Building A Bridge To Better Outcomes

Between Medical Care and Social/Behavioral Determinants of Health

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Integrating Health Care and Social Services
for People with Serious Illness
July 19, 2018

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Health Happens at Home

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Building A Bridge to Better Outcomes

Integrating Medical Care and Social/Behavioral Determinants of Health

Addressing social and behavioral determinants of health (SBDOH) is not what's new…community-based organizations (CBOs) have been doing that for decades.

What's new is the understanding—and its reflection in reimbursement and other incentives within the healthcare sector—that population health management and value-based care can only be achieved by integrating medical care with home- and community-based services that address SBDOH.

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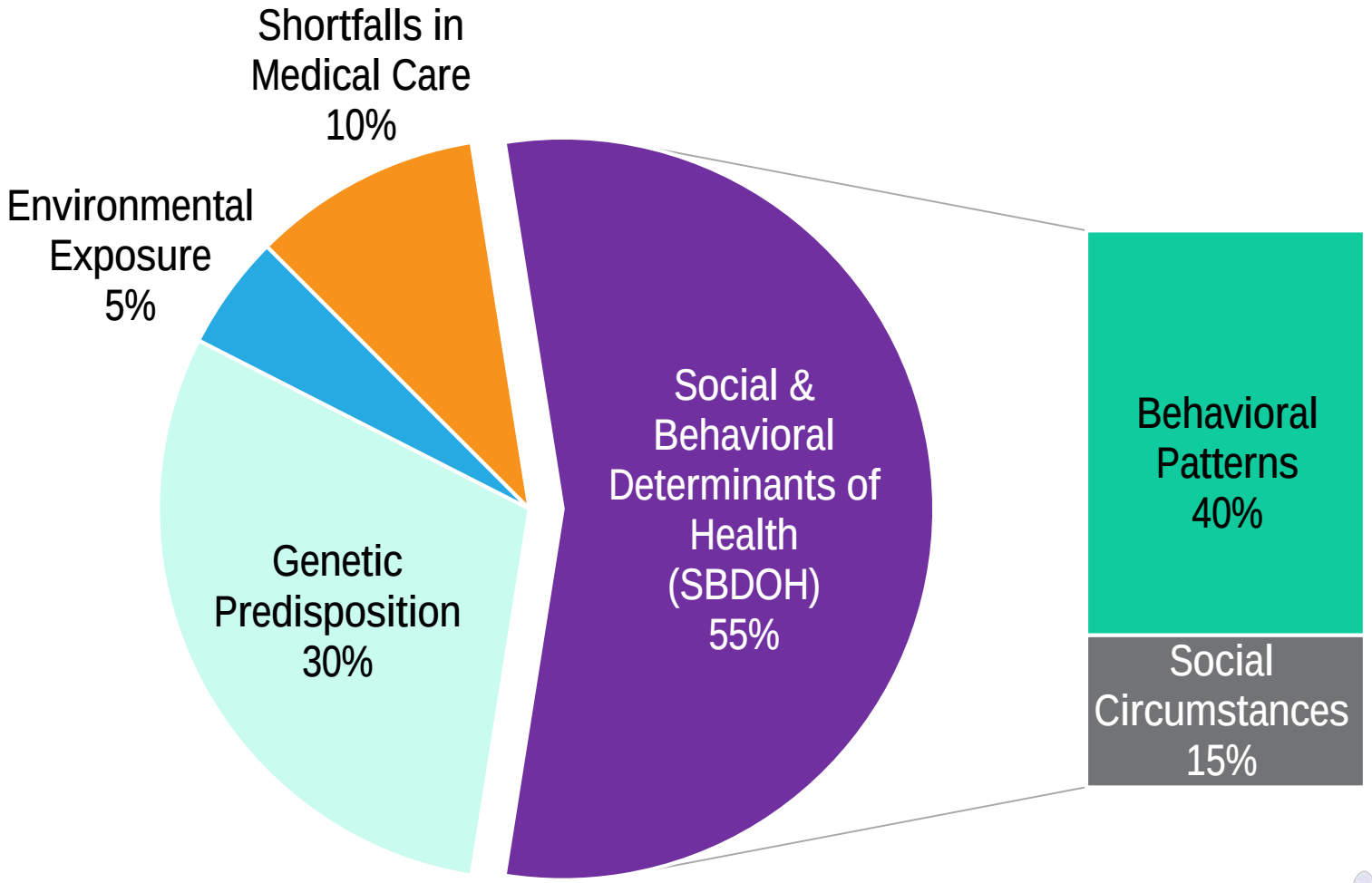
Factors in Premature Death, USA



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.

