MEALS ON WHEELS ANNUAL CONFERENCE AND EXPO

AUGUST 27-29, 2019

DALLAS, TX

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Building Bridges to Improve Service

Part 1

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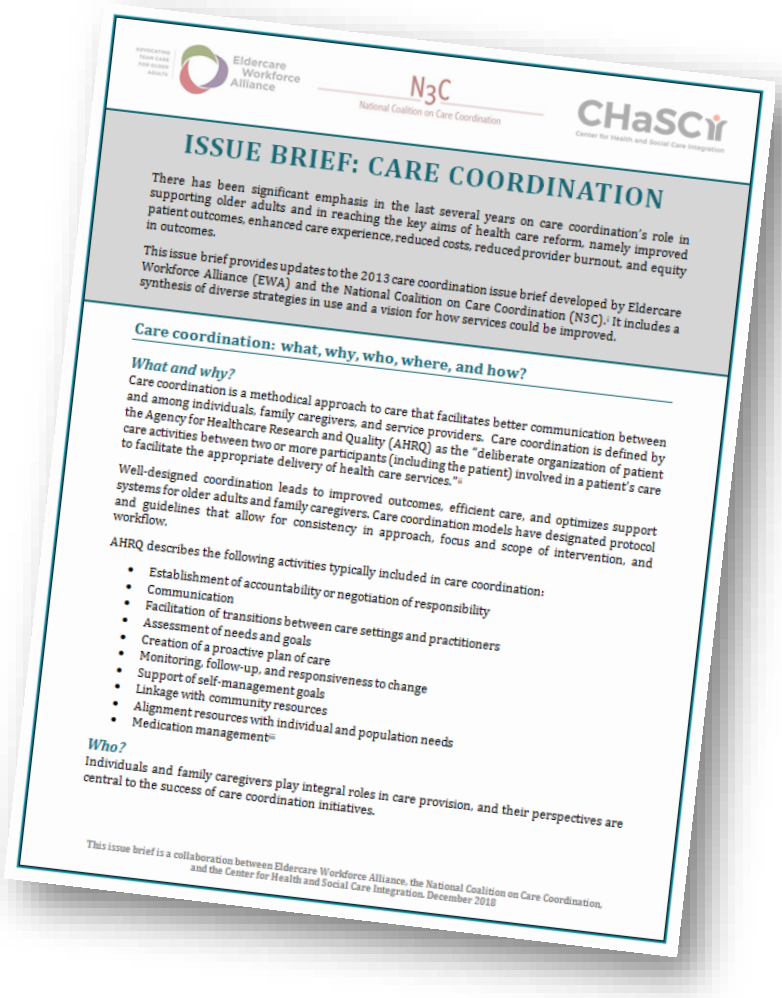
N3C and CHaSCI

The National Coalition on Care Coordination (N3C)

- A platform to identify & advocate for policies & practices that advance coordinated & integrated care
- A national membership coalition
- Housed by the **Center for Health and Social Care Integration (CHaSCI)** at Rush University Medical Center in Chicago
    - www.chasci.org



Eldercare Workforce Alliance

N3C National Coalition on Care Coordination

CHaSCI Center for Health and Social Care Integration

ISSUE BRIEF: CARE COORDINATION

There has been significant emphasis in the last several years on care coordination's role in supporting older adults and in reaching the key aims of health care reform, namely improved patient outcomes, enhanced care experience, reduced costs, reduced provider burnout, and equity in outcomes.

This issue brief provides updates to the 2013 care coordination issue brief developed by Eldercare Workforce Alliance (EWA) and the National Coalition on Care Coordination (N3C).[i] It includes a synthesis of diverse strategies in use and a vision for how services could be improved.

Care coordination: what, why, who, where, and how?

What and why?

Care coordination is a methodical approach to care that facilitates better communication between and among individuals, family caregivers, and service providers. Care coordination is defined by the Agency for Healthcare Research and Quality (AHRQ) as the "deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services."[ii]

Well-designed coordination leads to improved outcomes, efficient care, and optimizes support systems for older adults and family caregivers. Care coordination models have designated protocol and guidelines that allow for consistency in approach, focus and scope of intervention, and workflow.

AHRQ describes the following activities typically included in care coordination:

- Establishment of accountability or negotiation of responsibility
- Communication
- Facilitation of transitions between care settings and practitioners
- Assessment of needs and goals
- Creation of a proactive plan of care
- Monitoring, follow-up, and responsiveness to change
- Support of self-management goals
- Linkage with community resources
- Alignment resources with individual and population needs
- Medication management[iii]

Who?

Individuals and family caregivers play integral roles in care provision, and their perspectives are central to the success of care coordination initiatives.

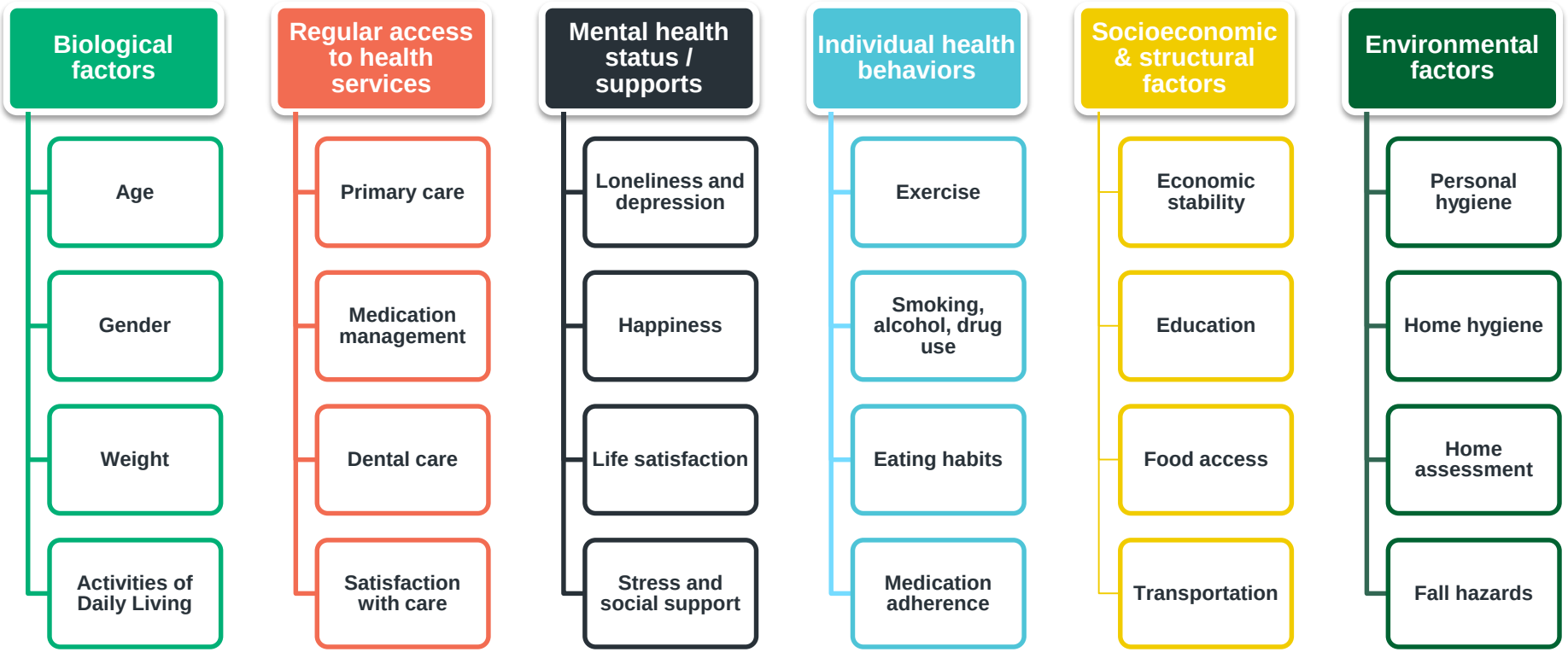
This issue brief is a collaboration between Eldercare Workforce Alliance, the National Coalition on Care Coordination, and the Center for Health and Social Care Integration. December 2018

What brings us here today?

