Together We're Better: Extending Patient Care Outside the Hospital Walls

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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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Goals of Transition Programs

- Engage patients (&/or caregivers) with chronic illness and activate self-care & behavior change
- Follow post-discharge to ensure meds/services received
- Teach/coach regarding medications, self-care, symptom recognition and management
- Remind and encourage patients to keep follow- up physician appointments – ensure transportation

How to achieve these goals differs across programs

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Coleman Care Transition Intervention

- Social Worker or Health Coach (one per 40 patients)
- Duration-30 days post hospital
  - One visit in hospital
  - One Home visit post-DC or post-SNF
  - Three follow-up calls within 30 days
- Based on four pillars
  - Medication Reconciliation & Management
  - Personal Health Record (PHR)
  - Primary care and specialist follow-up
  - Knowledge of red flags re: symptom exacerbation
- Results*
  - In RCT, CTI prevented 1 readmission per 17 patients
  - Savings $300,000 per 350 patients (cost<$170,000)

*California Healthcare Foundation-"Improving Care Transitions" October 3, 2007

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Bridge Model (Rush Medical Center)

- A telephonic intervention for patients who:
  - live outside of the service area or
  - decline a home visit.
- Social work assessment in hospital visit
- 30 days of phone support & care coordination
- Identify unmet post-discharge needs
- Facilitate connections to home and community-based services such as home-delivered meals and transportation
- Includes clarifying discharge instructions, arranging physician follow-up and obtaining/understanding medications

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Coleman/Bridge Commonalities

- **Identify at-risk patients**
  - Unit Nurse
  - Care Managers or Discharge Planners
  - EMR system data/risk algorithm
- **Room Visit**
  - Introduce & Explain
  - Determine need, coachability or appropriateness
  - Consent
  - Begin assessment
  - Leave info
  - Schedule visit or calls
- **Follow-Up at home or by phone**
  - Verify discharge orders complete: meds, equipment, home health, etc.
  - Ensure MD visits scheduled w/ transportation if needed
  - Connect with resources, including meals
  - Verify understanding of self-care
  - Encourage healthy behaviors
  - ***HomeMeds for medication reconciliation & safety***

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Best Practices (Coach focus group)

- **Identify at-risk patients**
  - Case managers who know patient & family provide fewer, but more appropriate patients
  - Hospital-based coach who gets to know staff, schedules, how to find patients – staff trusts more and therefore refers more
  - 24 hours pre-discharge is ideal time
- **Room Visit**
  - "I'm here on recommendation from"…someone patient knows – MD, case manager
- **Efficiency**
  - Field coach & hospital coach allows everyone to see more patients
  - Teamwork gives us more flexibility – cover more times of day and languages

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Issues/Challenges (Coach focus group)

- **Identify at-risk patients**
  - Volume (automated at-risk patient ID) vs. quality (case manager – BUSY!)
    - Have case managers briefly review list for appropriate patients
  - Timing – often too late; patient already discharged
  - Weekends!
- **Room Visit**
  - Patients out of room for tests & treatments, or asleep/too ill
- **Home Visit**
  - Hard to reach patients – not answering phone; no voicemail system
  - 48-hour home visit difficult – still too ill and exhausted
  - Family protects patient & blocks access
- **Efficiency**
  - We're bugging case managers for information & they don't have time – ***need direct access to face sheet & d/c summary***
    - Patient ID & info has to be exactly right or billing won't go through
    - Dx codes not known until d/c summary
    - We don't know where pt d/c to (home, SNF, etc)
- **30-40% readmitted elsewhere – how do we know?**

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Value-Added Service: HomeMeds℠ The Right Meds… The Right Way!

