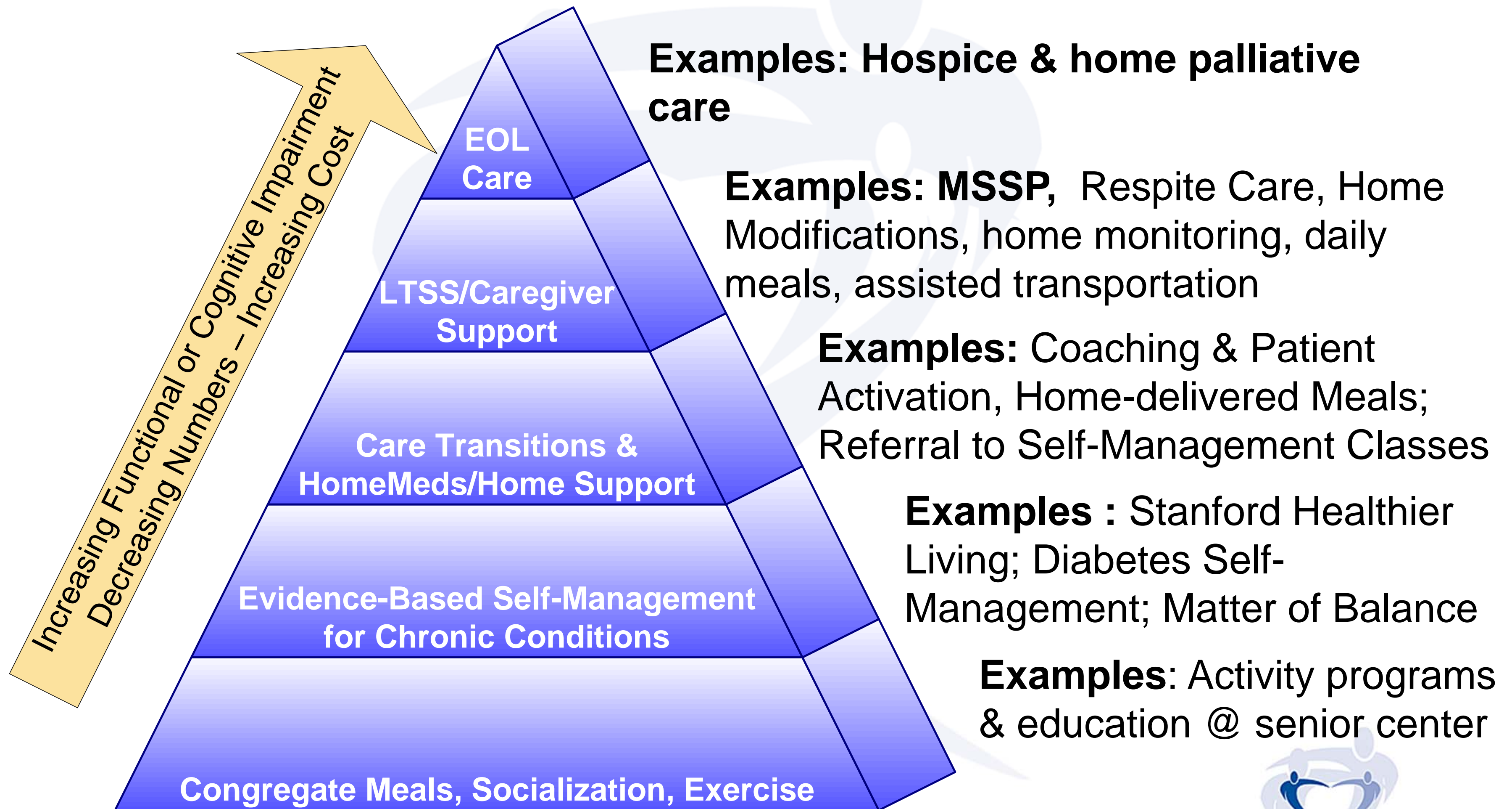
Targeting Home & Community-Based Services in Active Population Health Management