Before we get started…

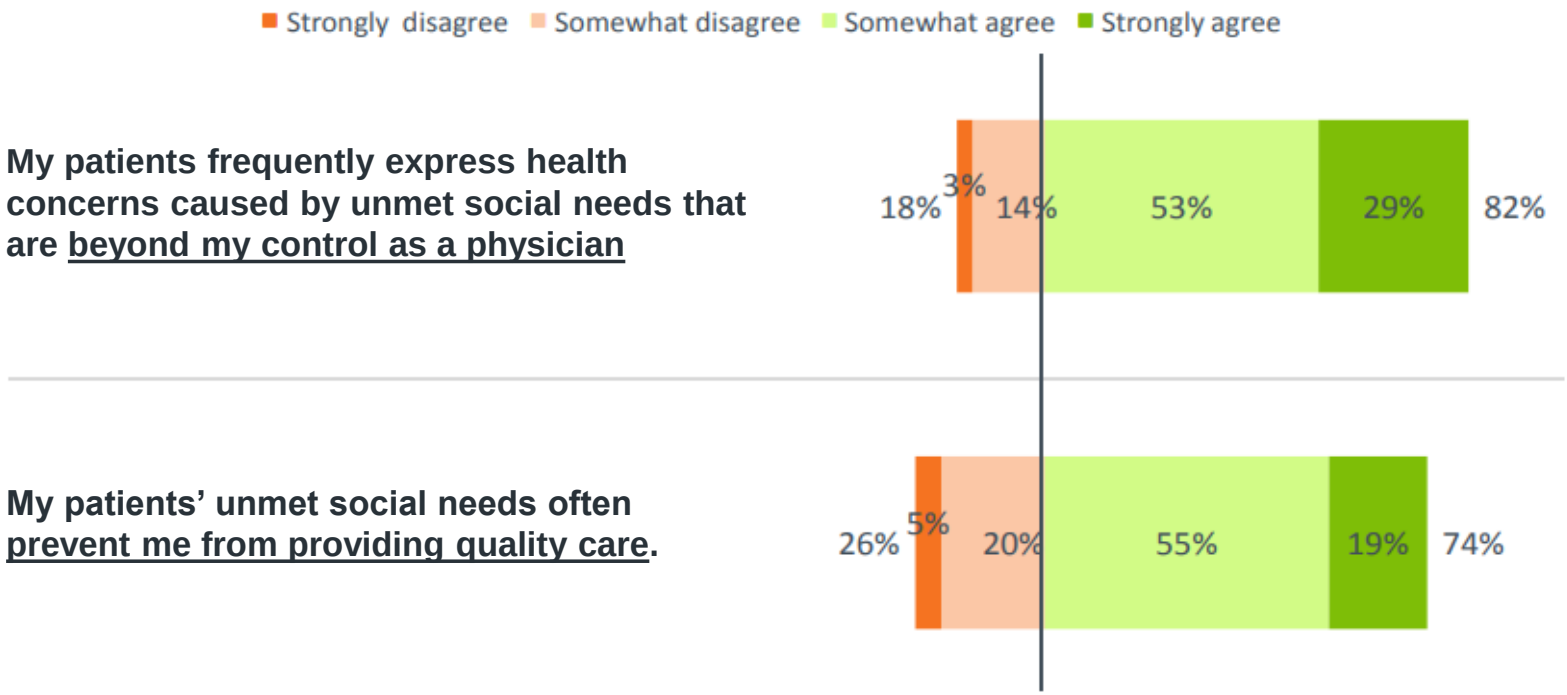
How many of you are currently helping to connect clients with other needed current services? How many of you have dedicated care coordinators on your team?

What shapes our health? What can we impact?



Source: Adapted from the Flourish Index, University of Louisville Trager Institute
https://www.tragerinstitute.org/assets/Website_Media_Files/Flourish_Network/Flourish_Program/Care_Coordination_Model/Index%20wLogo.pdf.

The majority of physicians agree their patients' health is impacted by unmet social needs beyond their control (82%) and these unmet social needs are impeding on their ability to provide quality care (74%)



BASE: Qualified Respondents Total (n=1000)

Q931 Please tell how strongly you agree or disagree with each of the following statements.

Harris Interactive

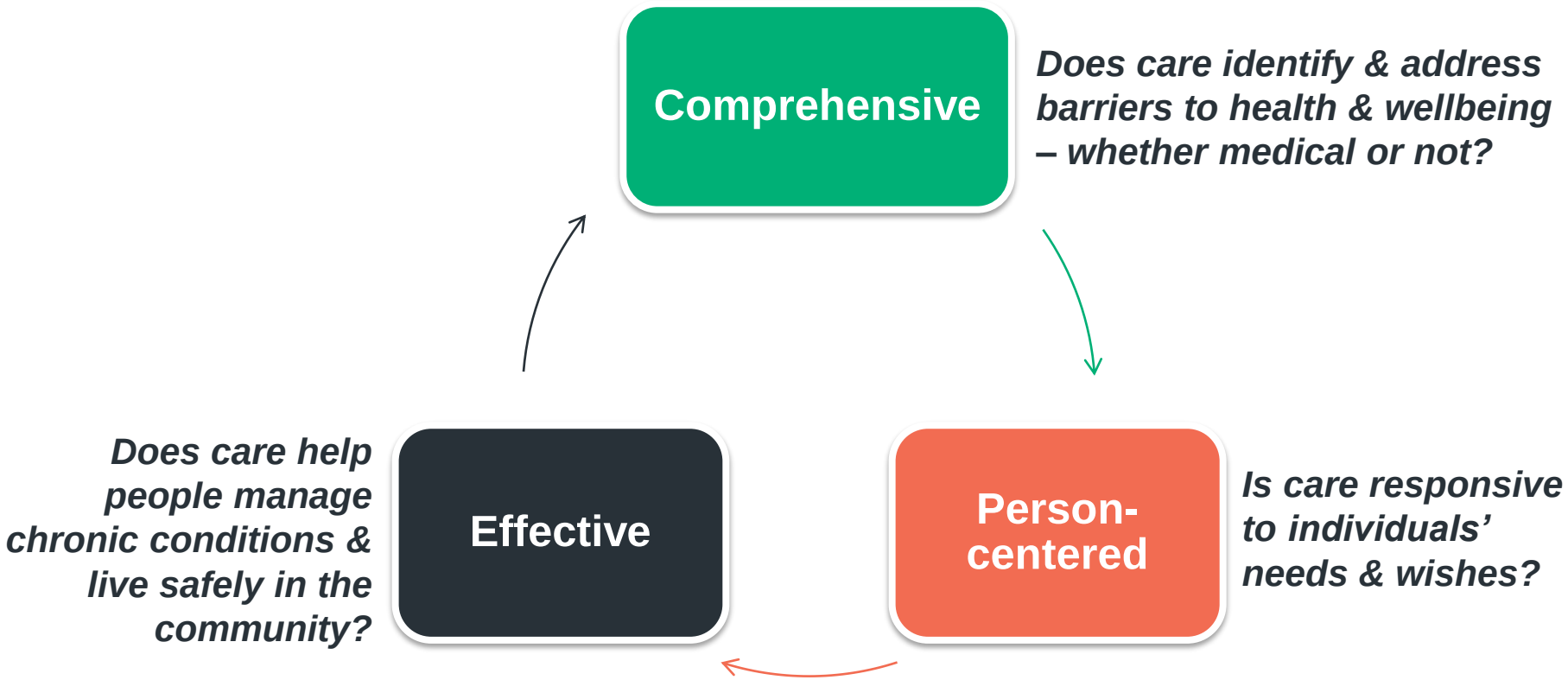
harris INTERACTIVE

Care coordination: The basics

"Care coordination is…
the deliberate organization of patient care activities
between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services"

- The Agency for Healthcare Research and Quality, https://www.ahrq.gov/downloads/pub/evidence/pdf/caregap/caregap.pdf