HomeMeds℠ proven solution in four important problem areas affecting seniors:

1. Unnecessary therapeutic duplication
2. Falls and confusion related to possible inappropriate psychoactive medication use
3. Cardiovascular problems such as continued high/low blood pressure or low pulse
4. Inappropriate use of non-steroidal anti-inflammatory drugs (NSAIDs) in those with high risk of peptic ulcer/gastrointestinal bleeding

Coach & software identify medication-related problems and pharmacist works with patient and prescribers to resolve them.

HOMEMEDS℠

www.homemeds.org

Evidence-BASED HEALTHY AGING PROGRAM

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Value-Added Service: Self-Management of Health

Promising Practice → Best Practice

- Supported by extensive research
- Measurable, proven outcomes to achieve specific goals
- Clear, structured, detailed program
- Peer-reviewed & endorsed by a federal agency
- Peer-led, replicable in many settings

Coaches refer patients to appropriate workshops:

- **Chronic Disease, Pain, Arthritis, & Diabetes Self-Management**
- **Fall Prevention**
- **Caregiver Skills**
- **Early Memory Loss**

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Bringing medicine, patients and community-based services together.

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The Expanded Chronic Care Model: **Integrating Population Health Promotion**

Barr V et al. The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. *Hospital Quarterly* 2003;7(1):73-82

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Healthcare + Community Services = Better Health & Lower Costs

Social determinants of health

- Personal choices in everyday life
- Social isolation
- Environment – home safety, neighborhood
- Family structure/issues, caregiver needs

Community Agencies Have Advantages

- ***Time*** to ask questions, observe, probe, develop trust
- ***Cultural/linguistic competence***
- ***Lower cost*** staff & infrastructure
- ***Knowledge of resources***

High impact evidence-based programs

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Providers see the need…
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, and 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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How Home and Community Services Improve Health Outcomes for High-Risk Patients

- Multiple, complex chronic conditions & self-care
  - Evidence-based self-care programs (e.g, Chronic Disease Self-Management, Diabetes Self Management)
  - Long-term supports and services (LTSS) to address functional & cognitive impairments – meet basic needs
  - Nursing home diversion/return to community
- Complex medications/adherence (**HomeMeds**℠)
- Fill gaps in care/communication & address root causes of inappropriate ED use (e.g., insurance, meals, transportation for care, socialization)
- Post-hospital support to avoid readmissions
- In-home palliative care in last year of life

