Aging and Disability BUSINESS INSTITUTE
Connecting Communities and Health Care

It Takes a Community:

Population Health Management for Members with Chronic Conditions and Functional Needs

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SWH SENIOR WHOLE HEALTH Simple. Secure. Independent.

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Elder Services of the Merrimack Valley, Inc. Choices for a life-long journey

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.

www.n4a.org/businessinstitute

Partners and Funders

Partners:

- National Association of Area Agencies on Aging
- Independent Living Research Utilization/National Center for Aging and Disability
- American Society on Aging
- Partners in Care Foundation
- Elder Services of the Merrimack Valley/Healthy Living Center of Excellence

Funders:

- Administration for Community Living
- The John A. Hartford Foundation
- The SCAN Foundation
- The Gary and Mary West Foundation
- The Colorado Health Foundation
- The Marin Community Foundation

National Association of Area Agencies on Aging

Senior Whole Health— Overview

A UNIQUE HEALTH PLAN:

- SWH is a Senior Care Options plan (SCO) (a.k.a. "FIDESNP"/CMS)
  - Serves dual eligible beneficiaries ≥ 65
  - Accepts full risk for all Medicare and Medicaid benefits including long term care
  - Year-round open enrollment
- Key principles
  - Coordinated funding to incent wiser and more efficient utilization
  - Full range of coordinated services
  - Comprehensive and transparent consumer protections
- Uses a robust, high touch, local model of care management
  - Addresses poverty issues compromising health care
  - Provides flexibility in allocating resources

QUICK FACTS :

- Enrolling members since August 2004 in MA
  - ~11,800 members
- Service area Eastern & Central MA
  - Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester Counties
- Independent & locally based
  - Cambridge, MA
  - Bridgewater, MA

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Medicare, Medicaid & Part D Consolidated Into One Program

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Who is Eligible?

- **Seniors 65 years and older with MassHealth Standard and Medicare (Dual Eligibles)**
- ***Rating Categories**
  - Community
  - Nursing Home Certifiable
  - Chronically Mentally Ill/Alzheimer's Dementia
  - Institutional
- **Voluntary Enrollment**

*some exclusions

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Challenges of Dual Eligibles

- **Many dual eligible beneficiaries over 65 have:**
  - Multiple chronic conditions and multiple medications from different providers (5 or more chronic conditions and 7 prescriptions)
  - Don't speak English as primary language (20% sign with an X)
  - Lower education levels
  - Are culturally diverse (68% do not speak English)
  - Non-medical issues that impact medical care
  - Limited or no coordination of care or benefits
- **This results in:**
  - Fragmented care and unnecessary hospital, outpatient, and radiology services
  - Revenue "gaming" between nursing homes and hospitals
  - Difficulty in receiving most appropriate and least restrictive services

Senior Whole Health Model of Care Structure

- The Interdisciplinary Care Team (ICT) coordinates the care of Senior Whole Health members through a comprehensive, integrated and individualized care planning process
- Primary Care Provider focal point for clinical decision making

Senior Whole Health Nurse Care Manager	Senior Whole Health Member Support Representative	Community Geriatric Support Services Coordinator	Other Team Members
▪ Focus on care coordination ▪ 24/7 availability ▪ Relationship with PCP ▪ Relationship with member ▪ ICP development	▪ Verifies language needs ▪ Confirms PCP selection ▪ Facilitates visit to PCP ▪ Notifies Senior Whole Health Nurse Care Manager of clinical issues identified ▪ Coordinates transportation benefits	▪ Case worker through ASAP/Elder Services ▪ BA/BS or equivalent experience in social work/human services ▪ In-home assessments for nonmedical home services ▪ Identifies and organizes home-based support services ▪ Coordinates community based services, i.e., Adult Day Health	▪ Specialists and other providers based on member needs ▪ Senior Whole Health Pharmacy consultants ▪ Behavioral health specialists ▪ Other as needed

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SWH Model of Care Structure

Additional services support and reinforce the physician's treatment plans and provide additional information that helps reduce medical expenses and avoid unnecessary acute interventions. These services include:

- Regular home visits by Registered Nurses
- Regular telephone contact by social workers
- Feedback to the primary care provider regarding events or issues at home for early problem identification and treatment
- Support care transitions
- Specialized behavioral health care managers integrated into care planning with SWH Nurse Care Managers
- Pharmacists on staff
- Caregiver support programs

MOC – Individualized Care Plan (ICP)

Core product of the Interdisciplinary Care Team (ICT) is the Individualized Care Plan (ICP).