Continuum of Home and Community-Based Services for Older Adults

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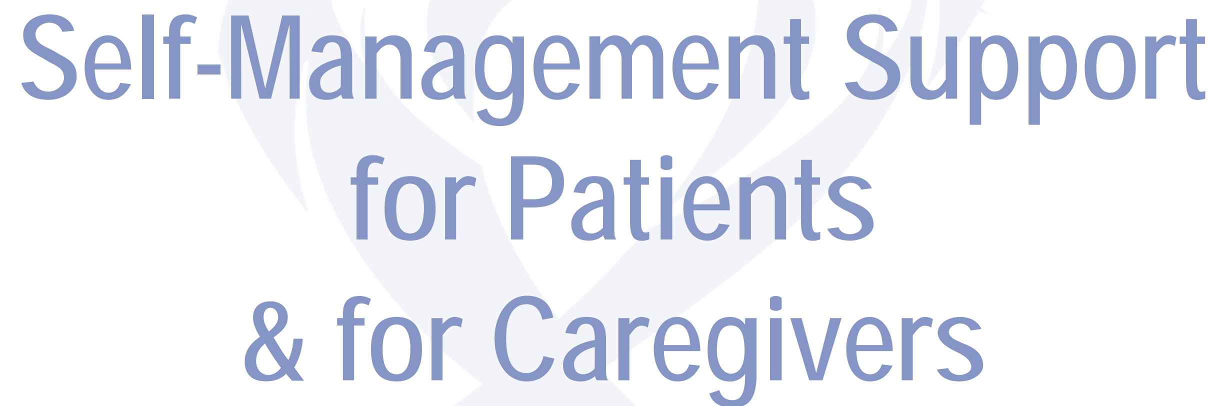
Focus Area #1



Self-Management Support for Patients & for Caregivers

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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

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Building the New Business Model: Focus Areas

Self-Management	Assessments, Care Coordination & Coaching	Efficient Delivery System Provider Networks
Chronic Disease	HomeMeds	Evidence-Based Leadership Council
Chronic Pain	Adult Day/CBAS Assessment	Care Coordination Network
Diabetes (billable)	Home Safety Evaluation	Care Transitions Provider Network
A Matter of Balance	Home Palliative Care	
Savvy Caregiver	Short & Long-Term Care & Service Coordination	
Powerful Tools for Caregivers	Care Transitions Interventions	
Arthritis Foundation Exercise & Walk with Ease		
UCLA Early Memory Loss		

Stanford Healthier Living (CDSMP): Participant Health Outcomes

Randomized, controlled trial of 1,000 participants

Increase in Exercise Energy Psychological well-being **Decrease in** Pain and fatigue Depression Shortness of Breath Limitations on Social and role activities	Overall Improved health status & quality of life Greater self-efficacy and empowerment Enhanced partnerships with physicians

Sources: Lorig, KR et al. (1999). *Med Care*, 37:5-14; Lorig, KR et al. (2001). *Eff Clin Pract*, 4: 256-52; Lorig, KR et al. (2001). *Med Care,* 39: 1217-23.

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CDSMP Healthcare Utilization Effects

- Results showed more appropriate utilization of health care resources through **decreased**:
  - Outpatient visits
  - Emergency room visits
  - Hospitalizations
  - Days in hospital

Ultimate Result: **Reduction in health care expenditures**

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Chronic Pain Self-Management Program

Medication isn't the only treatment….

- Developed by Stanford & Memorial Univ. of Newfoundland
- Designed to empower participants through a mutually supportive and interactive process
- Patients learn to manage & decrease chronic pain. **Outcomes**:
  - Less Pain & Lower Dependency on Others
  - More Energy
  - Improved Mental Health
  - Increased satisfaction with life
  - More involvement in everyday activities
- 6-week workshop, 2.5 hours/session, trained peer leaders
- Added benefit – *develop relationships with others suffering from chronic pain!*

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Diabetes Self-Management Program

- Developed at Stanford by Kate Lorig, RN, Dr.PH
- Patients with Type 2 diabetes learn to take charge and control of their diabetes. Develop tools to:
  - Learn about disease & self-care & monitoring
  - Understand and deal with emotions
  - Manage medications
  - Worth with health care providers
  - Make weekly action plans for exercise and healthy eating

- **One year after** 6-week workshop:
  - Improvements in eating breakfast, stress management, self-reported health, aerobic exercise, health distress, self-efficacy, communication with physicians
  - Fewer hospital days; more PCP visits

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Where are these available?