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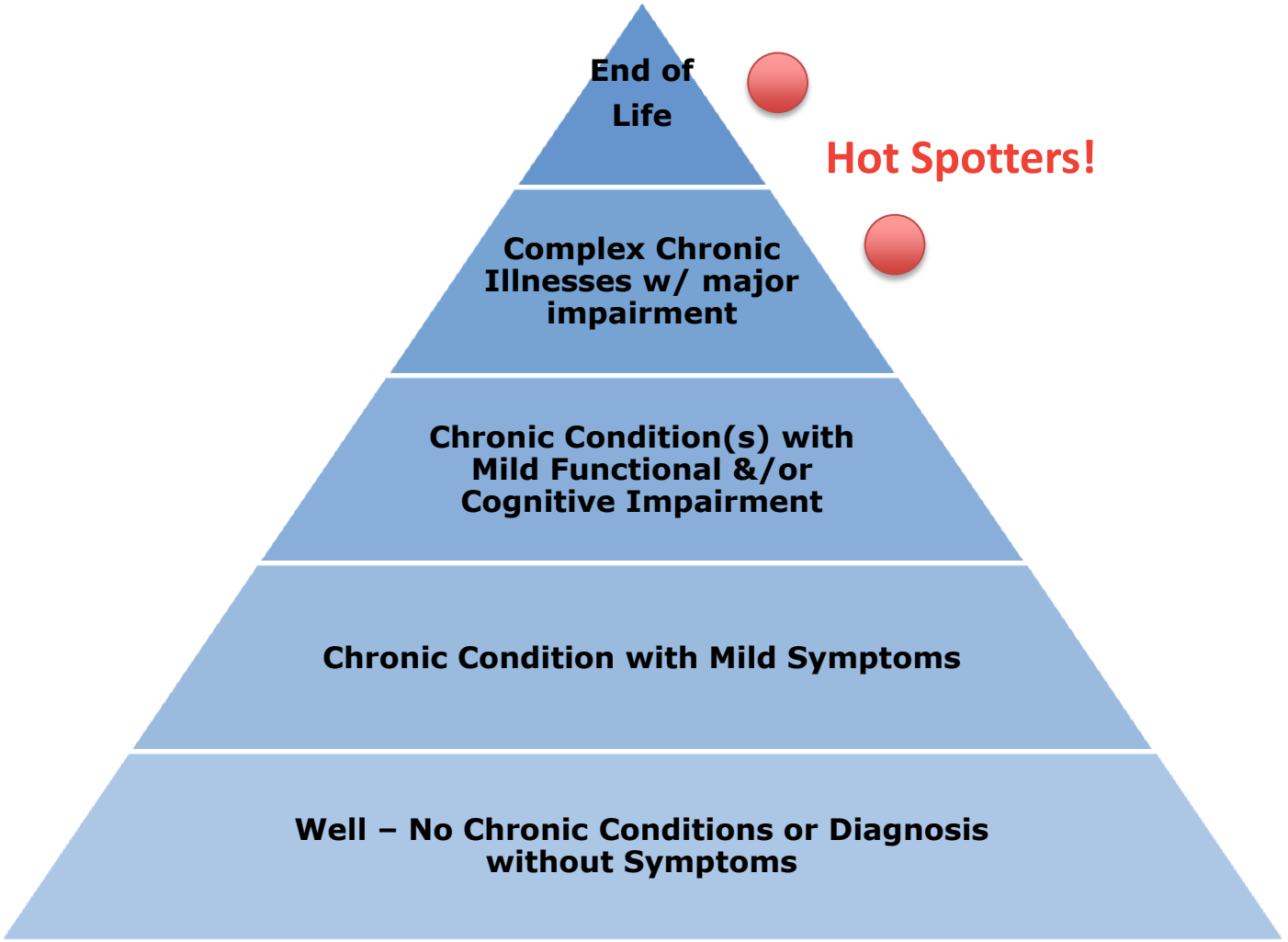
Active Patient Population Management



