Managing Care Transitions for Greater Value

W. June Simmons, CEO
Partners in Care Foundation
The Social Determinants Specialists.
February 26, 2019
Changing the Shape of Health Care

• Partners is a think-tank and a proving ground.
• Partners changes the shape of health care by creating high-impact, innovative ways of bringing more effective clinical and social services to people and communities.
• Partners’ direct services test, measure, refine and replicate innovative programs and services, and bring needed care to diverse populations.
Changes We Want to See

• Integration of medical care and social services
• Enhanced self-management/empowerment of consumers
• Integration of behavioral health
• Evidence-based interventions
• Community Agencies forming into regional delivery systems/networks, like IPAs
Choice: Spend Upstream on SDOH on Top 5%

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

1% spend 21%

5% spend 50%
Social + Medical = Health

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.
Address Social Determinants Across Settings and Populations

- **Partner** with hospitals, physicians & health plans
- **Focus** – The home
- **Payers** – Medi-Cal
  - Medicare
  - Private health plans
- **New Directions** transforming Medicare and Medi-Cal
Factors in Premature Death, USA

- Shortfalls in Medical Care: 10%
- Environmental Exposure: 5%
- Genetic Predisposition: 30%
- Social & Behavioral Determinants of Health (SBDOH): 55%
- Behavioral Patterns: 40%
- Social Circumstances: 15%

Adapted from McGinnis JM, Williams-Russo P, Knichman JR. The case for more active policy attention to health promotion. Health Affairs (Millwood) 2002;21(2):78-93
What CBOs do to Address Patients’ Social Needs

- Food, Housing, Transport, Benefits
- Access to Care: Coaching & Navigation
- Medication Safety & Management
- Patient Activation & Self-Mgt. Support
- Community Connection & Caregiver Support
- Care Coord. & Safe Handoffs
New Roles for the Medical System

• Risk **Stratification** — Active screening and targeting

• Continual **Monitoring** for "trigger events" that could change a risk category

• **Build** comprehensive partnerships with community providers as part of the delivery system for population health
Targeting Better Population Health Management

- End of Life
- Complex Chronic Illnesses w/ major impairment
- Chronic Condition(s) with Mild Functional &/or Cognitive Impairment
- Chronic Condition with Mild Symptoms
- Well – No Chronic Conditions or Diagnosis without Symptoms

Home Palliative Care
Advance Care Planning

Hot Spotters!

Everyday Self-Management Needed
Targeting the *Right* People

**Short-Term Care Management / Care Transition**
- >1 hospitalization or ED visit in last 6 months
- 5+ meds (or any psychoactive/CNS-affecting medication)
- Cognitive impairment
- Functional impairment
- Lives alone
- Inadequate caregiver support
- Comorbidity: depression &/or anxiety

**Long-Term Services & Supports**
- ADL/IADL impairment
- Needs in-home care/ supervision
- At risk for nursing home placement

**Health Self-Management Workshops**
- For people with 1+ chronic condition
Services for Diverse Populations

Tier 1 & 2 Moderate Risk – Chronic Diseases w/o disability
- Evidence-Based Self-Management
- HomeMeds

Tier 3: Complex – Eyes & Ears in the Home
- HomeMedsPlus Assessment & Services
- Care Transitions

Tier 4: Frail – Long term services & supports
- Ongoing care management
- Purchase of services
CBOs: Bridge to the Home

- CBOs have worked to improve health and functioning at home for decades
- Local trust, history and community support
- Know the lay of the land — quality of services — Not a call center approach — local employees
- Mobility and flexibility— responsive, nearby
- Health coaches, navigators, social workers, community health workers - an alternative and affordable workforce
- Culturally and linguistically matched
CBO Service Lines: Overview
Chronic Disease Self-Management Program (CDSMP) – Clinical Outcomes