- **Partners in Care - California technical assistance center**
  - Train the trainer, patient engagement strategies
  - Centralized calendar & resource base
    - https://www.cahealthierliving.org
- "Aging & Disability Network"—Area Agencies on Aging, Alzheimer's Association, Caregiver Resource Centers
- Health providers
- Community settings – work place, faith settings

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Focus Area #2

Assessments, Care Coordination & Coaching

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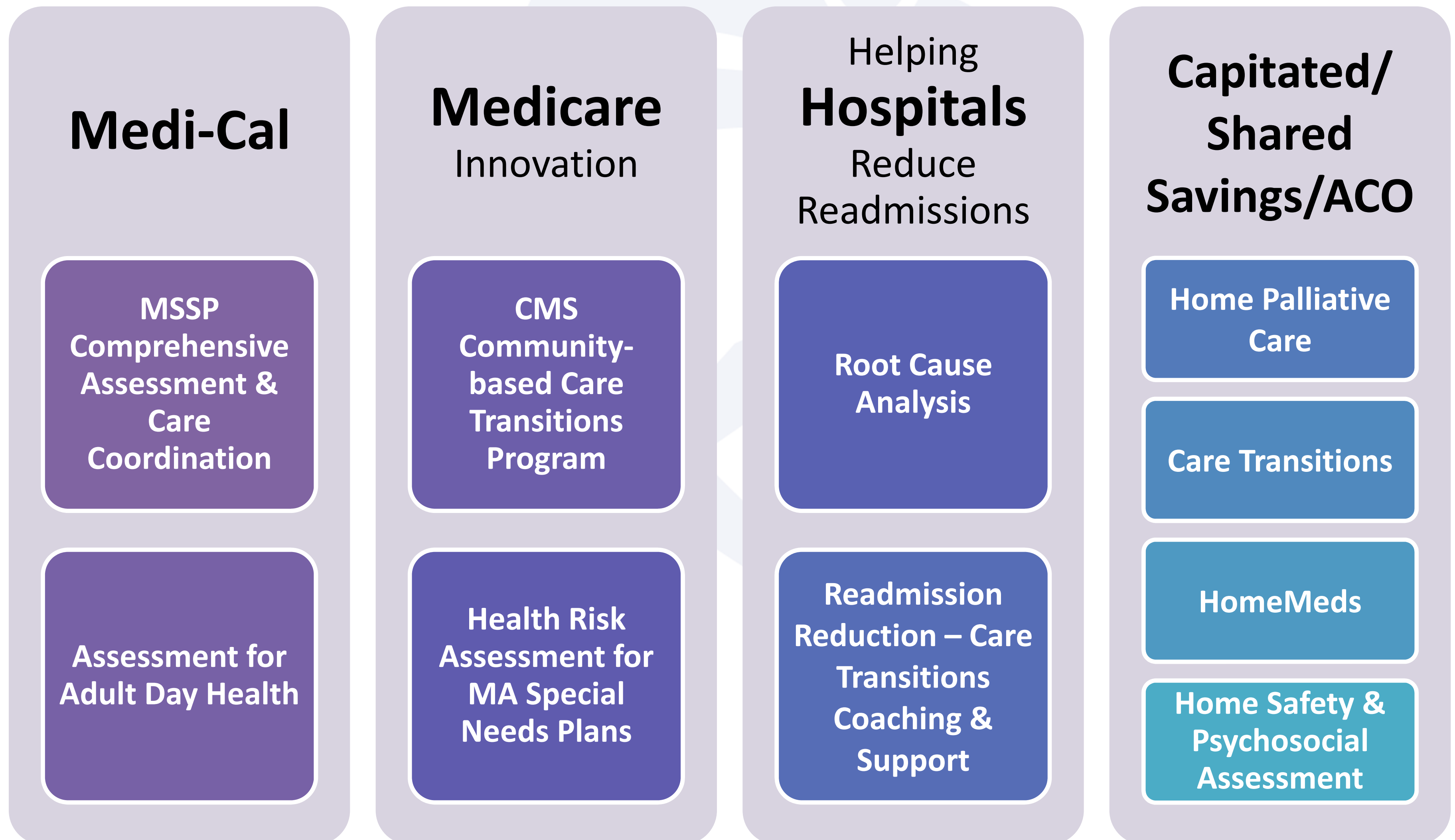
Assessments, Care Coordination & Coaching