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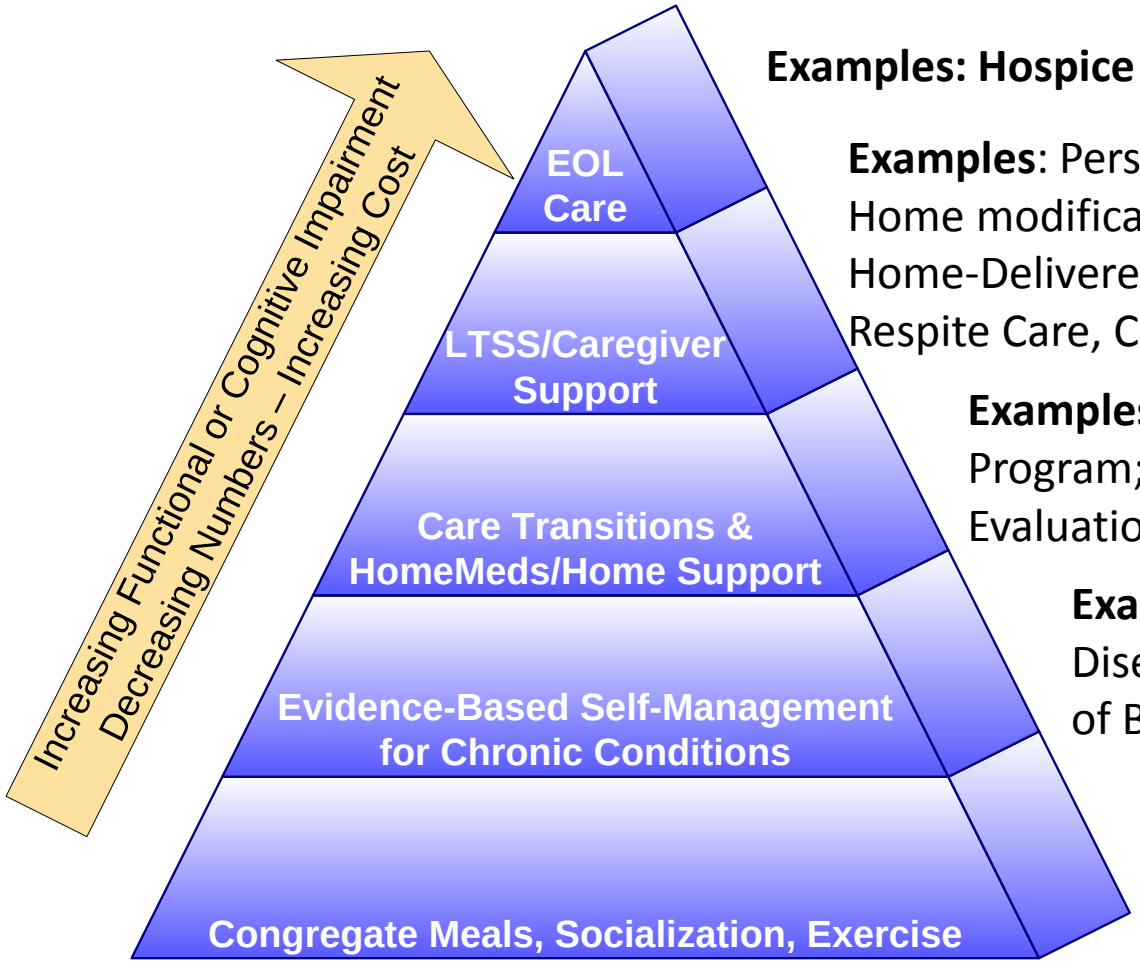
Home & Community-Based Services in Active Population Health Management



Examples: Hospice & home palliative care

Examples: Personal assistance; Home modifications; Chore/shopping; Home-Delivered Meals, Med Mgt, Respite Care, Caregiver Classes & Counseling

Examples : Coleman CTI; Rush Bridge Program; HomeMeds; Home Safety Evaluation & Social Assessment

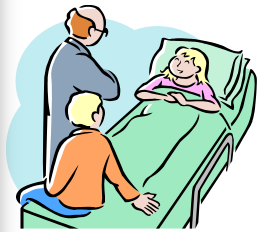
Examples : Stanford Chronic Disease Self-Management; Matter of Balance; PST/IMPACT

Examples: Tai Chi, Health Screenings & Education

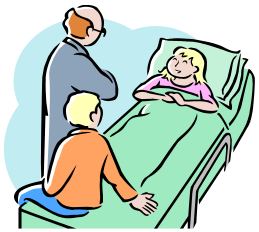
Continuum of Home and Community-Based Services for Older Adults

Care Transitions: Buy vs. Build Decision

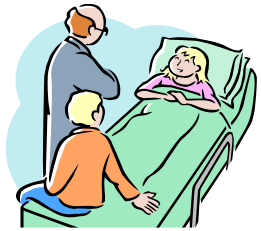
Patients discharged to geographically disparate parts of the County