- **Population:** 571 union members w/chronic conditions in MCO
- **Intervention:** CDSMP + monthly meetings + incentives
- **Outcomes:**
  - Compared to baseline, after 12 months
    - Self-rated health good or excellent: 60% vs. 32% at baseline
    - BMI ↓ 1 point
    - A1C ↓ 1 point
    - Systolic BP ↓ 11 points
    - Depression score ↓ from 5.8 at baseline to 3.2
    - Pain ↓ from 3.2/10 to 2.0/10
  - Compared to baseline, after 12 months
    - ↑ aerobic exercise from 51 to 75 minutes per week
    - ↑ stretching/strength exercise from 21 to 35 minutes per week
Community Care Management Structure

Comprehensive Psychosocial Assessment
- Social determinants of health
- Home Safety Assessment
- PHQ9 (Depression Screening Tool)
- SPMSQ (Mental status questionnaire)

HomeMeds
- Comprehensive medication inventory
- Computerized risk assessment and alerts
- Pharmacist review and recommendations for improvement

Person-Centered Care Coordination Plan
30/60/90 day implementation
Who Delivers Social Care Management

• Alternative workforce for non-medical in-home interventions
  – Experienced coach/navigator with a Bachelor’s degree in human services

• Serve as the “eyes and ears” in the home
  – Gather data and information that patient’s don’t share in a medical setting or encounter
  – Able to pay close attention to members and caregivers in their home setting, leading to proactive interventions
  – Trust and knowledge of local communities and available resources
  – Cultural/linguistic fit/competence
Community-Based Organizations (CBOs): Your Eyes and Ears in the Home

• Gather data and information typically not shared in a medical setting or encounter:
  – Comprehensive psychosocial and functional assessment
  – Home safety and fall-risk evaluation
  – Link medication issues with evidence-based pharmacist intervention
  – Advance directives
• Service coordination and connection to benefits/discounts
• Attention to caregivers — education/training, support, respite
• Evidence-based health self-management and fall-prevention workshops
Care Transitions

- New in last decade/Post Acute
- Post SNF/Rehab – changing patterns
- Brief and immediate interventions
- Address and resolve modifiable risk factors
- Variety of models in the field
- Social interventions address social determinants of health
Proven Results Over Time

Deploy evidence-based models:
  • Coaching/social services/medications

Multiple settings:
  • Post hospital
  • Post SNF
  • Post rehab
Outcomes of Partnership with UCLA

>8,300 patients helped by *Partners* in CMS-funded Community-based Care Transitions Program

- Average 34% reduction in readmission rate vs. baseline
- New propensity-score-matched study found substantial & significant decreases in 30, 60 and 90-day readmissions and 30-day ED use
- Innovative partnership between health coach and UCLA MyMeds Pharmacists using *Partners*’ nationally recognized HomeMeds program
Outcomes of Partnership with UCLA (cont.)

Over 1,000 Medicare Advantage/ Medical Group patients paid by UCLA
  >60% reduction in pre-post readmission rate within high-risk group

“Concerning the 10 cases that you pulled of the Medicare Advantage intervention: this appears to be the sort of post-discharge intervention that a high-risk patient should receive.”
CCTP DEMONSTRATION

32,000 Patients - $16 Million Saved

Care Transitions: Dr. Eric Coleman’s Coaching & Rush University Bridge Models

Results by CCTP Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Readmit Pre</th>
<th>Readmit Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westside (3)</td>
<td>21.1%</td>
<td>15.4%</td>
</tr>
<tr>
<td>Glendale (3)</td>
<td>20.2%</td>
<td>14.4%</td>
</tr>
<tr>
<td>Kern (5)</td>
<td>20.7%</td>
<td>12.5%</td>
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*Program to Date through Jul 2016

1 Baseline (Pre): All-Cause, All-Condition, Medicare FFS: Westside & Glendale = Jan – Dec 2012; Kern = Apr 2012-March 2013


