The Affordable Care Act (ACA) - Leadership and Practice Implications for Social Work

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Partners in Care
Who We Are...

• Partners in Care is a transforming presence, an innovator and an advocate to shape the future of health care
• We address social and environmental determinants of health to broaden the impact of medicine
• We have a two-fold approach: evidence-based models for practice change and for enhanced self-management
• Changing the shape of health care through new community partnerships and innovations
Agenda

• Ecological Framework for Practice
• Key Drivers of Health Reform
• Key Drivers of Health Outcomes
• Dual Eligibles Demo – an historic opportunity
  – The role community organizations have in addressing and improving health outcomes and cost
  – Separate strategies for LTSS impacting Medicare and Medi-Cal service use
  – Home & Community Services Integration

Ecological Social Work Practice Framework: A Perfect Fit for Health Reform
Healthcare & fiscal pressures on Government Budgets

US Healthcare Spending as % of GDP

- Federal funding on Medicaid & CHIP projected to double to 4% of GDP by 2035
- States worried that balancing the federal budget would mean shifting costs to the states through block grants, or blended/reduced federal matching rates

ACA Medicaid expansion in 2014

- ACA streamlines Medicaid eligibility rules
- Expands potential enrollment
- Federal government provides extra fiscal support for expansion till 2020

- The Base Case (CBO estimate) built on a 55% take up rate
- Actual enrollment could range from 8M to 23M
- Medicaid eligibility & enrollment simplification could boost take up rates
Medicaid spending – pressure points

- The elderly & disabled account for majority of Medicaid spending; a subset – the duals eligibles make up 15% of enrollees and account for 40% of program spending
- 70% of all Medicaid duals spending is on Long-Term Care (LTC) (mental disabilities, spinal chord injuries, severe chronic illnesses, nursing home care, home health care, etc.)
- States may have a Medicaid problem, but Medicaid has a long-term care problem

Why the Costs are so High

- For Medicare the reason for high costs among duals is the elevated need for acute care resulting from increased prevalence of chronic disease associated with age, disability, poverty and need for innovations in care and self-care
- Medical interventions alone are not enough
- With targeted evidence-based interventions at home, much better results can be achieved
How Home and Community Services Address and Improve Health Outcomes

- Multiple, complex chronic conditions
  - Evidence-based enhanced self-care programs (e.g., Chronic Disease Self Management (CDSMP), Diabetes Self Management (DSMP))
- Complex medications/adherence (HomeMeds™)
- Multiple ER visits – gaps in care/communication
- Post-hospital support to avoid readmissions
- Nursing home diversion/return to community
- In-home palliative care in last year of life

Determinants of Health & Contribution to Premature Death

- Behavioral Patterns 40%
- Predisposition 30%
- Social Circumstances 15%
- Environmental Exposure 5%
- Health Care 10%

Source: Stephen A. Schroeder, MD. We Can Do Better. NEJM 357:12
The Need for Social Work Leadership

- Dramatic changes in the shift from hospital to home and community-based care/patient-centered care
- Requires understanding community culture
  - understanding regulatory requirements
  - multicultural approach
  - understanding of different practice settings
The Expanded Chronic Care Model: Integrating Population Health Promotion
Hot Spotting

• High costs come from specific target groups, where the investment of a new intervention yields better health and quality of life outcomes while driving down costs
• Target Medi-Cal, keeping people out of nursing homes and......
• Impact Medicare more directly by reducing ER, hospital admissions and readmissions

Dramatic change is required

• Medicine seeks medical solutions
• We must bring and sustain community-based solutions
• Prevention, self management and support for functional losses and mental health issues key
• Ethnic and economic health disparities key
• We must bridge into a new world with different culture, language and requirements
Duals Demonstration Project – How the Risk Will Shift

- Total financial responsibility for the full continuum of Medicare and Medi-Cal services will now include:
  - medical care
  - behavioral health services, and
  - long-term services and supports (LTSS):
    - In-Home Supportive Services (IHSS)
    - Community-Based Adult Services (CBAS)
    - Multipurpose Senior Services Program (MSSP)
    - Nursing facilities when needed

- Social supports help dual eligible beneficiaries maintain their health and live at home as long as possible

Challenge of the Dual eligibles

Total Dual Spending, 2009: $321 Billion or 2.1% of GDP

Sources:
4. National Health Expenditure Accounts: 2010

America’s Dual Eligibles

The average Medicare spending per dual eligible is higher than for other beneficiaries.

