Health System Strategy
Better Care for Older Adults

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MaineHealth Elder Care Services
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What is MaineHealth?

- Health System with 8 member and 4 affiliate acute care general hospitals
  - Member hospitals operate over 1,400 inpatient acute care beds
- Physician-Hospital Organization: Over 1,000 independent and employed physicians
  - >300 primary care physicians
- Home health agency, senior living (skilled nursing facilities, long term care), inpatient psychiatric hospital, multi-service outpatient behavioral health organization, and clinical laboratory
Preparing for Maine’s Growing Population of Older Adults

• **Global Aim:** Enable MaineHealth (MH) to become a high performing system that meets the needs of the older population in a high quality, cost effective, efficient manner.

• **Strategic Aim:** Implement a 5-year plan that restructures, improves, and standardizes care for older adults throughout the MH system.
Strategic Plan Implementation

• **Access to Care** redesign primary care, provide access to geriatrics mental health, simplify access to appropriate care across the continuum

• **Collaboration and Integration** improve care transitions for older people, improve acute care and rehab by incorporating evidence based geriatrics programs, strengthen connection between health care and community services,

• **Sustainability** increase number of clinicians and paraprofessionals trained in geriatrics across the continuum throughout MaineHealth, improve geriatrics education for clinicians at all levels

Ensure as a whole system, integrated care – “seamless” for the patient…no matter where enter the system
MaineHealth Integrated/Aligned Provider Network

Patient
- Home Monitoring
- Patient Portal
- E-Visits
- Mobile Health
- E-Learning

Community
- Worksite Clinics
- Retail Clinics
- School clinics
- Telemedicine
- Mobile Health
- CHT’s
- Community partners - AAAs

Medical Home
- On site & e-visits
- Telemedicine
- Prevention
- CDM
- Care Coordination
- Pt. Education
- Care Management
  - **Mental Health Integration**

Medical Neighborhood
- Ancillary Services
- Specialty Care
- Remote Consults
- Lab
- Diagnostics/Imaging
- Urgent Care
- Home Health
- Pharmacy
- Palliative Care
- Hospice
- **Long-term care**

Acute Care
- Hospitals
- eICU
- Emergency Services
- **Rehabilitation**

Continuum of Care
- Well
- At Risk
- Chronic Disease
- Acute Care
- Catastrophic

Safe Transitions of Care

Triple Aim: Population Health, Patient Experience, High Value

Technology Enabled Processes
- Data Management Structure
- EHR
- HIE
- Patient Portal
- Tele-health
- Virtual LRC
- Home Monitoring
- On-Line Learning
Partnerships: The Key to Success
Medical Home/Primary Care

Behavioral Health Integration

• Work with community mental health care providers located within practice setting
  – Psychosocial intervention as alternative to medications
  – Address substance use, alcohol and prescription meds
  – Work on behavioral aspects of managing chronic conditions
Community Based Care Transitions Program

- Maine one of first 7 in the country
- Lead CBO: Southern Maine Area Agency on Aging
  - Senior Resource Specialists
- Partnership with MMC PHO
  - Care Transitions Coaches
- Partnership with 5 MH Hospitals
- Decrease unnecessary readmissions to hospitals
A Patient-Centered Partnership

**Care Transition Intervention™**

RN Transition Coach
- Hospital visit(s)
- Contact at SNF / skilled rehab if applicable
- Home visit within 72 hrs of hospital discharge
- Up to 3 follow-up phone calls in 28 days

**4 Pillars**
- Med reconciliation
- Prompt medical follow up
- Red flags
- Personal health record

**Aging & Disability Resource Center (ADRC)**

Resource Specialist
- Resource needs assessment
- Identify barriers to optimal safety & self management
- Create a patient-centered service plan
- Community resource development
- Connect individuals & families to community support systems
- Assist with various application completion, e.g. housing, financial assistance, medical insurance updates
Care Coordination across the system
Community Links Referral

Referring Provider
Name of Practice or Physician *

Name of person completing this form *
First Last

How would you like follow-up to this referral? *
- Email (quickest)
- Fax
- No follow-up needed

Email Address for Follow-up *

Patient Information
Patient Name *
First Last

Patient Town of Residence
- Managing Chronic Conditions
- Money Management
- Prescription Coverage
- Safety Concerns
- Volunteering

Patient Phone Number *
### ### ###

Contact Person
First Last

Contact Phone Number *
### ### ###

Was this patient discharged within the past 30 days? *
- Yes
- No

Referral Need(s) *
- Caregiver Concerns
- Diet / Nutrition
- Falls Prevention
- Financial Issues
- Health Insurance
- Housing
- In-home Support Services
- Legal Issues
- Managing Chronic Conditions
- Memory Concerns
- Mental Health Concerns
- Money Management
- Physical Activity
- Prescription Coverage
- Recreation/Social Concerns
- Safety Concerns
- Transportation

