The role of Community Based Services in Health Care Reform and the Post Acute continuum

March 2016

Ken D Wilson
Council on Aging’s Mission

Enhance people’s lives by assisting them to remain independent at home through a range of quality services.
Community Based Services…

- Often Overlooked
- Frequently Misunderstood
Community Based Services

- Avg. enrollment - two years
We have a Coordinated Network

- Single Point of Entry
- In-home Assessment
- Ongoing Care Coordination
- Managed contracted network of community based long term care providers.
  - Quality Standards and Measures
Council on Aging of Southwestern Ohio
One Stop Access to Services

Community Services and Resources To Which COA Connects
People

- Adult Protective Services
- Assisted Living (private pay)
- Behavioral Health
- Benefits Bank
- Centers for Independent Living
- Developmental Disabilities
- Foodbanks
- Food Stamps
- Home Care Services (private pay)
- Hospice
- Hospital Care
- Law Enforcement
- Legal Assistance
- Medicaid
- Nursing Homes (private pay)
- Retirement Communities (private pay)
- Transportation
- Veterans Administration

Services and Resources Funded by COA Provided By COA or Contracted Provider

- Alzheimer's Support Services
- Assisted Living Waiver
- Caregiver Support and Education
- Elderly Services Program
- Evidence-based Programs: Chronic Disease Self Management Program, Falls Prevention, etc.
- Home Care/Community Support Services (levy or Older American’s Act funded)
- Home Modification Assistance
- Hospital to Home Transition Support (Coordinated Transitions)
- Housing Resources, Search, and Assistance
- Legal Assistance
- Medicare Part D Assistance
- Older Americans Act Services: Meals on Wheels, Congregate Meals, Transportation
- Ombudsman
- PASSPORT Waiver
- Pre-Admission Review Screening for Nursing Home Placement
- Prescription Assistance
- Public Benefits Enrollment Assistance
- Senior Center Services
- Volunteer Recruitment
Our Community Based Care... by the numbers

- **19,855** clients receiving care coordination and in-home services
- **41,051** calls for information and resources
- **7,500** transitions from hospitals
- **1.5 million** meals
- **1 million** hours of in-home care (not skilled)
- **309,864** trips to doctor appointments and other settings.
- Thousands of Grab bars, med dispensers, etc.

From 2015 annual report
How are these services funded?

- Not a Medicare Benefit
- Medicaid Waiver Programs
- Senior Service Levies

Future:
- Funded via sharing in risk based contracts
The role of community based services is changing
Turned our world upside down
Our Legacy Focus (past)

- Providing LTC choices and options
- Building a delivery system in the community
- Argue with SNF industry over funding
We were successful:
LTSS impact on Nursing Home usage
– (per 1,000 60+ in Ohio)

<table>
<thead>
<tr>
<th>Year</th>
<th>Nursing Facility</th>
<th>Long Term Services and Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>24.5</td>
<td>7.3</td>
</tr>
<tr>
<td>2001</td>
<td>22.5</td>
<td>9.2</td>
</tr>
<tr>
<td>2005</td>
<td>21.2</td>
<td>11.4</td>
</tr>
<tr>
<td>2011</td>
<td>18.5</td>
<td>15.4</td>
</tr>
</tbody>
</table>

Source: Miami University, Scripps Gerontology, March 2013
Generating Cost Savings Across the Continuum of Care

- Home-and Community-Based Care
- Skilled Nursing and Rehabilitation Unit

Continuum of Care:
- Low cost/High Independence
- Interventions Between Hospital and Skilled Nursing That Reduce Cost
- Interventions Between Hospitals and Home That Reduce Cost

High Cost/Low Independence:
- Interventions Between Hospitals and Skilled Nursing That Reduce Cost:
  - Intervention 1
  - Intervention 2
The United States Spends a lot of money on health care

US spends two-and-a-half times the OECD average

Total health expenditure per capita, public and private, 2010 (or nearest year)

1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.
2. Total expenditure excluding investments.
Information on data for Israel: http://dx.doi.org/10.1787/888932315602.

