SPREADING SUCCESSFUL MODELS OF CARE COORDINATION

Monday, December 17, 2018

ADVOCATING TEAM CARE FOR OLDER ADULTS

Eldercare Workforce Alliance

N3C National Coalition on Care Coordination

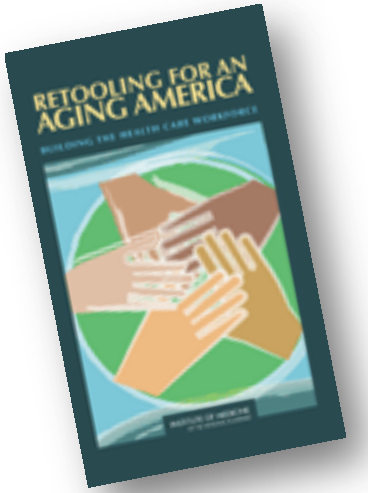
CHaSCI Center for Health and Social Care Integration

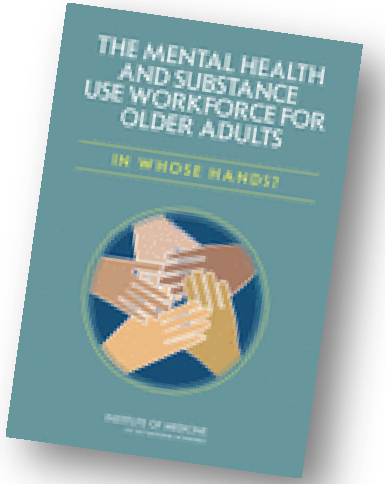

AARP
Real Possibilities
alzheimer's association
AFA
ALZHEIMER'S FOUNDATION OF AMERICA
amda
ASA
American Society on Aging
AAGP
American Association for Geriatric Psychiatry
AGS
Geriatrics Healthcare Professionals
Leading Change. Improving Care for Older Adults.
ANA
AMERICAN NURSES ASSOCIATION
APTA
American Physical Therapy Association
The Science of Healing. The Art of Caring...
CARING ACROSS GENERATIONS
CDF
AMERICAN PSYCHOLOGICAL ASSOCIATION
nac
NATIONAL ALLIANCE FOR CAREGIVING
NASW
National Association of Social Workers
PHI
Quality Care THROUGH Quality Jobs
ncoa
National Council on A
THE GERONTOLOGICAL SOCIETY OF AMERICA
CHaSCr
CSWE
COUNCIL ON SOCIAL WORK EDUCATION
NAGE
National Association for Geriatric Education
HARTFORD INSTITUTE FOR GERIATRIC NURSING
NYU RORY MEYERS COLLEGE OF NURSING
COMMUNITY CATALYST
ADVOCATING TEAM CARE FOR OLDER ADULTS
Eldercare Workforce Alliance
ncb
National Cooperative Bank
LeadingAge
formerly aahsa
FOA
SEIU
AS CP
American Society of CONSULTANT PHARMACISTS
CONSUMER VOICE
THE GREEN HOUSE PROJECT
NHCOA
NATIONAL HISPANIC COUNCIL ON AGING
Coalition of Geriatric Nursing Organizations
caring with one voice

EWA Mission

- **Addressing the immediate and future workforce needs in caring for an aging America by advancing recommendations in the IOM reports:**

- **2008 IOM Report:"Retooling for an Aging America: Building the Health Care Workforce"**





#TogetherWeCare

Advancing a Well-Trained Workforce as We Age

APRIL 11TH	LAUNCH
MAY	Geriatrics Training
JUNE	Alzheimer's and Dementia Training
JULY	Pharmacists
AUGUST	Direct Care Workforce
SEPTEMBER	Age-Friendly Workforce

OCTOBER	Mental Health
NOVEMBER	Family Caregivers and Veterans
DECEMBER	Care Coordination
JANUARY 2019	Cultural Competency Training
FEBRUARY 2019	EWA 10th Anniversary
MARCH 2019	Social Work

Our agenda today

- **CARE COORDINATION: ISSUE BRIEF & OVERVIEW**
  Bonnie Ewald, Associate Director, Center for Health and Social Care Integration at Rush University Medical Center

