Bringing healthcare, families and community-based services together.
The “Business Institute”

The mission of the Aging and Disability Business Institute (Business Institute) is to successfully build and strengthen partnerships between community-based organizations (CBOs) and the health care system so older adults and people with disabilities will have access to services and supports that will enable them to live with dignity and independence in their homes and communities as long as possible.

aginganddisabilitybusinessinstitute.org
• Challenges and Barriers to Integration
  – Disruptive concept and change process
  – Buy vs. build
  – Regulation / Change on both sides
  – Evolving system demands
    • Technology/PHI
    • Consolidation
      – National MSO for Home Community Based Svcs
Buy vs. Build: Why Partner?

- Community: A new specialty for SDOH
- System of Care vs. Social Work Staff
- Broad geographic coverage
- Diversity in language, culture and skills
- Efficiency – unpredictable spread of need
- Quality – NCQA accreditation for complex case management; HEDIS & Medicare Stars
CBO Networks – A Regional Specialty Care System

One call does it all!

- Service Coordination
- Comprehensive Assessments
- HomeMeds/Med Reconciliation
- Evidence-based Self-Management
- LTSS: Meals, home mods, transport., etc.
- Behavioral Health Specialists
Identifying Outcomes of Interest

- Reach members who need to improve health behaviors, are non-adherent, or have complex social needs
- Meet members’ community support needs
- Qualify members for benefits & programs
- Avoid adverse drug effects
- Improve medication adherence
- Improve self-care & self-management

• Improve Star ratings, HEDIS, meet NCQA CM standards
• Reduce inappropriate utilization
  – ED, Hospital, SNF/Rehab
• Optimize physician performance under MACRA
• Improve member satisfaction
• Improve member retention
Low Ratio of Social to Health Service Expenditures in U.S.

CBOs Can Affect 60% of US Premature Deaths

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.
CBOs & Social Determinants of Health (SDOH)

- Housing, Meals, Transport
- Benefits Counseling & Assistance
- Access to Care: Coaching & Navigation
- Community Connection / Caregiver Support
- Patient Engagement Activation

SDOH

changing the shape of health care
Hospitals, Primary Care & CBOs

- **Hospital** – GET them well
- **Primary care** – KEEP them well
- **CBOs** – support wellness at HOME
  - Lifestyle/self-management
  - Medication management support
  - Appropriate nutrition through meals, teaching, benefits
  - Caregiver support
  - Assistance with activities of daily living
  - Transportation to healthcare
  - Reduce falls & environmental risks
  - Eyes & ears in the home for healthcare
Missing Data = Increased Risk

• Typical in-home assessment includes:
  – Medications inventory – Rx from all sources, OTC, borrowed, etc.
  – Patient understanding of meds & adherence issues
  – Incidents/adverse effects – like falls, dizziness, confusion
  – Physical & cognitive functioning
  – Screening for depression, anxiety, sleep
  – Nutrition – diet, shopping, affordability, ability to cook
  – Financial info: ability to afford care
  – Transportation for access to care
  – Family & Caregiver information
  – Home safety & housing conditions – fall prevention
  – Advance directive – inquire, introduce, encourage, document
  – Behavioral health: Diet, physical activity, alcohol, tobacco
Why health care may miss adherence issues and other environmental threats
Targeted Patient Population Management with Increasing Disease/Disability

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

- Home Palliative Care
- Post Acute and Long Term Supports and Services

- Hot Spotters!

Evidence Based Self-Management, Home Assessment and HomeMeds

Partners in Care Foundation
Changing the Shape of Health Care

Partners AT HOME
A Community Network of Partners in Care
### Key to Value – Careful Targeting

<table>
<thead>
<tr>
<th>Partners/UCLA CCTP Readmission Risk Criteria</th>
<th>BOOST</th>
<th>LACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission within last 30 days; 2+ admissions in prior 12 months; or 2+ ED visits in last 6 months</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Length of stay greater than 10 days</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>8+ outpatient medications &amp;/or adjustment of 2+ meds at discharge</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Discharged home with limited caregiver support</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Two or more chronic conditions</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Depression as secondary diagnosis</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Mild cognitive impairment, especially with inadequate caregiver support</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>

**Patients to be excluded:**
- Children (patients under age 18 or 21)
- Patients with planned readmissions (e.g., inpatient chemotherapy)
- Patients who are enrolled in hospice.
What do CBOs provide to support health and avoid readmissions?

• Care Transition Choices
  – Coleman model – in-home coaching
  – Bridge model – telephonic social work

• Home visit with med review & psychosocial assessment and service coordination – by Coach HomeMedsPlus

• Nursing Home Diversion/Repatriation

• Evidence Based Self-Management Programs – Address falls, chronic pain, diabetes and other chronic/progressive conditions
HomeMedsPlus: Population-level readmission outcomes in Medical Group/Medicare Advantage

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% Readmission rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-Risk (LACE≥11)</td>
<td>15.1</td>
<td>13.7</td>
</tr>
<tr>
<td>Others (LACE≤10)</td>
<td>26.9</td>
<td></td>
</tr>
<tr>
<td>Intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pre-Post 3% Absolute Decrease among high-risk population; Net of “background” decrease</td>
<td>Intervention group 66% relative decr.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To Meet Increasing Needs, Statewide Aging/Disability Service Networks Are Expanding

CA Partners at Home Network

IN Indiana Aging Alliance

OH Direction Home

OK Oklahoma Aging & Disability Alliance

TX Healthy at Home, T4A

WA Conexus Health Resources

NY Western NY Integrated Care Collaborative

MA Healthy Living Center of Excellence & Greater North Shore Link

PA Aging Well, LLC

VA Eastern Virginia Care Transitions Partnership

Florida Health Networks

1 Not a full statewide network
June Simmons
President and CEO
Partners in Care Foundation
jsimmons@picf.org