Surviving in Senior Care

LONG TERM CARE FINANCE ASSOCIATION

OCTOBER 18, 2018

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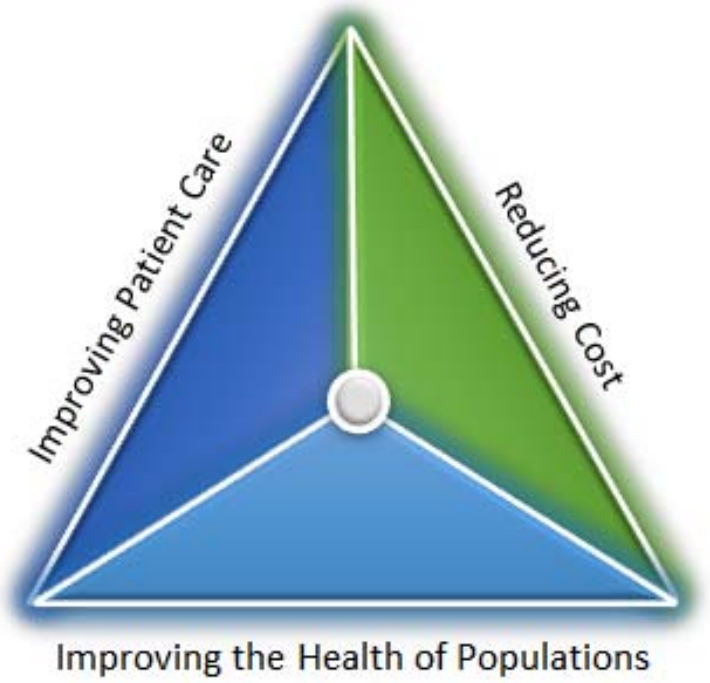
LeadingAge™ Massachusetts

The Triple Aim



Reducing Cost – Focus on PAC

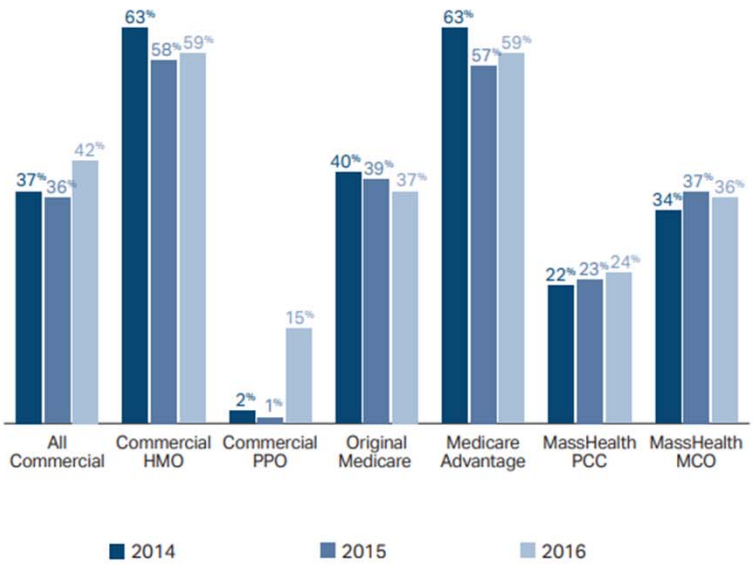
Steady decline in hospital discharged to institutional PAC since 2010 with increase in discharges to home health

Among all payers, Massachusetts has a higher rate of discharge to institutional post-acute care (PAC) and to home health than the national average.

Among payers, Medicare had the largest differential in 2014, with the Massachusetts rate of discharge to institutional PAC exceeding the national average by 4.3 percentage points.

*Source: Health Policy Commission 2017 Cost Trends Report

Alternative Payment Models in MA



Health Policy Commission Cost Trends Report for 2017

The percentage of commercial members covered by APMs increased from 36% in 2015 to 42% in 2016, driven by Blue Cross Blue Shield of Massachusetts implementing APMs in its commercial PPO product. The rate of commercial HMO members covered by APMs remained nearly the same, increasing from 58% to 59%.

MassHealth slightly increased the use of APMs in the PCC Plan in this time period. It is expected that use of APMs in MassHealth will significantly expand in 2017 and 2018, as the MassHealth ACO program is implemented.

The percentage of Original Medicare beneficiaries in ACOs remains relatively high compared to other parts of the U.S. (22% in 2016).