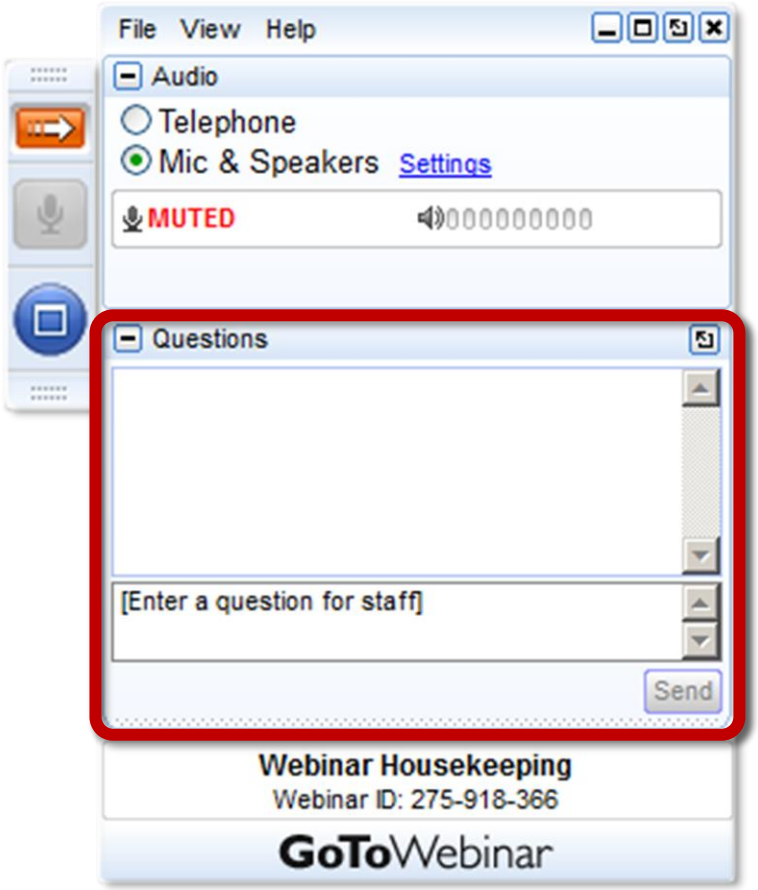
- **HOME-BASED PRIMARY CARE**
  Amy Berman, Senior Program Officer, The John A. Hartford Foundation

- **PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY**
  Amy Herr, Director, Health Policy, West Health Policy Center

How to ask questions during the webinar

- To submit a question or comment, please type your questions into the question box (right)

- If at any point during the webinar you experience technical difficulties, please call Citrix tech support at 888-259-8414



CARE COORDINATION: ISSUE BRIEF & OVERVIEW

Bonnie Ewald, MA

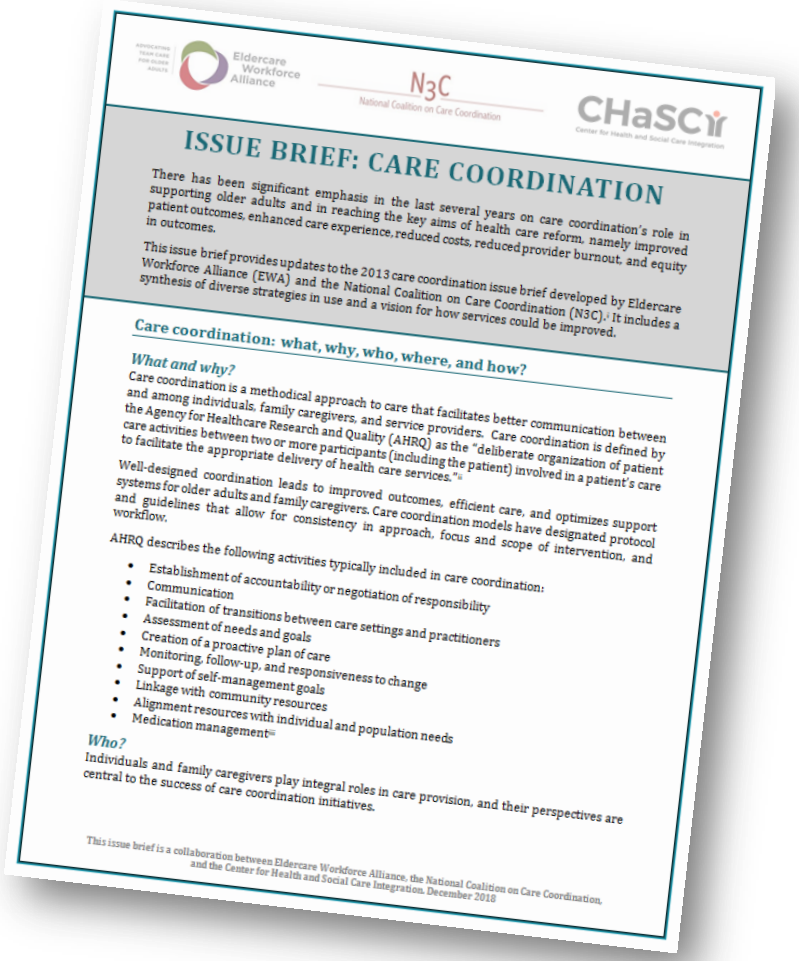
Associate Director, Center for Health and Social Care Integration at Rush University Medical Center