<table>
<thead>
<tr>
<th>Year</th>
<th>Dual eligibles</th>
<th>Medicare only</th>
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<tbody>
<tr>
<td>1997</td>
<td>5,000</td>
<td>3,000</td>
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<tr>
<td>2006</td>
<td>10,000</td>
<td>5,000</td>
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Sources: Centers for Medicare and Medicaid Services; Kaiser Family Foundation, Medicare Payment Advisory Commission
America’s Dual Eligibles

Many hospitalizations of dual eligibles are potentially avoidable, one study showed.
Total hospitalizations for dual eligibles, 2005
958,837
Potentially avoidable hospitalizations
382,846, 40%
For potentially avoidable hospitalizations
Average length of stay 6.7 days
Average cost to Medicare $7,846
Average cost to Medicaid $321

Sources: Centers for Medicare and Medicaid Services; Kaiser Family Foundation, Medicare Payment Advisory Commission

How to Best Care for the Duals to Achieve Optimal Health Outcomes
Evidence-Based Programs in California

Interventions shown in well-designed and implemented randomized controlled trials, preferably conducted in typical community settings, to produce sizeable, sustained benefits to participants*

- Provide statewide coordination & leadership
- Monitor and direct grant implementation
- Provide technical assistance statewide
- Disseminate Evidence Based Programs

*Top Tier Evidence Initiative: Coalition for Evidence-Based Policy
Evidence-Based Programs

• Self-Management
  – Healthier Living: Chronic Disease Self-Management
  – Tomando Control de su Salud
  – HomeMeds
  – Care Transitions Intervention
• Physical Activity
  – Matter of Balance
  – Arthritis Foundation Exercise Program
  – Arthritis Foundation Walk With Ease Program
  – Active Start
• Caregiver & Memory Programs
  – Powerful Tools for Caregivers
  – Savvy Caregiver
  – UCLA Memory Training

Medications & Care Transitions

• Seniors are most at-risk when transitioning from hospital to home or other care setting
• 20% of hospitalized Medicare patients are readmitted within 30 days
• Close to 1 in 5 patients discharged from the hospital suffer an adverse event – 72% of which are related to medications*

*from Mary Andrawis presentation to Drug Safety Panel, May 10, 2011
Care Transitions an entry point

- Economics rule
- Penalties for readmissions will rise
- CBOs are required and best
- Evidence-based interventions essential
- Once we win a contract, we must win the right to keep it – with results

Medication Safety

- Medication Errors are:
  - **Serious:** They cause approximately 7,000 deaths per year in the US
  - **Costly:** Annual cost of drug-related illness and death exceeds $170 billion
  - **Common:** Up to 48% of community-dwelling elders have medication-related problems
  - **Preventable:** At least 25% of all harmful adverse drug events are preventable
The Solution -- HomeMeds℠

• Core Components
  – In-home collection of a comprehensive medication list with notes on how each drug is being taken, plus vital signs, falls, symptoms, and other indicators of adverse effects
  – Use of evidence-based protocols and processes to screen for risks and deploy consultant pharmacist services appropriately
  – Computerized medication risk assessment and alert process with comprehensive report system
  – Consultant pharmacist addresses problems with prescribers

HomeMeds℠ Saves Money, Saves Lives

• Falls and other adverse effects improved through collaboration between pharmacists and members of the care team
• 46.7% of the older adults screened in 14 sites from 2007 to 2010 shown to have risk for medication-related injury – average of 2 to 3 potential problems per client.
• Estimated Savings from 7,000 Screenings: up to $1.5 million.
Evidence-based Protocols

Identified by expert panel – chosen for in-home intervention and positive response by prescribers (*minimize “alert overload”*)

1. Unnecessary therapeutic duplication
2. Use of psychotropic drugs in patients with a reported recent fall and/or confusion
3. Use of non-steroidal anti-inflammatory drugs (NSAID) in patients at risk of peptic ulcer
4. Cardiovascular medication problems
   - High BP, low pulse, orthostasis and low systolic BP

Pioneers in Palliative Care

- Developed with Kaiser / Dr. Brumley
- In-Home Palliative Care
  - Hospice – a big decision
  - Communication in need of major training
- Key elements of our model
  - Trust in home care team
  - Call Center 24/7
  - Decision support
What is Long Term Care?