Lancaster



San Pedro

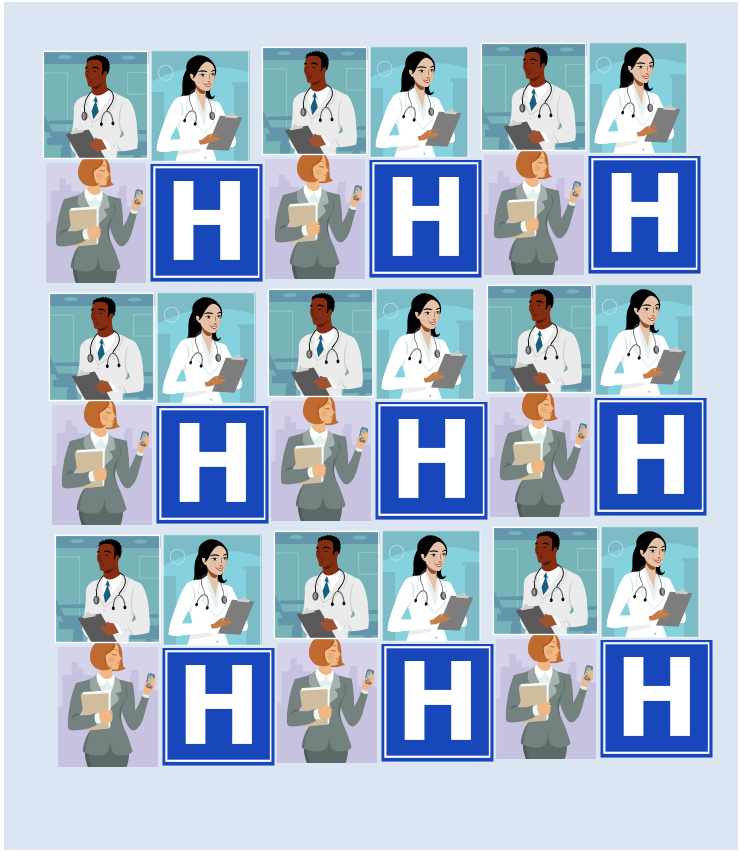


Woodland Hills

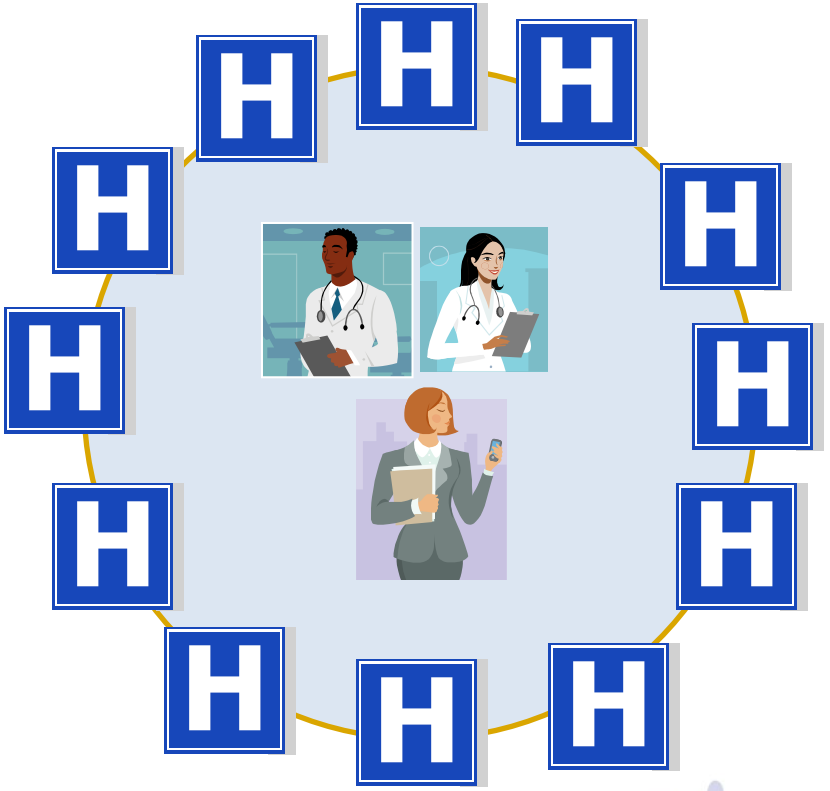
Considerations:

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

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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Single Provider – 11 Hospitals

