Ho’okele Health Navigators

“Complex Care Coordination”
A new line of business
NAHC – Private Home Care Leadership Summit and Exposition
March 19, 2013

"Medicine used to be simple, ineffective, and relatively safe. It is now complex, effective, and potentially dangerous."

Sir Cyril Chantler. BMJ 1998; 317:1666
Objectives

• Describe the need for improved care coordination to high risk/high cost individuals.

• Design a complex care coordination program that will have a positive impact it can have on the quality of individual’s lives and lower overall cost of medical care to a group of high cost individuals in particular Medicare and Medicaid members.

• Evaluate the impact of care coordination with health indices and cost of care measures.

Healthcare is a Maze
Ho’okele Overview

• Founded in 2006 - enabling families to navigate the complicated health and elder care systems

• Professional staff – RNs, MSWs, Health Coaches, In-Home Aides

• Customers – Individuals, Employers, Health Plans

• iHealthHome® technology developed to enable cost effective care coordination at home

The Aging Tsunami and Chronic Disease
Aging Tidal Wave

- 10.5 million seniors live alone, this number will double by 2030
- Over ½ of all humans that have ever lived to be 65 or older are alive today!

The Boomers are Here

Every 8.5 seconds a baby boomer in the U.S. turns 50 years old
Chronic Disease

• Eight of ten Americans age 65 or older are living with heart disease, diabetes or some other form of chronic disease.
  • U.S. Center for Disease Control and Prevention (CDC)
• Disproportionate drivers of healthcare costs.
• These individual’s in general experience poor health outcomes due to the fragmented healthcare delivery system.

What to Do?

“High blood pressure, high cholesterol, high blood sugar, high anxiety... getting high is no fun at my age!”
Care Coordination

What is Care Coordination

• An approach to healthcare in which all of a patient’s needs are coordinated with the assistance of a knowledgeable, single point of contact
  – Medical
  – Home & Community Based Services
  – Functional Assistance
  – Social Participation
  – Personal Goals
### Challenges

**Transitions**
- 42% were able to state their diagnosis
- 40-80% of medication information is immediately forgotten
- Almost half of the information was remembered incorrectly
  - Inner city NY hospital
  - Makaryus. Mayo Clinic Proceedings
  - Aug 2005;80:991

**Fragmentation**
- Medication compliance
- Missed MD appointments
- Life challenges
- Lack coordination-multiple providers

**Leads to:**
- ED visits
- Readmission

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### Readmissions

- Study involved 11,855,702 beneficiaries
- 19.6% readmission rate within 30 days
- Significant number with no follow up with primary care physician at the time of re-hospitalization
- $17.4$ billion spent on readmissions

Public reporting, shared incentives, shared accountability
Care Coordination Models

• Care Transitions Interventions (CTI)-Coleman model
  – 4 week intervention

• Transitional Care Model (TCM)-Naylor
  – 1 to 3 month intervention

• Guided Care
  – John’s Hopkins
  – Longterm contact usually for life

• Geriatric Resources for Assessment and Care of Elders (GRACE)
  – Longterm contact up to 2 years

Complex Care Coordination
One model
Complex Care Coordination Model

Who would benefit

- Multiple chronic conditions
- Frequent hospital admission, re-admissions
- Numerous ER visits
- Complex family and psychosocial environment
- Within the top 1% to 5% of highest cost members of a health plan
- High risk per health plan predictive modeling
- Challenging & time intensive for PCP’s and office staff
- May be approaching end of life
Complex Care Coordination

Attend to the highest risk and/or highest cost patients within a physician’s panel:

Population of Focus #1
• 72 members (3.4%) used 61% of cost ($3.4 M)

Population of Focus #2
• 449 members (5.0%) used 63.5% of cost ($45.6M)

RN Care Coordination

• Partnership with Primary Care Physician
• RN as central point of contact
• Initial intensive face to face interventions
• Pharmacist medication reconciliation
• NCQA care coordination standards
### Discharge Checklist

**Example Questions**

- I have been involved in decisions about what will take place after I leave the facility.
- I understand what my medications are, how to obtain them and how to take them.
- I understand what symptoms I need to watch for and whom to call should I notice them.

Tool developed by Dr. Eric Coleman, UCHRC, HCPR
Sign and Symptoms

Tools

• Great tool to train individuals on signs and symptoms and what to do if noted

ALL CLEAR

CAUTION! CALL DR. IF:

CALL 911- GO TO EMERGENCY!

Health Coaching

• Patient Activation
• Motivational Interviewing
• Self-Management Teaching
• Non-Clinical Model
Patient Activation - National Outcomes

The MORE ACTIVATED you are in your own health care, the BETTER HEALTH CARE you get...

<table>
<thead>
<tr>
<th></th>
<th>MORE ACTIVATED Patient</th>
<th>LESS ACTIVATED Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmitted to the hospital within 30 days of discharge</td>
<td>12.8%</td>
<td>28%</td>
</tr>
<tr>
<td>Experienced a medical error</td>
<td>19.2%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Have poor care coordination between health care providers</td>
<td>12.6%</td>
<td>41.8%</td>
</tr>
<tr>
<td>Suffer a health consequence because of poor communication among providers</td>
<td>13.2%</td>
<td>48.6%</td>
</tr>
<tr>
<td>Lose confidence in the health care system</td>
<td>15.1%</td>
<td>59.8%</td>
</tr>
</tbody>
</table>

Source: Adapted from AARP & You “Beyond 50/60” Patient Survey. Published in AARP Magazine. Study population age 50+ with at least one chronic condition. More Involved - Levels 3 & 4, Less Involved - Levels 1 & 2.
Personalized Education

- Personal
- Specific to Goals
- Relevant
- Digestible
- Easy to Access
- Easy to Review
- Virtual Delivery

Have you tried any of these ways to be more physically active?

