



Commonwealth of Massachusetts

Executive Office of Elder Affairs

**Bridging the Gap: Linking Health Care and Long-Term
Services and Supports (LTSS) for Massachusetts' Elders**



Bridging the Gap

Agenda



- Introductions
- Bridging the Gap – Opening Discussion
- State of Massachusetts HCBS Overview
- Bridging the Gap – What is Happening?
 - Current Efforts – 10,000ft
 - Community Care Linkages – Building Partnerships
 - AAA - Opportunities & Projects
- Technology Viewing (Community Links Portal)
- Questions & Answers - Technology Viewing (Community Links Portal)



Introductions



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AAA/ASAP – Elder Services of the Merrimack Valley

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Project Director

Community Care *Linkages* (A Mass Homecare Initiative)



Bridging the Gap

Opening Discussion



The Health Care Organization (HCO) Perspective...

- AAA's are “good people that provide Home Delivered Meals”

How do we change the way AAAs are viewed?

- Historically, we have had a difficult time selling the value of the AAA network
- Why is there a knowledge gap?
- Opportunities are available to change how we approach and partner with HCOs



About Massachusetts HCBS

Sizing Up HCBS

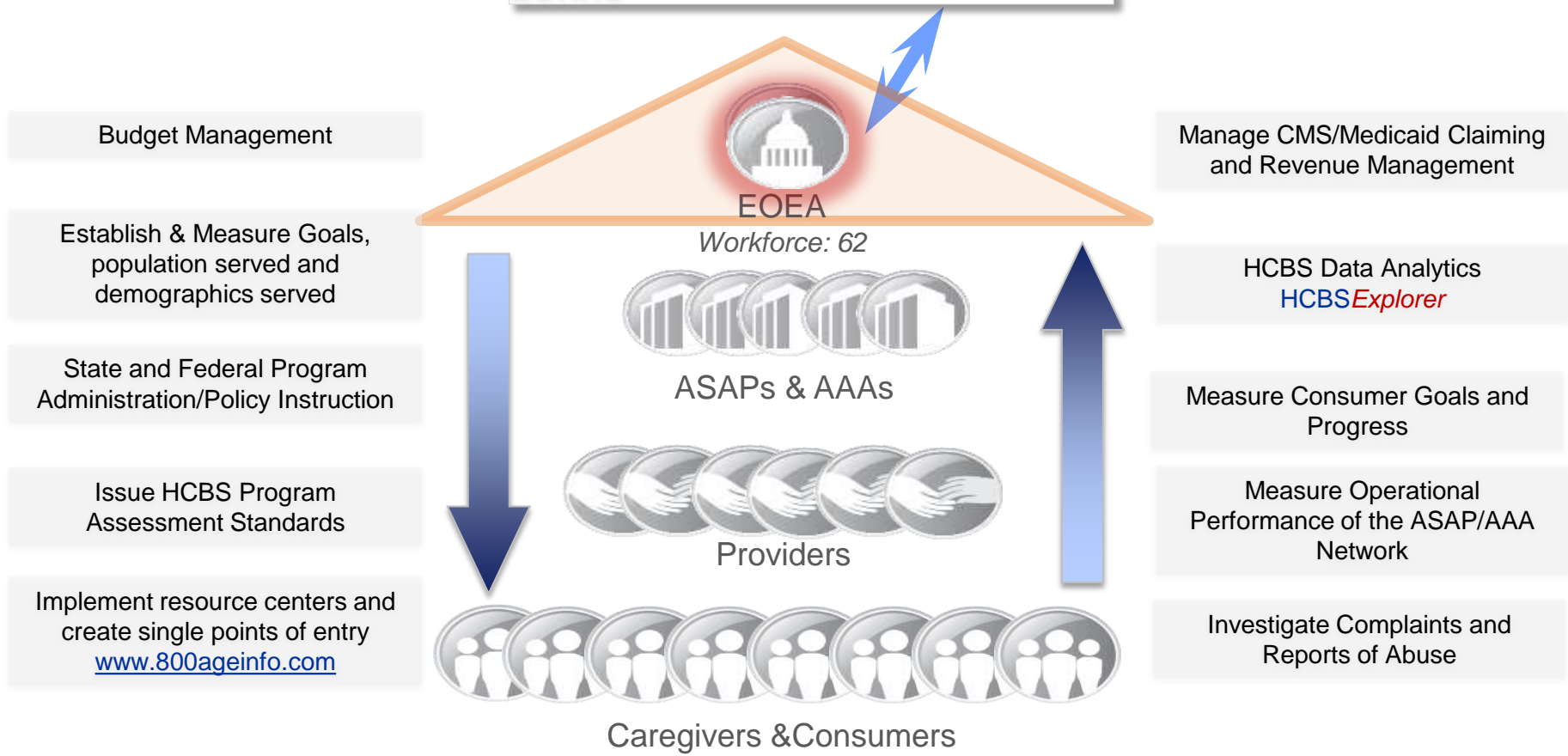


HCBS Programs	Expenditures	Consumers	Clinical Eligibility	Financial Eligibility
Home Delivered Meals Program provides nutritionally balanced meals to seniors through home-delivered meals.	\$20.2 M	24,428	Unable to attend congregate meal site	None
Home Care Basic / Respite Program provides supportive services for elders with moderate needs who do not require nursing facility level of care.	\$134.3 M	45,561	At least 4 I/ADLs	Income: <\$26,168 No asset test
Enhanced Community Options Program (ECOP) serves elders who are clinically eligible for nursing facility care and require more services than available in the Basic Program.	\$52.9 M	9,896	Nursing Facility Level of Care	Income: <\$26,168 No asset test
Community Choices provides intensive services to elders who are enrolled in the Waiver program and who are clinically eligible and at imminent risk of nursing facility placement.	\$147.2 M	8,953	Nursing Facility Level of Care	Income: <\$25,971 Assets: <\$2,000