Kern County Coalition	Westside (L.A.) Coalition	Glendale Coalition
Bakersfield Heart Hospital	UCLA Ronald Reagan Medical Center	Glendale Memorial Hospital & Health Center
Bakersfield Memorial Hospital	UCLA Santa Monica Medical Center	Glendale Adventist Medical Center
Kern Medical Center	St. John's Health Center	USC Verdugo Hills Hospital
Mercy Hospital		
San Joaquin Community Hospital		

How We Work Together Efficiently

- **Home and Community Services Network**
  - Broad geographic coverage with in-home Care Coordination through a central portal
  - Common assessment tool and EHR
  - Multi-lingual/cultural competence/home experts
  - Contracted, credentialed network of trusted vendors and linked partnerships
  - Administrative simplicity with full access to both arrange and purchase community care resources
  - Wraparound services and patient activation

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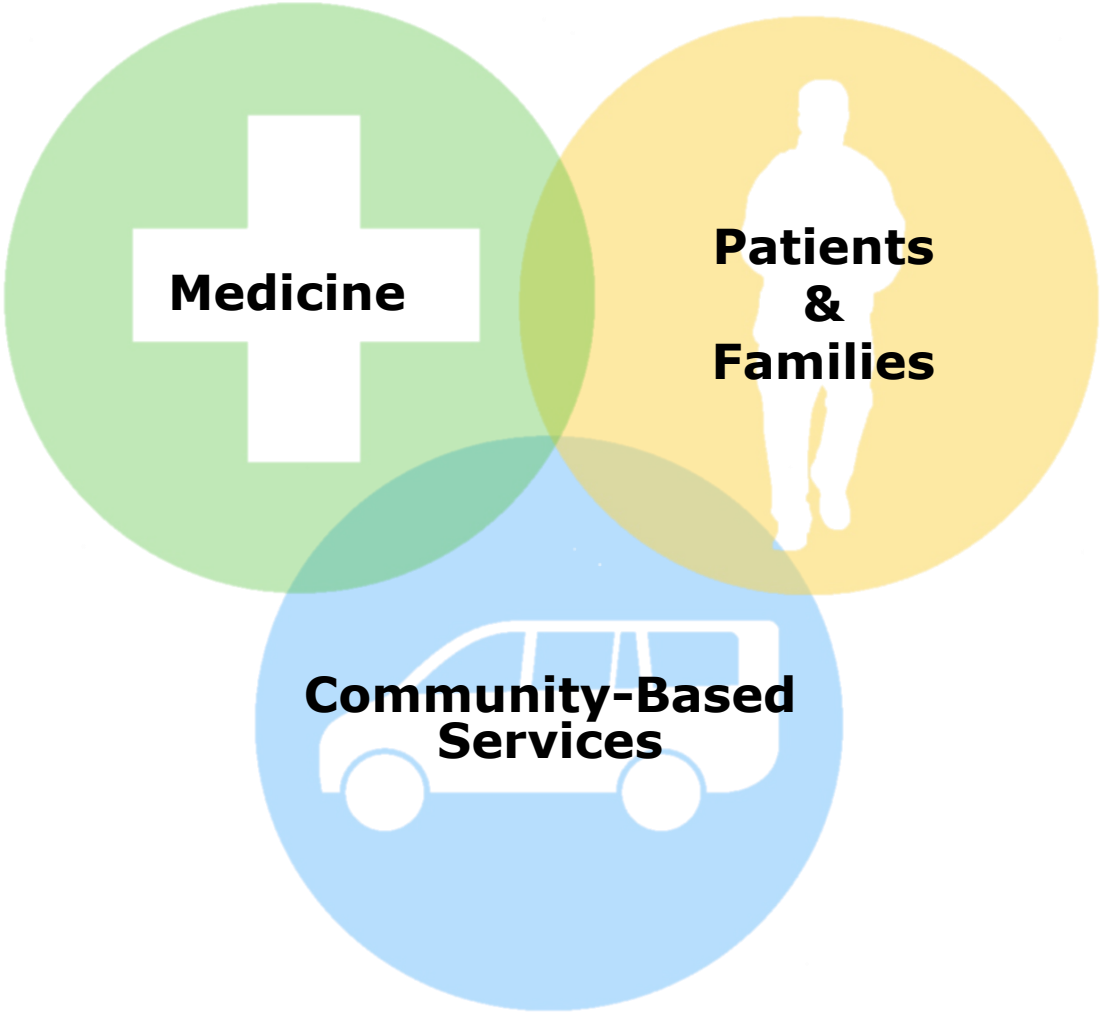
Three-way partnership for whole person care