Bonnie_Ewald@rush.edu

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



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

- www.chasci.org

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***"

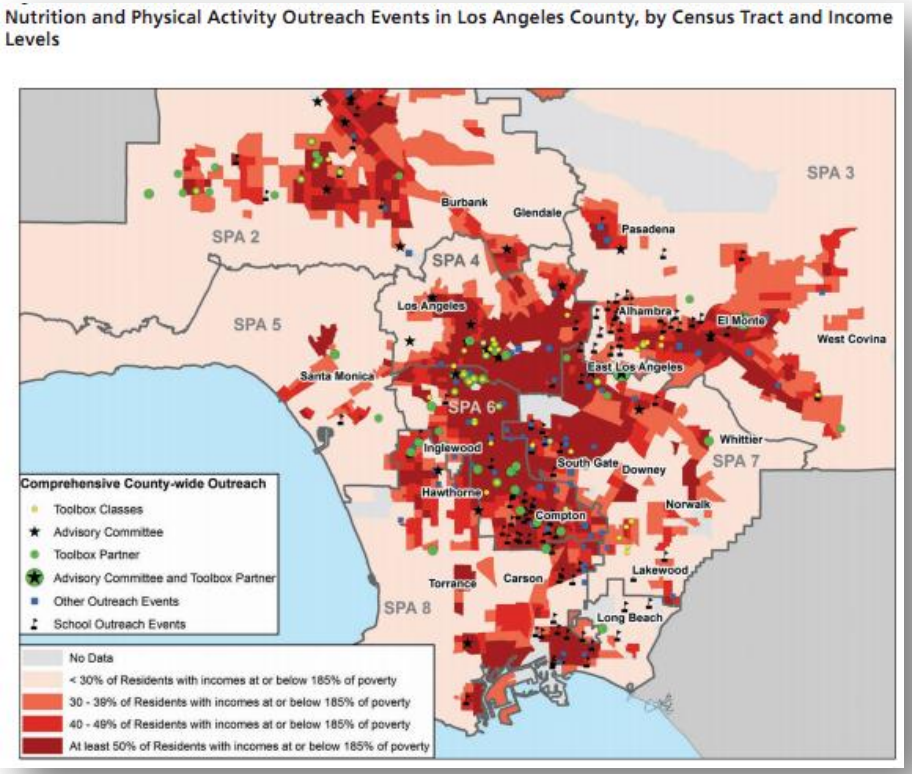
- The Agency for Healthcare Research and Quality,
https://www.ahrq.gov/downloads/pub/evidence/pdf/caregap/caregap.pdf

With which 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)

Engaging hard-to-reach populations

- **Systematic screenings in the community to identify and engage individuals in care**
  - i.e., places of worship, health fairs, libraries
- **No-wrong-door policies**
  - Access care from any entry point
- **"Hot spotting"**
  - using data to identify and target individuals



Learning from the past

> *Based on successful pilot projects in the late 1990s… Medicare launched a national case management payment methodology. Large firms quickly developed with nurses calling assigned individuals to provide case management. By 2007, Medicare determined that the vast majority of these firms failed to deliver on either quality or cost parameters, and the program was essentially discontinued.*
>
> *Follow-up analysis has shown that* ***the few that did succeed… had one key element in common: first-name, caring, personal relationships in which the case manager was an advisory friend*** *who got to know the individual and connected with him or her at a personal level. However, the majority of systems used nurses who had no personal connection to the individual, and the calls were often characterized by those receiving them as "harassment" rather than friendly coaching and facilitation.*

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. http://www.ihi.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx

What works?

