Developing a Hospital-to-Home Transitions Program

Health Care Contracting and Integrated Care

Somerville Cambridge Elder Services

About Somerville-Cambridge Elder Services (SCES)

Mission Statement

Somerville-Cambridge Elder Services promotes the right of all individuals to live with dignity, in the setting of their choice by offering older people, younger people with disabilities and their caregivers the information, services and support needed to make choices which enhance health, well being and independence

- SCES has a dual designation
  - Federally-designated **Area Agency on Aging (AAA)**
  - State-designated **Aging Services Access Point (ASAP)**

Cambridge Health Alliance

- Public Safety Net hospital system
- Serves over 140,000 residents in the greater Boston area
- Apprised of 2 large hospitals and 15 clinics
- Designated as one of MA's Community Behavioral Health Center (CBHCs)
- Population
  - 85% of patients have subsidized health insurance plan
  - 40% primary language other than English (top 3: Haitian Creole, Spanish and Portuguese)
  - Census data indicates higher than state average of residents who live alone

Care Transitions Initiative: Hospital-to-Home

- Began as a CMS demonstration in 2012
  - Community Care Transitions Program, funded through the Affordable Care Act
  - Community based-model of care
  - Primary goal to reduce rehospitalizations
- CBO and Hospital system started meeting in 2011

Care Transitions Initiative: Hospital-to-Home

- **Model**
  - Coleman Model of Care Transitions
  - 30-day intervention
  - Transition Facilitators hired by CBO
  - Met patient in the hospital, conducted HV within 3 days of d/c
  - Goals:
    - Assess for in-home service needs
    - Assess for medication issues/questions
    - Review discharge paperwork
    - Ensure re-connection with PCP within 7 days post discharge

Outcomes:

- Unnecessary hospital readmissions reduced by about 37% for patients enrolled in the program
- All-cause readmission rate reduced by about 6%

Care Transitions Initiative: Hospital-to-Home

- 2016 CCTP funded ended as planned
- CHA made financial commitment to continue funding for H2H

- **Today**
  - 3 Community Care Coordinators providing transition support with CHA's Accountable Care Organization (ACO) patients
    - Part of CHA's Complex Care Management teams
  - 2 Hospital Liaisons who work on the inpatient floors of the hospitals with a focus on assisting older adults in transitioning home

> *"I didn't understand why CBOs were in charge with this program. If they were not mandated to be a part of this, we would not have come to CBOs. Obviously I've changed my mind" – Dr. Rich Balaban*

Health Related Social Needs

Nutrition

Medications

Transportation

Language

Financial

Literacy level

Mental Health

Unsafe living environment

Lack of adequate informal supports

Metrics, Measurement and Outcomes

- Ongoing Data Collection
  - Understand your work
  - Where you add value
  - Who are you serving? Was this program intention?
  - Meeting agreed upon goals/benchmarks

- Continual Quality Improvement Activities
  - 5 Why's
  - PDSA Cycles

Lessons Learned

- Evaluate readiness
- Understand pain points
- Champions at different levels
- Meeting structure(s) and set cadence
- Access to the Electronic Medical Record
- Data plus stories
- Billing codes – are there new opportunities for payment?

Future of Contract and Next Steps

- Risk-based contracts
  - Use positions to sustain model and expenses
- More measurement of outcomes and impact
- Align new HRSN fee schedule with this work to identify reimbursable billable opportunities
- Expand programs by partnering with other key health systems
- Expanding to more focused, innovative opportunities that can consider risk and billable opportunities for the AAA (GUIDE Model)

Thank You!

Marta Corvelo, Chief Executive Officer

Marta.Corvelo@eldercare.org

Annie Fowler, Chief Program Officer

Annie.fowler@eldercare.org