Bridging the Gap
Agenda

• Introductions

• Bridging the Gap – Opening Discussion

• Bridging the Gap – Health Reform Imperative

  Community Care *Linkages* – Building Partnerships

  ASAPs - Opportunities & Projects

  ESMV – CCTP, Care at Hand

• Questions & Answers
Bridging the Gap

Introductions

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AAA/ASAP – Elder Services of the Merrimack Valley

Mass Home Care
26 Crosby Drive, Bedford, MA 01730
“There’s No Care Like Home Care”
Bridging the Gap
Opening Discussion

The Health Care Organization (HCO) Perspective…

• ASAP’s are “good people that provide Home Delivered Meals”

How do demonstrate the value of ASAPs to health care organizations?

• Why is there a knowledge gap?

• How can technology help?
About Massachusetts LTSS

ASAP/AAA Role

Community Based
Coordination of Care: Eligibility, Care Planning and Service Authorization
RN/CMs Conduct In-Home Consumer Assessments
Provider Management and Oversight

EOEA

ASAPs & AAAs
27 Organizations, Workforce: 1,700

Providers

Caregivers & Consumers

Compliance Reporting: Federal and State
Information & Referral: Manages Resource Centers
Executes Nursing Home Diversion Models
Protective Services: Investigate Complaints and Reports of Abuse
Massachusetts has committed itself to a “Community First” approach to long term supports, promising members their right to care “in the least restrictive setting” in state law.

- Home care system has been one of the key drivers in reducing institutional costs, with programs like pre-admission and post-admission nursing facility relocation (Options Counseling, Money Follows the Person, and CSSM), plus basic home care, Enhanced home care, and Community Choices purchased service.

- “For LTSS, there are opportunities to deliver more supports in home- and community-based settings, expanding options for patients to receive care in their preferred setting while potentially achieving savings over time.” –Health Policy Commission Trends 2013
  - CHART 1 and 2: Care Transitions & Care Coordination
  - 8-10 ASAPs to be funded under CHART 2 for Care Transitions/Coordination services
Agencies on Aging (AAA)/ Aging Service Access Points (ASAP) A network of 27 non-profit agencies with delegated authority from EOEA, with distinct geographic jurisdiction. These agencies are responsible for regional planning, Information & Referral, Screening and Assessment, Service Plan Development, Case Management, and Provider Oversight.

ASAP “conflict free” model:
• The person who assesses what services a member needs does not have any financial interest in the services being provided. Care plans are based on the member’s needs, not the provider’s need to sell.
  ✓ Geriatric Service Support Coordinators for the SCOs
  ✓ Independent Long Term Support Coordinators for One Care
MA MassHealth Reform Initiatives

Future of Coordinated LTSS

“The nature of LTSS is different from medical care, as LTSS primarily address individuals’ functional and social support needs, often over a long period of time, in addition to their clinical needs.”

--The Future of MassHealth, MMPI, Blue Cross Foundation

**Improving care and sustainability for LTSS: priorities and discussion**

- **Goal:** every LTSS member has an entity accountable for coordinating overall care and outcomes/cost, based on level of need and direction from the individual

- **Principles**
  - Increased access to and integration of LTSS care
  - Community first
  - Person-centered planning along with improved coordination of care
  - Financial sustainability and cost-effectiveness

- **Potential strategies**
  - Expand integrated care model (like One Care, PACE, and SCO)
  - Promote integration of LTSS care into new payment models (ACOs, episodes of care) where appropriate

- **Topics for further discussion**
  - Best approach for scaling One Care, PACE, and SCO
  - Role of episodes of care or ACO models encompassing LTSS
  - Types of supporting data and infrastructure required
  - Approaches to assessing the level of care needed for each member
Bridging the Gap
Shifting Care To the Community

• For the past decade, MassHealth has been implementing care coordination programs designed to help consumers coordinate LTSS care to avoid or delay the need for institutional care.