Frequent touch points	**Person-specific interventions**	**Ability to effectively link individuals with services** that address broad range of needs
Empathetic language and gestures	**Anticipation of an individual's needs to support self-care**	**Provision of actionable information**
Minimal handoffs	**Trusting team relationships**	**Provider commitment to and understanding of the program model**

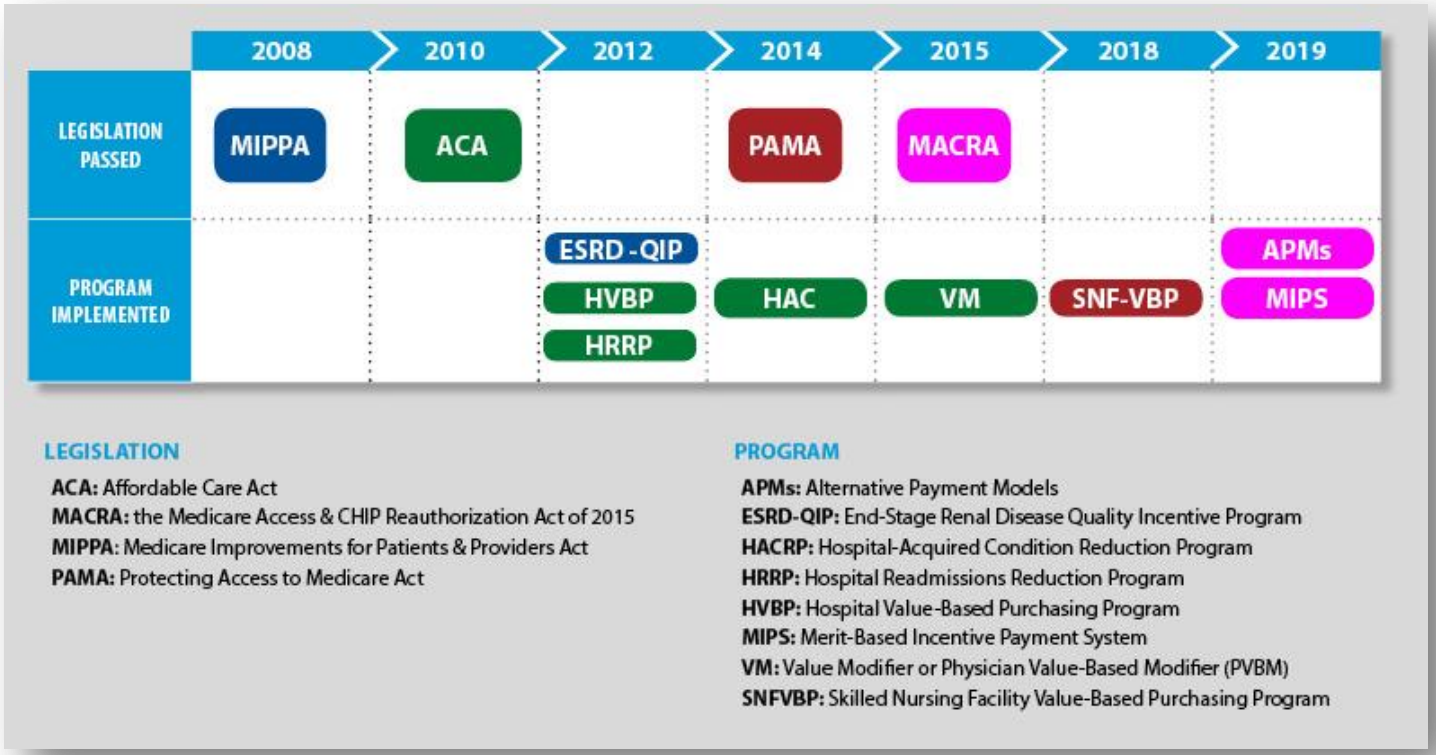
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5890872/
- https://onlinelibrary.wiley.com/doi/abs/10.1111/jgs.14086
- http://www.annfammed.org/content/16/3/225

What gets in the way of success, scale, and spread?