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What Electronic Health Records Don't See

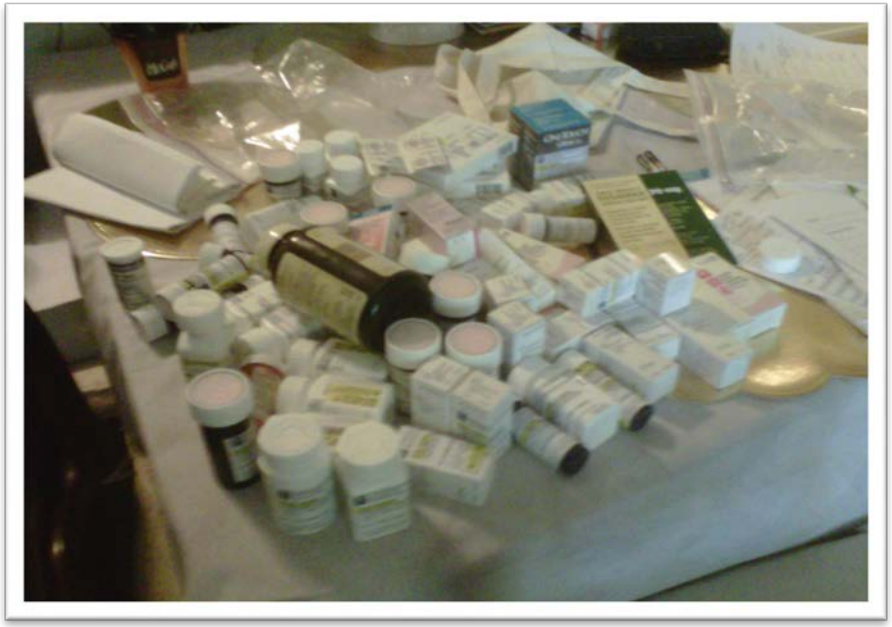

Photo sources: stock and other source images

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Impact of what you don't see…unless you go to the home

Photo sources: stock and other source images

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CBOs Are “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

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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 & linguistically matched

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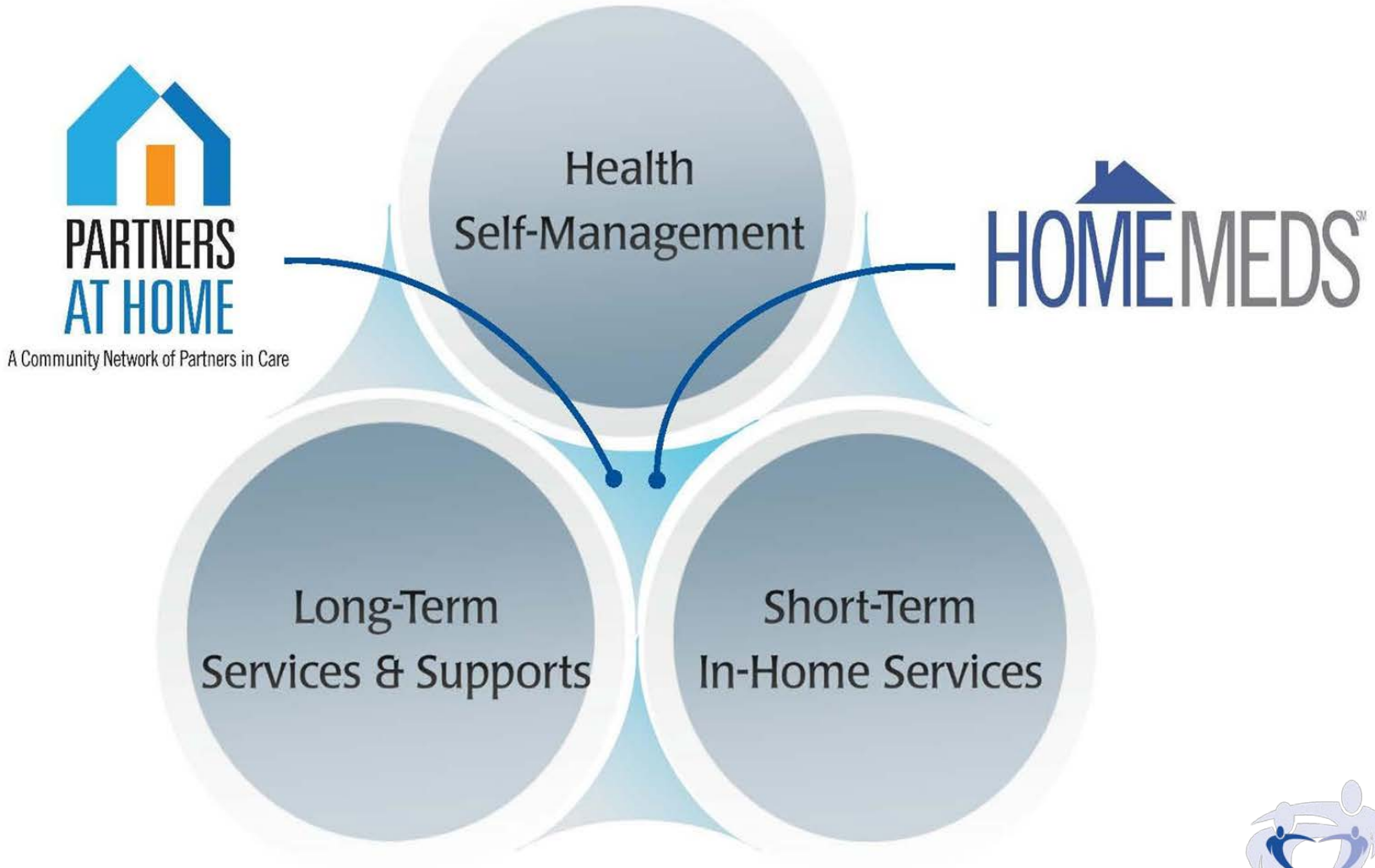
Programs & Services Organized into Three Areas



