Geriatric Care and Transitions of Care for Older Adults

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Partners in Care FOUNDATION℠

Driving the new shape of care

Disclosures

The following CME planners and faculty do not have relevant financial relationships with ineligible companies in the past 24 months:

- Leilanie Mercurio, Provider Continuing Education (PCE) Program Manager, L.A. Care Health Plan, CME Planner.
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- Bettsy Santana, MPH, Senior Manager of Initiatives, Quality Improvement, L.A. Care Health Plan, CME Planner.
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Commercial support was not received for this CME/CE activity.

Learning Objectives

Recommend a community-based organization with an effective and successful care transitions program for older adults

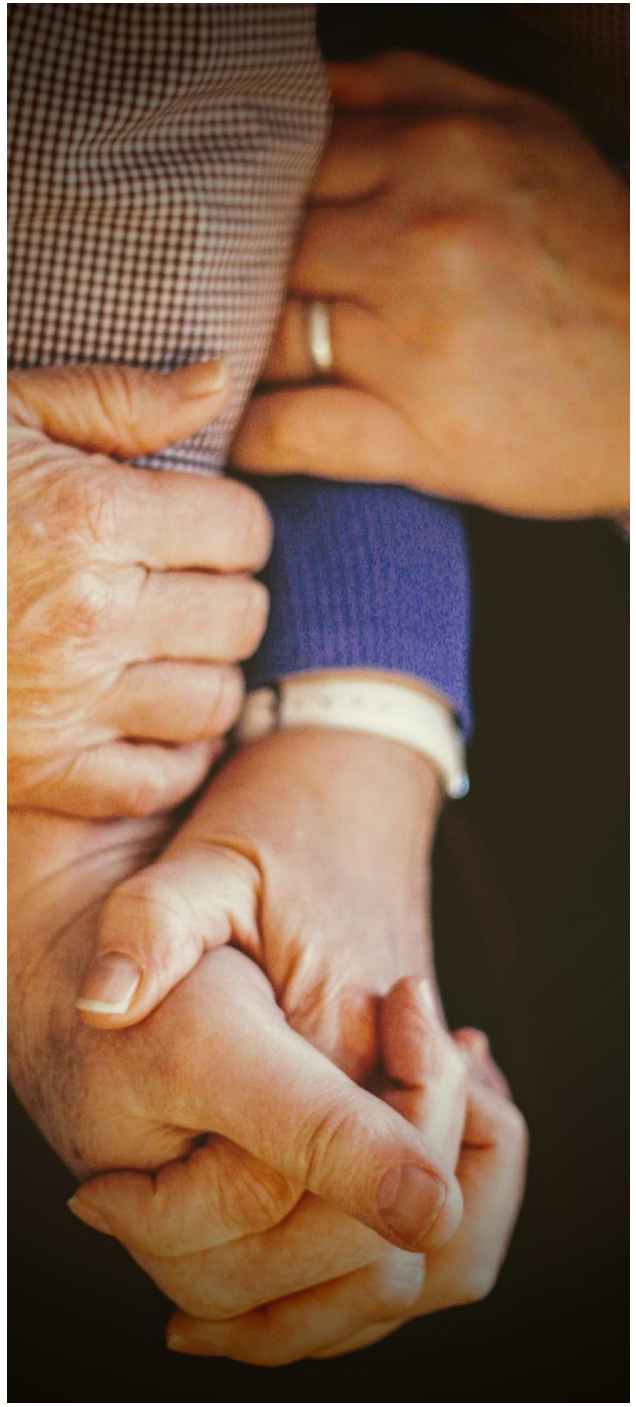
Identify at least two (2) ways to target individuals at risk for potential readmission

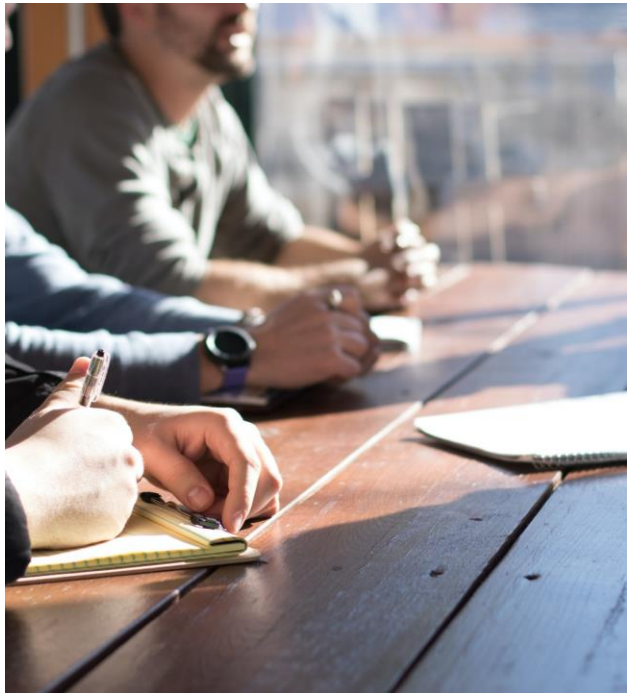
Specify at least two (2) care transitions techniques for older adults

Summarize three benefits of working with a Community Care Hub (CCH) to support transitions of care

A Mission-Driven Organization

Addressing Health Disparities and Inequities.





Mission

Partners aligns social care and health care to address the social determinants of health and equity disparities affecting diverse, under-served and vulnerable populations.

Vision

A world where every person has equitable access to health and social care.

Our Values

Develop Innovation

Develop innovations through our efforts focusing on new ways to effectively promote health-producing behaviors and establish supportive services that enable high-risk populations to achieve optimum functioning in community settings.

Create Impact

Create impact as we create and scale easily replicable models of care to improve lives and we work for their broad adoption.

National Leadership

Provide national leadership as we work respectfully with those we serve and with public and private providers, payers, agencies, and funders.