• These programs are in addition to the traditional home care, Enhanced Community Options, and Community Choices programs that are the foundation for the community-based care programs in Massachusetts.
  – Choices had 6,169 clients—all nursing home eligible---at an average annual cost of $20,542.56, or $48,676 cheaper than a nursing home.
  – Total annual net savings in FY 14 from the Community Choices program alone to MassHealth was $300.28 million.
# ASAPs by the Numbers

## Services Provided

<table>
<thead>
<tr>
<th>Services Provided/ Payer</th>
<th>Consumers served annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Delivered Meals/EOEA</td>
<td>1,400,000</td>
</tr>
<tr>
<td>Home Care Basic, Respite, Enhanced Options, Community Choices/MA EOEA</td>
<td>65,000</td>
</tr>
<tr>
<td>GSSC/Senior Care Options</td>
<td>60,000</td>
</tr>
<tr>
<td>Long Term Supports Coordination/One Care Plans</td>
<td>2,550</td>
</tr>
<tr>
<td>Community Transitions Coordinator/CMS Community-Base Care Transition Programs</td>
<td>40,000</td>
</tr>
<tr>
<td>Community Resource Coordinator/ACOs</td>
<td>1,000</td>
</tr>
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</table>
Bridging the Gap
Current Efforts – 10,000ft

Healthcare Organization (HCO) Education: ASAPs provide education on who we are, what we do and how we can help whenever possible – CommunityCareLinkages

Partnerships: Demonstrating consumer success stories where the HCO/AAA partnership was key to a healthy transition from a hospital/rehab stay and how maintaining a close relationship with AAA care coordination can prevent readmissions.

Financial Opportunities: Identify potential joint projects through existing and emerging grants, technology development, and local initiatives that would benefit both sides
  • Community-Based Care Transitions Program (CCTP) – Section 3026 of the Affordable Care Act
  • Community Hospital Acceleration, Revitalization, & Transformation (CHART) Investment Program – State of MA
  • Care Coordination Contracts with HCOs and ASAPs

LTSS Information to HCOs: Give HCO’s a lens into the consumers assessments, care plan, and services delivered and early alerts on health status in the home, e.g., Community Links Portal, Care at Hand.
### Community-Based Care Transitions Programs (CCTP)

#### Evidence-based Approach to Reducing Readmissions*

<table>
<thead>
<tr>
<th>Community-Based Care Transitions Program (Start Date)</th>
<th>Individuals Served To-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merrimack Valley Care Transitions – Care Transitions Team in 6 hospitals, SNFs and Home, Care at Hand <em>(February 2012)</em></td>
<td>30,000</td>
</tr>
<tr>
<td>Central Mass/MetroWest Transitions in Care Collaborative – Coleman Coaching Team with 7 Hospitals <em>(July 2012)</em></td>
<td>11,000</td>
</tr>
<tr>
<td>Mystic Valley Basin Care Transitions Collaborative – Naylor Model with Nurse Practitioners in 4 Hospitals <em>(December 2012)</em></td>
<td>8,000</td>
</tr>
<tr>
<td>Total</td>
<td>49,000</td>
</tr>
</tbody>
</table>

*3 Lead ASAPs and 15 ASAPs serving individuals

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December 1, 2012 to July 31, 2014, this Care Transitions project reduced the hospital readmission rate from 25% for this target population to 19.5%—a **decrease of 37% in the readmissions rate.**

Another CCTP project using trained transitions coaches supported by tablet-based software enrolled community-based Care Transitions Program patients, and after six months, found that a subset of admissions they were tracking saw hospital readmissions dropped from 24% to 14%—a **39.6% reduction.** There was a **net savings to Medicare of $567,071** during the six months. (Source: AHRQ)

As of March, 2015, two of the CCTP projects are in the **top 8 performing projects in the country.** One project has served over 10,000 patients since mid-2012. This site targeted patients at high risk of readmission and has achieved **more than a 50% reduction in the 30-day Readmission Rate among its CCTP Participants.**
Community Care Linkages
Mass Home Care

Community Care Linkages is a strategic initiative that effectively integrates services of the Massachusetts Aging Service Access Points (ASAPs)/AAAs into the evolving healthcare delivery system.