Care Transitions Coaching & Support

- Evidence-based home & social services models proven to reduce readmissions
- **Coaching** (Coleman Care Transitions Intervention) for those who are capable (or have caregivers)
  - Help patients learn to monitor for red flags of exacerbation, make appointments, manage medications, activate for long-term self-management
- **Social services** (Rush U. Bridge Program) for those who are not
  - Connect patients to services and supports for recuperation, rehabilitation, education

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Comprehension of Medicare Patients with Low Health Literacy

(i.e. what do they understand?)

	Percent Correct
• Identify next appointment	73%
• Take medicine every 6 hours	52%
• Take medicine on empty stomach	46%
• Interpret blood sugar value	32%
• Upper GI exam instructions (written @ 4th grade)	24%

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New Public and Private Models

- Penalties inspiring rapid change
- CMS testing new Medicare models
  - Coaching by community based organizations
  - Southern California – 9 hospital groups
- Private contracts with community agencies growing
  - Integrated regional delivery system

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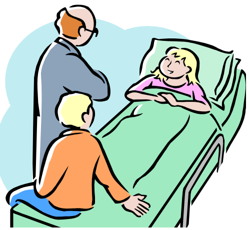
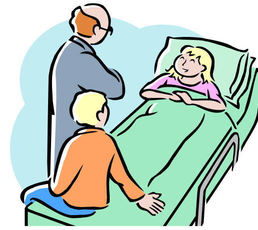
Care Transitions: Buy vs. Build Decision

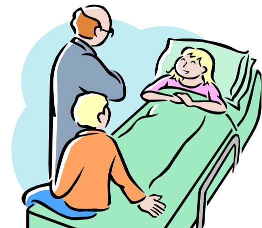
Patients discharged to geographically disparate parts of the County



Lancaster



San Pedro



Woodland Hills

Considerations:

- Driving distances to patient home
- Knowledge of local services
- Training and experience
- Language / Culture
- Data collection / patient monitoring

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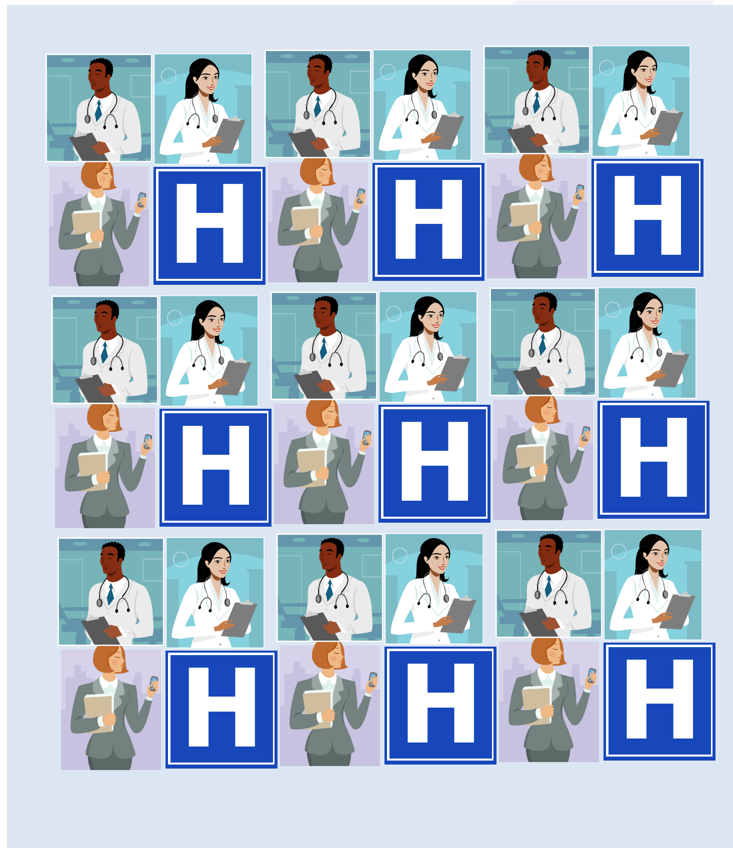
Individual Hospital Approach: Each hospital must hire, train, manage and pay transitions directors and health coaches