- **Implementation**
  - Workflow and practice changes
  - Team dynamics and organizational culture
- **Financial sustainability**
- **Workforce**
  - Role definition and shortages
- **Other systemic barriers**

A promising look ahead

- **Many effective care models being disseminated across the country – and payment reform to support them**



- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html

Various resources available

- **The Better Care Playbook www.bettercareplaybook.org/**
- **Social Interventions Research and Evaluation Network (SIREN) sirenetwork.ucsf.edu/tools-resources**
- **Center for Health and Social Care Integration www.chasci.org**
- **National Association of Social Workers – Standards for Social Work Case Management (2013) www.socialworkers.org/Practice/Practice-Standards-Guidelines**

The John A. Hartford Foundation
Dedicated to Improving the Care of Older Adults

Successful Models of Care Coordination: Home-Based Primary Care

EWA Webinar
December 17, 2018

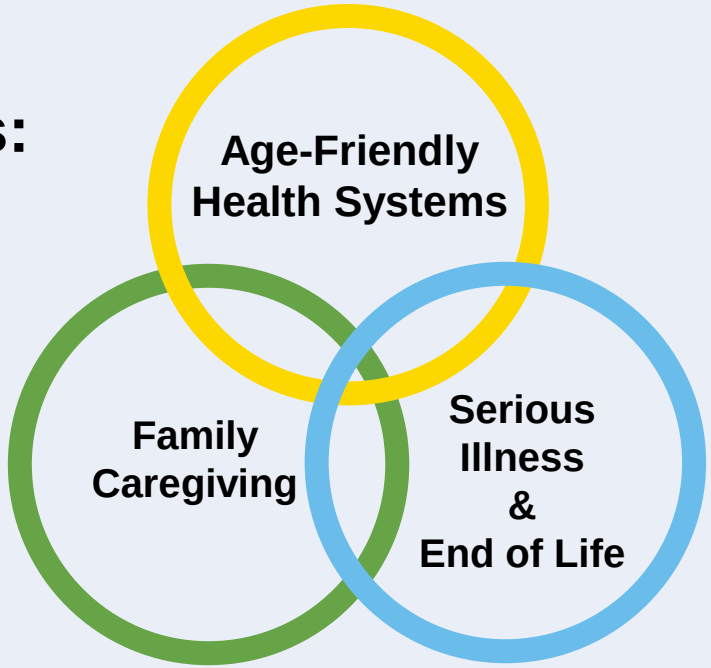
Amy Berman, RN, LHD, FAAN
Senior Program Officer
The John A. Hartford Foundation

The John A. Hartford Foundation

A private philanthropy based in New York, established by family owners of the A&P grocery chain in 1929.

Dedicated to Improving the Care of Older Adults

Priority Areas:



The Leader in Improving Care of Older Adults

Health Care for Older Adults Needs to Change

Many factors contribute to poor outcomes

- **Poor care coordination**
- **Duplication of services**
- **Polypharmacy**
- **Error-prone transitions**
- **Unnecessary hospitalizations**
- **Care discordant w/patient goals**

Priority Area:

Age-Friendly Health Systems

Few hospitals and health systems meet the needs of older adults.

Evidence-based, age-friendly approaches to better care exist.

- Focusing on what *matters* to older adults receiving care
- Improving health outcomes and reducing harm
- Achieving lower costs and better value

Priority Area:

Family Caregiving

More than 18 million people are family caregivers of older adults.

They are often invisible and unprepared, better support can improve outcomes.

- Helping health systems assess and address needs of family caregivers
- Advancing policies for family-centered care

Priority Area:

Serious Illness & End of Life

Care during serious illness or at end of life often fails to meet goals and preferences.

Palliative care reduces harm and burden.

- Making palliative care more widely available
- Supporting clinician training
- Promoting advance care planning

What is Home-Based Primary Care?

- **Home-based primary care (HBPC) provides:**
  1) primary care
  2) palliative care
  3) social services
  4) care coordination
- **2 million "invisible homebound"**
- **Today, serves 100,000+ high-risk and medically fragile**

Achieving Measurable Impact with Grantee Partners

Moving and Scaling Home-Based Primary Care (HBPC): 3-part initiative (data registry, workforce development, payment policy) to improve health for most frail older adults living in the community.

- Independence at Home demo[1]:
  - $25 million in Medicare savings in 1st year
  - $3,070 per beneficiary
- VA HBPC Program[2]:
  - Reductions in:
    - hospital days (89%)
    - nursing home days (59%)
    - 30-day readmissions (21%)
  - $9,000 savings per veteran