ASAPs/AAAs are a valued partner in moving health reform efforts forward:

- Extensive Care Coordination and Care Transitions Experience
- Partnering with Senior Care Organizations (SCOs), Accountable Care Organization (ACOs), Patient Centered Medical Homes (PCMHs), and One Care Plans (dual eligibles)
- PCMHs/Physician Practices (MD practice based Community Care Coordinators)
- CCTP/Section 3026 (care transitions)
- HPC CHART (care transitions)
Current ASAP Activities in MA
Care Coordination and Care Transitions

Current partners:

• Non-profit health care organization with 1,000+ MDs in 50+ practice sites

• Physician and hospital network, 2,000+ network of physicians, Pioneer Accountable Care Organization (ACO).

• Physician led network of 1,000+ physicians, Medicare Shared Savings Program ACO

• Federally Qualified Community Health Center

• National health insurer serving 70 million people and nationwide network of 750,000+ physicians

AAAs, while not Medicare providers, can be an important resource in improving care coordination and care transitions.
Bridging the Gap – Success Story
The Community Linkages Program (CLP)

- This program improves the care coordination of patients and expand ASAPs “no wrong door” approach to accessing services. (6 months/60 patients)

- The Primary Care Team at Beth Israel Deaconess Medical Center (BIDMC) refers on behalf of the patient directly to the Community Linkages Specialist (CLS). The CLS is a member of the Social Work Team at the BIDMC practice.

- **The Community Linkages Specialist:**
  - Provide ongoing education & training
  - Screen for and immediately activate referrals
  - Consult on facilitating in-home & outpatient supports
  - Provide complementary services in conjunction with certified agencies at discharge, i.e., meals, home-making, laundry, grocery shopping.
  - Coordinate existing services / reactivation and referrals to new services
  - Quick connect to Boston Elder Info (Free Tel Hotline for Info & Referrals) via on-site Specialist

1. Participates in roster reviews.
2. Established office hours on-site: (up to 21 hours per week).
3. Documentation rights via email.
Bridging the Gap – Success Story
Community Resource Coordinator (CRC) at BIDCO*

- **One full time on-site CRC assist BIDCO care managers** to provide information and resources for patients, e.g. home care, caregiver support, etc. and documents information directly into EMR.

- **Referrals from BIDCO care management staff to CRC** (BIDCO has 8 care managers and 12 in MD practices). MDs are now referring directly for patients with psycho social needs.

- Created **web-based shared library of community resources** for BIDCO care managers.

- Track **Healthy Living Programs** to enhance referrals from RNs, save RNs time with improved communication.

- Assist with **connecting patients to mental health professionals**, e.g., make the first calls to facilitate connection.

- Over 2 years, served 900+ patients to date

*BIDCO – Beth Israel Deaconess Care Organization (2,100 PCPs/Specialists & Numerous Hospitals)*
Community Living Coach
Primary Care Setting

- **6 month Pilot** funded by Boston Senior Home Care (Mass Home Care grant)

- **CLC** part of Harvard Vanguard Health Care Team at Kenmore.

  *The CLC uses a coaching model to help elderly and disabled patients learn new skills and gain confidence to better manage their health conditions…*

- The CLC provides:
  - **1:1 coaching to patients** through face-to-face visits at Kenmore practice, hospital and home visits, telephonic assessment, education, & support
  - **Referrals** to Home Care & Mass Health Programs, Evidence-Based Programs & Community Resources.
Current Strategy
Being the Preferred LTSS Provider

- Align ASAP’s value to healthcare organization’s vision
- Identify point person for communication, referral and follow up
- Develop pilots to demonstrate value
  - Identify quality and performance metrics
  - Establish for monitoring and reporting
  - Share and spread lessons learned
- Analyze and promote results
  - Continuous sales to internal and external stakeholders

➢ Be present, visible: “on radar screen”
➢ Be ready when “they” are ready:
  - Strengthen core services and capacity to be ready to respond
  - “Having the right people, resources and reputation” to partner
Bridging the Gap
AAA/ASAP Opportunities & Projects

• AAA (Area Agency on Aging) – Private, non-profit 501(c)3 organization serving 23 cities and towns in Northeastern Massachusetts for 40 years

• ASAP – designated by Massachusetts as Aging Services Access Point

• Core Functions; over 100 RN’s and Social Work staff provide care coordination, care management, screening and assessment for community based care and SNF (skilled nursing facility) approval

• Manage a network of over 75 vendor contracts for over 120 different community based services

• Over 30% of staff are bilingual/bicultural
CCTP (Community Care Transition Program)

- Over 20,000 referrals since inception 28 months ago
- (6) Lead Coaches imbedded into the Case Management staff at hospital
  A. Consistency!
  B. Physician and staff education
  C. Connect hospitalized patients to community resources
  D. FULL Integration into the hospital care team!