## Participating Hospitals

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<thead>
<tr>
<th>Westside</th>
<th>Kern County</th>
<th>Glendale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Monica UCLA Medical Center</td>
<td>Bakersfield Memorial Hospital</td>
<td>Dignity Health Glendale Memorial Hospital</td>
</tr>
<tr>
<td>Ronald Reagan UCLA Medical Center</td>
<td>Mercy Hospital</td>
<td>USC Verdugo Hills Hospital</td>
</tr>
<tr>
<td>Providence Saint John's Health Center</td>
<td>Kern Medical Center</td>
<td>Glendale Adventist Medical Center</td>
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<tr>
<td></td>
<td>San Joaquin Community Hospital</td>
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<td></td>
<td>Bakersfield Heart Hospital</td>
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Criteria for Identifying Readmission

High-risk patients must have 2+ of the following:

- Two or more readmissions in last 12 months
- Two or more ED visits in last 6 months
- Length of stay greater than 10 days
- Limited caregiver support at home
- Two or more chronic conditions
- Depression as a secondary diagnosis
- 8+ medications at discharge
Interventions

Three Evidence-Based Interventions:
• Care Transitions Intervention (CTI)
• Bridge Patient-Activation Model
• HomeMeds

Trained, nonclinical transition coaches worked with patients on improving patient engagement and empowerment after returning home from the hospital.
Dr. Coleman’s CTI

• Develop patient/family skills for self-care and connecting with community resources to recuperate safely at home
• Hospital visit to introduce program and gain consent.
• Home visit by coach (social worker) within 72 hours of discharge:
  – Review red flags for disease exacerbation
  – Plan what to do if signs/symptoms get worse
  – Patient activation for self-care and self-management
  – Instruct on use of Personal Health Record, including medication list
  – Reminders and coaching to schedule follow-up medical appointments, with transportation if needed
  – HomeMeds medication risk screening & pharmacist intervention can be added
  – Ensure DME, prescriptions, diet-compliant meals, etc. available as ordered
  – Refer to longer term self-management programs as appropriate
• Telephonic follow-up for 30 days
Rush Medical Center’s Bridge

Transitional support through intensive service coordination that starts in the hospital and continues after discharge to minimize the risk of complications

- Hospital visit to introduce program and determine needs
- Telephonic service coordination by social worker
- Address caregiver issues and arrange for services and follow-up appointments as needed after discharge
- Refer to longer term self-management programs as appropriate.
- Follow-up for 30 days
Adherence Inquiry:
1. Why do you take this (purpose)?
2. How much do you take at one time?
3. How often do you take it?
4. How long have you been taking the medication (months or years)?

- Medication Non-Adherence Accounts for 30% to 50% of Treatment Failures
- Increases Hospital admissions by 40%
- 89,000 premature deaths could be avoided with proper adherence

Source: National Council Medical Director Institute, September 2018

Partner’s HomeMeds

- **Inventory all meds being taken**: out of system meds, drugs from other countries, borrowed, and OTC
- **Assess for potential adverse effects**: e.g., BP, pulse, falls, dizziness, confusion
- **Document adherence** issues and understanding
- **Algorithm identifies targeted potential medication-related problems** (MRPs)
- **Pharmacist reviews** potential MRPs & makes **recommendations for resolution**, contacts provider and/or patient

Pharmacist reviews potential MRPs & makes recommendations for resolution, contacts provider and/or patient.
What EHRs and Call Centers Don’t See
# Medication Non-Adherence Rates

50% of prescribed medications are not taken, with medicines for chronic conditions not taken at a higher rate than those for acute conditions.