Broadening our goal



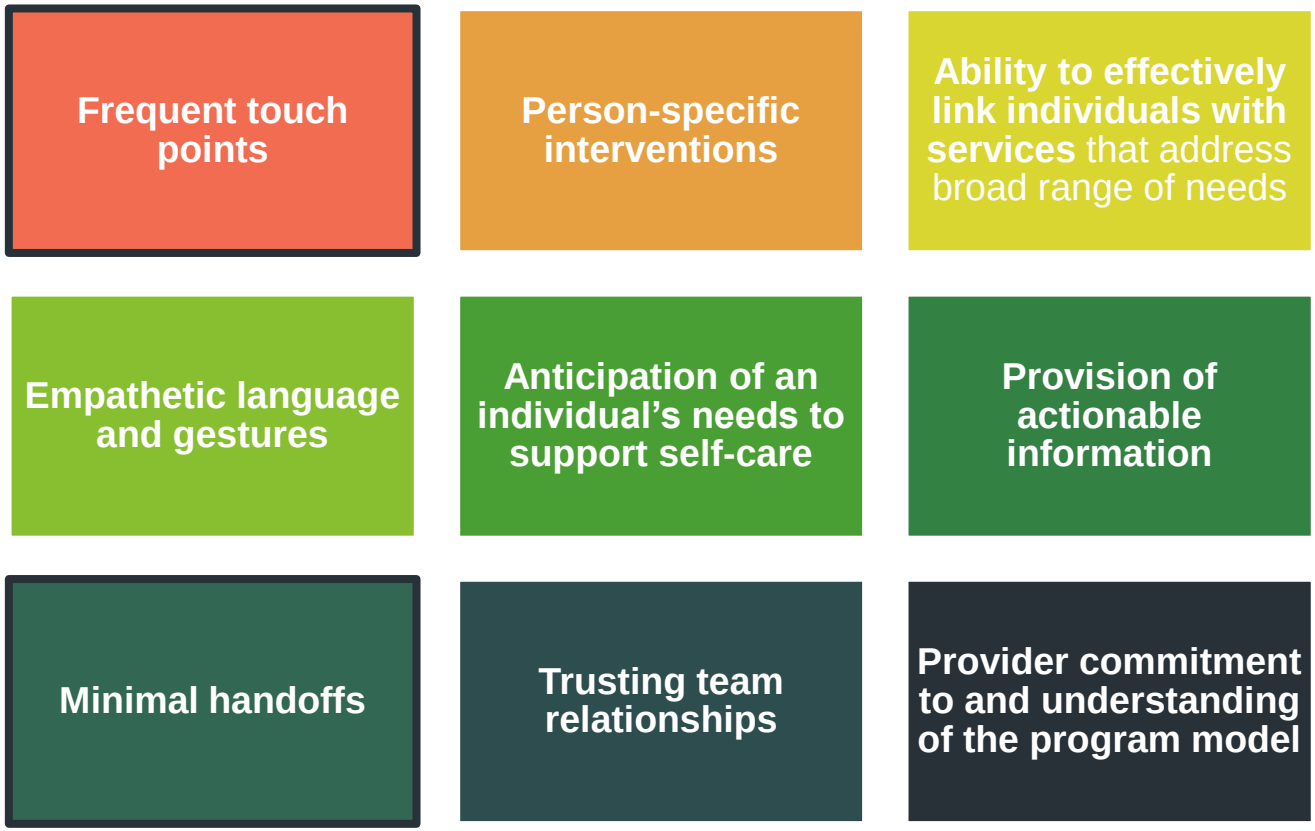
Broadening our goal

Care coordination is a "person-centered, assessment-based interdisciplinary approach to integrating health and social support services in which a care coordinator manages and monitors an individual's needs, goals, and preferences based on a comprehensive plan"

- National Coalition on Care Coordination

Robert Berenson and Julianne Howell, Structuring, Financing and Paying for Effective Chronic Care Coordination: A Report Commissioned by the National Coalition on Care Coordination (New York: National Coalition on Care Coordination, July 2009).

What works in coordinating care?



1. Mitchell, Suzanne E., et al. "Care transitions from patient and caregiver perspectives." The Annals of Family Medicine 16.3 (2018): 225-231.
2. Boutwell, Amy E., Marian B. Johnson, and Ralph Watkins. "Analysis of a social work–based model of transitional care to reduce hospital readmissions: Preliminary data." Journal of the American Geriatrics Society 64.5 (2016): 1104-1107
3. Kirst, Maritt et al. "What works in implementation of integrated care programs for older adults with complex needs? A realist review" International journal for quality in health care : journal of the International Society for Quality in Health Care vol. 29,5 (2017): 612-624.
4. 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.

The importance of relationships

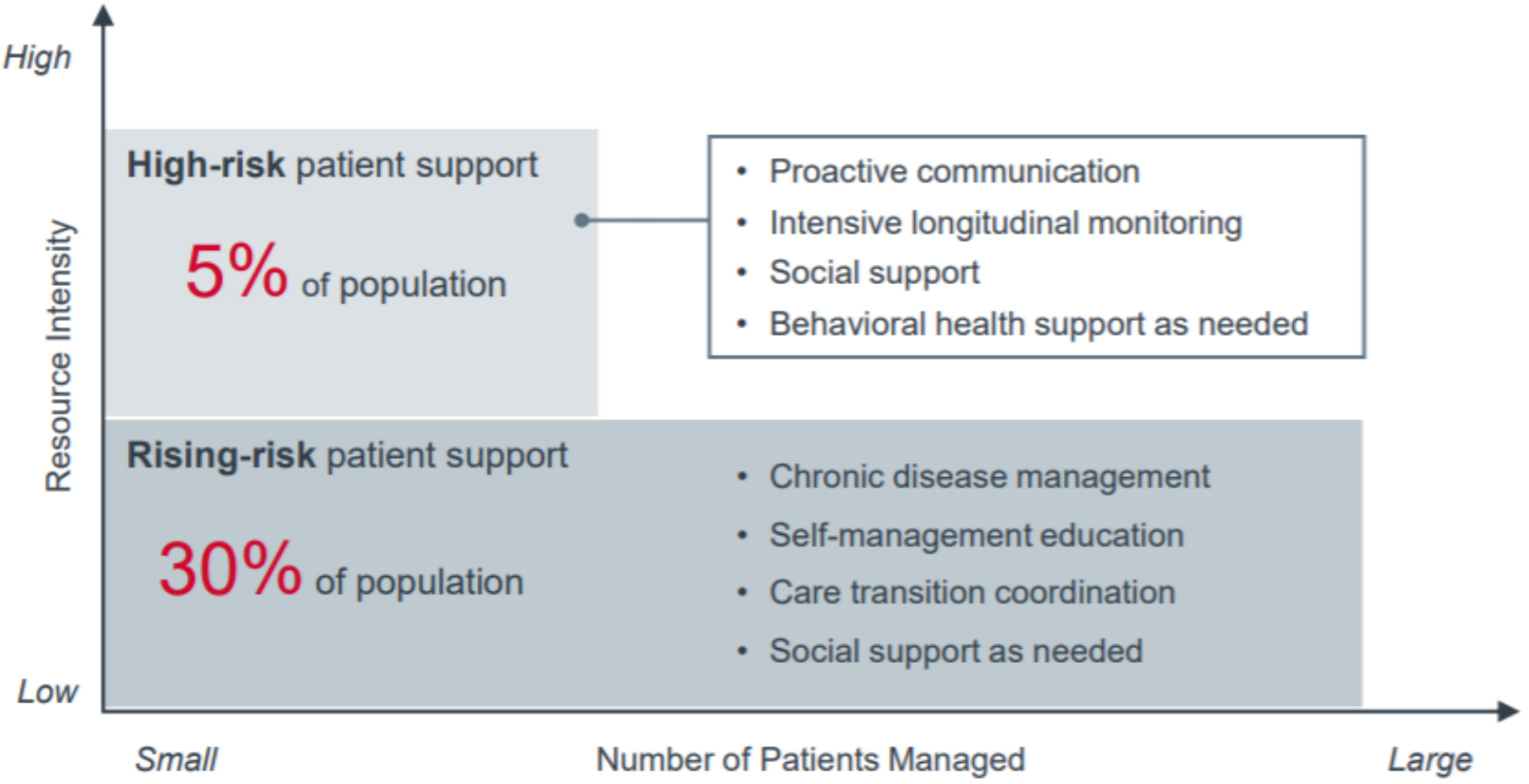
"I've learned that people will forget what you ***said***, people will forget what you ***did***, but people will never forget ***how you made them feel***."

-Maya Angelou

Common target populations

- With **high medical costs** or frequent hospitalizations
- Who are **at risk of incurring higher medical costs** if their chronic conditions and health-related social needs are not managed appropriately
- Who are **eligible for benefits** under the Older Americans Act, Medicaid waivers, or other public benefit programs
- Who are **referred directly** by a provider
- With **specific conditions** in the medical record
  - i.e., chronic conditions, clinical indicators, or reported unmet social needs
- At high risk for adverse outcomes by using **predictive algorithms**
- Within certain **geographic areas** (often using geography as a proxy for risk)

Responsibilities of high- and rising-risk care managers



The Advisory Board Company, Primary Care Roles 101: RN care managers. 2018.

Payers have a vested interest

"Drawing on lesser-known economic models and available data, we show how a properly governed, collaborative approach to financing could enable self-interested health stakeholders to earn a financial return on and sustain their social determinants investments."


Health Affairs

TOPICS JOURNAL

POLICY INSIGHT COMMUNITY HEALTH

HEALTH AFFAIRS > VOL. 37, NO. 8: MEDICAID, MARKETS & MORE

POLICY INSIGHT

Social Determinants As Public Goods: A New Approach To Financing Key Investments In Healthy Communities

Len M. Nichols[1] and Lauren A. Taylor[2]

AFFILIATIONS

PUBLISHED: AUGUST 2018 Free Access https://doi.org/10.1377/hlthaff.2018.003

SECTIONS VIEW ARTICLE PERMISSIONS SHARE TOOLS

ABSTRACT

Good research evidence exists to suggest that social determinants of health, including access to housing, nutrition, and transportation, can influence health outcomes and health care use fo vulnerable populations. Yet adequate, sustainable financing for interventions that improve social determinants of health has eluded most if not all US communities. This article argues that underinvestment in social determinants of health stems from the fact that such investments are in effect public goods, and thus benefits cannot be efficiently limited to those who pay for them—which makes it more difficult to capture return on investment. Drawing on lesser-known economic models and available data, we show how a properly governed, collaborative approach to financing could enable self-interested health stakeholders to earn a financial return on and sustain their social determinants investments.