Partners in Care FOUNDATION

Driving the new shape of care

Partners in Care Foundation – The Social Determinants

1. Our work serves as a bridge between medical care and the personal health milestones achieved at home.

2. We manage the gaps in non-medical care that affects a person's recovery and overall health.

3. We represent a California network of community-based organizations (CBO's) - Partners Community Care Hub.

4. The result: enhanced well-being and health for individuals at a lower expense through care at home.

Defining A Community Care Hub (CCH)

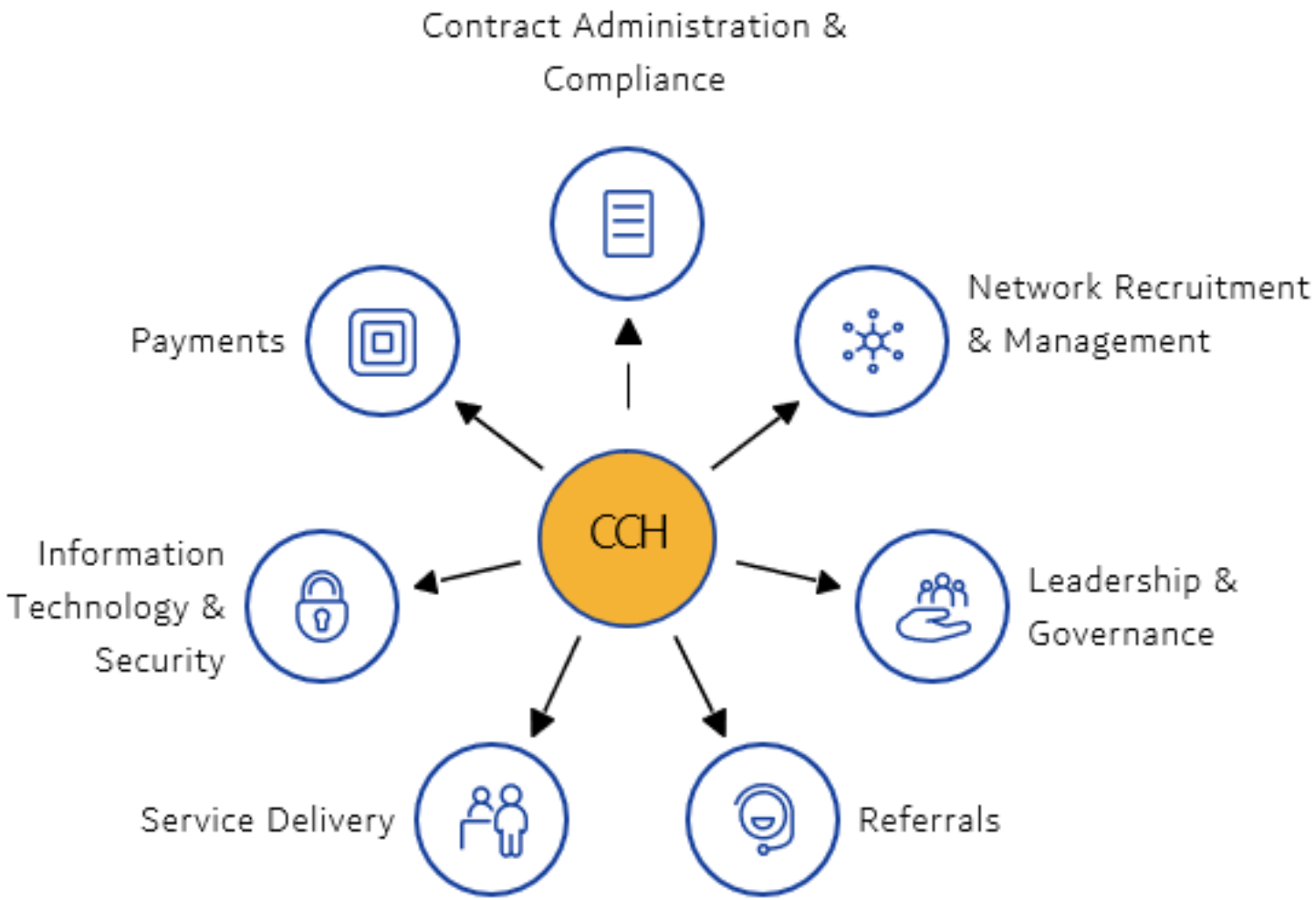
Addressing Social Determinants of Health

"A Community Care Hub (CCH) is a community-focused entity that **organizes and supports** a network of community-based organizations providing services to address health-related social needs. It **centralizes administrative functions and operational infrastructure** including, but not limited to, contracting with health care organizations, payment operations, management of referrals, service delivery fidelity and compliance, technology, information security, data collection, and reporting.

A Community Care Hub has **trusted relationships** with and understands the capacities of **local community-based and healthcare organizations** and fosters cross-sector collaborations that practice **community governance with authentic local voices."**

Source: Partnership to Align Social Care

Partners Community Care Hub (CCH) Centralizes:



One Call Does it All

Comprehensive, Culturally Meaningful and Linguistically Appropriate Patient Care Coordination.

- Patient Education, Engagement and Eligibility Screening
- Care Management, Service Coordination, ECM
- Medication Reconciliation
- Community Supports: Meals, Private Duty, Housing

Comprehensive Patient Care Coordination

Patient Education, Engagement and Eligibility Screening

Provide comprehensive and personalized patient education, engagement, and eligibility screening to ensure patients are informed and able to access necessary care services.

Care Management and Service Coordination

Coordinate and manage patient care by providing case management, service coordination, and enhanced care management (ECM) to address the complex medical and social needs of older adults.

HomeMeds and Medication Reconciliation

Conduct comprehensive medication reviews, including HomeMeds assessments and medication reconciliation, to optimize medication management and prevent adverse drug events.

Comprehensive Patient Care Coordination cont.

Culturally Appropriate Care Coordination

Deliver culturally meaningful and linguistically appropriate patient care coordination to ensure patients receive personalized, inclusive, and culturally sensitive services.

Community Support Services

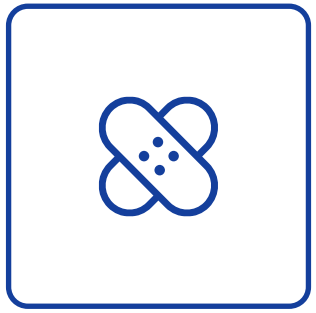
Connect patients with community-based resources and services, such as meals, private duty care, and housing assistance, to address social determinants of health and promote independent living.

Transportation Assistance

Facilitate transportation services to ensure patients can access necessary care and community-based resources.