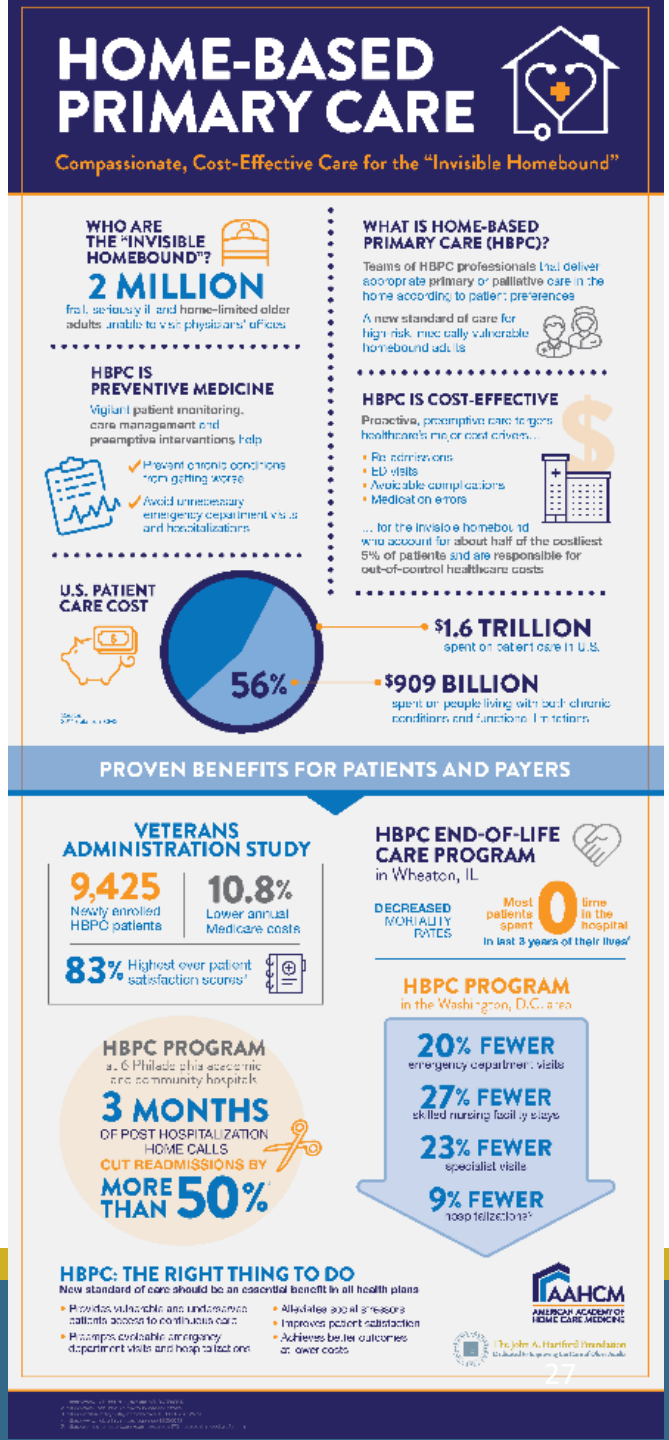
[1] CMS, "Affordable Care Act payment model saves more than $25 million in first performance year," June 2015
[2] Edes, T. et al. (2014), Better access, quality, and cost for clinically complex veterans with home-based primary care J Am Geriatr Soc, 62: 1954–1961

Toolkit for Health Partners

https://www.aahcm.org/general/custom.asp?page=hbpc_toolkit

Toolkit for Health Partners

- White paper
- FAQs
- Proven cost savings
- Effects of the care
- Implementing HBPC



Thank you

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www.johnahartford.org

The John A. Hartford Foundation
Dedicated to Improving the Care of Older Adults

GARY & MARY westhealth™ policy center

The PACE® Model of Care

December 2018

Amy Herr, MHS, PMP

Director, Health Policy, West Health Policy Center

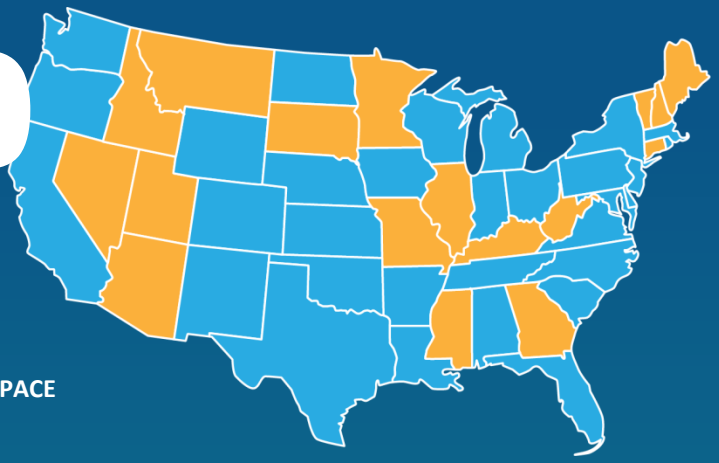

westhealth
westhealth institute
Applied medical research
westhealth policy center
Policy research and advocacy
GARY & MARY
west foundation
EST. 2006
Outcomes-based philanthropy