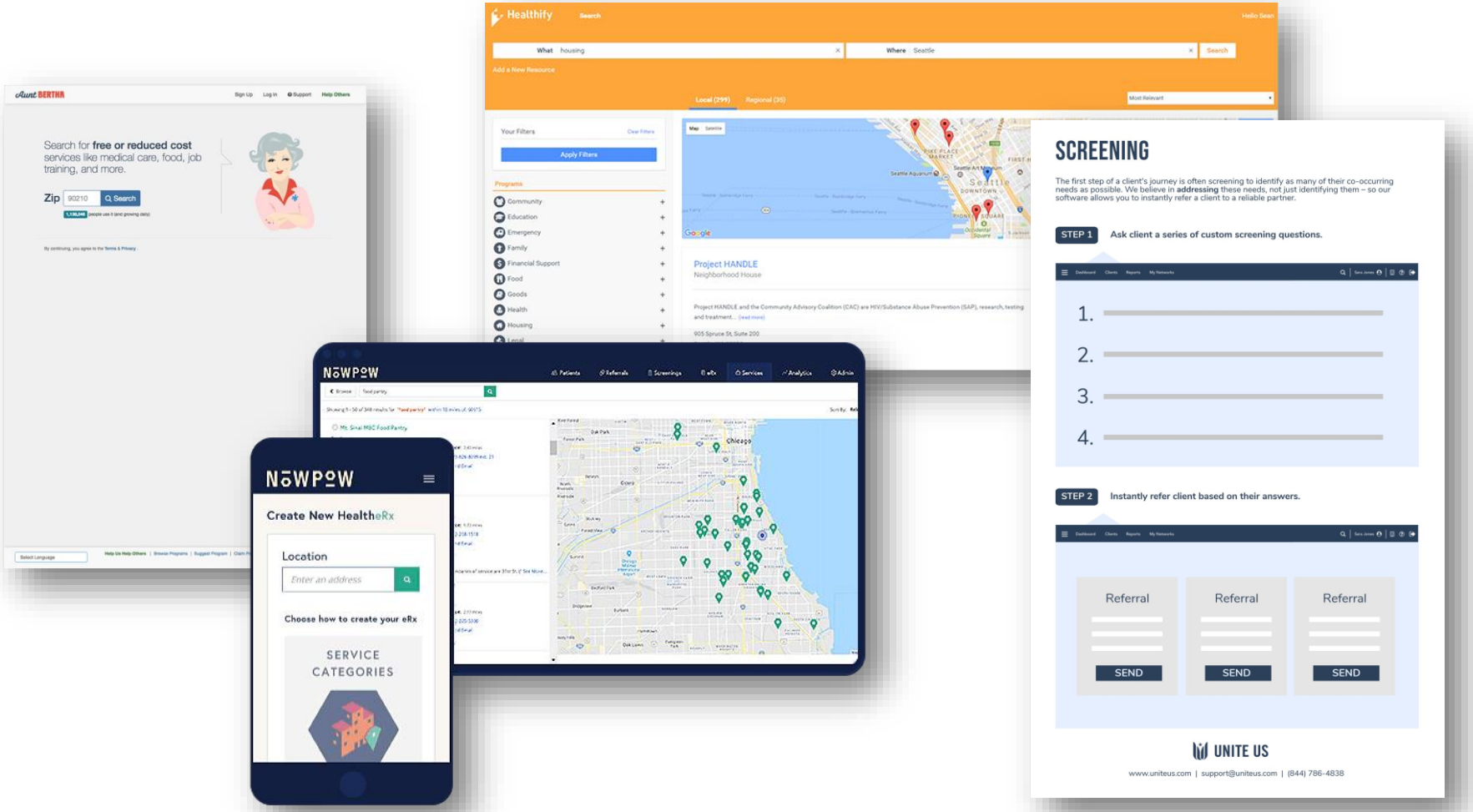
Health Affairs, August 2018 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0039

Yet, addressing SDOH and coordinating care lacks business case

- **Government investments haven't kept up with population change and inflation**

- **Challenges to defining value include:**
  - Lack of metrics and data that span sectors and meaningfully capture quality of life
  - Defining art of relationship-based care and systems navigation
  - Qualitative feedback not enough
  - Accessing reliable sources of data (health outcomes, utilization claims)
  - Studying impact of intervention amidst continuous quality improvement and moving targets

A healthcare approach to accessing social care: Opportunities and threats



Our imperative

"Future work must develop an evidence base about:

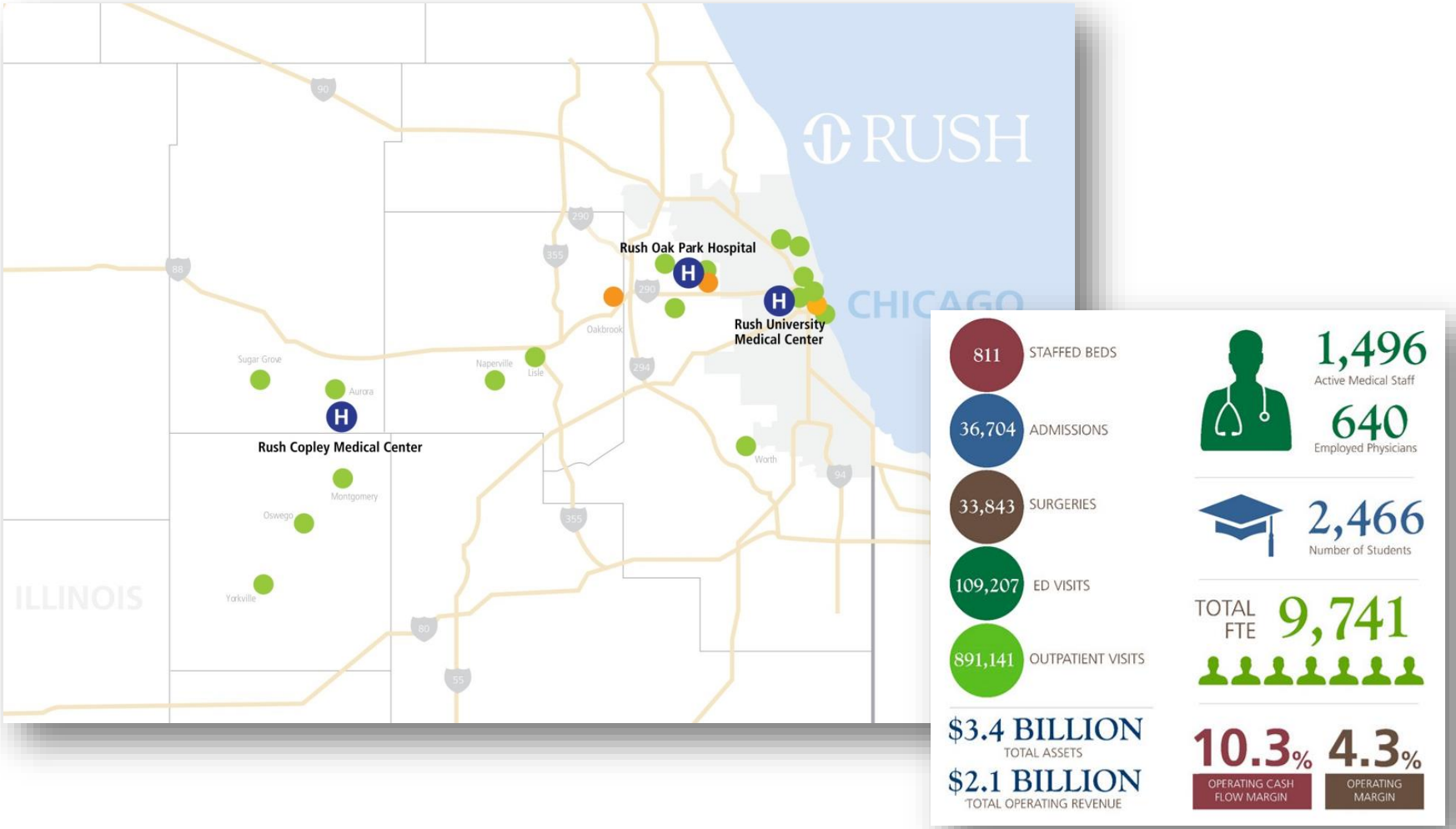
- **the professional skills and knowledge** that are required to address social needs successfully within health care settings;
- the **activities, tasks, and services** addressing social needs that directly result in improved outcomes;
- and the **patient risk factors** that are most susceptible to social support.

This level of specificity is required to support the development and refinement of models that are **credible, replicable, and sustainable**."

