Underserved Population (UP) Network Webinar

presented by

Home Health Quality Improvement (HHQI) National Campaign
Cross-Setting Collaboration

- Hospitals/ED
- Nursing Homes
- Home Health/Hospice
- Physician Practices
- Pharmacy
- Patient/Caregiver
- Academia
Population Health Management from the Home Health Perspective

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Healthcare Senior Executive
Circle Home, Inc.
Lowell, Massachusetts
POPULATION HEALTH MANAGEMENT
A COLLABORATIVE APPROACH
BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION
MAKING HEALTH CARE AFFORDABLE (MHCA)

State-wide Program - 14 Grants  1 Home Health Agency Awarded

Three year demonstration program focused on the Underserved Population

Goals:

• Reduce Hospital admissions and ED visits
• Reduction of A1C measures
• Increased Quality of Life
  • Self Management of Chronic Disease
ENROLLMENT AND MONITORING EXPECTATIONS

- Enroll 100 participants with Chronic Disease of CHF, COPD and or Diabetes
- Participants are non-homebound status—Adults 21+
- At least 1 hospitalization or ED visit within last 12 months or A1C>8
- Enrollment limited to 10% Medicare beneficiaries—focus on Underserved Population

Monitor for 1 year:
- Tele-health Monitoring (Philips) Vitals—Weight, BP, O2
- Case Management
- 5 On-site Visits by RN or other team member
- Health Coaching—CDE and CHW’s, RN Case Manager
Three Quarters of Enrollees are in MHCA’s Target Population

Enrollees by Insurance Status

- Medicaid: 55%
- Medicare: 9%
- Dually Eligible: 13%
- Commercial: 7%
- Uninsured: 5%
- Commonwealth Care: 9%
- Unknown: 2%
KEY COMMUNITY STAKEHOLDERS

• Lowell Community Health Center

• Circle Health
  • PHO – Primary Care Physician Groups

• Local Community and Cultural Organizations
  • Cambodian Mutual Assistance Association
TIPS FOR DEVELOPING COLLABORATION IN YOUR COMMUNITY

Understand your landscape
- Identify who the potential stakeholders are in the market-
- Does an existing relationship exist?
- Use your board members and staff!

Seek mutual benefits for each organization
- Understand strategic initiatives
- How may your initiative bridge a gap for the other organization as well
- Look for win-win scenarios (example CMAA and the Community Health Worker)

The Power of Face to Face (it is not just a requirement for payment.....)
- Introductory meetings are best live vs. phone or letter (PHO letter example)
- Brainstorm together- what if we.....
- Create opportunity for organizations to be speakers/educate your staff
INTEGRATION OF SOCIAL SUPPORT MODEL

Community Health Workers- Non-Clinical Team members

- Certified Program – Lowell MA
- Provide 1:1 on-site and telephonic coaching
- Interpreter support for medical appointments, home visits, family meetings
- Identify Root Cause Barriers
- Participate in Interdisciplinary Team Care Conferences

Building Trust between Clinical and Non-Clinical Team is Critical to Your Success
OUTCOME MEASURES — SUSTAINABILITY

• Trends to date are favorable —
  o Reinforce the value-add of a pro-active intervention through tele-health in combination with case management communication with participant and physicians
  o CHWs help to identify and remove root cause barriers and have the time to assist in establishing trust and goal setting readiness

• Satisfaction Surveys indicate- “Strongly Recommend”
  o Participants do not want to “graduate”

• Physicians support the need to continue a personalized community care approach

• Pricing models for payer discussions are underway
RESOURCES

Community Health Education Center
CHEC, Lowell Community Health Center

Community Health Worker Encounter Tool

Philips Hospital to Home Programs
http://www.hospitaltohome.philips.com/

For more information contact Sharon N. Fisher:
sharon.fisher@circlehomehealth.org

www.circlehomehealth.org
Additional Resources

• Underserved Population BPIP
  – Simple Tips for Creating Health Care Collaborations (p. 21)
## Additional Resources

### Collaboration Opportunities

<table>
<thead>
<tr>
<th>In-Patient Settings</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hospitals</td>
<td>• <a href="#">Cross-Settings I BPIP</a></td>
</tr>
<tr>
<td>• Nursing Homes (NH)</td>
<td>o Focus is on care transitions, health coaching, SBAR communication,</td>
</tr>
<tr>
<td>• In-Patient Rehab Units (IRU)</td>
<td>discharge worksheets, and other tools/resources</td>
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<tr>
<td>• Long Term Acute Care Hospitals (LTACH)</td>
<td>• <a href="#">Care Transitions: Special Barriers/Issues for the Underserved UP Webinar</a></td>
</tr>
<tr>
<td>• Possible topic areas</td>
<td>• <a href="#">Evidence-Based Health Coaching: The Newest Trend in Patient Engagement</a></td>
</tr>
<tr>
<td>o Focus on reducing hospitalizations or readmissions</td>
<td>• National Transitions of Care Coalition’s <a href="#">Improving Transitions of Care: Hospital to Home</a></td>
</tr>
<tr>
<td>o Improve care transitions</td>
<td></td>
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<tr>
<td>o Utilize post-acute care providers effectively</td>
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<tr>
<td><strong>Post-Acute Care Providers</strong></td>
<td>• <a href="#">Best Practices for Care Transitions: Engaging Emergency Departments &amp; Urgent Care Centers</a> UP Webinar</td>
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<tr>
<td>• Emergent Departments &amp; Urgent Care Centers</td>
<td>• <a href="#">Underserved Population BPIP</a></td>
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<tr>
<td>• Primary Care Practices</td>
<td>o Doctor Reminder Notice (patient tool)</td>
</tr>
<tr>
<td>• Health Centers (including HRSA centers)</td>
<td>o ©Morisky Medication Assessment (clinician tool)</td>
</tr>
<tr>
<td>• Area on Aging Associations (AAA)</td>
<td>• <a href="#">Cross-Settings I BPIP</a></td>
</tr>
<tr>
<td>• Possible topic areas</td>
<td>o Physician engagement (pp. 54-55; 68)</td>
</tr>
<tr>
<td>o Focus on reducing hospitalizations or readmissions</td>
<td>o SBAR Communication (pp. 56-63)</td>
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<tr>
<td>o Improve communications</td>
<td>• National Transitions of Care Coalition’s <a href="#">Improving Transitions of Care: Emergency Department to Home</a></td>
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### Collaboration Opportunities