Partners' Multi-Payer Service Partnerships

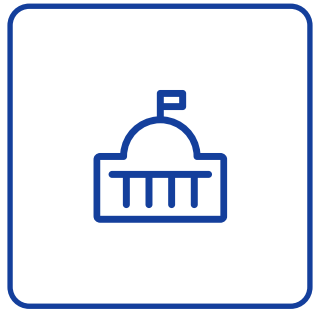
Supporting Blending & Braiding



Health Plans

Medical Practices

Health Systems/Hospitals



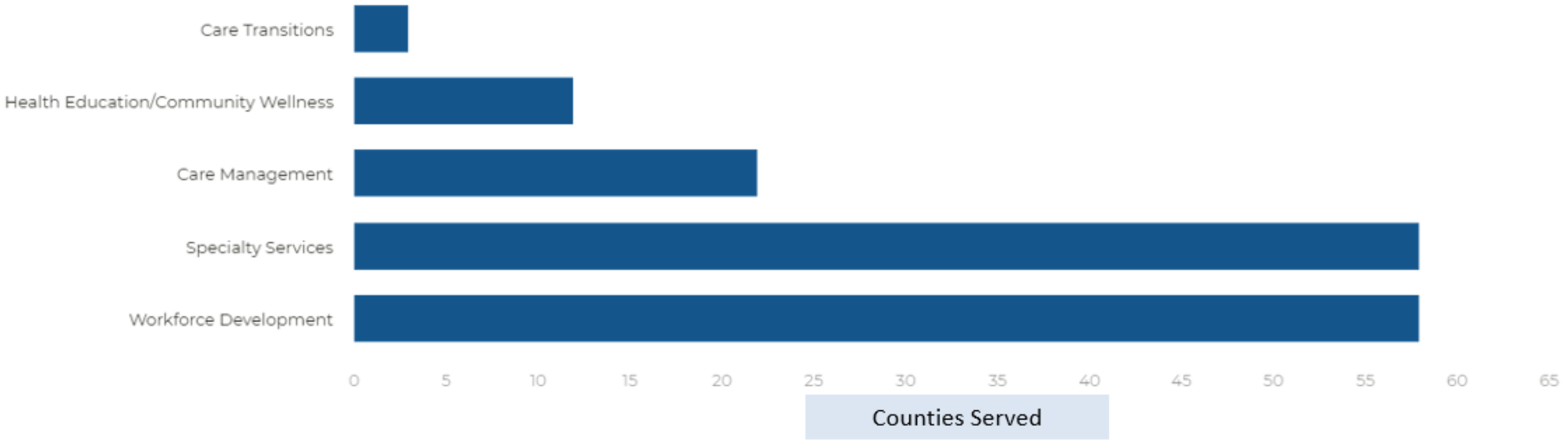
Federal, State, & Local Agencies

Services Offered Through Community Care Hub

- Short-Term Social Care Coordination/Care Management
- Care Transitions
- Private Duty Services
- Meals/Food
- Enhanced Care Management

Partners’ Statewide Network

Empowering statewide impact with comprehensive support across diverse service lines, connecting thousands to essential care with over **20,000 members served** with **86 network providers** and **9 organizations in contracting que** in Q1-Q2, 2024.



Community-Based Organizations:
Your Eyes and Ears in the Home

Local Non-Profit Partners

Focus on the home setting, augmenting clinical staff with streamlined access to multiple community-based care 'extenders' without fixed costs.

Billing Capabilities

Ability to code and bill under the Medical Loss Ratio (MLR).

Support Quality and Patient Experience

Contribute to quality and patient experience scores.

Community-Based Organizations cont.:

Your Eyes and Ears in the Home

Trained Alternative Workforce

Community Health Workers (CHWs) and social workers who live in the local communities, have depth of knowledge of Home and Community-Based Services (HCBS), and are culturally and linguistically competent.

Evidence-Based Interventions

Interventions like Care Transitions that help gather data and information typically not shared in a medical setting or encounter.

The Impact of Community Care Hubs (CCH)

- Foster Cross-Sector Collaborations
- Organized Social Care Delivery System
- Integrated Care Enhances Quality and Star Ratings
- Maximizes ROI through Social Care
- Improved Health Outcomes
- Sustainability

Care Transitions Programs for Reducing ED and Hospital Readmissions in Older Adults

CBOs delivering these services:

- Meals on Wheels Orange County
- Partners in Care Foundation

Health Happens At Home

The Impact Of What You Don't See

Implementation Design and Targeting the Right Patient

1. Implementation Team Launch Meeting and Project Planning
2. Workflow and Patient Selection Criteria Development
3. Co-Branded Collateral Creation
4. Secure Electronic Health Record Access
5. Thoughtful Rollout Strategy

Evidence-based Interventions

Care Transitions Intervention

CTI (Coaching Model)

Short-term model that complements a system's care team by empowering the patient to develop self-care skills and helps them assume a more activated role in their health through a whole-person approach.

Bridge Patient Activation

Care Coordination
Telephonic Model

A coaching model that empowers patients to develop self-care skills and assume a more active role in their health through a whole-person approach.

HomeMeds℠

An evidence-based tool that can identify potential medication-related problems that endanger the lives of a high percentage of older adults.

Care Transition Intervention (CTI)

Short-term model that complements a system's care team by empowering the patient to develop self-care skills and helps them assume a more activated role in their health through a whole-person approach.

Centered around 4 pillars

Medication self-management

Personal Health Record (PHR)

Timely primary/specialty care follow-up

Knowledge of red flags

www.caretransitions.health

Care Transition Intervention (CTI) cont.

