From Hospital to Home: Integrating Care from Acute to Community Settings

Abigail Morgan, MSS, MLSP, MBA
Sr. VP Business Strategy
WHO WE ARE

We provide choices for people to live independently in the place they want to call home.
WHO WE ARE

- National Network: 622 AAAs nationwide
- In Ohio: 12 AAAs
- In our area
  - Portage, Stark, Summit, Wayne
  - Private Not for Profit 501 (c) 3
  - 30 Member Board of Directors
  - 200+ Staff
  - 75+ Volunteers
WHAT WE DO

 DH Core Services

Elder Rights

Home-based Supportive Services & Provider Network

Nutrition

Caregiver Support

Aging & Disability Resource Center: Info & Referral

Health & Wellness
HOW WE’VE GROWN

Supporting all Ages
Multiple Populations and Payers
  • Medicare
  • Medicaid
  • Health Plans

History of innovative programs with health systems
Care Management Interdisciplinary Team (CMIT)
Hospital-based RN assessors
Community-based care transitions
  • Acute care transitions
  • NF transitions
LONG TERM SERVICES & SUPPORTS

Long-term services and supports (LTSS) help older adults and people with disabilities accomplish everyday tasks such as bathing, dressing, preparing a meal, or managing money.

These ongoing services include health and social services that maximize the independence and well-being of an individual.
<table>
<thead>
<tr>
<th>LTSS EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Services</td>
</tr>
<tr>
<td>Case Management</td>
</tr>
<tr>
<td>Community Transition Service</td>
</tr>
<tr>
<td>Congregate Meal Sites</td>
</tr>
<tr>
<td>Counseling</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>Emergency Response Systems</td>
</tr>
<tr>
<td>Enhanced Community Living</td>
</tr>
<tr>
<td>Home Care Attendant</td>
</tr>
<tr>
<td>Home-Delivered Meals</td>
</tr>
<tr>
<td>Home Health Care</td>
</tr>
<tr>
<td>Home Maintenance/Modification</td>
</tr>
<tr>
<td>Homemakers</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
</tr>
<tr>
<td>Medical Transportation</td>
</tr>
<tr>
<td>Non-Medical Transportation</td>
</tr>
<tr>
<td>Out-of-Home Respite</td>
</tr>
<tr>
<td>Respite</td>
</tr>
<tr>
<td>Safety Monitoring</td>
</tr>
<tr>
<td>Senior Volunteers</td>
</tr>
<tr>
<td>Socialization</td>
</tr>
</tbody>
</table>
SOCIAL DETERMINANTS OF HEALTH
FOCUS ON SOCIAL DETERMINANTS OF HEALTH

Five Most Pressing Social Determinants of Health

Housing
- Housing quality and instability
- Neighborhood violence

Food
- Inaccessible, unaffordable healthy food
- Disconnection from benefits (e.g., SNAP)

Economics
- Insufficient wages
- Lack of insurance coverage

Interpersonal
- Social isolation
- Discrimination
- Provider bias

Education
- Health illiteracy
- Lack of language skills
- Quality of public schools

Impact
- Years of reduced life expectancy for those experiencing homelessness: 26-36
- Of food insecure households had to choose between paying for food and medicine: 74%
- Greater mortality risk for Medicaid beneficiaries vs. private insurance: 2x
- Increased risk of mortality resulting from loneliness: 26%
- Gap in life expectancy for those without a high school diploma vs. college graduates: 9 years
Cost of Social Determinants

Patient Behaviors Exert a Far Greater Influence on Health Outcomes than Do the Efforts of Payers and Providers

Health Care Spend

- Healthy Behaviors: 4%
- Other: 8%
- Medical Care: 88%
- Environment: 20%
- Human Biology: 20%
- Lifestyle and Behaviors: 50%
SUMMIT COUNTY

When do you plan to research your options for aging services?

n=683

- When I am approaching the need: 48.9%
- I have never researched aging service options and do not plan on doing any research: 22.4%
- Long before I need it: 18.7%
- When I am in crisis and need it immediately: 8.1%
- Long after I first need service: 1.9%
The result is a system where your address alone can determine what level of services are available to you.
COMMUNITY & HEALTHCARE PARTNERSHIPS

THE CENTER OF POPULATION HEALTH
Patients vs. Community Members

Sphere of Patient Activity and Interactions

Common Community Partners
- Public health departments
- County mental health agencies
- School districts and universities
- Faith-based organizations
- Service leagues (e.g., Lions, Rotary)
- Environmental organizations
- Local agencies (e.g., housing and city planning departments)
- Nonprofit service providers (e.g., Meals on Wheels, food banks)
- Local businesses (e.g., barber shops)
- Public safety providers (e.g., EMS)
‘Eloise’

- 68 year old woman needing help with ADLs
- Lives alone in her 2 story home
- One daughter comes to visit 1x a week to bring groceries
- Has signed all of her finances, assets over to her daughter
- Expresses need for additional food and help with bathing, dressing and meal prep
- Daughter attends all medical appointments and offers no suggestions or help
STAY HAPPY. STAY HEALTHY. STAY HOME.