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Targeting the *right* people

Short-Term Care Management / Care Transition

- Multiple hospitalizations or ED visits 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

LTSS

- ADL/IADL impairment
- Needs in-home care/supervision
- At risk for nursing home placement

Health Self-Management Workshops

- For people with 1+ chronic condition

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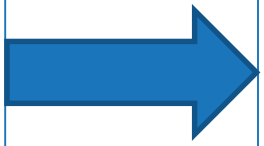
Defining Success

- Reach members who need help
- Improve self-care & self-management
- Meet members' community support needs
- Qualify members for benefits/programs
- Avoid adverse drug effects
- Improve medication adherence
- Caregivers educated and supported – stay able to help



- Reduce inappropriate utilization:
  - ED
  - Hospital
  - SNF/Rehab
  - SNF LTC
- Substantial positive ROI
- High member satisfaction
- High member retention
- Provider satisfaction

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Example of True Partnership: Partners in Care and UCLA

- Champions in the C-Suite
- *Partners* CEO participates in Primary Care Redesign Team
- Apply together for home palliative care CMMI
- Collaborative Root Cause Analysis about readmissions
- CMS Community-based Care Transitions Program - >8,300 patients
- Integration of *Partners'* HomeMeds with UCLA MyMeds pharmacists
- Outstanding outcomes
- Complete data sharing
- Access to EHR
- Both CM referrals and automated LACE-Plus
- Incentives aligned
- Apply together for awards, letters of support/commitment
- Co-present at conferences

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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
- Over 1,000 Medicare Advantage/Medical Group patients paid by UCLA
  - >60% reduction in pre-post readmission rate within high-risk group
  - 3% fewer readmissions across the entire high-risk MA population

"Concerning the 10 cases that you pulled of the Medicare Advantage intervention:

I read them and found them to be impressive. This appears to be the sort of post-discharge intervention that a high risk patient should receive."

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Now is the time!
CMS: Financial & 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 & SNP-C
- Medicare FFS Physician Fee Schedule
  - Transitional Care Management
  - Chronic Care Management
  - Dementia Assessment & Care Plan
  - Behavioral Health Care Management

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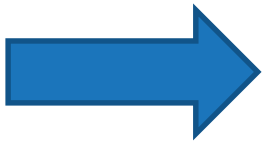
Now is the time!
Population Health &
Value-based Payment

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



<u>Exactly</u> 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!