- Gardening
- Walking to mailbox
- Walking dog
- Walking in the mall
- Doing yard work
- Walking in place while watching TV
- Chair exercises
- Parking car further from
- Call a friend to join you
- Join a gym or the YMCA
- Local groups, churches
- Nintendo Wii

Technology

iHealthHome
Complex Care Coordination - National Outcomes

- Veterans Administration
  - 25% reduction in bed days
  - 19% reduction in hospital admissions

- Geisinger Proven Health Navigator Program
  - 18% reduction in hospital admissions
  - 36% reduction in re-admissions
  - 7% reduction in overall cost

- TriHealth Cincinnati
  - 23% reduction in readmissions

- Massachusetts General Hospital
  - 15% reduction in ER Visits and Hospital Stays

In-Home Remote Monitoring
A Story

Mrs. B

• 68 years old female lives with her 70 y/o husband in public housing.
• English is their second language.
• She is dependent on her husband for her care
Goals

Personal Goal
• To travel to her home country to see her 14 grandchildren.

Clinical Goals
• Blood glucose range – 110 -130 mg/dl
• HgA1c - < 7 %
• Weight range – 135-137 lbs
• BP range – 130-138/70 -78
• Minimize readmissions due to respiratory infections
• Increase self management and compliance

Outcomes

Personal goal
• Mrs. B visited her children and grandchildren in 2012

Improved Health and Cost
• Blood Glucose –Goal Met- 50% improvement
• HbA1c – Goal Met - decreased 8%
• Weight – Goal Met - lost 12 lbs
• Lipids – Goal Met – 6% improvement in total cholesterol
• Reduced hospitalizations by 20%
• No Admissions in Last 10 months
• Technology in Place = Automated hovering
A New Line of Business

Home Care Agencies

Business Opportunity

• Home care agencies are in a unique position to include complex care coordination as a new service line.

• Home care nurses roles can be expanded to coordinate care and resources for individuals with complex chronic disease as a value added service line.
A Need

AHRQ White Paper – January 2012: private physicians

• Smaller practices have little “reserve capacity” or flexibility to devote extra time to the complex patient.

• Lack of time and emotional energy to spend on anything other than the acute needs of the complex.

Private Physicians

• Time required to navigate the variety of community based, social and behavioral programs is overwhelms the lean practice staff

• Lack of time to maintain breadth of knowledge in multiple narrow topics for care of complex patients.

• Low prevalence of complex cases in a panel
Complex Care Coordination Goals

Clinical
- Reduce ER Visits, hospitalization, re-admissions
- Improve chronic condition health measures

Technology
- Increase care coordinator efficiency
- Engage patients-self management

Payment Alignment
- Cost savings
- Increased automation-scale

Common Attributes
- Care team
- Comprehensive assessments.
- Individualized Plans of Care
- Enable access
- Community resources
- Monitoring and communication
How to Begin

• Design as a part of the current home care position or a separate service line
• Training
• NCQA or other evidence based standards
• Design workflows

Complex Care Coordinator

Role
• Coordinate care for medically complex individuals in their homes and community.
• Fosters partnerships with the individual’s physician and healthcare team to promote continuity of services.

Responsibilities
• Comprehensive assessment
• Understand the individual’s culture, family and community relationships.
• Develop customized and comprehensive service plan.
• Provide individualized patient education.
• Evidence based tools
• Accompany clients to medical appointments care.
• Referral to community resources
Measurement

Quality Improvement

Measures

- Biometric improvement
  - Hba1C
  - Blood Pressure
  - Lipids, Others as relevant
- Patient Activation Score
- Predictive Modeling Score
- Medication Reconciliation

- Medication Adherence
  - % refills
- Pre vs. Post Intervention
  - Cost of Care
  - Hospitalization rate
  - ER Visits
- Physician and Patient Satisfaction
A1c

Impact on A1Cs

- 25.7% improvement (p<.05)
- 7.8% improvement (p<.05)

- All Grads
- Worst Start

2 Times more improvement (p<.05)

Weight

Impact on Weight

- 11.4% improvement (p<.05)
- 2.9% improvement

- All Grads
- Worst Start

6.5 Times more improvement among those most needing it (p<.05)
Patient Activation

Impact on PAM Level Score

- 27.4% improvement (p<.05)
- 95.8% improvement (p<.05)

3.2 Times more improvement among those most needing it (p<.05)

Summary

Video Visits, Shared Plan of Care, Customized Patient Education, Remote Health Monitoring, Asynchronous Communication, Coordination, Engagement & Motivation, Motion Sensors, Alerts, Telehealth, Touchscreen User Interface, Activity Sensors, Interactive Social Media, Personal Journal, Engaged Healthy Client

Technology Enabled Care Coordinator

3/7/2013
The time is now

• The prevalence of chronic diseases and aging population.
• Hospital and MD incentives to improve transitions of care and care coordination across the continuum.
• Unique position and trained labor force

Thank you

Questions?

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