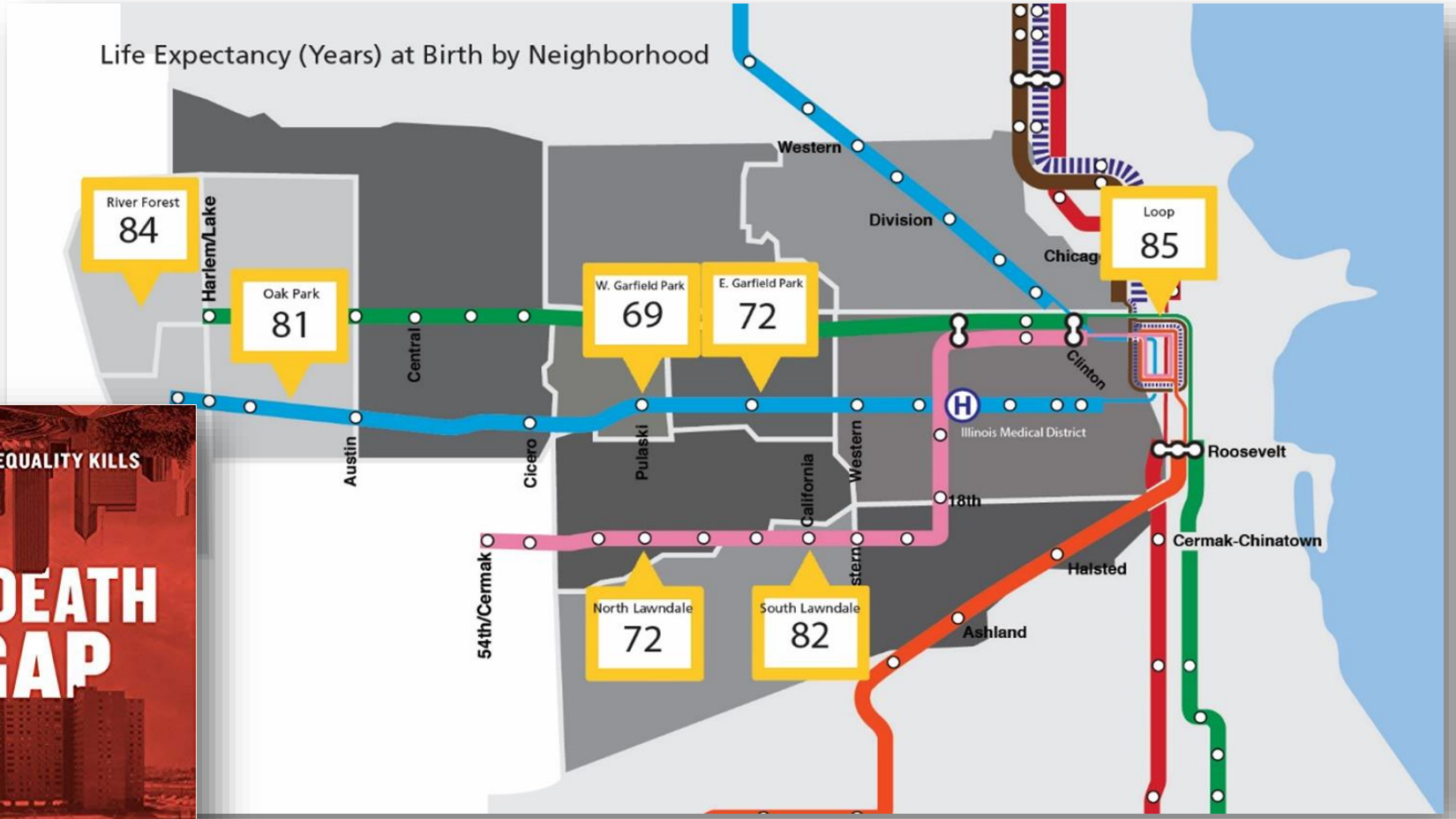
Health Affairs 2013, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2012.0170

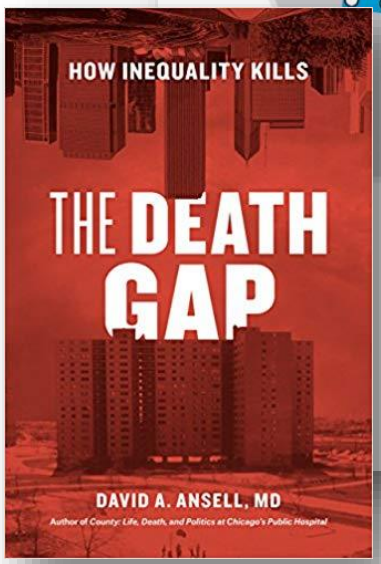
OUR WORK AT RUSH & THE CENTER FOR HEALTH AND SOCIAL CARE INTEGRATION (CHaSCI)

Rush: An integrated health system serving south and west Chicagoland



Complex and structural issues affect people's health





Screening for social determinant needs – and interventions to address them

Utilities

- Pilot with CEDA (emergency assistance program)

Hunger

- Give food (Top Box, on-site food pantry)
- Referral to Greater Chicago Food Depository
- Pilot with AgeOptions
- Rush Surplus Project
- FoodQ

Transportation

- Rides to medical appointments (Kaizen)
- PACE connection

Housing

- Medical legal partnership
- Housing high-utilizer pilot with the Center for Housing and Health

Access to care

- Benefits counseling
- Transitional care clinic and CommunityHealth partnership

Complex or multiple needs? → Ambulatory care management

- Comprehensive assessment and care planning, then care coordination, case management, and patient activation to work toward goals

ACL Nutrition Innovations Grant

2 year grant with AgeOptions (AAA in Oak Park, IL), in partnership with Rush Oak Park and various others

Healthcare entity identifies need and refers food-insecure individuals

- Screening in ED and inpatient settings
- Referrals using an on-line resource database and referral system (NowPow)

AgeOptions screens for array of needs

- Includes assessment of need for home-delivered meals

AgeOptions staff links participants with food resources and other relevant programs and services, including:

- Local Home Delivered Meal providers
- Congregant Dining sites
- Food pantries
- Farmer's markets

Closing the loop

- AgeOptions obtains confirmation of referral completion
- AgeOptions informs referring entity and integrates into EHR

Bridging practice and research

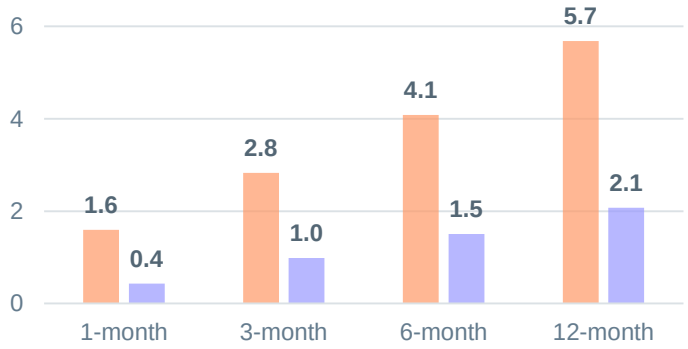
Building the evidence for ambulatory care management:

- The **Bridge Model of transitional care**, bridging inpatient and outpatient care
- The **AIMS Model** (Ambulatory Integration of the Medical Social), in primary and specialty care clinics

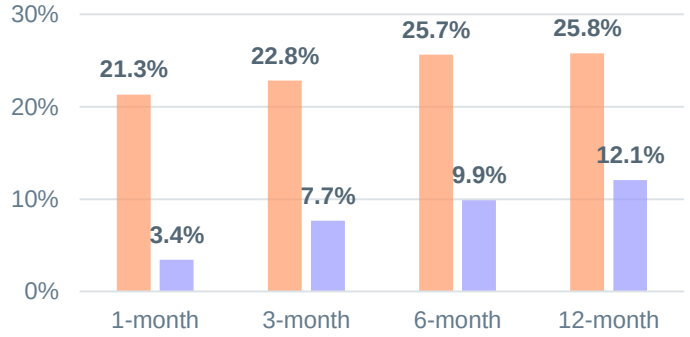
Both emphasize interprofessional collaboration, community supports, and integrating social work therapeutic techniques into care management activities

A look at Bridge's impact with frequently-hospitalized patients (n=423)

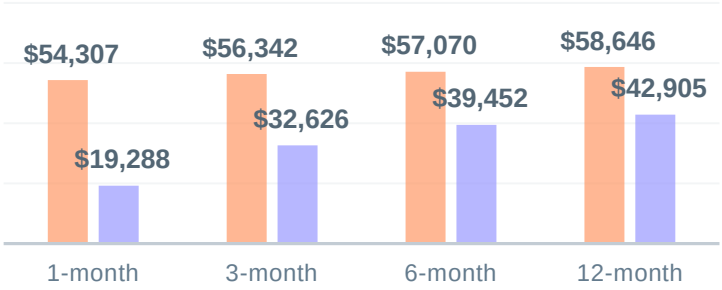
of inpatient admissions*



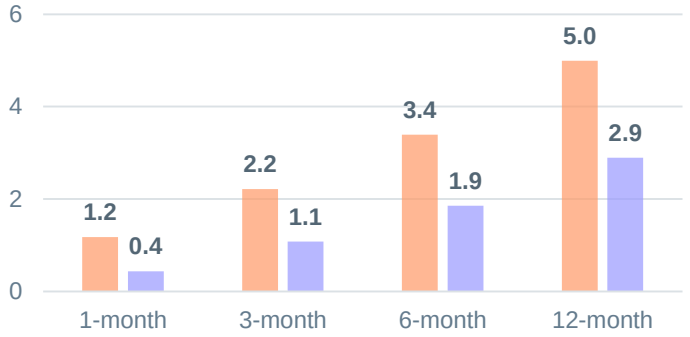
30-day readmission rates*



Average hospital cost per episode



of ED visits*



*p<.001

Source: Xiang, X., Zuverink, A., Rosenberg, W., & Mahmoudi, E. (accepted). Social work-based transitional care intervention for super utilizers of medical care: A retrospective analysis of the Bridge Model for Super Utilizers. Social Work and Health Care, "Social Workers in Integrated Healthcare: Improving Care throughout the Life Course" Special Issue.

