Joining forces to reduce emergency room and hospital admissions among the frail elderly

- Declining Revenues
  - Elimination of Estate Tax
  - Reduction in local government fund
  - Tough climate for passing Fire/EMS levies
The Financial Reality: Council on Aging & LTCSS

- Shrinking federal/state revenues
- Shifting funding to managed care organizations
- Levies – no growth, under scrutiny
- Continued “anti tax” climate
- More competition for fewer dollars
- “Do more with less” - unsustainable
For us, this is today’s environment...
And tomorrow?:

- Today Ohio has 305,000 individuals of all ages with severe disability – 40% receive LTC through Medicaid
- Today, 24% of state budget is Medicaid – 36% goes to LTC
- By 2020, 348,000 with severe disability – 30-35% of state budget could be Medicaid, with 440-45% going to LTC
- By 2040, 600,000 with severe disability and more than 50% of state budget Medicaid with more than 60% going to LTC
The Opportunities

- Health Care Reform provides a window for us to change funding
- State Revenue Income Bond
- Managed Care Organizations
- CMMI Grants
- Private Foundation Grants
The Opportunities

To succeed, we must:

- Target those at highest risk for emergency room/hospital admission
- Be “uber-creative”
- **Transform** the way we provide care
- **Save** “the system” money (Medicaid and Medicare)
- **Coordinate** with Primary Care
- Be **Sustainable** and **generate revenue**
- Start small, figure out what works, and spread it.
What are funders signaling?

- Reduce nursing home placements
- Reduce ER visits
- Reduce hospital readmissions
- Major shift away from “institutions” to community based services and to home
Funders may be signaling one thing and systems are doing another....
Generating Cost Savings Across the Continuum of Care

- Home-and Community-Based Care
- Skilled Nursing and Rehabilitation Unit
- Hospital

Low cost/High Independence

Interventions Between Hospital and Skilled Nursing That Reduce Cost
Intervention 1
Intervention 2

Interventions Between Hospitals and Home That Reduce Cost
Intervention 1
Intervention 2

Interventions Between Hospitals and Skilled Nursing That Reduce Cost:
Intervention 1
Intervention 2
Models of Care

- Single Point of Contact
- Community Wellness Checks
- Co-locating Resources
- Mobile Urgent Care

Cost/Complexity vs. Community Impact
Model 1

Single Point of Contact

**COA Role**
- Provide a single phone number for EMS partner
- Connect EMS to care managers who can assess client, identify root cause issues, and connect clients to resources
- Identify appropriate community referrals to address patient issues

**EMS Role**
- Identify individuals who frequently use emergency rooms.
- Assist care manager in identifying root cause issues.
Single Point of Contact
- Why we like it

- Ease of implementation
- Increases efficiency
Single Point of Contact – why we don’t like it

- Has an expense – no funder
- Not going to make change that results in the outcomes sought by funders
Model 2
Community Wellness Checks/ Medical Neighborhood Approach

COA Role
- Provide coaching to clients to address root cause issues that lead to emergency visits.
- Follow-up with clients post ER/Hospital visit.
- Connect patients to community resources and long term care services.
- Identify clients who are at high risk for emergency care and request Community Wellness Checks
- Keep PCP informed

EMS Role
- Check on COA clients who have recently been discharged or who frequently are admitted or use emergency room.
- Identify root cause issues.

PCP Role
- Identify and refer patients who need LTCSS
- Identify root cause issues
- Identify components of wellness checks
Community Wellness Checks – Why we like it

- Builds on our joint strengths
- Ease of implementation
- Proven models already exist
- Flexible model – it can fit many scenarios
- Leverages the whole system of care: LTC, EMS, and PCP
- Saves money across the system
- Provides new sources of revenue
Co-locate Care Management with EMS

- Not a Viable Option
- Infrastructure is expensive
- Duplicates existing system of care
### Model 4
### Urgent Mobile Care

<table>
<thead>
<tr>
<th>COA Role</th>
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<tbody>
<tr>
<td>- Identify clients who are at high risk for emergency care and appropriate for urgent care at home</td>
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<tr>
<td>- Help coordinate care</td>
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<tr>
<td>- Provide coaching to clients to address root cause issues that lead to emergency visits.</td>
</tr>
<tr>
<td>- Follow-up with clients post ER/Hospital visit.</td>
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<tr>
<td>- Connect patients to community resources and long term care services.</td>
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<tr>
<td>- Keep PCP informed</td>
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<th>EMS Role</th>
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<tbody>
<tr>
<td>- Provide urgent care at home.</td>
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<tr>
<td>- Identify root cause issues and report to COA</td>
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<table>
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<tr>
<th>PCP Role</th>
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</thead>
<tbody>
<tr>
<td>- Support urgent care unit</td>
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<tr>
<td>- Provide physician orders for urgent care at home</td>
</tr>
<tr>
<td>- Identify and refer patients who need LTCSS</td>
</tr>
<tr>
<td>- Identify root cause issues</td>
</tr>
<tr>
<td>- Identify components of wellness checks</td>
</tr>
</tbody>
</table>
Mobile Urgent Care – Why we like it

- Leverages existing resources
- Extremely innovative – on the cutting edge of where we are going
- Transformational: Changes the way care is delivered
- Lowers cost across the system
- Attracts new sources of revenue

We recognize it is complex – and many details need to be worked through.
Next Steps

- Identify partners willing to explore partnerships and models
- Develop models of care
- Identify and seek funding sources