About Massachusetts HCBS

EOEA Role



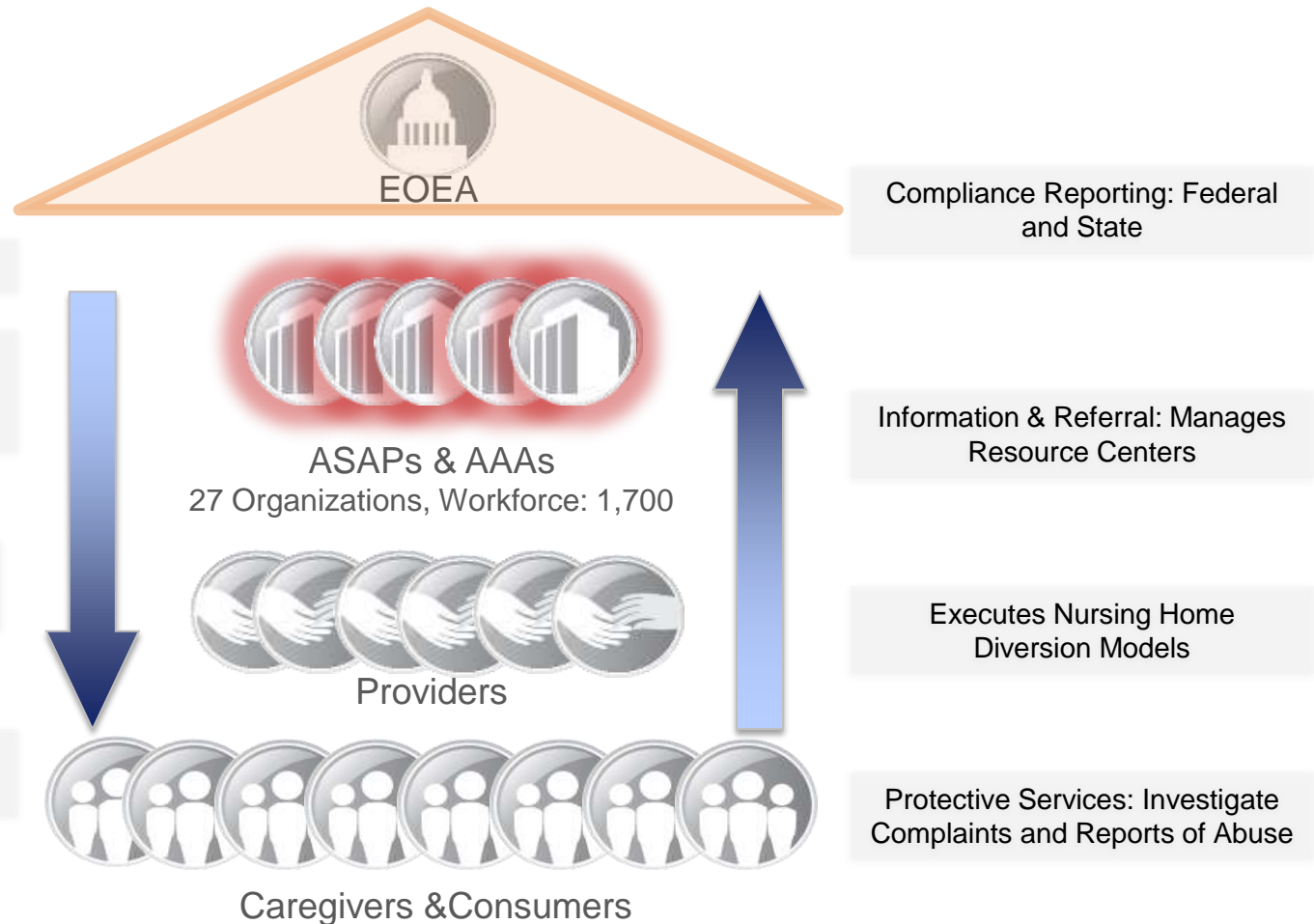
EOEA: State Unit on Aging

The Executive Office of Elder Affairs is responsible for management and oversight of approx. \$397.5M in state and federal funding for programs