Hospital Visit

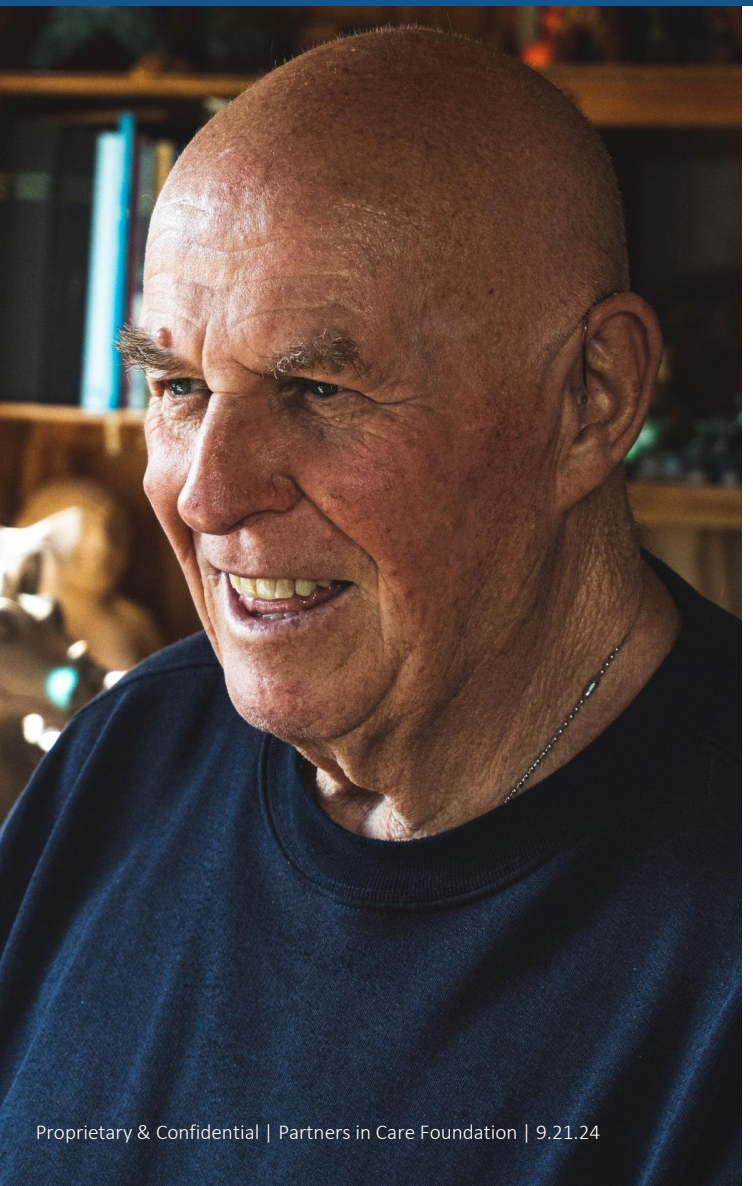
- Program introduction & obtain patient consent.
- Provide co-branded handouts.
- Access hospital EMR to understand discharge plan.
- Assist with PCP follow-up appointment.

Upon Discharge

Care transitions home visit 24-72 hours post-discharge from hospital or post-acute SNF (depending upon patient availability).

www.caretransitions.health

Care Transition Intervention (CTI)
Home Visit and Beyond



1. Comprehensive Patient Coaching

2. Follow-Up and Transportation Coordination

3. Active Patient Engagement

4. Educational Support

5. Facilitate HomeMeds℠ and On-Going Patient Support

www.caretransitions.health

Bridge Model of Transitional Care

A person-centered, social work-based, interdisciplinary transitional care intervention that helps adults with complex health and social needs to safely transition from the hospital back to their homes and communities.

- Initial Hospital Visit
- Co-Branded Handouts
- Access to EMR
- PCP Follow-Up Appointment
- Understanding Potential Needs and Barriers

www.transitionalcare.org
www.chasci.org

Bridge Model of Transitional Care: Post-Discharge

www.transitionalcare.org
www.chasci.org

HomeMeds℠

www.homemeds.org

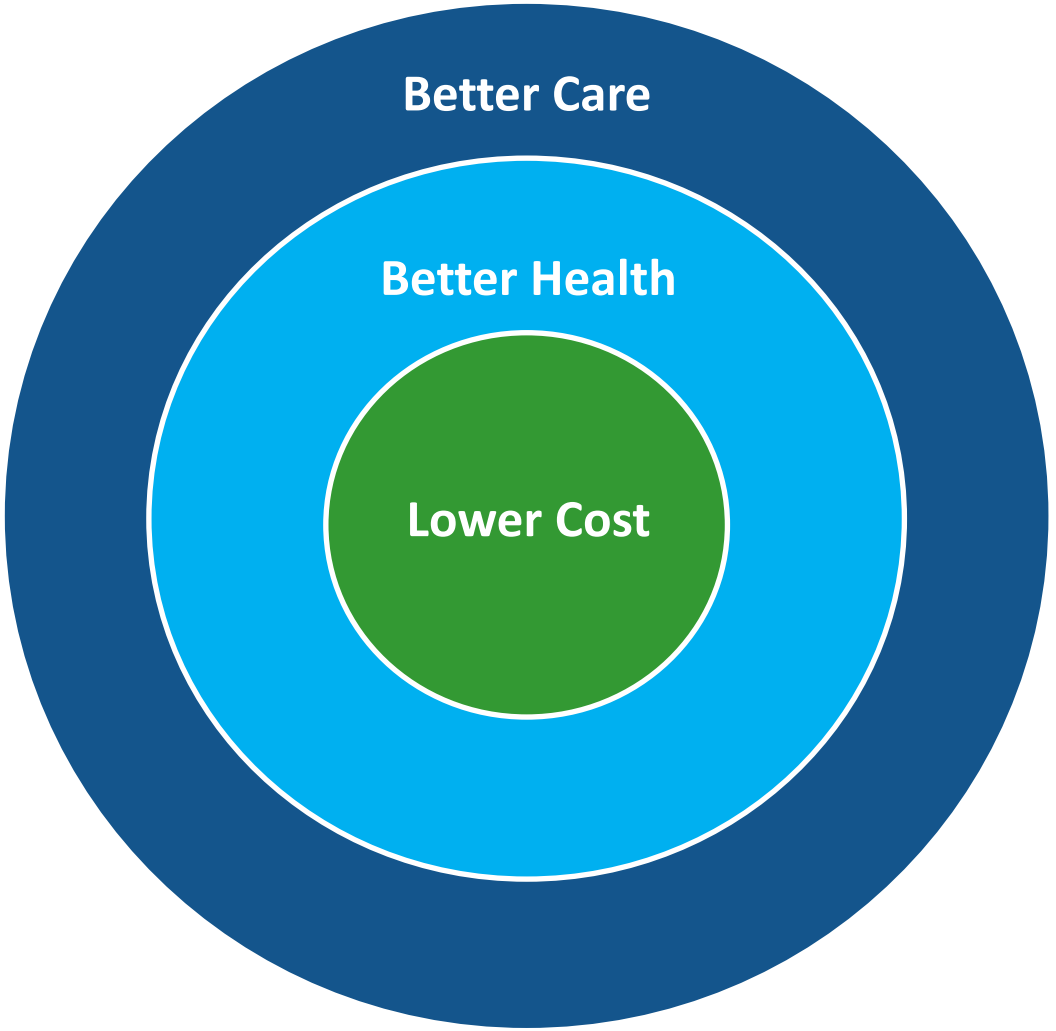
- Inventory Of Medications
- Assess For Potential Adverse Effects
- Document Adherence Issues
- Algorithm Identifies Medication Related Problems
- Pharmacist Review And Recommendations

HomeMeds℠ and the Triple Aim Expected Results

Better Care: Reduced ER and hospital visits due to effective medication management.

Better Health: Reduced falls, improved BP control, less confusion, and more.