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Building the Future Together

- Integrated system of care to address social and behavioral issues that reduce the effectiveness of medical care
  - Use the system that's already there—CBOs
- Integrated data and technology
- Everyone operates at the top of their "license"
  - Affordable alternative workforce gathers information in the home so licensed/professional staff do their best
- Reinvest medical dollars for higher yield through CBO partnerships for SBDOH
- Positive healthcare outcomes, better quality of life
- ROI

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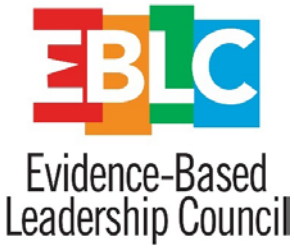
National Movement to Support Integration



- Stanford CDSMP
- A Matter of Balance
- Healthy IDEAS
- PEARLS
- Fit & Strong
- Enhance Wellness
- Enhance Fitness
- HomeMeds
- Healthy Moves

- Admin for Community Living
- National Assn. AAAs
- American Society on Aging
- John A. Hartford Foundation
- SCAN Foundation
- Nat'l Assn States United for Aging & Disability
- Partners in Care Foundation
- Healthy Living Center of Excellence
- Independent Living Research Utilz.

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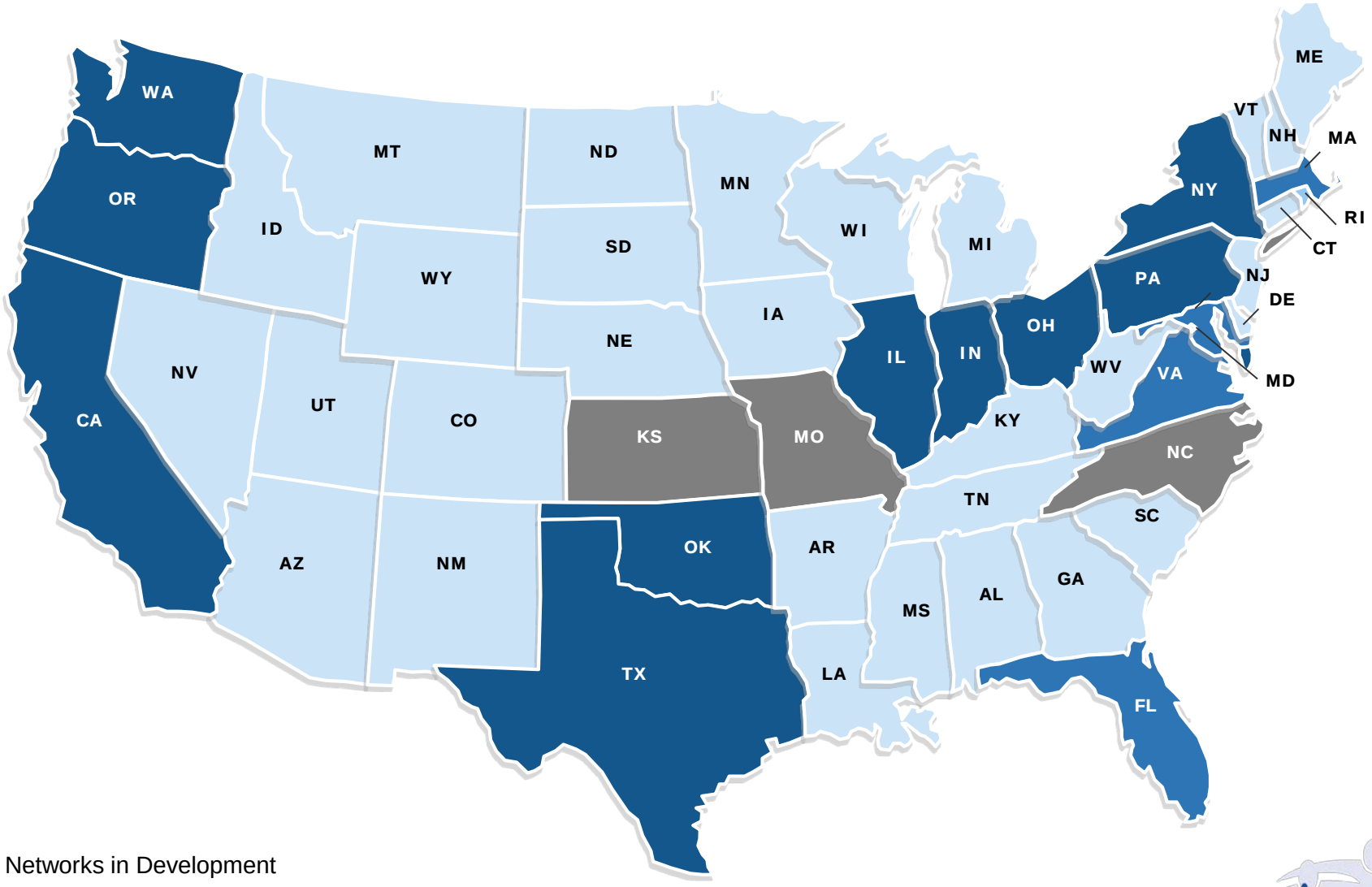
A National Network of Partnerships