- Nurse Coordination using technology to provide clinical intervention in “real time” to complex medically compromised patients.

Managed Care provider contract currently in place for care transitions.

One Care contract in place for younger disabled dual eligible population with a managed care provider.

Healthy Living Center of Excellence – regional collaborative that provides readiness for statewide payer contracting for the dissemination of 12 evidenced based programs including CCTP and dually eligible managed care seniors.
Before Care at Hand – communication breakdowns between nurse and nonclinical coach

We were underutilizing our existing non-clinical staff
Alerts triggered by Care at Hand technology

Digitizing the “hunch” of non-clinical workers to detect early decline
Health Coach

- Same community
- Same education level
- Same language
- Same cultural background

Nurse Care Coordinator

- Care Coordination
  - Med rec
  - Red flags education
  - f/u appointments

- Care management
- Communication with physicians
- Triage
- Sick vs Not Sick
- Education of coach

For 800 patients per month, need **20 health coaches** ($30k/yr) + 1 nurse*
Over the past month, has the client had more difficulty paying for their food than most other months?

Yes  No

Does the client have a fever or feel more warm today compared to most other days?

Yes  No

Did the client sleep on more pillows last night than most other nights?

Yes  No
Interoperability PDSA: Information sent to CBO upon d/c from hospital

P: TOC (transition of care) document sent electronically from the hospital through the HIE to the CBO will this improve community coordination.

D: Nurse Coordinators used TOC on 100 pts over 2 weeks to coordinate care.

S: Only 30% of the TOC was useful in the coordination of care. It took the NC too much time to sift through the documents to provide any real value.

A: No action
Interoperability took a back seat to.....snow!
Time to First Visit Performance

Discharge date

# of weekend discharges

Days until first visit

Home  SNF  Acute Rehab  Assisted Living Facility  Weekend discharges

PDSA 1

Frequency:
Weekly

Due date from:
12/30/2014

Due date to:
03/30/2015
Time to First Visit Performance

Discharge date

Days until first visit

Frequency: Weekly
Due date from: 12/30/2014
Due date to: 03/30/2015
Back to interoperability…PDSA 3: Access to community data

Plan: (Hypothesis) Providing hospital access to CBO real-time data would enable hospital care management to be more comfortable sending patients to community rather than institutional care

Do: Provide hospital care management staff access to CBO dashboards through Care at Hand.

Study: …
Discharge location: decreased SNF, increased home

Percent of all discharges from hospital

- SNF
- Home
- ARH
- AL

PDSA 1

PDSA 2


+12%

-19%

+10%
Discharge location: decreased SNF, increased home
Timely completion of decision support assigned tasks improved after education PDSA
Individual staff contribution to outcomes enables real-time targeted promotion and capacity building, decreasing turnover.
Prevented ED visits used to calculate ROI of transition program, daily rather than quarterly
Population Health Management in a cost effective way!
Success with hospitals/MCOs made them want more…

- 2 MCO contracts
- 4 hospital contracts (CHART)
- 1 bundled payment contract with VNA
- Expanding to chronic disease self management

- Next steps…
Bridging the Gap

What barriers did we meet along the way?

Misconception - Many think the AAA only serves elder with Home Delivered Meals
- Break the barrier and show that the AAA is on the cutting edge ready to assist PCP’s and hospitals in patient coordination.

Proactively lower barriers by implementing a technology solution or shared data agreement
- Provide robust training and education for all staff
- Provide written “easy to read” instructions
- Contact support person at the AAA for issues and concerns
- Provide regular face to face meetings with Physician practices and Hospitals

Be open to new possibilities
- Look for feedback to improve experience.
- Look for new innovative ways to think “outside the box”

Meet them where they are at –
- Be prepared to adapt to what is needed and be flexible.
- Offer a no-fee pilot to prove yourself!
- Ask for 1 case, 1 cohort, 1 month. Show them what you can do and tell that story.