Lower Costs: Enhanced medication utilization.



Community-Based Care Transitions Program

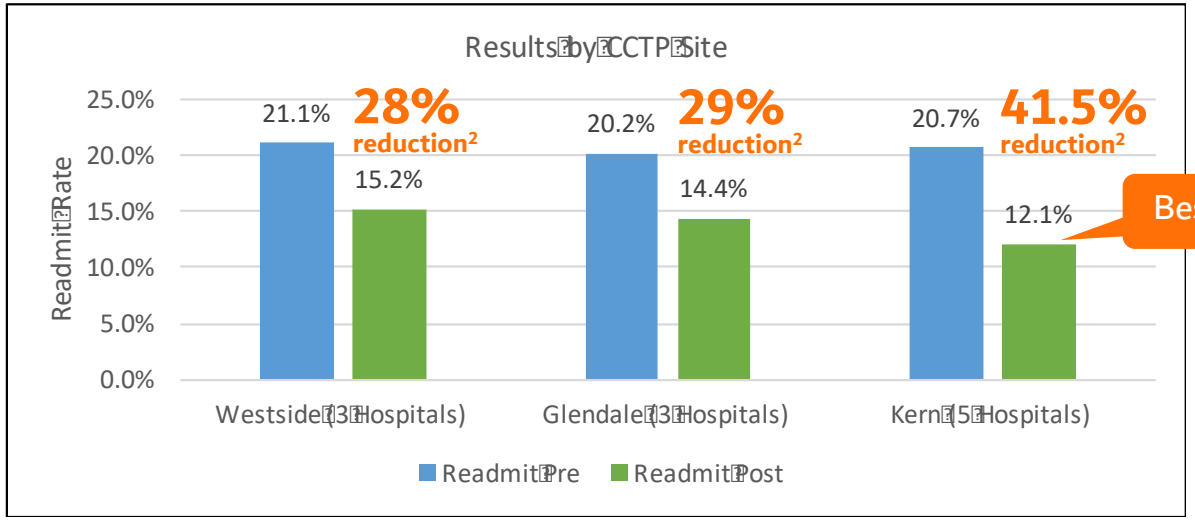
CTI, HomeMeds℠, and Bridge Patient-Activation Models

Partners' participation in CMS' Demonstration Project

Readmission Rates for:

- Pre-Intervention Baseline
- All Cause
- All Condition Medicare FFS Patients

Compared to Post-Intervention CCTP Participants across 11 hospitals.



Source: HSAG, CA QIO, November 2016

CCTP Collaborative	Participants Served	% Reduction in Readmissions	# Readmits Averted Program to Date
Westside	14,086	28%	831
Glendale	6,745	29%	391
Kern	10,508	41.5%	904

Program to Date through October 2016

[1] Baseline (Pre): All-Cause, All-Condition, Medicare FFS: Westside & Glendale = Jan – Dec 2012; Kern = Apr 2012-Mar 2013

[2] CCTP (Post): Medicare High-Risk FFS Population, Readmission Rate to Date (Westside= May 2013 – Jul 2016; Glendale = May 2013-Mar 2016; Kern = Nov 2013 – Jul 2016

Source: CMS Quarterly Monitoring Report Released March 21, 2017

SQUIRE Results

Mortality

Intervention group's mortality rates were significantly lower than the comparison group for the entire year after discharge.

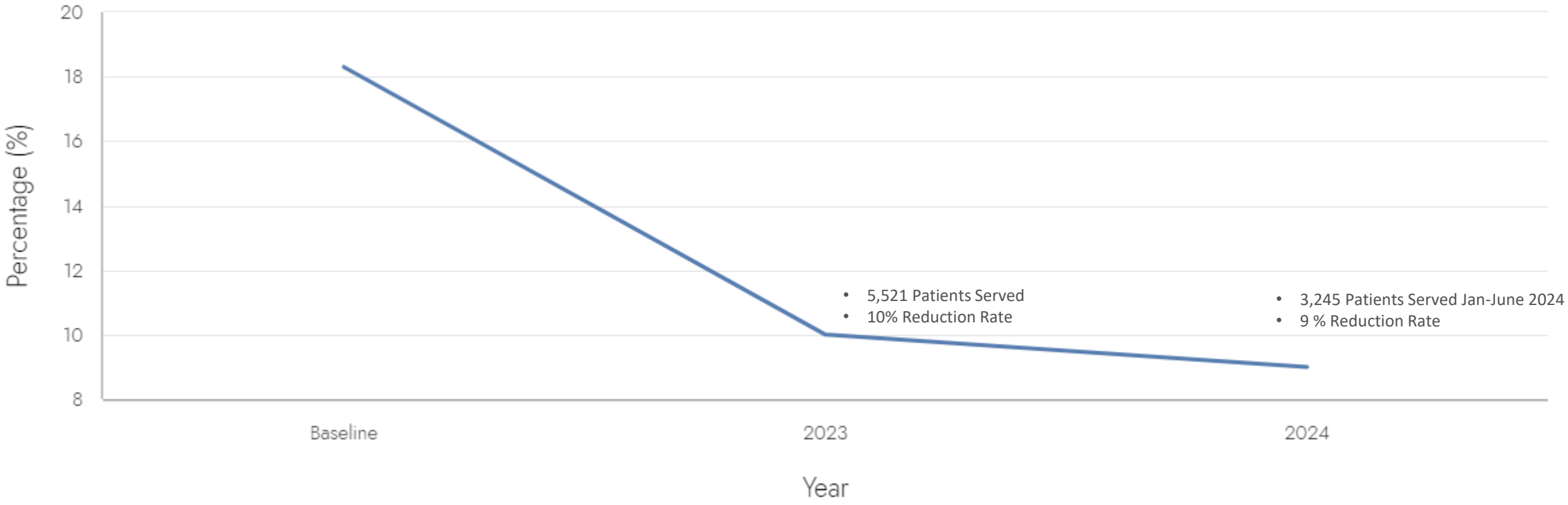
Readmissions

Intervention group's readmission rates were significantly lower than comparison group up to 60 days after discharge.

Medicare Spending Per Beneficiary

Intervention group's average MSPB was significantly lower than comparison group at 30, 60 and 90 days after discharge.

Readmission Reduction in California Large Health System



The readmission rate has declined steadily from the baseline of 18.3% to 10% in 2023 with over 5,521 patients served and further down to 9% with over 3,245 patients served from Jan-Jun 2024.