Electronic Signature
The patient consents to the referring provider and ADRS sharing information specifically related to this referral. *
- Yes
- No

Name *
Organization *
Submit
Transitions – Skilled Nursing Facilities

• Senior Living Collaborative
• Reducing avoidable rehospitalizations
• Preparation for MSSP/ACO
  • Medicare Shared Savings Program/Accountable Care Organization; measures
Community: Evidence Based Programs

- Matter of Balance – falls prevention
- CDSMP – Chronic Disease Self Management Program
- Healthy IDEAS - Identifying Depression Empowering Activities for Seniors
- Enhance Fitness - Ys, Hospital
- Savvy Caregiver
Across the Care Continuum

• Falls Prevention
  - Hospitals
  - Senior Living Facilities
  - Primary Care
  - Home Healthcare
  - Community

• Advance Care Planning
• Patient Engagement
Sustainability - Education

- Curriculum development - geriatric syndromes

- Foundational Competencies - *The Partnership for Health in Aging Multidisciplinary Competencies*

Concepts in Common – Key Points

• Safety and Quality
• Team = all who “touch” the patient
  – Patient, professionals, staff, family, transport, etc.
• Interdisciplinary
  – all team members taught together
  – each discipline understanding roles and
  – standardized communication (SBAR) to support quality work together
• Recognition and Action
  – Must know next steps – what to do with the information
• “Shared Language for Shared Care”
• Train the Trainer model — create system champions
• Culture change
## MaineHealth System Measures – February 2013

<table>
<thead>
<tr>
<th>Measure</th>
<th>Period</th>
<th>Target (%)</th>
<th>Prior (%)</th>
<th>Current (%)</th>
<th>Trend</th>
<th>5 Period Rolling Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Better Care for Individuals</strong></td>
<td></td>
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<tr>
<td>Falls</td>
<td></td>
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<tr>
<td>Falls with Injury - Hospitals (rate per 1,000 patient days)</td>
<td>Q2 ’12</td>
<td>0.7</td>
<td>0.73</td>
<td>0.71</td>
<td>+</td>
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</tr>
<tr>
<td>Falls with Injury - Long Term Care (rate per 1,000 bed days of care)</td>
<td>Q3 ’12</td>
<td>1.4</td>
<td>1.6</td>
<td>2.1</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Fall Risk Assessment - Home Health</td>
<td>7/11-6/12</td>
<td>97.0</td>
<td>95.8</td>
<td>95.8</td>
<td>=</td>
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<tr>
<td>Fall Risk Assessment - Medical Offices*</td>
<td>1/12-12/12</td>
<td>28.0</td>
<td>21.9%</td>
<td>20.6%</td>
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<tr>
<td><strong>AHRQ Culture of Safety Survey - Hospitals</strong></td>
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<tr>
<td>Staff feel like their mistakes are held against them (Strongly Agree)</td>
<td>2012</td>
<td>4.0%</td>
<td>2.9%</td>
<td>4.7%</td>
<td>-</td>
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<tr>
<td>We work in &quot;crisis mode&quot; trying to do too much, too quickly (Strongly Agree)</td>
<td>2012</td>
<td>4.0%</td>
<td>4.1%</td>
<td>4.9%</td>
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<tr>
<td>In this unit, we discuss ways to prevent errors from happening again (Always)</td>
<td>2012</td>
<td>32.0%</td>
<td>33.8%</td>
<td>30.9%</td>
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<tr>
<td><strong>Preventable Readmissions</strong></td>
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<tr>
<td>Medicare 30-day Readmissions Rate - 4-quarter rolling average</td>
<td>7/11-6/12</td>
<td>14.6</td>
<td>15.0%</td>
<td>15.1%</td>
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<tr>
<td>Medicare 30-day Readmissions Rate - single quarter</td>
<td>Q2 ’12</td>
<td>14.6%</td>
<td>15.7%</td>
<td>14.8%</td>
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<td><strong>Patient Experience</strong></td>
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<td>HCAHPS - Hospitals (Value Based Purchasing 8-Dimension average)</td>
<td>Q3 ’12</td>
<td>74.1% 8 of 8</td>
<td>74.9% 7 of 8</td>
<td>71.6% 1 of 8</td>
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<td><strong>Palliative Care</strong></td>
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<td>Patients (age 65 or older) with advance care directive - Hospitals</td>
<td>Q3 ’12</td>
<td>53.0%</td>
<td>54.0%</td>
<td>51.1%</td>
<td>-</td>
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</tbody>
</table>

**Notes:**
- Higher numbers are better
- Lower numbers are better

* The data sources for this measure are currently in transition. This may result in variability in the reported information which may not reflect actual performance and/or quality of care.

* Data points in red indicate considerable fluctuation due to Martin’s Point exit from the Clinical Improvement Registry.
For More Information

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