Aging and Disability BUSINESS INSTITUTE

Connecting Communities and Health Care

n4a

advocacy | action | answers on aging

ASA American Society on Aging

More Than Just a Partnership: Why a Hospital and a Community-Based Organization Joined Together to Provide Population Health

Part of the Aging and Disability Business Institute Series- a collaboration of n4a and ASA

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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

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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

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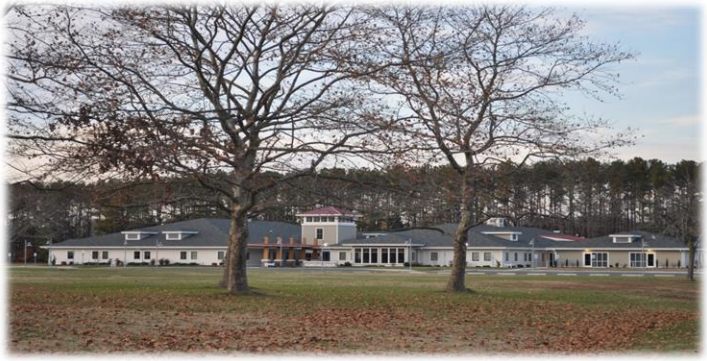
MAC, Inc. Maintaining Active Citizens



MAC is dedicated to the principle that older persons are entitled to lives of dignity, security, physical, mental, and social well-being; and to full participation in society.

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MAC, Inc. Services

- MARYLAND ACCESS POINT (Information & Assistance - MAP)
- Advocacy and Assistance Programs
- Caregiver Resource Center
- Wellness Center
- In-Home Services
- Senior Centers
- Nutrition (Meals on Wheels and Congregate Meals)
- Volunteer Services
- 50+ Network for Creative Engagement
- Assisted Transportation
- Community Outreach
- Living Well Center of Excellence

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MAC, Inc. Services

- Peer mentoring/ support
- Independent living skills
- Computer training
- Information and referral
- Family and caregiver support
- Assistive technology
- Employment and vocational training
- Nursing facility outreach
- Case management/ supports planning for Medicare/Medicaid
- Individual and systems advocacy
- Recreational activities

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Living Well Center of Excellence Services

MAC Maintaining Active Citizens

Living well Take Charge of your Health Chronic Disease Self-Management Program

DIABETES PREVENTION PROGRAM

PEARLS™

STANFORD UNIVERSITY

A MATTER OF BALANCE

ENHANCE FITNESS®

CHRONIC DISEASE SELF-MANAGEMENT EDUCATION PROGRAMS

Stepping On Building Confidence and Reducing Falls

STEPPING UP YOUR NUTRITION

Otago Research-based Balance treatment

Living Healthy with High Blood Pressure

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Living Well Center of Excellence Services

- Statewide Licenses for Stanford University Chronic Disease Self-Management Education (CDSME) and Stepping On Falls programs
- Training and technical assistance for multiple evidence-based programs
- Centralized referral, certified workforce, community-based locations, quality assurance measures, HIPAA compliant
- Statewide calendar, quarterly reporting includes: participant completion, clinical measures (bp, weight, body fat, handgrip strength), patient activation and satisfaction, and long-term goals

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Community Impact

- 8th Largest Hospital in Maryland (per bed size @ 289)
- 6th Most Busy Emergency Room in State (@ 95,000 visits)
- **Drive-Thru Flu Clinic** with 2,000 people vaccinated in a 12 hour span. 23rd year
- Largest Single-Site Employer in the Region
- Nearly 3,000 Employees
- 330 Physicians on staff
- Significant Population Health program

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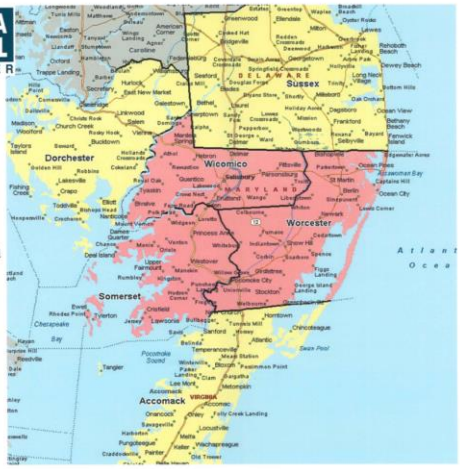
Our Service Area