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

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Medications & Care Transitions

- 72% of post-discharge adverse events are related to medications—and close to 20% of discharged patients suffer an adverse event. *
- Medication reconciliation and risk assessment is a core element of every care transition intervention

*Mary Andrawis, PharmD, CMMI, presentation to Drug Safety Panel, May 10, 2011 (Forster et al. Annals of Internal Medicine. 2003; 128: 161-167./ CMAJ FEB 3, 2004;170-3)

"A study of older adult outpatients who took five or more medications found that 35 percent experienced adverse drug events."

(Marek and Antle, 2008, pp. 499)

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HomeMeds – Improve med safety

- Home visit by nurse or social worker
  - Collect comprehensive medication information
  - Assess for possible adverse effects & discrepancies
  - Screen through software
  - Pharmacist review & resolve problems, educate
- Original Model: Find a home visit—add HomeMeds
- Emerging Models
  - Targeted home visits for high-risk patients
  - Add to care transitions, CDSMP, etc.

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Factors at Play Nationally

- National Patient Safety goals
- Medication reconciliation
- STAR Ratings
  - Minimizing hospital readmissions
  - High-risk medications
  - Patient adherence
- HEDIS Measures
  - High-risk medications

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Long-Term Services & Supports

- LTSS required because of loss of functioning (cognitive &/or physical/sensory)
  - **ADL**: Eating, transferring, toileting, bathing, etc.
    - *Usually DAILY*
  - **IADL**: Shopping, meals, money management, chores, transportation
    - *Often less frequent need*
- Rehab failed/not possible
- Family provides 80%
- *Alternative is nursing home - $$$ forever*
- Public payment – only Medi-Cal – IHSS & MSSP
  - MSSP for nursing-home eligible Medi-Cal

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

Purchased Services
(Credentialed Vendors)

- Safety devices, e.g., grab bars, w/c 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

Role of Agencies Like Partners in Care

- "Eyes and ears" in the home
- Skilled at building trust and relationships
- Gather data and information that is not shared in a medical setting or encounter
- Link in medication issues with evidence based intervention
- Cultural competence in local communities
- Comprehensive psychosocial & environmental assessment

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Focus Area #3

Comprehensive, Coordinated Delivery System

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Bringing Local Person-Centered Services to Large Regional Systems

- National movement to change the business model of the Aging & Disability Services Network
  - U.S. Administration for Community Living
- Add upstream value to save downstream costs
- Local knowledge, trust, experience
- Low-cost models
- ***But…how do you create an efficient system with dozens of smallish agencies?***

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Enter: Administration on Community Living
John A. Hartford Foundation

- Initiative Overview
  - Create networks of community-based organizations (CBOs) to create an integrated system of non-medical care and services
  - Contract with healthcare organizations (Medicare Advantage, Medi-Cal managed care, duals plans, large medical groups, ACOs/Medicare Shared Savings, etc.)
  - Measure & document value added
  - National dissemination & technical assistance

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Program Logic

- IF agencies join together to present a unified contracting entity to healthcare organizations
- AND they can meet the quality, volume, confidentiality, geographic coverage and IT needs of healthcare
- AND they can demonstrate their value in terms of the Triple AIM, including positive ROI
- THEN patients will have comprehensive, coordinated care from the best, most trusted, culturally competent local providers

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Project Goals

- **Build prototype social service agency/community care network models** that develop shared business services for healthcare contracts.
- **Articulate service lines for networks** to bring high value evidence-based programs and services to healthcare partnerships.
- **Contract and conduct rapid-cycle learning/evaluation.**
- **Communicate and disseminate lessons and tools through a national technical assistance structure:** a learning lab of contracted community agency networks