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Comprehensive Person-Centered Coordinated Community Care

Referred Services

- Adult Day Services
- Home Health
- Hospice/Palliative Care
- Hospice
- DME
- Caregiver Support Programs
- Senior Center Exercise/Evidence-Based Health Programs
- Home-delivered meals
- Housing Options
- Legal Services
- Financial/Insurance/Legal Assistance
- Transportation

In-Home Assessment & Service Delivery

- Nurse
- Client & Family
- Social Worker

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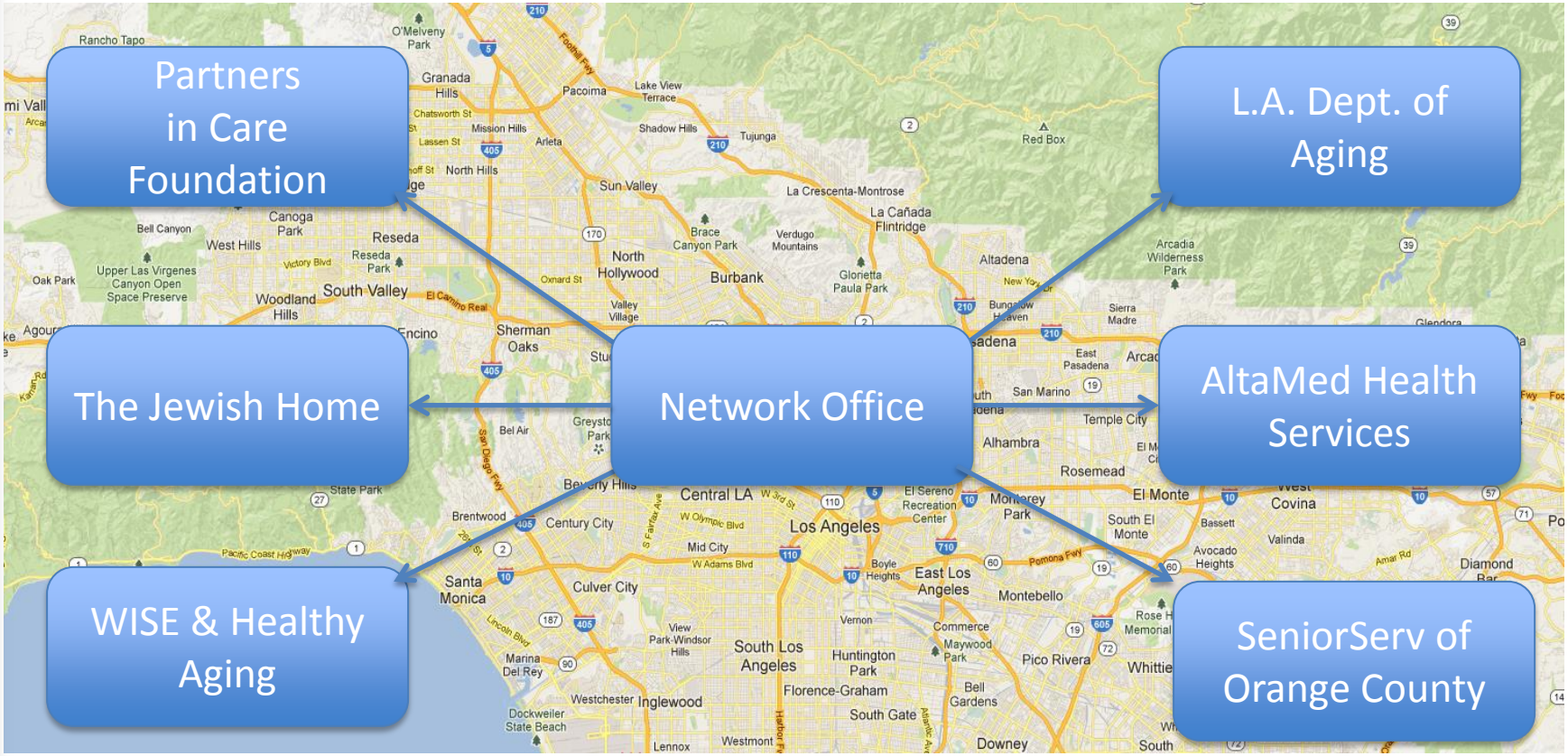
Purchased Services (Credentialed Vendors)