PENINSULA REGIONAL MEDICAL CENTER

Primary Service Area	
Wicomico	101,614
Worcester	51,713
Somerset	26,252
	179,579

Secondary Service Area	
Sussex	211,254
Accomack	33,409
Dorchester	32,696
	277,359
Total	456,938



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Maryland

- Current Maryland All Payer Model began on January 1, 2014 and is contracted to run 5 years
  - Discontinuation of original waiver in effect since January 1st, 1977
  - Contract approved by the Center for Medicare and Medicaid Innovation
  - Current focus
    - Reduction in readmissions
    - Reduction in AHRQ Potential Quality Indicators
      - CHF
      - COPD
      - Diabetes

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Building the Plane While Its in Flight

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How the Relationship Began

- Two small projects first
  - Educating Care Transitions Nurses and CHWs about MAC and LWCE programs and services
  - Million Hearts initiative – BP screening and CDSME
- Contract for Services began July 2015
  - CDSME, Stepping On, expanded to PEARLS
  - Co-located services
- Evolution into integration
  - ACO pathways
  - Building referrals into EPIC
  - Health Information Exchange – data sharing

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Lower Eastern Shore, Maryland and National Comparison – CDSME

September 1 2015 – November 31 2017

Measure	Dorchester, Somerset, Wicomico, Worcester N=907	Maryland N=4,923	Nation
Completer rate	80%	77%	66.5%
African American	42%	45%	26.1%
Hispanic	11%	5%	12.3%
Medicare	66%	62%	NA
Medicaid	24%	15%	NA

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How a CBO Can Add Value to Service Delivery and Improve Health Outcomes

- Peninsula Regional Health System
  - Maryland All Payer Model
  - Community Health Needs Assessment
  - Increased need to understand social determinants of health
- MAC/LWCE 'Value Added'
  - Trusted partner already in the community
  - Wide array of programs and services
  - Screening for SDoH; Providing wrap-around services
  - Increased patient activation/engagement

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Diabetes Success Story

Diabetes Self-Management workshop participant:

- Attended class complaining of feeling dizzy, light headed, having difficulty staying awake
- Leader took her aside and patient explained that she had not eaten that day due to lack of resources to purchase food.
- Call made to County Social Services and Health Department.
- Community Health Worker assigned
- Resources for food supplementation on a regular basis
- Housing needs identified (person was living in a trailer with no windows and needed a ramp) - new windows and a ramp installed
- Participant was unable to complete the current Diabetes Self-Management Workshop, but she enrolled in another workshop and attended all six sessions.

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The Types of Patients Who Can be Helped by a CBO

- MAC/LWCE
  - Hispanic and African American outreach workers can engage hard to reach individuals
  - Drivers delivering daily meals identify risks/needs
  - Services and programs that provide long-term support and/or build skills
- Peninsula
  - High risk ACO patients
  - High utilizers of the emergency department
  - Rural, geographically isolated

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The Roles of the Healthcare System and the CBO

- Peninsula Regional
  - Majority of skills and competency clinical
  - Need to collaborate with other agencies already engaged in community outreach and education
  - Use of evidence-based community programs with proven ROI
- MAC/LWCE culture changes
  - Increased level of accountability and documentation of outcomes
  - Frequent in person communication
  - Ability to pilot-test strategies

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Determining the ROI of EBPs in Reducing Admissions, Readmissions, and Length of Stay

- Peninsula
  - Referrals from transitions of care nurses to EBP has resulted in reduction in readmissions
  - Depression Screening and plan = $1100 savings in health care costs per patient (Grypma, et al. 2006)
  - Controlled hypertension estimated cost savings per patient $460
- MAC- LWCE
  - Hospital to Home initiative documenting value of home and community-based services
  - Contract with Chesapeake Regional Information System (CRISP) to determine ED/hospitalization pre- and post-EBP workshops
  - Access to CRISP to document workshop or services and potential risks in 'Care Alert'

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PEARLS Success Story

Ms. M is a cancer survivor who was referred to PEARLS due to depression.

- Initial RN assessment revealed participant took several medications, including a sleeping pill
- Participant had experienced several falls recently
- The Geriatric Psychiatrist reviewed all her prescriptions.
  - Now medication free
  - Actively engaged in several social support programs
  - Has lost 40 pounds
  - No longer is experience depression.

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

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

"The Flourish Care Model: Utilizing the Geriatric Workforce Enhancement Program (GWEP) to Implement A Shared-Care Approach to Health Care for Older Adults" –

January 23, 2018

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

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Questions about the Aging and Disability Business Institute?

Email us:

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