that provide HCBS and supports to elders and younger disabled individuals throughout the Commonwealth



About Massachusetts HCBS

ASAP/AAA Role



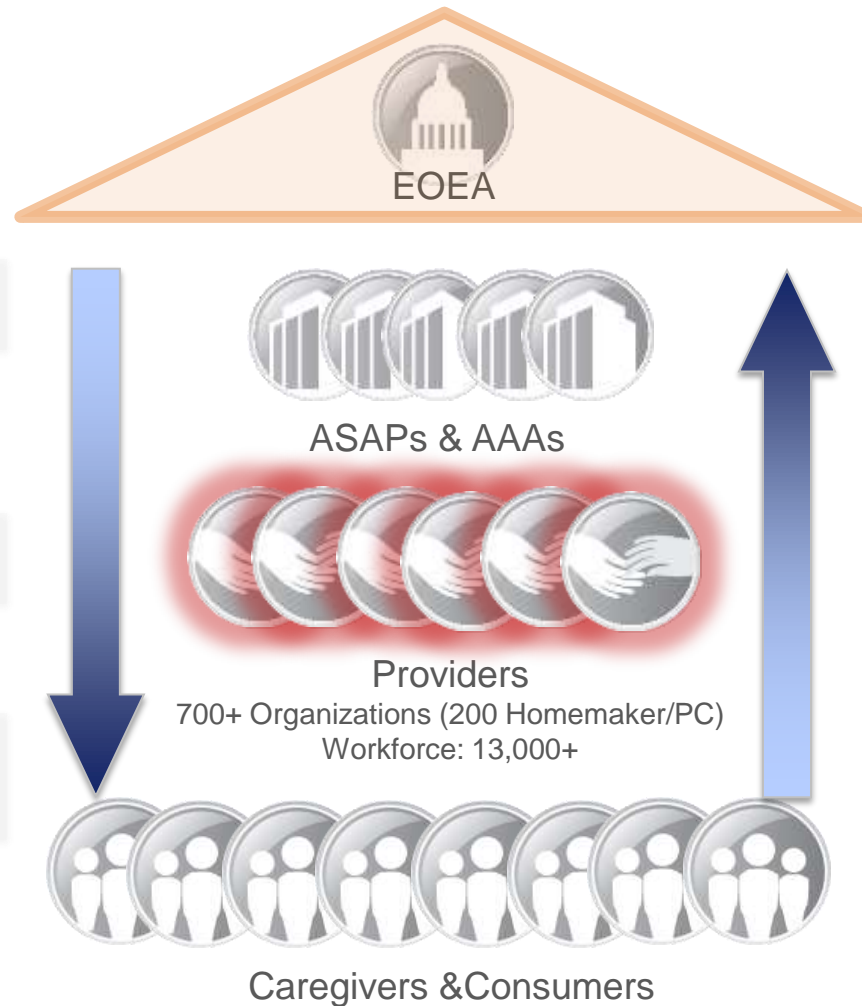
Agencies on Aging (AAA)/ Aging Service Access Points (ASAP)