Expanded Care Transitions Services & Impact Beyond Readmission Reduction

- **PCP Post-Discharge Appointments**

  While still hospitalized, 90% of referred patients had post-discharge appointments with their PCP scheduled by Partners' coach.

- **Patient Engagement**

  More than 67% of patients reported attending a follow-up appointment with their physician after discharge.

- **Medication Management**

  Each patient had an average of two medication alerts requiring pharmacist review.

- **Social Determinants of Health**

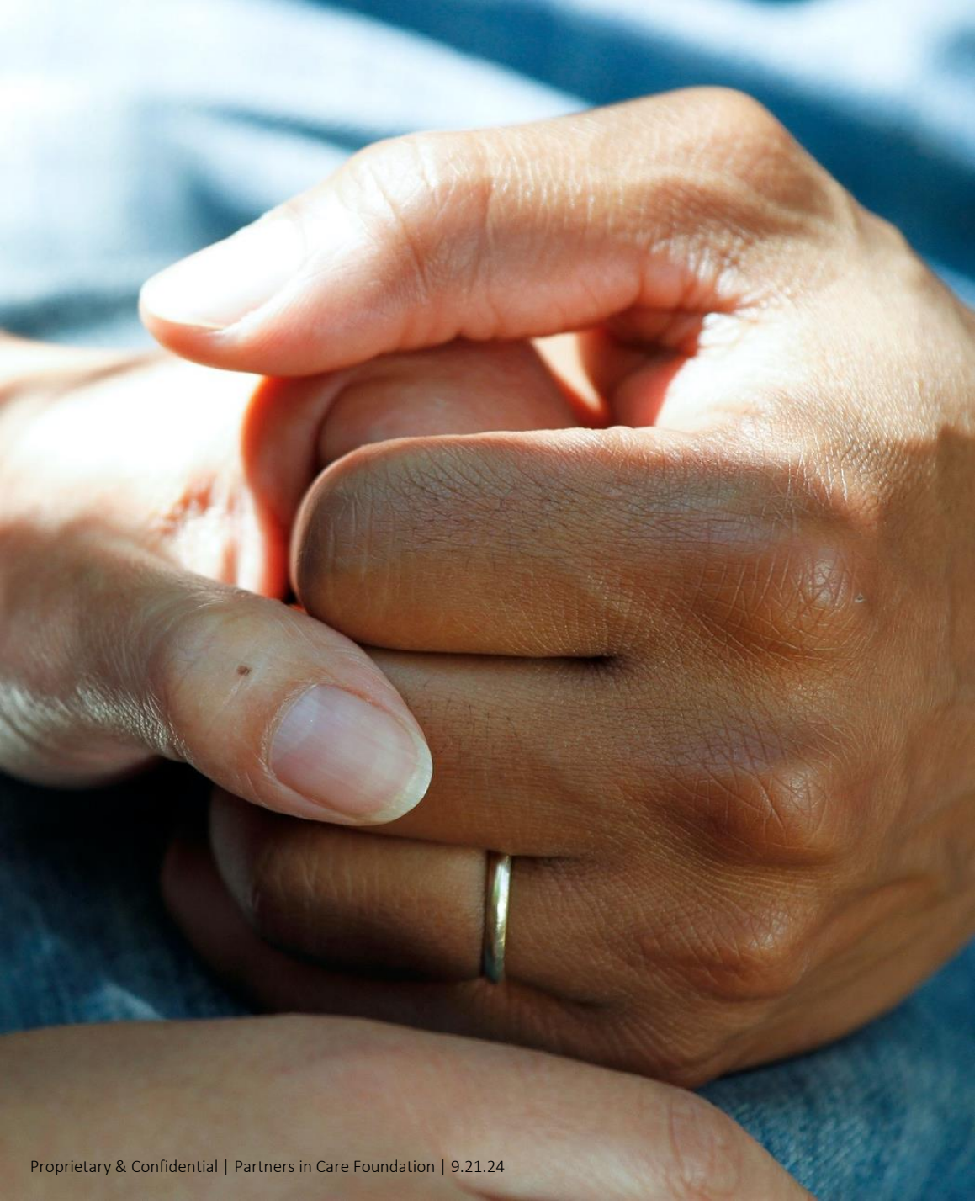
  Partners' staff addressed an average of 3 SDOH needs per patient.

- **Patient-Centered Goals**

  Each patient sets a personal goal used to motivate and enhance engagement.

- **Interdisciplinary Collaboration**

  Partners participate in IDT meetings and monthly readmission reviews.



Geriatric Social Care Programs: Care Management and Community Wellness

Enhanced Care Management (ECM)

CBOs delivering these services:

- MEND Poverty
- Green Tree Home Care
- Senior Home Advocates

CalAIM Enhanced Care Management

Whole-Person Care Approach

ECM addresses both clinical and non-clinical needs of high-need Medi-Cal managed care members.