A role for the aging network

- Aging Care Connections implements Bridge and AIMS with nearby hospital (AMITA)
- Leverages internal connections with Older American's Act funded services, including home-delivered meals

Table 1. COPD Discharges/Readmissions Supporting Data

		December	January	February	March	Total
No Intervention (12/15 - 3/16)	Discharges	12	13	15	12	52
	Readmissions	3	3	3	4	13
	Readmission Rate	25.0%	23.1%	20.0%	33.3%	25.0%
Bridge Intervention (12/16 - 3/17)	Discharges	19	20	13	14	66
	Readmissions	4	4	3	1	12
	Readmission Rate	21.1%	20.0%	23.1%	7.1%	18.2%

Data Source No Intervention: Telligen Hospital Readmission Reports for 2015 and 2016.
Data Source Bridge Intervention: Bridge self-reported data.

Aging and Disability BUSINESS INSTITUTE

Resource Categories

Get Started

Understand the Landscape

Define Your Value

Build Your Network

Manage Finances

Evaluate Contracts

Deliver Measurable Results

Building Partnerships with Primary Care to Become a Hub for Service Delivery for Older Adults in Our Community

6/28/2018 - Dana Schrage Transitional Care Supervisor, Aging Care Connections

This blog entry describes a care model that community-based organizations (CBOs) working as part of the Aging Network can implement when partnering with local primary care providers.

The last decade has seen health systems move toward payment reforms that incentivize outcomes. There has also been a substantial growth in Medicaid managed care across the country that is focusing on rebalancing care toward the community, in conjunction with significant growth in initiatives that enable individuals to age at home and in the community. While partnerships between Aging Network providers and primary care practices offer great promise, these partnerships often don't grow naturally – due to historic fragmentation, varying funding streams, and differences in organizational culture. The Ambulatory Integration of the Medical and Social (AIMS) Model helps bridge this gap and provides patients with a continuum of care.

https://www.aginganddisabilitybusinessinstitute.org/building-partnerships-with-primary-care-to-become-a-hub-for-service-delivery-for-older-adults-in-our-community/

Bridge and AIMS in use across the country

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COORDINATING CARE IN YOUR COMMUNITY: OPPORTUNITIES AND CONSIDERATIONS

How to pay for programs?

Grants from governmental or philanthropic entities

Payers

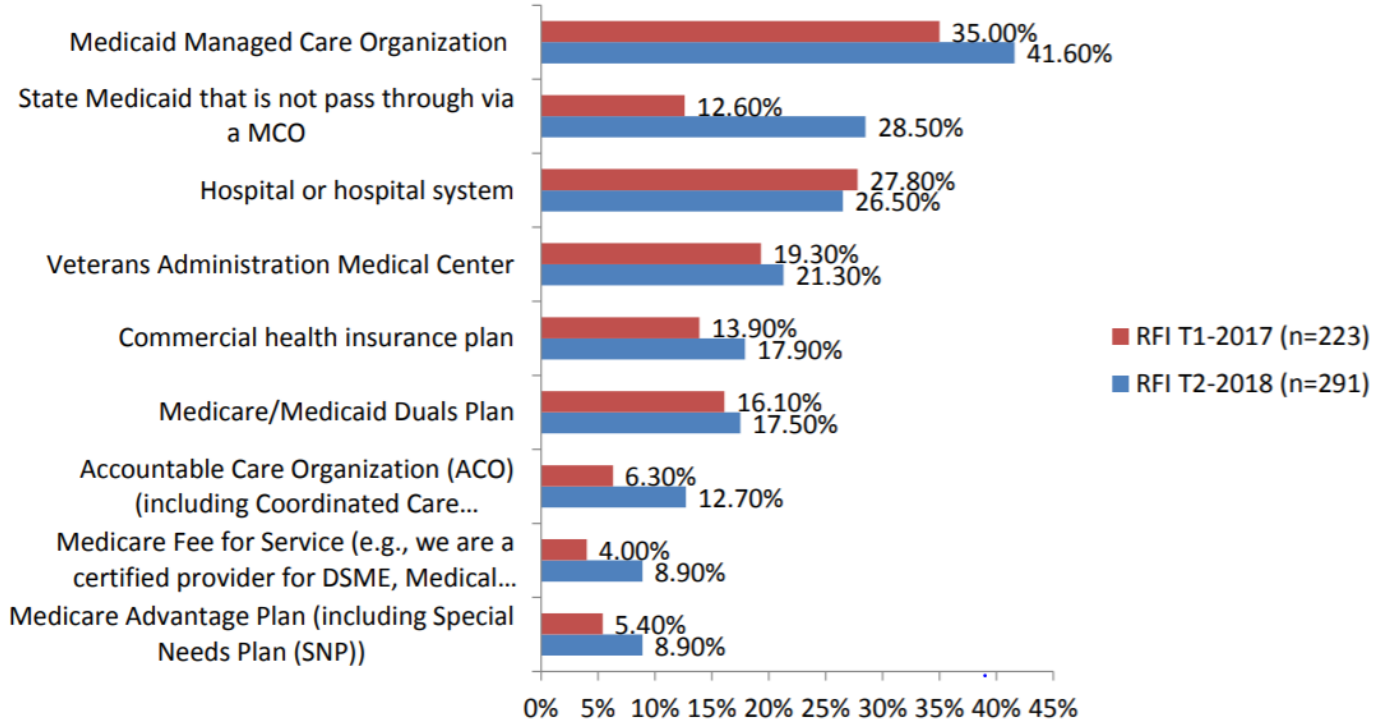
- Medicare Advantage
- Medicaid managed care
- Medicaid HCBS waivers
- Commercial

Health system / hospital $

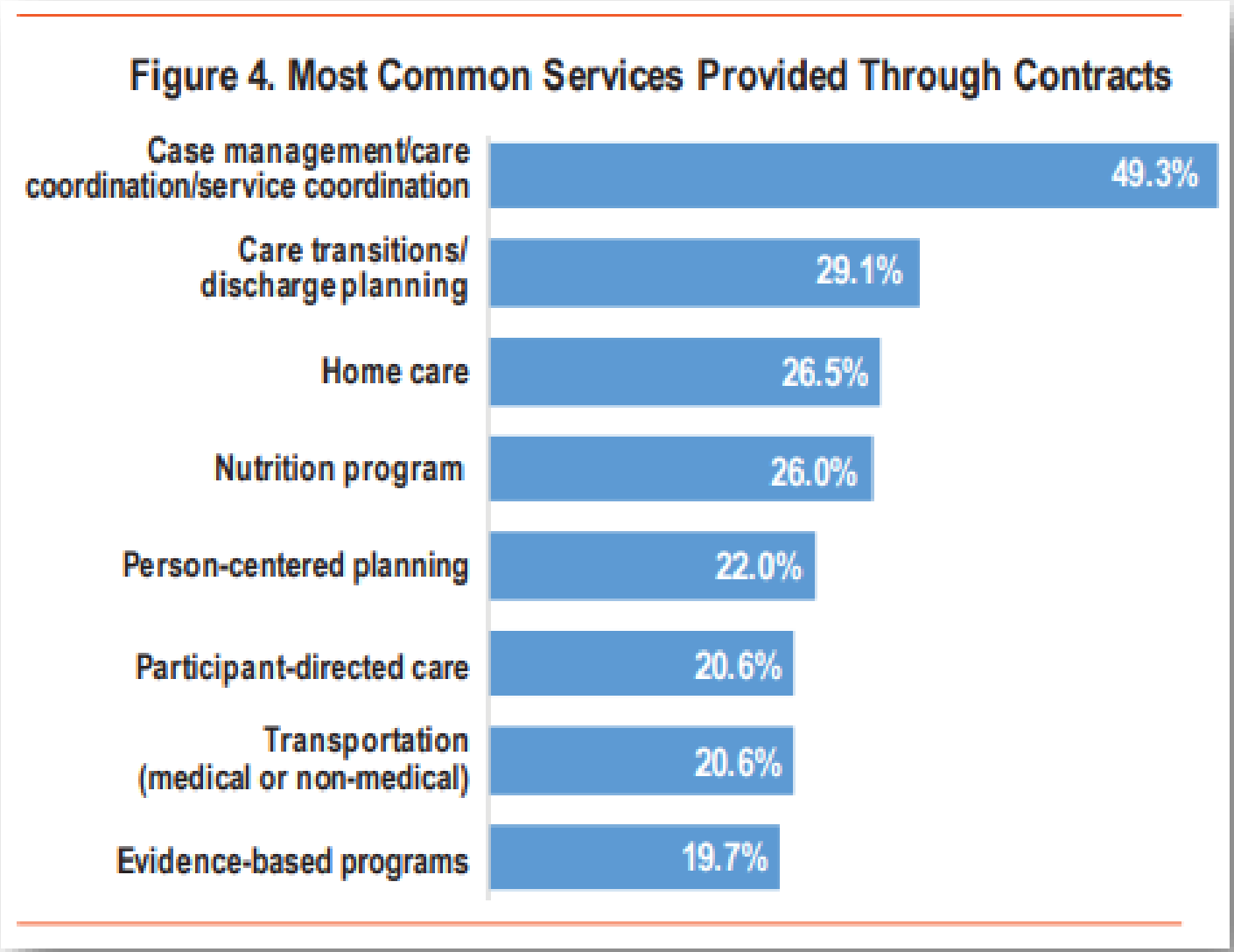
- Value-based contracts
- Fee-for-service billing
- Community benefits reports (non-profit hospitals)