A network of 27 non-profit agencies with delegated authority from EOEA, with distinct geographic jurisdiction. These agencies are responsible for regional planning, Information & Referral, Screening and Assessment, Service Plan Development, Case Management, and Provider Oversight.



About Massachusetts HCBS

Provider Role



Contracts Directly with ASAP/AAA

Provides Direct Services to Consumers

Communication: Maintains communications with Case Managers through length of care

Technology Partner

98% of Providers using the state-funded system of record (SAMS) to retrieve daily Service Authorizations, view Care Plans, and direct deliver authorized Service Deliveries

Direct Service Providers

A diverse array of organizations providing social services and community supports to consumers. All providers are contracted with the ASAP/ AAA network.

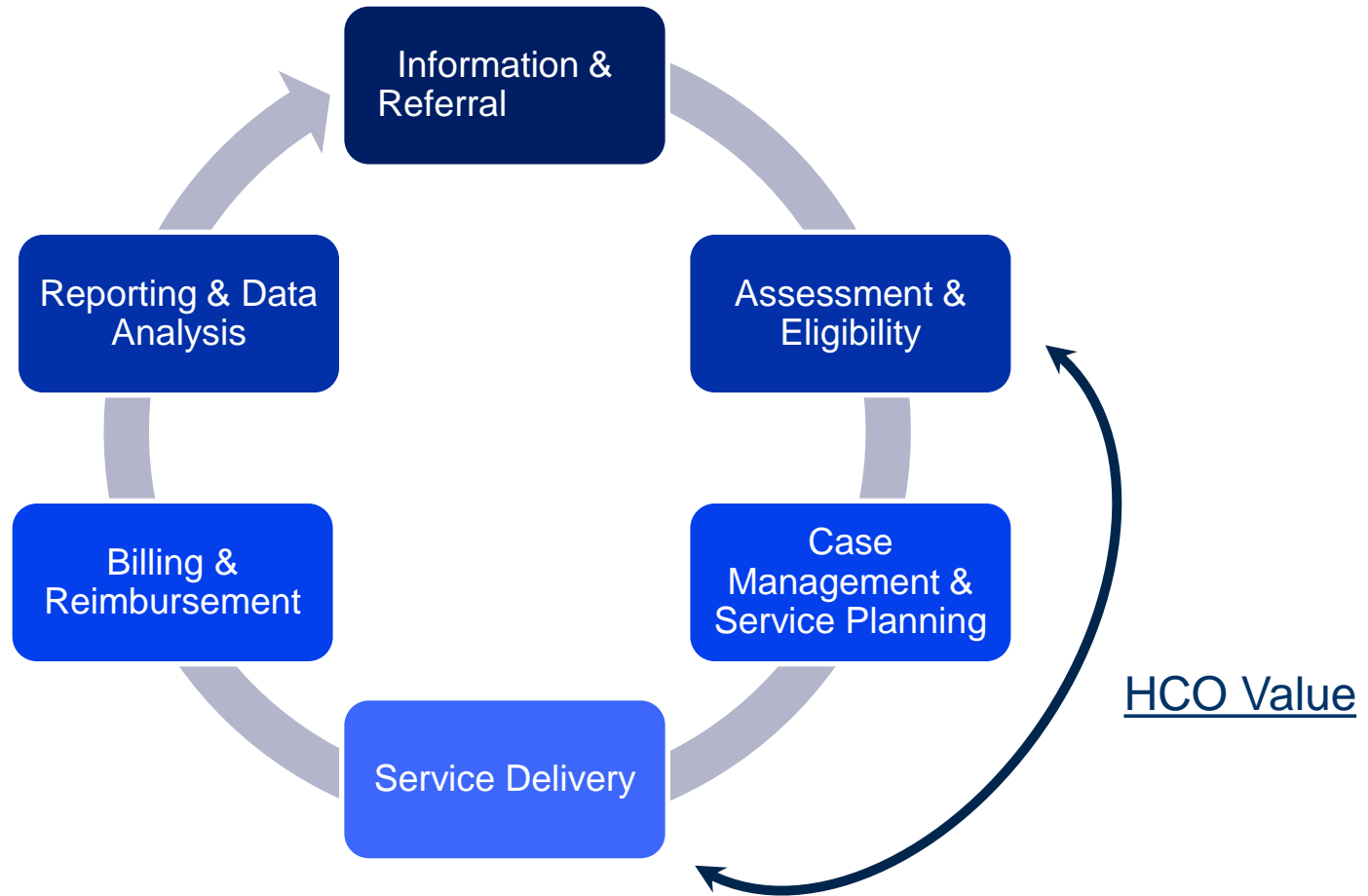


About Massachusetts HCBS

HCBS Business Continuum



Massachusetts HCBS Business Continuum





Bridging the Gap

Current Efforts – 10,000ft



Current Efforts

Healthcare Organization (HCO) Education: ASAPs provide education on who we are, what we do and how we can help whenever possible – Community Care *Linkages*, Community Links Portal

HCBS Partnerships Work: Demonstrating consumer success stories where the HCO/AAA partnership was key to a healthy transition from a hospital/rehab stay and how maintaining a close relationship with AAA care coordination can prevent readmissions.

Financial Opportunities: Identify potential joint projects through existing and emerging grants, technology development, and local initiatives that would benefit both sides

- Community-Based Care Transitions Program (CCTP) – Section 3026 of the Affordable Care Act
- Community Hospital Acceleration, Revitalization, & Transformation (CHART) Investment Program – State of MA
- State Innovation Model Grant - CMS

Pushing HCBS Information to HCOs: Give HCO's a lens into the consumers assessments, care plan, and services delivered via technology

Current Technology Project:
 Funding Source:
 Status:

Community Links Portal
 CMS – State Innovative Model (SIM) Grant
 Pilot



Community Care LinkagesSM

Mass Home Care



Community Care *Linkages* is a strategic initiative that effectively integrates services of the Massachusetts *Aging Service Access Points (ASAPs)/AAAs* into the evolving healthcare delivery system.