Networks in Development

[1] Not a full statewide network

Sources: n4a and Aging & Disability Business Institute

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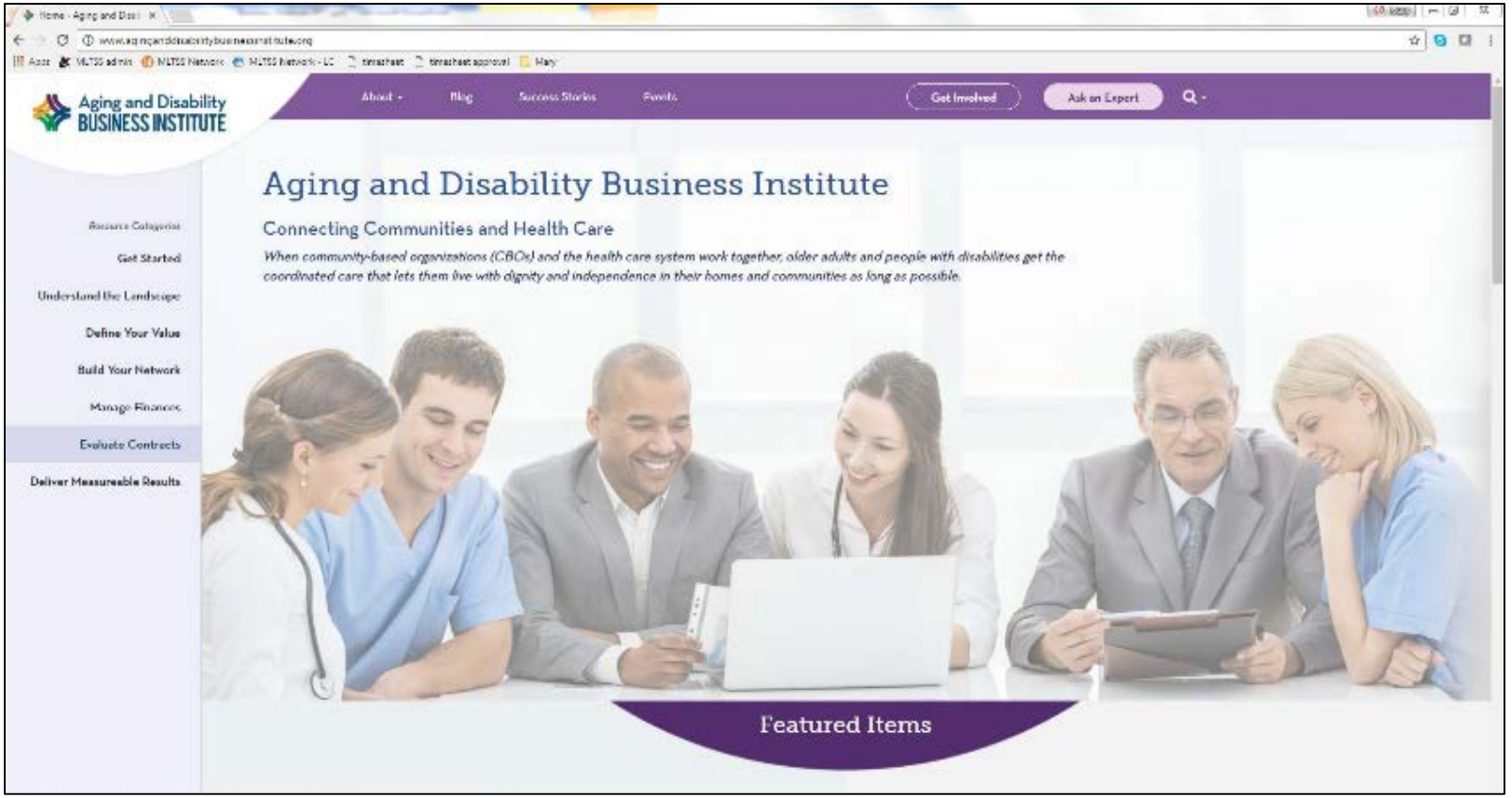
aginganddisabilitybusinessinstitute.org



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