- **The SWH-Nurse Care Manager (NCM) ensures that the member and his/her family are included in the development an implementation of the ICP.**
- **Every SWH member receives and signs an ICP.**
- **Essential elements of the ICP:**
  - Results of the evaluation of clinical status, functional status, nutritional status, and physical well-being
  - Results of PCP clinical assessment of diagnoses, medications, preventive services, special needs and the PCP's concerns and priorities for the member
  - Medical history of the member, including relevant family members and illnesses;
  - Results of screenings for mental-health status and tobacco, alcohol and drug use and requirements for care
  - Identifies specific clinical services and referrals, and pharmacological needs
  - Identifies goals important to the member/caregiver
  - Identifies requirements for long term care services and/or other services such as palliative care
  - Identifies the member's social support system, required home and community health care services, and special equipment needs

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Performance & Health Outcome Measurement

SWH utilizes multiple approaches to evaluate the performance and effectiveness of the Model of Care.

- **Short Cycle: identification of process errors, opportunities for improvement in real time to develop action plans. Examples include:**
  - Clinical Rounds
  - Regular review of medication adherence
  - Daily review of admissions and discharges
  - Care Transitions

- **Long Cycle: regular collection of data on key indicators of care and services, identifying goals, reporting on regular basis, and developing corrective action plans. Examples include:**
  - HEDIS reporting
  - Quarterly indicator reporting (i.e. member grievances, claims processing, enrollment processing)
  - Annual Quality Improvement Program Evaluation

SWH Partnership w/ ESMV

- Provides key resources with assistance from the **Geriatrics Support Services Coordinators.**

- Assist with identifying Social Determinants of our members.

- Providing a effective way of contracting and managing contracts with ADH,AFC,GAFC, and Home Health Agencies.

- Also assist with “Meals on Wheels” and other LTSS services our member needs.

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Additional Areas of Concentration with ESMV

- **Care Transitions**
- **Healthy Living Center**
  - Diabetes
  - Chronic Disease Management
  - Matter of Balance (Fall Prevention)

SWH Model of Care Works

- **SWH Inpatient Admissions Trend for SWH Massachusetts Members:**
  - Inpatient admissions/1000 declined 8.5% over 3 years
  - Inpatient days/1000 declined 18% over 3 years overall; Nursing Home Certifiable 12% decline in inpatient days from 2008 through 2013.
  - 1.6% decrease in readmissions in the last 2 years; 1.8% for NHC
  - Inpatient costs decreased 5% in the last year and 22.75% for Nursing Home Certifiable over 4 years.

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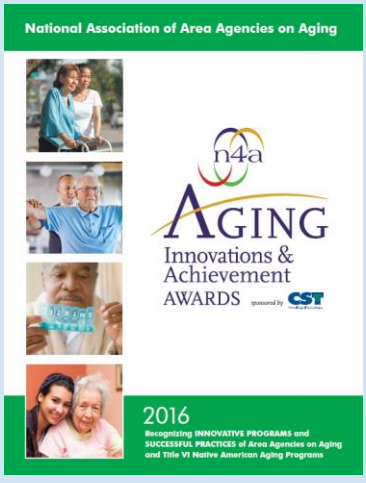
Benefits to a Carrier: Why Did SWH Get Involved

- **Improve Outcome for our Members:**
  - Improve on their daily lifestyle
  - Reduce costs due to improved lifestyle
  - Experience better quality of life
- **Improves Retention of existing Members:**
  - Participating members have a higher satisfaction with carrier
  - Not all carriers are participating. Helps SWH to set themselves apart from others.
  - Member might lose program if they leave SWH.
- **Provides a Marketing opportunity:**
  - Helps attract potential members
  - Helps SWH to differentiate themselves from others.

"The Evidence Is In…Healthy Living Programs Catch the Eye of Managed Care" Senior Whole Health and Healthy Living Center-- 2016 Recipients



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Healthy Living Center and Senior Whole Health

- First MCO to reimburse per participant
- Single contract for all regions/programs
- 14 Evidence-based Programs
- Four pronged referral approach
  - Registry of high risk members identified through internal analytics
  - GSSC (Geriatric Support Services Coordinator) referrals
  - Referrals from case/care managers and other SWH providers
  - Self-Referral
- Bifurcated rate (recognizes cost and value)
  - 50% when member contacted
  - 50% upon program completion
- Data collection and Feedback

Sample Workshop:

- **A Matter of Balance (Boston)**
- **Low income housing**
- **Chinese Speaking**

82 referrals	• Internal SWH registry • All called with MI techniques
14 attendees	• 17% translation rate from initial referrals
12 completers	• 13.4% translation from referrals • 78% completion rate

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Date

<Member Name >
< Member Address>
<Member City, State Zip >

Dear <Member Name>:

Take charge of your health by attending a free Healthy Living Program!

Senior Whole Health takes pride in providing you the best medical care services to keep you healthy and feeling your best. Managing your health doesn't just happen in your doctor's office. You do it every day at home, and with your family and friends. To help manage your health, Senior Whole Health is partnering with the *Healthy Living Center of Excellence* to offer you a new type of care called self-management education.

As part of this care, the *Healthy Living Center of Excellence* is offering you a free self-management education program that is designed to teach you how to manage your symptoms and overall health. During the program you will learn from others who are like you, and make new friends to share what you learn when the program ends.