ASAPs/AAAs are a valued partner in moving health reform efforts forward:

- ✓ Extensive Care Coordination and Care Transitions Experience
- ✓ Partnering with Senior Care Organizations (SCOs), Accountable Care Organization (ACOs), Patient Centered Medical Homes (PCMHs), and One Care Plans (dual eligibles)
- ✓ PCMHs/Physician Practices (MD practice based Community Care Coordinators)
- ✓ CCTP/Section 3026 (care transitions)
- ✓ HPC CHART (care transitions)



Current ASAP Activities in MA

Care Coordination and Care Transitions



Current partners:

- Non-profit health care organization with 1,000+ MDs in 50+ practice sites
- Physician and hospital network, 2,000+ network of physicians, Pioneer Accountable Care Organization (ACO).
- Physician led network of 1,000 +physicians, Medicare Shared Savings Program ACO
- Family practice group of 7 MDs, 3 Physician Assistants
- Federally Qualified Community Health Center
- National health insurer serving 70 million people and nationwide network of 750,000+ physicians

AAAs, while not Medicare providers, can be an important resource in improving care coordination and care transitions.





Bridging the Gap – Success Story

*Community Resource Coordinator (CRC) at BIDCO**



- One full time on-site CRC assist BIDCO care managers to provide information and resources for patients, e.g. home care, caregiver support, etc. and documents information directly into EMR.
- Referrals from BIDCO care management staff to CRC (BIDCO has 8 care managers and 12 in MD practices). MDs are now referring directly for patients with psycho social needs
- Created web-based shared library of community resources for BIDCO care managers.
- Track Healthy Living Programs to enhance referrals from RNs, save RNs time with improved communication.
- Assist with connecting patients to mental health professionals, e.g., make the first calls to facilitate connection.
- Over 2 years, served 900+ patients to date

“medical staff did not know what they did not know”

“helped RN with complicated case and news spread!”

* BIDCO – Beth Israel Deaconess Care Organization (2,100 PCPs/Specialists & Numerous Hospitals)



Relevant Quality Metrics

How can ASAPs/AAAs help to move the needle?



Pioneer Accountable Care Organizations (ACOs)

- Patient/Caregiver Experience
 - How Well Your Providers Communicate
 - Patient Rating of Provider
 - Health Promotion and Education
 - Shared Decision Making
 - Health Status/Functional Status
- Care Coordination/Patient Safety
 - Risk Standardized All Condition Readmission
 - Falls: Screening for Future Fall Risk

Patient Centered Medical Homes (PCMHs)

- Use of high risk medications in elderly
- Care for older adults
- Cholesterol management for patients with cardiovascular conditions
- Comprehensive adult diabetes care
- Fall Risk Management
- Physical activity in older adults



Current Strategy

Being the Preferred LTSS Provider



- Align ASAP's value to healthcare organization's vision
- Identify point person for communication, referral and follow up
- Develop pilots to demonstrate value
 - Identify quality and performance metrics
 - Establish for monitoring and reporting
 - Share and spread lessons learned
- Analyze and promote results
 - Continuous sales to internal and external stakeholders

- Be present, visible:
“on radar screen”
- Be ready when “they” are ready:
 - Strengthen core services and capacity to be ready to respond
 - “Having the right people, resources and reputation” to partner



Bridging the Gap

AAA/ASAP Opportunities & Projects



- AAA (Area Agency on Aging) – Private, non-profit 501(c)3 organization serving 23 cities and towns in Northeastern Massachusetts for 40 years
- ASAP – designated by Massachusetts as Aging Services Access Point
- Core Functions; over 100 RN's and Social Work staff provide care coordination, care management, screening and assessment for community based care and SNF (skilled nursing facility) approval
- Manage a network of over 75 vendor contracts for over 120 different community based services
- Over 30% of staff are bilingual/bicultural



Bridging the Gap

AAA/ASAP Opportunities & Projects



CCTP (Community Care Transition Program)

- Over 20,000 referrals since inception 28months ago
- (6) Lead Coaches imbedded into the Case Management staff at hospital
 - A. Consistency!
 - B. Physician and staff education
 - C. Connect hospitalized patients to community resources
 - D. FULL Integration into the hospital care team!
- Nurse Coordination using technology to provide clinical intervention in “real time” to complex medically compromised patients.

Managed Care provider contract currently in place for care transitions.