DON’T BE AFRAID TO TAKE A RISK!
Bridging the Gap
Where are we going next?

CHART - Meaningful use –

The Medicare and Medicaid EHR Incentive Programs provide financial incentives for the meaningful use of certified EHR technology to improve patient care. To receive an EHR incentive payment, providers have to show that they are meaningfully using their EHRs by meeting thresholds for a number of objectives. The EHR Incentive Programs are phased in three stages with increasing requirements. The hospital only gets paid when they attest and meet the requirements.

- ESMV is currently running a 1 month pilot to assist the hospital in meeting the 3 requirements below. Evaluation and negotiation of pricing to be completed when pilot is complete.

  - **Criteria #6**: Provide patients the ability to view online, download and transmit their health information about a hospital admission via a patient portal.

  - **Criteria #10**: Use clinically relevant information to identify patient-specific education resources and provide those resources to the patient.

  - **Criteria #12**: The hospital who transitions their patient to another setting of care should provide a summary care record for each transition of care or referral.

SEEK OUT NEW TECHNOLOGY TO PROVIDE EFFECTIVE PATIENT CARE IN A COST SUSTAINABLE WAY!

- Technology is only as good as the staff you have to send and receive the information.

  BE CREATIVE!
Welcome

The Healthy Living Center of Excellence is an innovative collaborative between Elder Services of the Merrimack Valley, Inc., a community based organization and Hebrew Senior Life, a medical provider with a goal of helping seniors remain independent and in the community as long as possible. By combining our expertise in the aging service and medical networks, the collaborative encourages older adults to become active partners in managing their health.

LEARN MORE

http://www.healthyliving4me.org
What is the Community Links Portal?

The Community Links Portal (CLP) is a secure web portal that provides an Electronic Health Record (EHR) about elders & disabled adults in the community, who receive home care program services and care management from one of 27 Massachusetts Aging Services Access points, known as ASAPs, under the auspices of the Executive Office of Elder Affairs (www.mass.gov/elders).

A read-only Electronic Health Record (EHR) about your patient (an ASAP consumer)

from the Registered Nurse who determines clinical eligibility and the Care Manager who designs the Plan of Care that coordinates & authorizes Home- & Community-Based Services.

Based on Assessments at Home Visits at least every six months.

http://community-links.800ageinfo.com/what-is-the-clp.html
## Relevant Quality Metrics

*How can ASAPs/AAAs help to move the needle?*

### Pioneer Accountable Care Organizations (ACOs)

- **Patient/Caregiver Experience**
  - How Well Your Providers Communicate
  - Patient Rating of Provider
  - Health Promotion and Education
  - Shared Decision Making
  - Health Status/Functional Status

- **Care Coordination/Patient Safety**
  - Risk Standardized All Condition Readmission
  - Falls: Screening for Future Fall Risk

### Patient Centered Medical Homes (PCMHs)

- Use of high risk medications in elderly
- Care for older adults
- Cholesterol management for patients with cardiovascular conditions
- Comprehensive adult diabetes care
- Fall Risk Management
- Physical activity in older adults
Bridging the Gap
Connecting with HCOs – How did we do it?
Hospitals want to know what you can do for them!

• Most hospitals / PCP’s or payers are data outcome driven – Show them the DATA!

• By providing access to consumer data via available technology, you will show them what you are doing with their patients in the community.

  A. Vital information they cannot obtain other than from a AAA.

• If you have a CCTP program use that data to build a framework for rapid cycle change.

  A. Provide weekly success stories.

  B. Show up to the table with an open mind and the ability to make changes when needed.

• Use outcomes and PDSA’s to show value and Quality improvement consistently

  A. Hospitals are built on QUALITY! They need reassurance and proof of what you can do.

  B. Frequent reports and outcome measure updates on program status.

  C. Reach out to the Director of Quality at the hospital and work with them not against them..

What do you have that they would want???
Bridging the Gap
Questions & Answers