Source: OECD Health Data 2012.
Health Care Coverage 65+

**Medicaid** - a small payer for health care

- **Medicare**: 85%
- **Dual-Medicare/Medicaid**: 15%

Legend:
- Medicare
- Dual- Medicare/Medicaid
And a big payer for long term care

- **Medicaid**: 62%
- **Out of Pocket**: 22%
- **Private**: 12%
- **Other Public**: 4%

Source: The Scan Foundation, 2013
Southwest Ohio has a unique opportunity

- Local Senior Levies $34 Million local investment
- Flexibility
- ROI in health savings re-invested to provide more services
Current Long Term Services and Supports for older adults via Council on Aging

N= 19,855

85% Medicare Population

Senior Services Levy 65%

PASSPORT 6%

Assisted Living 2%

Ohio Home Care 4%

MyCare - Aetna 14%

MyCare - Molina 9%
New Focus - Better Care at Lower Costs

- Developing coordinated models of care in the community that lowers the cost of health care
- Ensuring smooth transitions between hospital or skilled nursing facility and home
Non-medical services have a significant impact on health care costs

- Food
- Bathing, Dressing, Grocery Shopping
- Family caregiver support
- Medication Adherence
- Accessibility of the home
- Transportation to the PCP
Think about the CJR Bundle

- Shorter hospital stay
- Shorter SNF Rehab
- Fast and smooth transition home
Care Transition – Medical Adherence Program

- Hospital
- Home
Pillars of our intervention

- Person Centered Goal
- Understanding Red Flags
- Medication Reconciliation
- Physician or Specialist follow-up
- Connection to community based services
Top Admitting Diagnosis

- Hypertension
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Pneumonia
Care Transition – Medical Adherence Program

32% and 34% improvement

Hospital Readmission Rate
- Benchmark: 21.9%
- COA: 14.9%

ED Visit
- Benchmark: 14.6%
- COA: 9.7%

N= 19,701, source- CMS QMR 11/2015
Overall Hospital Readmission decline

14% overall reduction

N= 19,701, source- CMS QMR 11/2015
Primary Care Follow up within 7 days

18% improvement

Baseline: 30.7%
COA Patients: 36.3%

N = 19,709
Post Acute Care Setting

- Home, 68%
- Skilled Nursing Facility, 32%

N = 19,709
COA LTSS Program

- In a COA program: 8%
- New enrollment: 13%
- Not eligible or no LTSS need: 79%

N= 19,709
Cost Savings

- Net savings to Medicare:
  - **$5.5 Million** from Feb 2012 – July 2015
  - 81% ROI

- Average readmission cost to Medicare is **$13,800**
Value of Community Based Organizations

- We are in the home. Feet on the street.
- Home based service delivery and care coordination system already exists.
- We understand complexity of family caregiving, home environment, nutrition, medical compliance, etc.
Meet COA client Mr. Victor @ physician office

- Well dressed, clean in a wheelchair.
- Diagnosis: Diabetic, COPD, underweight, lower back pain.
- Taking all medications as prescribed
- Diabetes appears under control
- Blood pressure in normal range
- Good diet
Mr. Victor @ home visit

- Bumping into walls, unsteady on his feet.
- Bed is a mattress on the floor... crawling on the floor exacerbating the back pain
- Bags of candy and cake all over the house.
- Unable to shower or bathe
- Missing medications, High blood pressure.
Interventions after home visit

- Nutrition education
- Diabetic home delivered meals
- Battery powered medi-set.
- Medication education
- Hospital bed
- Grab bars in the bathroom
- Physical therapy, home care aide
Today’s Caregiver: Colleen
The six imperatives for adapting to health care payment reforms
Imperative #1: non-medical solutions

- Keeping at-risk patients safe at home requires many non-medical solutions
  - In the home assessments
  - Transportation to primary care
  - Grab bars in the bathroom
  - Family caregiver support
  - Home modifications
  - Home delivered meals
  - Person centered goal setting
Imperative #2: Risk

- Skilled nursing facilities and community based organizations must share in the risk/reward to develop an effective post acute network and process for patients.
Imperative #3: Partnerships

Health systems must partner with entities that have already figured out how to make it work.

- Buy instead of build.
- Don’t reinvent the wheel
Imperative #4: Scale

- We be larger in size and geography
  - State-wide consistent product
  - Mergers
  - Formal Partnerships and Alliances
Imperative #5: We must be nimble & innovative

- Rapid cycle improvement
- Examples:
  - Fast-track enrollment into community based programs
  - Efficient quality transportation
Imperative #6: Performance

- Proven performance (data)
- Standardization
- Access to health care data
Thank You!

Clavilia, caregiver for her husband, Forrest (Alzheimer’s)