One Care contract in place for younger disabled dual eligible population with a managed care provider

Healthy Living Center of Excellence – regional collaborative that provides readiness for statewide payer contracting for the dissemination of 12 evidenced based programs including CCTP and dually eligible managed care seniors.



Bridging the Gap

Connecting with HCOs – How did we do it?



Hospitals want to know what you can do for them!

- Most hospitals / PCP's or payers are data outcome driven – Show them the DATA!
- By providing access to consumer data via available technology, you will show them what you are doing with their patients in the community.
 - A. Vital information they cannot obtain other than from a AAA.
- If you have a CCTP program use that data to build a framework for rapid cycle change.
 - A. Provide weekly success stories.
 - B. Show up to the table with an open mind and the ability to make changes when needed.
- Use outcomes and PDSA's to show value and Quality improvement consistently
 - A. Hospitals are built on QUALITY! They need reassurance and proof of what you can do.
 - B. Frequent reports and outcome measure updates on program status.
 - C. Reach out to the Director of Quality at the hospital and work with them not against them..
What do you have that they would want???



Bridging the Gap

What barriers did we meet along the way?



Misconception - Many think the AAA only serves elder with Home Delivered Meals

- Break the barrier and show that the AAA is on the cutting edge ready to assist PCP's and hospitals in patient coordination.

Proactively lower barriers by implementing a technology solution or shared data agreement

- Provide robust training and education for all staff
- Provide written "easy to read" instructions
- Contact support person at the AAA for issues and concerns
- Provide regular face to face meetings with Physician practices and Hospitals

Be open to new possibilities

- Look for feedback to improve experience.
- Look for new innovative ways to think "outside the box"

Meet them where they are at –

- Be prepared to adapt to what is needed and be flexible.
- Offer a no-fee pilot to prove yourself!
- Ask for 1 case, 1 cohort, 1 month. Show them what you can do and tell that story.

DON'T BE AFRAID TO TAKE A RISK!



Bridging the Gap

Where are we going next?



Community Hospital Acceleration, Revitalization, & Transformation

(CHART) Investment Program – Sponsored by the Health Policy Commission, State of Massachusetts

- The goal of the program is to promote care coordination, integration, and delivery transformations; advance electronic health records adoption and information exchange among providers behavioral health services, and coordination between hospitals and **community-based providers and organizations**.
 - A. Embedded Nurse and Care Coordinators in Physician practices
 - B. Expansion of CCTP to other payers in the hospital providing high risk complex patient care enabled by technology (**Care at Hand**) to provide real time clinical triage by a Nurse Coordinator.
 - Population Health Management by NC in a cost sustainable way.
 - Fast paced Quality Improvement PDSA's to effectively manage rapid cycle change.



Bridging the Gap

Where are we going next?



CHART - Meaningful use –

- The Medicare and Medicaid EHR Incentive Programs provide financial incentives for the meaningful use of certified EHR technology to improve patient care. To receive an EHR incentive payment, providers have to show that they are meaningfully using their EHRs by meeting thresholds for a number of objectives. The EHR Incentive Programs are phased in three stages with increasing requirements. The hospital only gets paid when they attest and meet the requirements.
- ❖ ESMV is currently running a 1 month pilot to assist the hospital in meeting the 3 requirements below. Evaluation and negotiation of pricing to be completed when pilot is complete
 - **Criteria #6:** Provide patients the ability to view online, download and transmit their health information about a hospital admission via a patient portal.
 - **Criteria #10:** Use clinically relevant information to identify patient-specific education resources and provide those resources to the patient.
 - **Criteria #12:** The hospital who transitions their patient to another setting of care should provide a summary care record for each transition of care or referral.

SEEK OUT NEW TECHNOLOGY TO PROVIDE EFFECTIVE PATIENT CARE IN A COST SUSTAINABLE WAY!

- Technology is only as good as the staff you have to send and receive the information.

BE CREATIVE!



Questions & Answers

Technology Viewing Community Links Portal (CLP)

<http://community-links.800ageinfo.com/what-is-the-clp.html>