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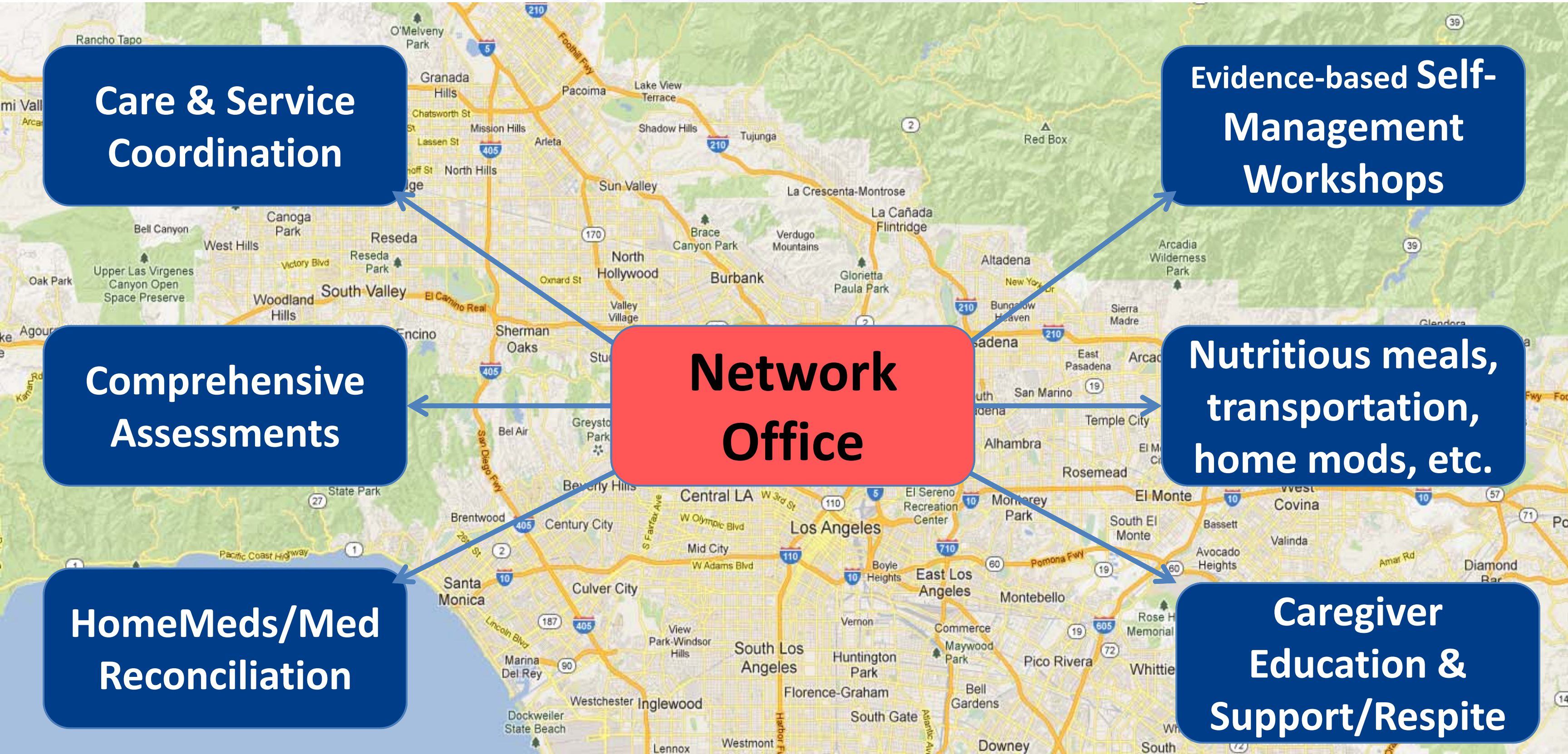
Integrated Community Care System

One Call Does It All!