Common CBO health care partners

Survey from n4a and the Scripps Gerontology Center at Miami University:



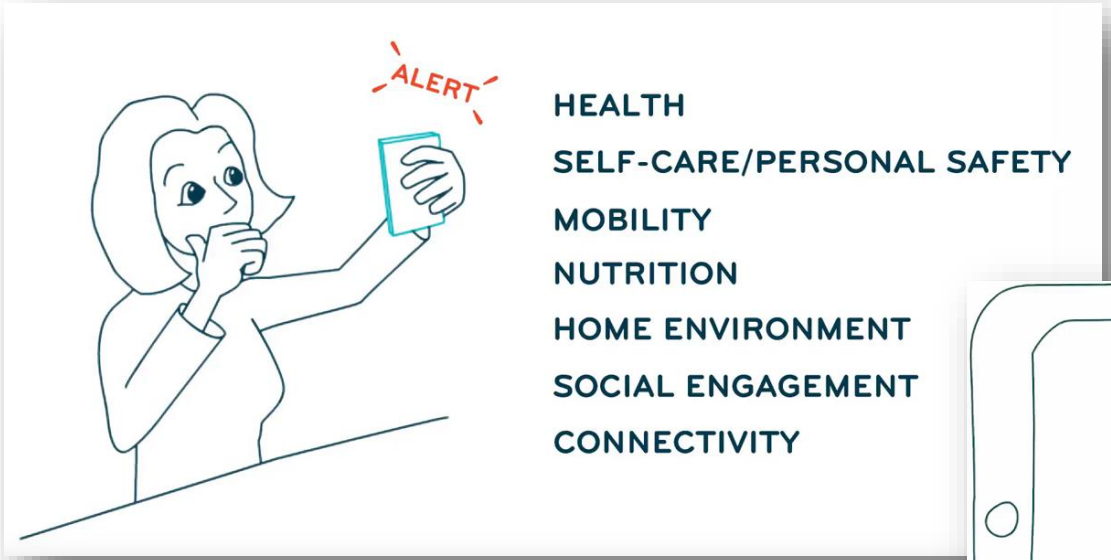
https://sc.lib.miamioh.edu/bitstream/handle/2374.MIA/6280/Kunkel-Community-Based-Organizations-and-Health-Care-Contracting.pdf, https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2018/12/RFI-II-draft-slides_final.pdf



Source: Kunkel SR, Straker JK, Kelly EM, Lackmeyer AE. Community-based organizations and health care contracting: research brief. Oxford (OH): Scripps Gerontology Center; 2017. A survey of 593 area agencies on aging and centers for independent living.

Meals on Wheels providers

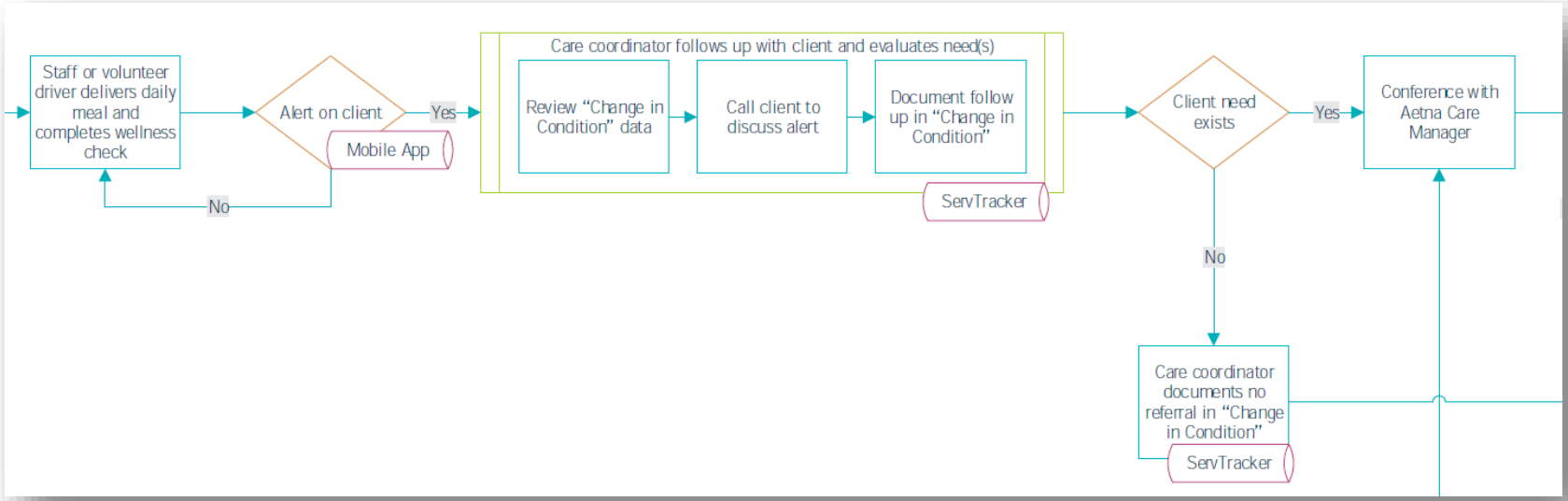
Natural partners in flagging risks and enabling coordinated care



https://www.youtube.com/watch?v=0JXGHm3c87c&feature=youtu.be

Aetna pilot: Offering enhanced Meals on Wheels service to its high need members

- Meals on Wheels programs using the **Change of Condition process** to monitor and report on any changes they notice in clients
- Interface directly with Aetna Care Manager to determine best course of action



Group discussion

What local opportunities do you have to engage in coordinated care initiatives?

What implementation challenges would you anticipate from taking on a care coordination initiative?

The value of coordinated care

A health system perspective

1. **Contributing toward billable services**

2. **Impact on utilization**
   - Reduce unnecessary ED visits and hospital readmissions
   - Total cost of care
   - Reduce no-shows

3. **Provider satisfaction**
   - PCP burnout a significant issue

4. **Patient satisfaction**
   - …and downstream marketing impact for partner organization

The Medicare landscape

Part A

- Hospital Value-based Purchasing Program
- Hospital Readmission Reduction Program
- Bundled Payment initiatives
- Skilled Nursing Facility Value-based Purchasing Program

Part B

- Chronic Care Management
- Transitional Care Management
- Behavioral Health Integration
- Health and Behavior Assessment and Intervention
- Welcome to Medicare & Annual Wellness Visit
- Medicare Diabetes Prevention Program
- Diabetes Self-Management Training
- Comprehensive evaluation of cognitive impairment
- Psychotherapy

Part C

- Provision of Part B benefits
- Supplemental benefits
- Value-based care management contracts

“CMS established separate payment under billing codes for the additional time and resources you spend to provide the between-appointment help many of your Medicare and dual eligible patients need to stay on track with their treatments and plan for better health.”

Chronic Care Management (CCM)*
- Monthly
- 99490, 99487, 99489
- G0506, 99491

Behavioral Health Integration (BHI)*
- Monthly
- 99484
- 99492, 99493, 99494

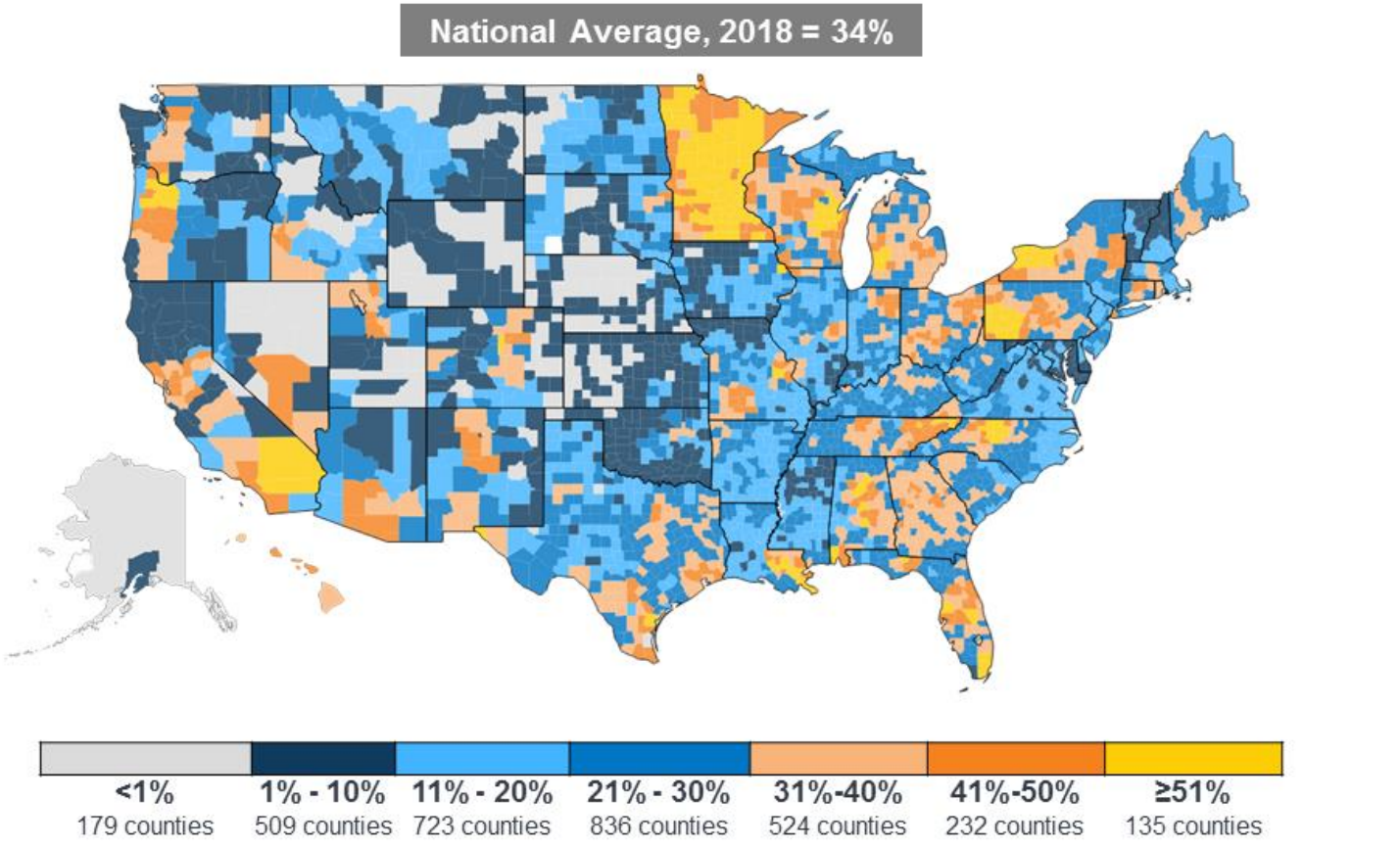
Transitional Care Management (TCM)*
- Once per hospitalization
- 99495, 99496