## Medical Conditions with the Highest Non-Adherence Rates

<table>
<thead>
<tr>
<th>Condition</th>
<th>Non-Adherence Rate</th>
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<tbody>
<tr>
<td>Asthma</td>
<td>25-75%</td>
</tr>
<tr>
<td>Major Depression</td>
<td>51-69%</td>
</tr>
<tr>
<td>Diabetes - Oral Meds</td>
<td>7-64%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>30-60%</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>57%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>40-50%</td>
</tr>
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Source: MCOL; National Council Medical Director Institute, www.nationalcouncildocs.net
Evidence-Based Programs and Services

Impressive results for 250 post-acute high-risk seniors in a large SoCal Medical Group

*Compared to patients who did not receive a home visit
Care Transitions 2.0

Providence Health and Services
- Saint Joseph Medical Center
- Holy Cross Medical Center
- Tarzana Medical Center
- Little Company of Mary Medical Center, Torrance
- Little Company of Mary Medical Center, San Pedro
Preliminary Outcomes

- Program Began October 2017
- Coach access to EPIC
- October 2017 – June 2018 Results:

Data files provided to Health Services Advisory Group (HSAG) by the Centers for Medicare & Medicaid Services (CMS) were used for analysis in this report. The data files include Part-A claims for Medicare Fee-for-Service beneficiaries.
Value Proposition

• Improves quality outcomes/HEDIS measures
• Improves after-discharge patient satisfaction
• Manages ED/inpatient throughput
• Improves patient mix — tertiary & quaternary rather than chronic
• Enhances interprofessional alliances and partnerships
Recognition Growing … Adoption is Slow

• These are “foreign” approaches – especially going into homes
• Adoption is occurring – mostly pilot programs
• True proof of impact requires significant populations
• Too small an intervention group won’t impact population outcomes as fully as needed
Now is the Time!
Population Health and Value-Based Payment

Medicaid Waivers
Dual eligible plans
MA SNP-D & SNP-C

Exactly the populations where SBDOH impede success of medical care and where CBOs excel at providing home and community-based services.

Whither goes Medicare...there goes Commercial!
Now is the Time!
CMS: Financial and Policy Alignment

2019 Advance Notice and Call Letter & 2020 CHRONIC Care Act

• Expands scope of "primarily health-related supplemental benefit standard" allowing those that "have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee"

• Uniformity: supplemental benefits can be provided to all beneficiaries who meet certain health status criteria

• Permanently authorizes MA SNP-D and SNP-C
Now is the Time!
CMS: Financial and Policy Alignment (cont.)

Medicare FFS Physician Fee Schedule
– Transitional Care Management
– Chronic Care Management
– Dementia Assessment and Care Plan
– Behavioral Health Care Management
Long Term Services and Supports

- Move to massive Medicaid enrollments of highest-risk populations – especially Duals
- Dramatic expenditures over time for homeless, behavioral health, addiction, dementia, disabling conditions
- Move to integrated and supported housing + services – ongoing care coordination
Why a CBO Network?

• Health plans and providers have large service areas.
• Offer variety of skills, ethnicities, languages.
• Shared accreditation, IT, sales, billing, contract negotiation, compliance, quality.
  – Members focus on service provision.
Providing Services Through A Statewide Network Covering a Large Geographic Footprint

- HomeMeds/Med Reconciliation
- Care & Service Coordination
- Evidence-Based Self-Mgt Workshops
- Comprehensive Assessments
- LTSS: Meals, Transportation, Home Mods, etc.
- Caregiver Education & Support/Respite
Partners at Home Network: Delivery System for Integrated Community Care

One Call Does It All!
Programs Contribute to Improving Quality/HEDIS Measures and Star Ratings

• Fall risk-management
• Medication reconciliation post-discharge
• Potentially harmful drug-disease interactions
• Blood pressure control
• Antidepressant medication management
• Older adults receive:
  - Advance care planning
  - Medication review
  - Functional status /home safety assessment
  - Pain assessment

... And, optimize physician performance under MACRA
Questions

Raise your hand or submit questions at www.menti.com and enter code 36 75 60
Thank You!

Feel free to follow up for more information with:

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The Social Determinants Specialists