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Shared Network Office Functions

- One-stop for payers/purchasers
- Consistent services and quality standards
- Member/Provider Credentialing
- Shared Business Development
- Data/Privacy/Security Communication Systems
- Shared Call Center
- Quality & Fidelity Assurance
- R & D/Evaluation

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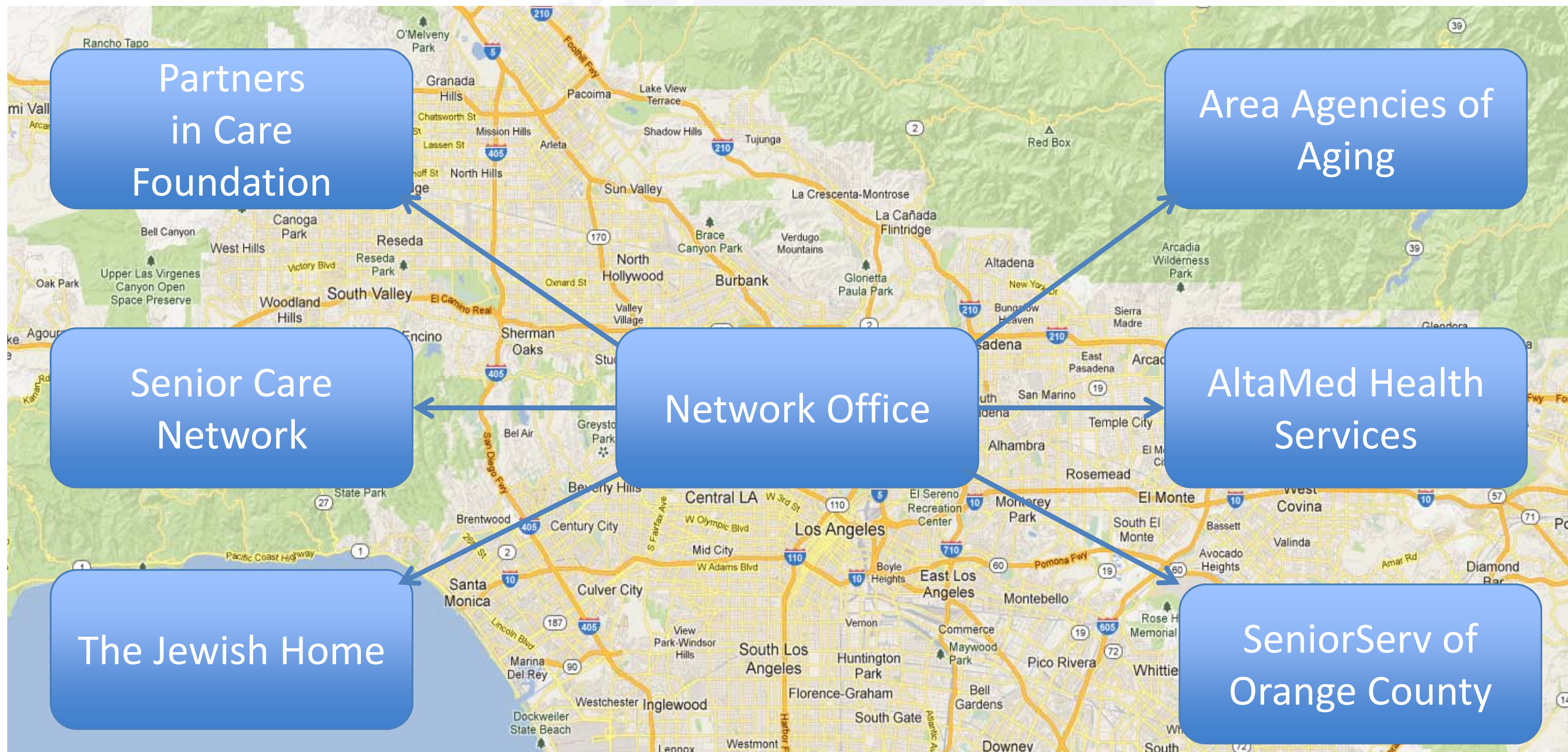
Integrated Community Care System

One Call Does It All!



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Contact Us

June Simmons, CEO

Partners in Care Foundation

732 Mott St., Suite 150, San Fernando, CA 91340

Main #: 818.837.3775

jsimmons@picf.org

www.picf.org

www.HomeMeds.org