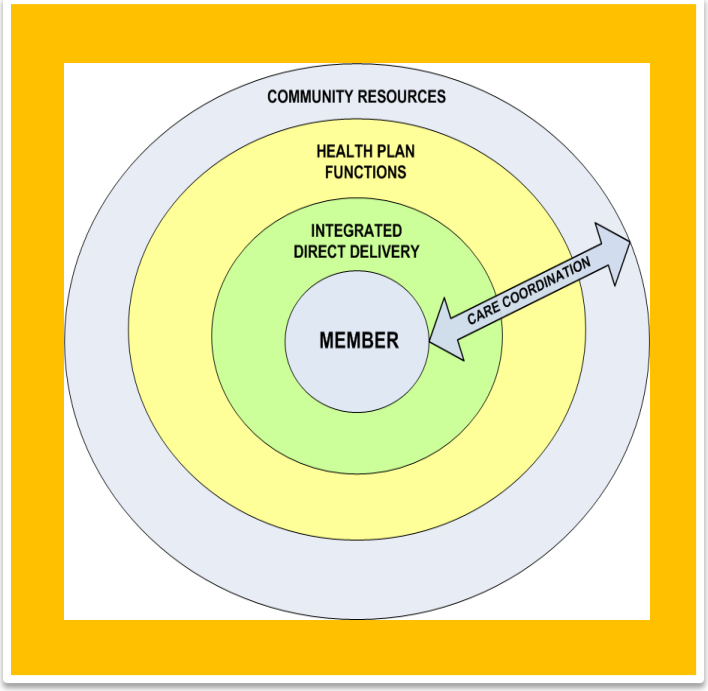
- Home Safety Adaptations
- Home Maintenance
- Emergency response systems
- In-home psychotherapy
- Emergency support (housing, meals, care)
- Assisted transportation
- Home maker (personal care /chore) and respite services
- Heavy cleaning
- Home-delivered meals – short term
- Medication management (HomeMeds, reminders, dispensers)
- Other products & services to support independence

Integrated Community Care System

One Call Does It All!



Together – We Can Manage Population Health and Lower Costs



Health Plan Functions

- Enrollment and disenrollment/UM & CM
- Claims and Data Analysis
- Tiered & comprehensive coverage

Hospital and Physician Functions

- Identify patients in need of home follow-up
- Connect patients with coaches
- Provide complete discharge information

Community Resources

- Comprehensive assessment to identify high-risk patients & target appropriate services:
  - Patient activation & self-care coaching
  - Care coordination/in-home support
  - Access to Public benefits/IHSS/CBAS
  - Caregiver Support
  - Transportation, food assistance, housing
  - Evidence-based self-management & HomeMeds
  - Feedback/data to PCP, Hospital & Health Plan

For more information

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