The programs will teach you how to:

- Treat symptoms such as stress, anger, loneliness, and poor sleep;
- Exercise properly to improve your strength and flexibility;
- Take your medicine the correct way;
- Eat a healthier diet; and
- Talk with your health care team when you make a choice about your care.

Someone from the *Healthy Living Center of Excellence* will call you soon with more details about the program. To find out more information, or sign up, call the *Healthy Living Center of Excellence* at 978-946-1211.

Let's work together one step at a time to make a difference in your life!

Sincerely,

Scott Latimer, MD
SWH Chief Medical Officer

healthy living Center of Excellence

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Programs Offered Through HLCE Since October 2015

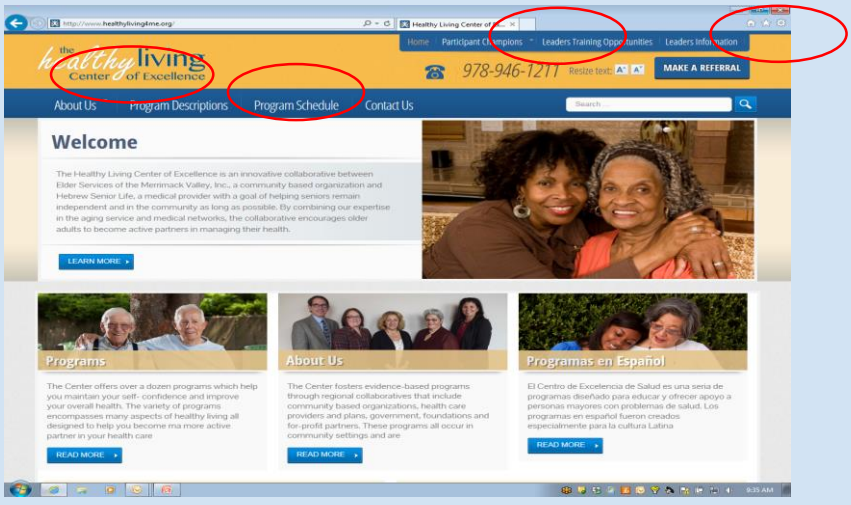
- 96 SWH members have attended programs, 77 members completed-80% completion rate
- Offered 11 "SWH-specific" workshops and 12 additional workshops that SWH members attended

Proposed Goals for 2017

- Have each AAA/ASAP in Massachusetts hold at least one Diabetes, Chronic Disease Self Management Program, or Matter of Balance Workshop in 2017
- Refer into existing calendar of workshops

How to Make a Referral

Link: www.healthyliving4me.org



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Care Transitions

- Program modeled after the Coleman Model –
  - Four pillars focusing on Review of red flags for discharge diagnosis, medication reconciliation, verify follow-up appointments, provide personal health record (PHR)
- Goals –
  - Improve transitions from the Hospital to community
  - Increased patient activation and engagement,
  - Increased communication, coordination and transfer of information to the SWH in Case Trakker), increased care coordination for members
- Intervention- 30 days post discharge, initial contact within 72 hrs of discharge, subsequent follow-up calls at 7, 4,21 days
- Barriers to Intervention – Difficulty to reach members, refusers, language barriers, family dynamics

Your Value Proposition

Why did SWH buy vs. build?

- Problem Solving, Not just service providing
- Integration of Care
- Community Experience and Presence
- Single Contract for Healthy Living Programs
- Marketing and Outreach
- Improved Feedback and Communication
- Quality & Efficiency
- Improved Health and Retention Outcomes

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Demonstrate Your Operational Excellence!!!

- **Operationalize for Success**
  - Be VERY clear how they define success beyond the contract language.
- **Be Proactive**
  - Don't wait for referrals to come to you.
- **Create Ongoing QI and Evaluation Processes**
  - Identify problems before they do! Communicate to them on a regular basis. They may focus on data but antidotal stories are powerful!
- **Go above and beyond!**
  - Coverage, cross training, clients outside of the program…even if it doesn't "pay".
- **Nurture the relationship**
  - Key to contract renewal.
- **Identifying Additional Opportunities**
  - BE CREATIVE! Identify their "pain points' and offer an additional service.
- **Be flexible and have a "can do" attitude ALWAYS!**

Contact Information

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Questions & Answers:
Please Submit Using the "Questions" Box

Please join us for future webinars in the Aging and Disability Business Institute Series

AAAs & Hospitals – Partnerships Toward Common Goals – Oct. 19

Leadership and Change Management for Community-Based Organizations – Nov. 16

Is My Organization Ready? Assessing CBO Capacity to Partner with Health Care Entities – Dec. 13

Learn more and pre-register here:
http://www.asaging.org/series/109/aging-and-disability-business-institute-series

Questions about the Aging and Disability Business Institute?

Email us:

BusinessInstitute@n4a.org