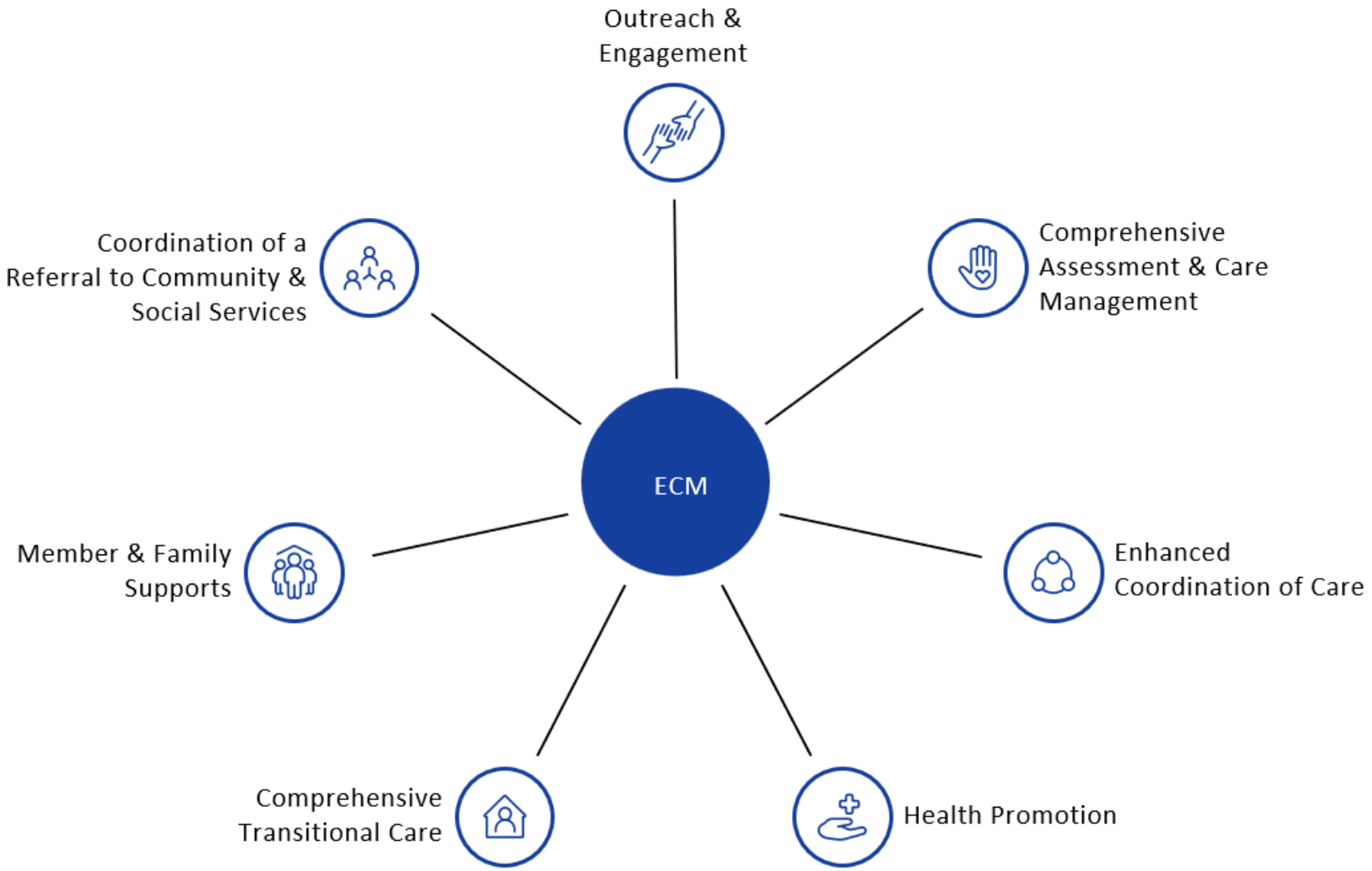
Experience-Based

Builds on Health Plans' experience with county-based Whole Person Care (WPC) pilots and the plan-based Health Home Program (HHP).

Addressing SDOH

WPC and HHP use whole-person care approaches to tackle underlying social determinants of health (SDOH).

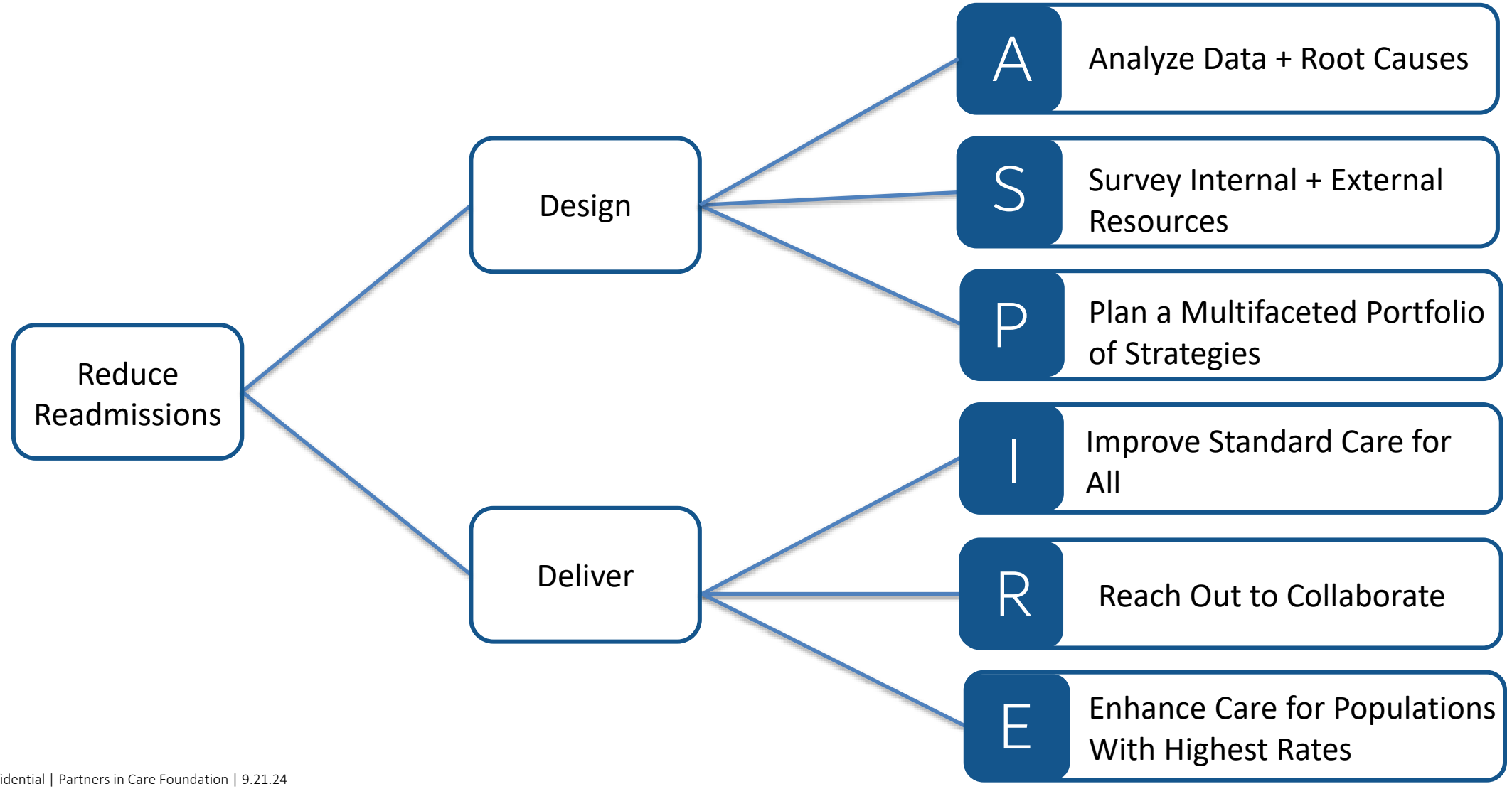
ECM’s Seven Core Services



ASPIRE

To Improve Hospital-ECM Connections

What is ASPIRE?