- Encompasses a wide array of medicine, social, personal and supportive and specialized housing services
- Social, self management and environmental factors are crucial to determining full positive impact of medicine
- Needed by people who have lost some capacity for self-care
- Care at home or in a nursing home
- Most who need LTC are over age 76 (63%)

Activities of Daily Living (ADLs)

- Personal care activities people engage in every day
- Fundamental to caring for oneself to maintain personal independence
- Assessment determines level of care/assistance needed
- Certifies LTC level of care/payment level
ADL Functions

- ADL Functions
  - Bathing
  - Dressing
  - Grooming
  - Mouth care
  - Toileting
  - Transferring bed/chair
  - Climbing stairs
  - Eating

Each function is rated to determine level of support required:
- INDEPENDENT
- NEEDS SOME HELP
- VERY DEPENDENT
- CANNOT DO

Instrumental Activities of Daily Living (IADLs)

- Related to independent living
- Valuable for evaluating level of disease
- Determinant of person’s ability to care for themselves and their environment
IADL Functions

- IADL Functions
  - Shopping
  - Cooking
  - Managing medications
  - Using the phone and looking up phone numbers
  - Doing housework
  - Doing laundry
  - Driving or using public transportation
  - Managing finances

Each function is rated to determine level of support required:
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Home and Community LTC System Helps Avoid Nursing Home Placement

- Care at home can sustain independence
- Comprehensive in-home assessment identifies risks, basis to craft an in-home careplan
- Currently 6 separate MSSP agencies across LA County offer care in the home to Medi-Cal beneficiaries
- Purchase or arrange for in-home care/environmental modifications as needed
What This Network of Services Can Provide

**Purchased Services** (Credentialed Vendors)
- Safety devices, e.g., grab bars, w/c ramps, alarms
- Home handyman
- Emergency response systems
- In-home psychotherapy
- Emergency support (housing, meals, care)
- Assisted transportation
- Home maker (personal care /chore) and respite services
- Replace furniture /appliances for safety/sanitary reasons
- Heavy cleaning
- Home-delivered meals – short term
- Medication management (HomeMeds)
- Special needs required to maintain independence

**Referred Services**
- AAA
- IHSS
- Community Based Adult Services (formerly Adult Day Health Center)
- Regional Center
- Independent Living Centers
- Home Health
- In-Home Palliative Care
- Hospice
- DME
- Families / Caregivers Support Programs
- Senior Center Programs
- Evidence-based Health Impacting Self-Care programs
- Long-term home-delivered meals
- Housing Options
- Communication Services
- Legal Services
- HICAP
- Ombudsman
- Benefits Enrollment for services (i.e., food stamps)
- Money management
- Transportation
- Utilities
- Volunteer services

AAAs and Sponsors of MSSP Offer Core Resources
- Area Agencies on Aging – crucial safety net
- MSSP sponsors can evolve expanded home care expertise
- Scaling up from solid base and clinical infrastructure safer than “reinventing”
- Scaling best led by neutral community player, not health care entity
How We Could Work Together

• Home and Community Services Network
  – A proposed model for experienced in-home care coordination through a central portal
• Key Elements:
  – Contracted, credentialed network of trusted vendors and linked partnerships
  – Community Care Management including in-home
  – Administrative simplicity with full access to both arrange and purchase community care resources

Home and Community Services Network - Key Elements

• Full geographic coverage of L.A. County - one portal for all
• Credentialed contractors for purchase of home and community-based services and personal care
• Common data system
• Strong business case
• MSSP model is prototype
  – Build on base of 3,400 clients/170 care coordination staff – RNs and Social Workers in 7 locations
  – Cost effective, proven, and uniform model of care
• Ability to scale up and differentiate
  – Tiered care management models possible
Current System

- Area Agencies on Aging/ senior centers and core services
- Caregiver Resources Centers
- In-home Supportive Services (IHSS)
- Adult day health/Community-Based Adult Services (CBAS)
- MSSP – nursing home diversion

Health Reform - an historic opportunity – a time to lead

Health Plan Functions
- Enrollment and disenrollment/UM & CM
- Claims and Data Analysis
- Coordinating Medicare & Medicaid

Integrated Direct Delivery
- Different facility needs – primary care clinic integrated with behavioral health institution
- Coordination of referrals, appointments, care mgmt., clinical best practices, staff, clinical records
- Clinical integration with health plans/community

Community Resources
- Care coordination/in-home support
- Access to Public benefits/IHSS/CBAS
- Transportation, food assistance, housing
- EB Targets – meds/palliative/coaching/self-care
The Time is Now

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Resources

This presentation available at:
www.picf.org >EVENTS>PRESENTATIONS

Blue Sky document available:
www.picf.org >EVENTS>PRESENTATIONS
Blue Sky resource articles document available:
www.picf.org >EVENTS>PRESENTATIONS
“Reducing the Risk of Warfarin-Related Hospitalizations”
Aging Well September/October 2012
Available online at: www.agingwellmag.com
A Robert Wood Johnson document on health disparities:
Six Steps to Curb Disparities