HOW IT COULD WORK

Healthy & Wellness

Elder Rights

Home-based Supportive Services & Provider Network

Aging & Disability Resource Center: Info & Referral

Nutrition

Caregiver Support

DH Core Services
It starts with an **IDEA**

**IDENTIFY** key stakeholders

**DEVELOP** relationships

**EXPLORE** common interests

**ALIGN** our efforts to achieve mutually desired outcomes
ACUTE CARE TRANSITIONS—RESULTS

- **24.5% Reduction in Program Participant Readmissions***
- **$28.9 Million Saved in Part A & B Expenditures***
- **11 Hospitals over 6 Years**
- **>27K Medicare Beneficiaries Coached***
- **94.7% Patient Satisfaction**


**Hanna Research Group. Dr. Heesoo Kim
Akron stands out for having improved on more performance measures (19 of 33) than any other region...Including Scorecard indicators of health care access, quality, avoidable hospital use, costs, and outcomes.

Commonwealth Fund’s Scorecard on Local Health System Performance
MAKING THE CONNECTION

Considerations for partnerships
Physician Engagement & Interdisciplinary Teams

Number of Complex, Co-Morbid Patients Continues to Climb

Prevalence of U.S. Adults with 3 or More Chronic Conditions 2015-2030

Chronic Disease By The Numbers

- Of Medicare beneficiaries with 2+ chronic diseases: 66%
- Of Medicare spending accounted for by patients with 2+ chronic diseases: 93%
- Of Medicare patients with 30-day readmissions have 2+ chronic diseases: 99%

$1.1T
Total direct cost of health care treatment for chronic diseases in the US, 2016

Source: Chronic Conditions Charts 2015, Centers for Medicare and Medicaid Services; 2015, "The Cost of Chronic Diseases in the US". Milken Institute, 2017; Population Health Advisor interviews and analysis.
Physician Engagement & Interdisciplinary Teams

- Interdisciplinary & Simulation
- Students & Professionals

- Geriatrician, Pharmacist, Care Manager

- Shift from FFS ➔ Value-based
- Engaged pop health strategy
Community Service Bundles

Distribution of Medicare Episode Payment by Site

Within 90 Days of Index Discharge
All Congestive Heart Failure

Payments per Episode

Site of Service

Index Admission  SNF  Home Health  Readmissions  Physician  OP  Hospice  LTAC  Rehab

0%  25%  50%
## Community Service Bundles

<table>
<thead>
<tr>
<th>Adult Day Services</th>
<th>Home Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>Home Maintenance/</td>
</tr>
<tr>
<td>Community Transition</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Modification</td>
</tr>
<tr>
<td>Congregate Meal Sites</td>
<td></td>
</tr>
<tr>
<td>Counseling</td>
<td>Homemakers</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
</tr>
<tr>
<td>Emergency Response Systems</td>
<td>Medication Reconciliation</td>
</tr>
<tr>
<td>Enhanced Community Living</td>
<td>Medical Transportation</td>
</tr>
<tr>
<td>Home Care Attendant</td>
<td>Non-Medical Transportation</td>
</tr>
<tr>
<td>Home-Delivered Meals</td>
<td>Out-of-Home Respite</td>
</tr>
<tr>
<td></td>
<td>Respite</td>
</tr>
<tr>
<td></td>
<td>Safety Monitoring</td>
</tr>
<tr>
<td></td>
<td>Senior Volunteers</td>
</tr>
<tr>
<td></td>
<td>Socialization</td>
</tr>
</tbody>
</table>
St. Louis Metro Market is a mobile farmers market—paired with HTN focused med recs, cooking classes and pop-up grocery stories, working to control high blood pressure.

Catch us today at the Annie Malone MAY DAY PARADE in Downtown St. Louis!! The MetroMarket bus (and the Veggie Bike 😊) will be in the parade itself handing out free fruit and getting down with the festivities.

It's an honor to be a part of this great St. Louis tradition. Thanks to our AMAZING partner MISSOURI CARE for sponsoring the MetroMarket's presence at this great event, and investing in the health of our St. Louis community.

See y'all down there!!!
WRAP UP

QUESTIONS & DISCUSSION