Meet PACE Participant Phyllis Benning

https://vimeo.com/289955281/a22bb38859

PACE is a Successful Integrated Care Model

250
PACE CENTERS
IN 31 STATES



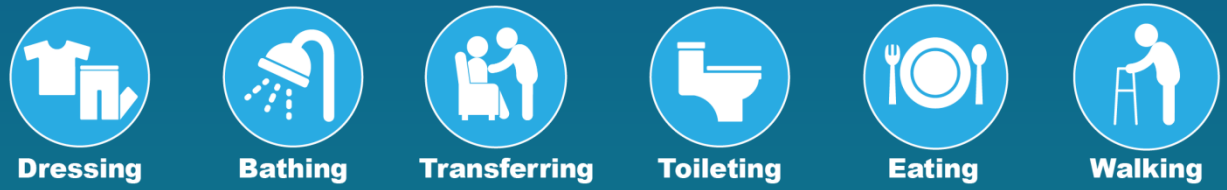
WITH PACE WITHOUT PACE

45,000
PARTICIPANTS

100% **NEED**
NURSING HOME
LEVEL OF CARE

NEED HELP

WITH ACTIVITIES
OF DAILY LIVING



Average number of ADLs with which participants need assistance

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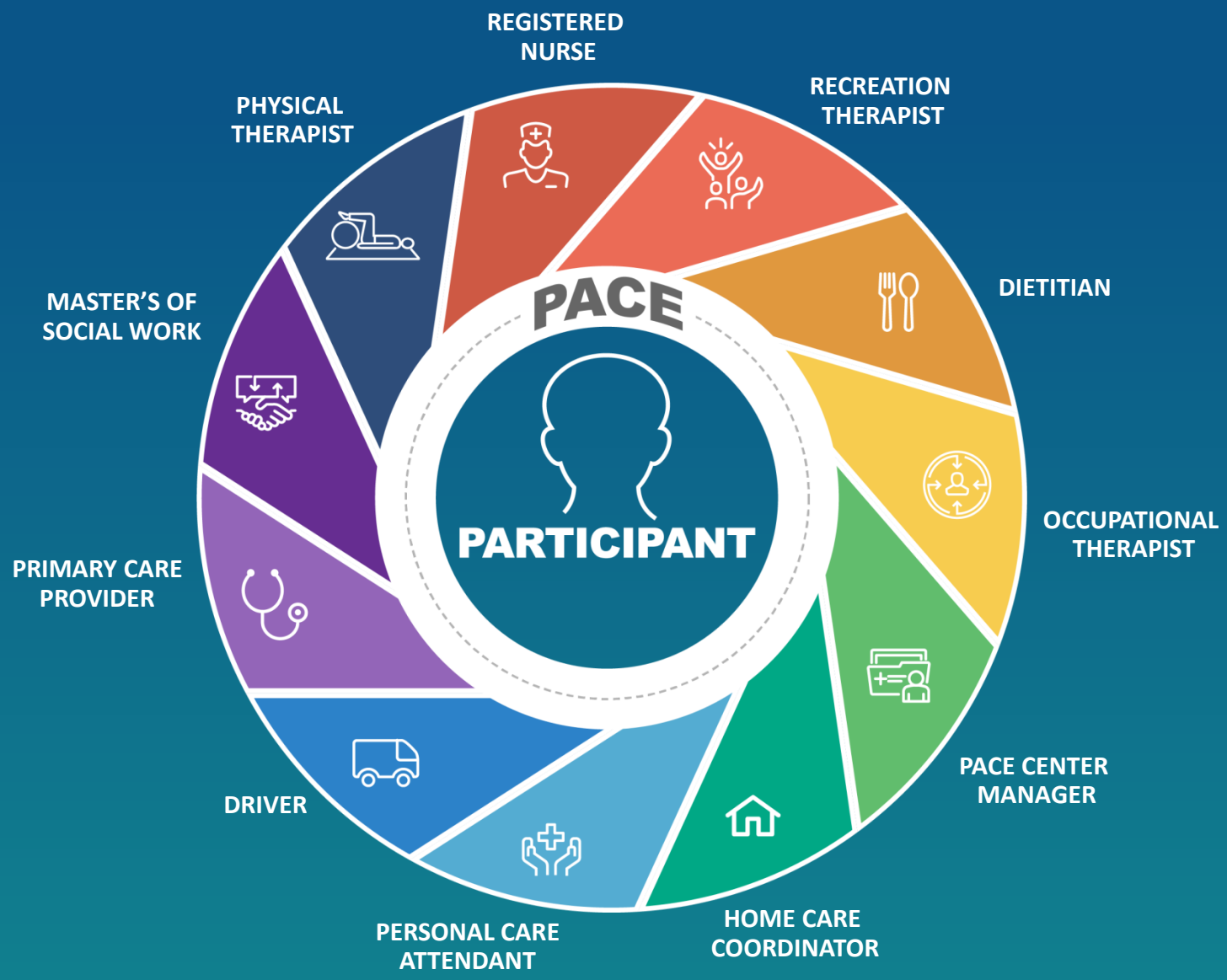
Program of All-Inclusive Care for the Elderly (PACE®)