**Pharmacies**
- Reach out to community and chair pharmacies to create a network
- Request staff education sessions on high-risk or problematic medications, medication management solutions, reconciliation, etc.
- Develop strategies to address community and patient issues:
  - Access including delivery
  - Adherence
  - Fall Prevention
  - Financial barriers
  - Medication reconciliation
- Communication with physicians

### Resources
- **Medication Management BPIP** (Focused)
- **Improving Management of Oral Medications BPIP**
- **Underserved Population BPIP** (pp. 51-53)
  - ©Morisky Medication Assessment (clinician tool)
- **Gravity of Falls: Evidence-Based Preventative Strategies** Webinar
- **Duquesne University's Community Pharmacy Initiative** UP Webinar
# Additional Resources

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<th>Mental Health Centers</th>
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<tr>
<td>• Research all available services</td>
<td>• Alzheimer’s Disease: A New Way of Understanding for the Home Care Worker UP Webinar</td>
</tr>
<tr>
<td>• Discuss opportunities to bridge patients from one setting to the other</td>
<td>• Community Mental Health on Wheels UP Webinar</td>
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<tr>
<td>• Troubleshoot for unmet needs</td>
<td>• Underserved Population BPIP (pp. 47-50)</td>
</tr>
<tr>
<td>• Share education cross both settings</td>
<td>• Success Story - Behavioral Health Issues &amp; Home Health Care - A Holistic Approach</td>
</tr>
<tr>
<td>o Ex: Behavioral health topics, home health benefit, patient engagement strategies, etc.</td>
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<td><strong>Community Outreaches</strong></td>
<td><strong>Diabetes Risk Assessment &amp; Prevention</strong> in Disease Management: Diabetes (Focused) BPIP</td>
</tr>
<tr>
<td>• Flu clinics</td>
<td><strong>Everyone with Diabetes Counts: The Impact on Rural Southern West Virginia</strong> UP Webinar</td>
</tr>
<tr>
<td>o Include BP, glucose, or fall screenings</td>
<td><strong>Gravity of Falls: Evidence-Based Preventative Strategies</strong> Webinar</td>
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<tr>
<td>• Provide other health education</td>
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**Food Bank**
- Organize a food drive at the agency for donation
- Offer education or create a list of healthy food donations or for disease specific boxes (e.g., Diabetic, Heart Failure)
- Provide a list of local food banks with location, times, requirements, etc. to all potentially needy patients
- Offer screening for food bank participants (e.g., BP, glucose) and offer education

### Resources

- [Improving Patient Outcomes with Early Intervention to Fill Nutritional Gaps](#) UP Webinar
- [Underserved Population BPIP](#) (pp. 54-58)
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| **Faith-Based Organizations** | • [Coordinating Medicare & Medicaid](#) UP Webinar  
• [Underserved Population BPI](#) (pp. 10; 32)  
• [100 Congregations for Million Hearts®](#) |
| • Establish contact person(s) at organizations  
• Discuss community needs and what the organization could assist with  
  - Ex: Transportation, clothing, food, housing, etc.  
• Offer screenings or education  
• Ex: Cardiovascular Health, Diabetes, Falls Prevention, Palliative and Hospice Care, etc. |
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<tr>
<td>• Discuss collaborative and pilots with managed care organization</td>
<td>• <a href="#">Population Health Management from Home Health Perspective</a> UP Webinar</td>
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<tr>
<td>• Develop relationships with Medical Assistance organizations to improve communication</td>
<td>• <a href="#">Underserved Populations: A Managed Care Perspective</a> UP Webinar</td>
</tr>
<tr>
<td>• Begin care planning for dual-eligible patients upon Medicare admission for seamless transitions and obtaining needed services</td>
<td>• <a href="#">Coordinating Medicare &amp; Medicaid</a> UP Webinar</td>
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<tr>
<td></td>
<td>• <a href="#">Making the Most of Telehealth to Care for Underserved Populations</a> UP Webinar</td>
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<tr>
<td></td>
<td>• <a href="#">Underserved Population BPIP</a> (pp. 15-20)</td>
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<table>
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<th>Academia</th>
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<tr>
<td>• Create partnerships or internships to assist with education, research</td>
<td>• Duquesne University's Community Pharmacy Initiative UP Webinar</td>
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<td>project, data analysis, assist with other collaborations, etc.</td>
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<tr>
<td>• Find graduate students for home health focused project, thesis, and/or</td>
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<tr>
<td>dissertation</td>
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</table>
UP Network Resources

- UP Best Practice Intervention Package
- UP Networking Events (archived)
- UP Date e-newsletter (archived)
LiveChat

Request an email reminder or just join the live online event:

http://bit.ly/1ikqSln

July 11
2-3pm (ET)
HHQI - Phase 4

Stay Tuned
THANK YOU!

Please Complete the Evaluation

This material was prepared by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication Number: 10SOW-WV-HH-MMD-070914.