Health and Behavior Assessment and Intervention (HBAI)
- 15 min increments, various
- 96150-96154

(NEJM 2015, PYA 2017)

Figure 4

Medicare Advantage Penetration, by County, 2018



NOTE: Includes cost plans, which comprise the majority of enrollment in MN, ND, and SD, as well as Medicare Advantage plans. Excludes all territories.
SOURCE: Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2018.

KFF
HENRY J KAISER FAMILY FOUNDATION

https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage/

Medicare Advantage's advantage

Figure 1: New Supplemental Benefit Offerings in 2019

Examples of Supplemental Benefits Categories	Number of Plans Offering Benefit
Nicotine Replacement Therapy	1,653
Caregiver Support Services	429
In-home Support & Personal Care Services	107
Social Worker Phone Line	80
Adult Day Care	26

Note: Includes plans in the market in both 2018 and 2019 and new plans entering the market in 2019.

Avalere

What else lies ahead?

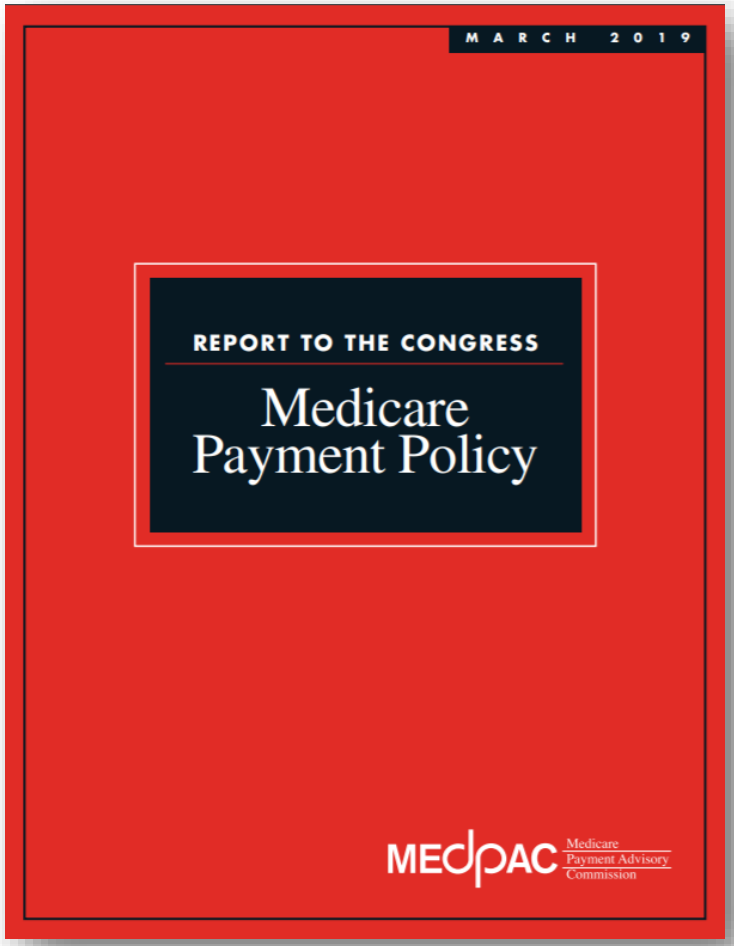
Medicare will continue evolving toward value-based payments

- Pay for performance
- Growth in at-risk value-based contracting opportunities

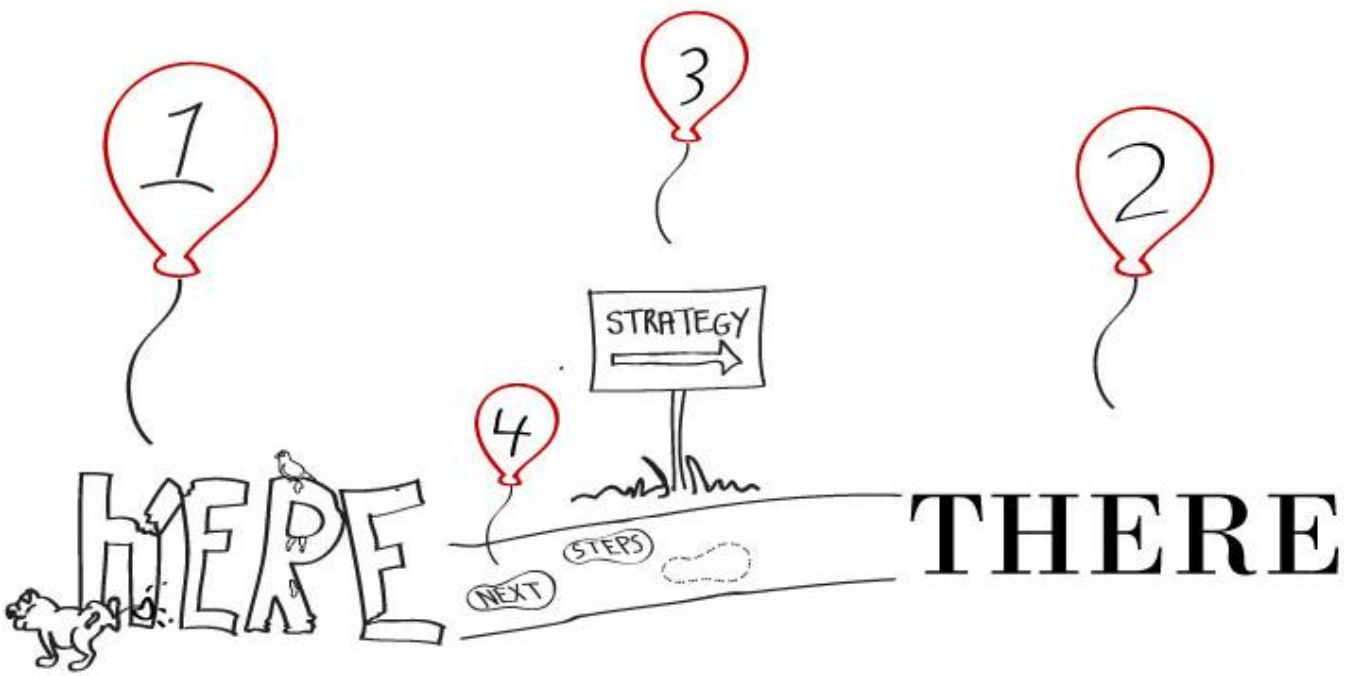
Commercial payers

Networks of CBOs

- Management Services Organizations (MSOs)



Engaging in care coordination: Getting from “here” to “there”



Administrative & implementation tasks needed for successful projects

Identify key stakeholders	Define target population	Assemble implementation team (“guiding coalition”)	Secure overhead
Hire/reassign staff	Draft workflows	Identify data measures to track	Identify data sources
Draft dashboard	Plan meetings and huddles	Assign roles	Implement/monitor PDSA cycles

Navigating it all

“You’ve got to have a full-picture understanding of the ultimate contract your organization is being asked to sign before you agree on rates, otherwise you could wind up with surprises that impact business and the cost to deliver on what you’ve agreed to.”

- Suzanne Burke, CEO of the Council on Aging of Southwestern Ohio

https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2019/02/Partnership-Profile-CC-COA-508.pdf

Looking ahead to a more coordinated and integrated future

Q&A - and - CLOSING DISCUSSION

Bonnie Ewald, MA
bonnie_ewald@rush.edu

Don’t forget to evaluate today’s session in the Conference App!