ASPIRE Collaboration with Partners

Goal: Increase the number of patients in the ED/hospital referred to the CalAIM Enhanced Care Management (ECM) program to avoid readmissions through the process of creating a basic learning system workflow.

Through 12 weekly sessions, the collaborative's objectives include:

- Timely Linkage: Provide definitive, timely linkage while the patient is in the hospital or ED.
- Closed-Loop Communication: Ensure effective communication throughout the process.
- Simplified Identification: Work with hospitals to identify ECM-eligible patients easily.
- Personalized Engagement: Offer warm, professional recommendations to hospital teams.
- Optimal Linkage Process: Collaborate to determine the best hospital-to-ECM linkage process.

Multipurpose Senior Services Program (MSSP)

Supporting Older Adults to Remain Safely at Home and Age in Place

MSSP Purpose

Supporting older adults and allowing them to age in place, by:

delaying or avoiding entirely, unnecessary, and costly nursing home placement through the provision of long-term care services and supports necessary for independent living.

MSSP Description and Benefits

Interdisciplinary Team

Provides a team consisting of a nurse and social work care manager to determine unmet needs of older adults through the assessment of two disciplines.

Assessment and Care Planning

Comprehensive health and psychosocial assessment performed by interdisciplinary team to develop an individualized person-centered care plan to address the unmet needs and gaps in care identified through the assessment process.

Care Management

Carrying out care plan through extensive coordination of community resources, advocacy, service arrangement and ensuring delivery of services, and monitoring changes in care needs.

MSSP Description and Benefits (cont.)

Eligibility

Older Adults 65+ enrolled in Medi-Cal who live within the catchment area of designated agency, have a physical residence, willingness to participate in the care plan by allowing services to be provided in their homes and demonstrate need for care management to avoid placement in a nursing facility and prevent repeated hospitalization

Services Provided

Emergency Response System, incontinence supplies, household items (i.e., microwave), safety equipment (i.e., handrail, grab bars), oral nutritional supplements, transportation, respite for caregivers, delivered meals, household chore and personal care assistance, minor home repairs

Locations

There are 35 MSSP sites in the state of California. They can be found on the California Department of Aging website:

MSSP Sites

Community-Based Adult Services (CBAS)

- Promoting Mental & Physical Activity
- Reducing Isolation
- Improving Health
- Preventing Decline in Older Adults

CBAS *(formerly known as Adult Day Health Care Centers)*

Purpose

Supporting frail older adults, who may be at risk of being placed in a nursing home, with a variety of community-based day care services to restore or maintain their optimal capacity for self-care.

Services Provided through Multidisciplinary Team

Medical services, nursing and personal care services, physical, occupational and speech therapy, psychiatric and psychological services, social services, therapeutic activities, hot meal and nutritional counseling, transportation to and from the center.

Locating a Center

CBAS Centers are located across California.

They can be found on the California Department of Aging website:

CBAS Centers

Evidence-Based Programs

Bringing health education and self-management skills to older adults.

Evidence-Based Workshops

Self-Management

Chronic Disease Self-Management Education (CDSME) providing tools to help older adults better manage chronic conditions such as diabetes, heart disease, arthritis, chronic pain, and depression.

Examples include Chronic Pain Self-Management and Diabetes Self-Management.

Fall Prevention

Workshops that have been proven to reduce falls, fear of falling, and fall related injuries in older adults.

Examples include A Matter of Balance, Bingocize, and Tai Chi for Arthritis.

Physical Activity

Programs focused on effective ways to help older adults with common conditions, like arthritis, get more active.

Examples include Arthritis Foundation Exercise Program, Walk With Ease, and Enhance Fitness.

Find a Workshop

Resources

- CMS: Evaluation of the Community-based Care Transitions Program (CCTP)
- JAGS: Complexities of care: Common components of models of care in geriatrics
- Impact of a Combined Coleman Care Transitions Interventions® and Bridge Model Intervention on Readmissions and Medicare Spending
- Ten Years of the Hospital Readmission Penalty: Lessons Learned & Best Practice Providers
- Better Care Playbook: Understanding How Social Care Programs Impact Health
- Medicare Learning Network Booklet: Health Equity Services in the 2024 Physician Fee Schedule Final Rule
- Community Care Hub Primer: Background, Evolution, and Value Proposition of Working with a Local CBO Network Led by a Community Care Hub
- Functions of a Mature Community Care Hub
- Health Affairs Blog: Linking Health And Social Services Through Area Agencies On Aging Is Associated With Lower Health Care Use And Spending
- Health Affairs Blog: Improving Health and Well-Being Through Community Care Hubs
- HHS Call to Action: Addressing Health-Related Social Needs in Communities Across the Nation
- US Playbook to Address Social Determinants of Health
- Linking Technology to Address the Social and Medical Determinants of Health for Safe Medicines Use
- Evidenced-Based Program: HomeMeds
- JAGS: A Collaboration Among Primary Care–Based Clinical Pharmacists and Community-Based Health Coaches
- LACE+ Readmission Risk Screening Tool

Frequently Asked Questions

What is a Community Care Hub (CCH)?
"A Community Care Hub (CCH) is a community-focused entity that **organizes and supports** a network of community-based organizations providing services to address health-related social needs. It **centralizes administrative functions and operational infrastructure** including, but not limited to, contracting with health care organizations, *payment operations, management of referrals, service delivery fidelity and compliance, technology, information security, data collection, and reporting.*

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Source: Partnership to Align Social Care

Frequently Asked Questions (cont.)

Which evidenced-based interventions make up Partners in Care Foundation's care transitions program?

- Care Transitions Intervention (CTI), Bridge Patient Activation, and HomeMeds.

What is the average number of health-related social needs (HRSNs) addressed per older adult patient by Partners in Care Foundation's care transitions coach?

- On average, 3 HRSNs per patient were identified and addressed by transitional coach in Partners in Care Foundation's 30-day care transitions program.
- This includes need for durable medical equipment to help prevent falls, lack of access to transportation for medical appointments and socialization, and support in making timely follow-up physician appointments post discharge.

What percentage of HomeMeds assessments identify a possible medication-related problem?

- In 60% of HomeMeds assessments some possible problem is identified.
- A pharmacist will then review the HomeMeds report and make recommendations to PCP or another prescriber.

Thank You!

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Partners in Care FOUNDATION
Driving the new shape of care

ACCREDITED NCQA CASE MANAGEMENT FOR LONG-TERM SERVICES & SUPPORTS 3 YEARS