Population Health Management

Individual focused

Reactive; sick care

vs

Population focused

Proactive; keep populations healthy and intervene before crises occurs

Population Health Management

Greater emphasis on prevention and early intervention

Consider social determinants (education, income, living conditions, etc.) that also influence health outcomes

Coordinate care across providers to ensure care is not fragmented

Engage patients in understanding how to manage their care and to take an active role

Why focus on affordable housing?

PEOPLE

Large percentage of dual – eligible individuals

More likely to have multiple chronic conditions

Average per member per month (PMPM) costs for Medicare FFS and Medicaid FFS were higher for HUD-assisted dual eligible beneficiaries than for unassisted dual eligibles in the community

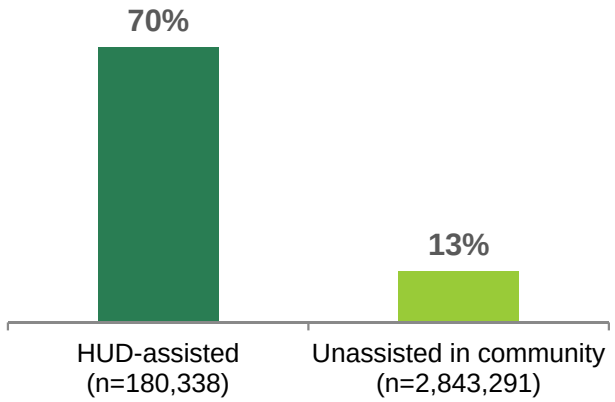
INFRASTRUCTURE

Physical and personnel infrastructure

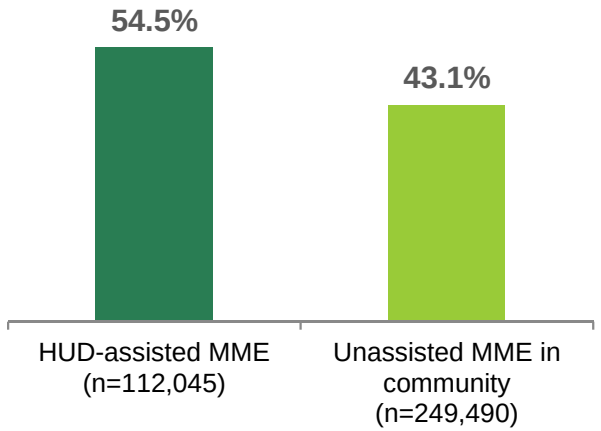
- Trusting relationships
- Monitoring
- Facilitate greater follow-through and compliance
- More complete understanding of social factors

High Level of Chronic Illness

Proportion of Medicare beneficiaries dually enrolled in Medicaid



Proportion of Medicare-Medicaid enrollees with 5+ chronic conditions



Source: *LeadingAge Center for Applied Research*

Supports and Services at Home

SASH® a caring partnership
SUPPORT AND SERVICES AT HOME

PROGRAM COMPONENTS

SASH Team:

- Wellness Nurse
- Embedded Resident Service Coordinator

Person-directed plans based on personal goals

Evidenced-Based programming

Partner with community-based providers

OUTCOMES

Reductions in Blood pressure

Increase in completion of advance directives

Reduction in falls

SASH participants experienced a reduction in total average expenditure growth of $1536 per beneficiary per year

Support And Services at Home (SASH) Annual Report, 2nd Report, U.S.Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy

CAPABLE

Developed at Johns Hopkins School of Nursing for low-income seniors

Team includes a nurse, occupational therapist, handyman

Focuses on goals and strengths of individuals

$3,000 program costs yielded average of $22,000 in savings in medical costs

Reduced by half difficulty with ADLs for participants after five months

Reduced symptoms of depression

Improved motivation

Johns Hopkins School of Nursing CAPABLE Program
https://nursing.jhu.edu/capable

Challenge

We have the evidence? Will payment follow?

Other Housing + Healthcare models

Hebrew SeniorLife – R3 (Boston)

Staying at Home program (Pittsburgh, PA)

Presbyterian Senior Living and Pinnacle Health Systems

Housing with Services initiative (Portland, OR)

Housing + PACE

Hospital investment in housing

Technology and Population Health

Care Coordination Technologies

- Data Sharing
- Direct and secure messaging
- Electronic transitions of care

Social Connectedness and Engagement Technologies

- Care.coach (Element Care)
- IN2L

Telehealth and Remote Monitoring

CAST case studies: http://www.leadingage.org/center-aging-services-technologies/case-studies

Leaders in Population Health?

"The Apple Watch is getting a new feature that can monitor heart health — here's why that matters" – CNBC

UBER Health

amazon alexa