The Virginia Story: MLTSS Demo to Innovation Statewide

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

“Boundary Spanning is Not for Sissies”
Leading and building bridges between two cultures
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
Eastern Virginia Care Transitions Partnership

A community partnership of health systems, area agencies on aging, independent physicians’ groups and other public and private health and human service providers.

**HEALTH SYSTEMS**
- Riverside Health System
- Bon Secours
- Mary Washington Healthcare
- Rappahannock General Hospital
- Sentara Health Care

**AREA AGENCIES ON AGING**
- Bay Aging – Lead Community Based Organization
- Eastern Shore Area Agency on Aging community and CAaction Agency, Inc.
- Peninsula Agency on Aging, Inc.
- Rappahannock Area Agency on Aging, Inc.
- Senior Services of Southeastern Virginia

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**EVCTP Zip Code Area**

[Map of EVCTP Zip Code Area]
CONTINUES TO INNOVATE

• Telehealth
• Chronic Disease – Self Management
• Fall Prevention
• Advance Care Planning
• Substance Abuse Counseling
• Healthy IDEAS

Boundary Spanning: Integrated Care

Biomedical Model

Financing

Medicare
Indemnity
Private Pay

“Boundary Spanners”

Probability of level being addressed:
Most likely

Level 1
Acute illness

Level 2
Chronic medical problems

Level 3
Functional issues

Level 4
Psychosocial

Social Model

Financing

Entitlements
Public Funds
Welfare
Private Pay

Probability of level being addressed:
Least likely
Engineering Health Systems for Older Adults and Those With Advanced Chronic Illness

System and **community approach** for improving care for those with advanced and serious illness

- Hospital Compassionate Care Network
- Advance Care Planning Coalition of Virginia
- Coalition for Chronic Disease Self Management Program coordination
- Eastern Virginia Care Transitions Program
- Clear Care- Dementia and Memory Clinical Practice Guideline with Patient/CG/CBO Advisory Group

In addition to clinical outcomes “Private Labeling” benefit to health system

Ms. G, a 62 year old woman living alone, was discharged with COPD and other chronic conditions

Hospital Visit Summary:

- PHQ9 screening indicated moderately severe anxiety and depression score = 15
- Patient had received a cut-off notice from the electric company
- Patient did not have transportation to follow-up appointments
- Patient did not have funds for medications at discharge

Outcomes:

- Patient was enrolled in the Healthy IDEAS 90-day program for depression
- Emergency Services were requested by the coach and payment was made for electric bill
- Patient was provided with a free book of transit tickets from Bay Transit so she could keep her follow-up appointments and shop
- Coach assisted patient with DSS application and she is now receiving services
- PHQ9 score at the end of 90 days = 8
- No further hospitalizations have been reported
Managing chronic disease

Preventing hospital admissions

Avoiding long-term NF stays

Activating patients

CBOs for Aging & Disability

State aging & disability agencies

ACL

Traditional Scope of LTSS
- Home-delivered/congregate meals
- Transportation
- Medication review
- Respite/Caregiver support
- Falls/Home risk assessments
- Information and assistance
- Personal care
- Employment-related supports
- Housing
- Homemaker
- Shopping
- Money management

Managing chronic disease
- Stanford model of chronic disease self-management
- Diabetes self-management
- Nutrition counseling
- Education about Medicare preventive benefits

Preventing hospital admissions
- Evidence-based care transitions
- Care coordination
- Medical transport
- Evidence-based medication reconciliation
- Evidence-based fall prevention
- Caregiver support

Avoiding long-term NF stays
- Nursing facility transitions (Money Follows the Person)
- Person-centered planning
- Assessment/pre-admission review

Activating patients
- Evidence-based care transitions
- Person-centered planning
- Chronic disease self-management
- Benefits outreach and enrollment

Integration of CBOs into Healthcare

*Target Group data reported by hospitals includes only those diagnoses that are considered primary to the admission, while EVCTP includes target diagnoses that may be primary or secondary to the admission.
EVCTP Readmission Rate by Alzheimer’s/Dementia Status

EVCTP % of Live Discharges Readmitted Within 30 Days by Alzheimer's/Dementia Status

- Alz/Dementia
- Linear (Alz/Dementia)
- No Alz/Dementia
- Linear (No Alz/Dementia)

EVCTP Admissions per 1,000 Benes

- National
- EVCTP
- Virginia
- Linear (EVCTP)
- Linear (Virginia)

140 X 61.73 = 8,669 Admits/Qt = 2,890/Mo = 96/Day
(96 previous quarter)
**EVCTP Readmissions per 1,000 Benes**

EVCTP 30-Day Readmissions per 1,000 Beneficiaries

- **National**
- **EVCTP**
- **Virginia**
- **Linear (EVCTP)**
- **Linear (Virginia)**

140 X 9.80 = 1,376 Readmits/Qtr = 459/Mo = 15/Day

(16 previous quarter)

**EVCTP % of Live Discharges Readmitted Within 30 Days**

EVCTP % of Live Discharges Readmitted Within 30 Days

- **National**
- **EVCTP**
- **Virginia**
- **Linear (EVCTP)**
- **Linear (Virginia)**
Getting the Word Out
Governor Terry McAuliffe
at
Virginia 2017 Governor Conference On Aging

You must develop a tolerance for risk taking.
Champions are critical for access to health systems and health plans.
Building relationship is key - for a statewide partnership – and for successful contracts.
Shared control is key to coalition building
"Lead – Follow – or get out of the way!"
Proven results and value are fundamental, especially ability to manage volume and turn data into compelling predictive information.
Developing staff skillsets and bandwidth is challenging, but essential.
Leveraging external expertise – consultants/technicians is a must.
Health systems think they can build it. – Remington Report
You can’t win them all, but keep trying!
Questions & Answers:
Please Submit Using the “Questions” Box
Please join us for future webinars in the Aging and Disability Business Institute Series

“The Social Determinants of Health: Key Factors in Creating Value Through CBO-Health Care Partnerships” – Oct. 25


Questions about the Aging and Disability Business Institute?

Email us: BusinessInstitute@n4a.org