The PACE Interdisciplinary Team

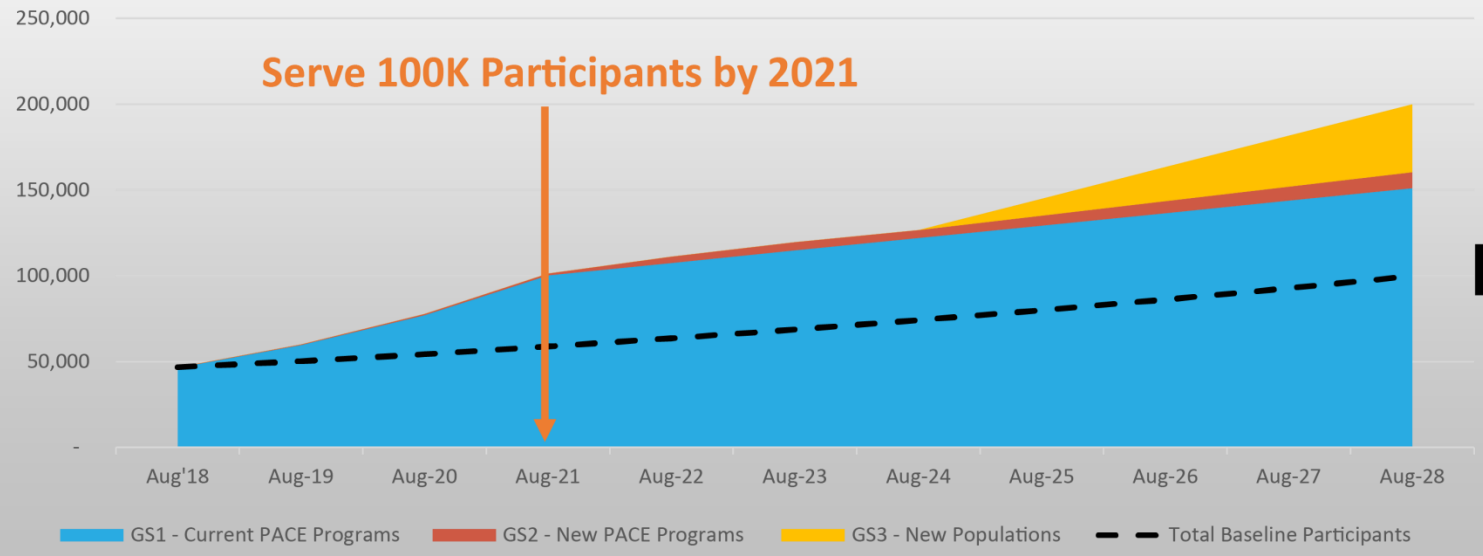


Growing PACE to Help More People

ONLY 2%
OF PEOPLE WHO COULD BE HELPED BY PACE ARE CURRENTLY ENROLLED.

PACE 2.0 WILL GROW THE PROGRAM TO SERVE

200
THOUSAND



PACE 2.0

westhealth

National PACE Association

The John A. Hartford Foundation

Resources

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Learn more about PACE
National PACE Association website

Learn more about West Health
www.westhealth.org

Learn more about PACE expansion
PACE 2.0 webpage

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Thank you for joining the discussion!

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