Age + Action

June 17–20, 2019 | Washington, DC

ncoa
National Council on Aging

What's Hot Now?

Dianne Davis, MPH

June 17, 2019

#AgeAction2019 | #WeAgeWell

What's Hot Now?

NCOA Age + Action

Washington, DC

Dianne Davis, MPH
Vice President, Health Self-Management Services
Partners in Care Foundation
The Social Determinants Specialists

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The Social Determinants of Health Experts.

Objectives

- Learn 3 key facts about each of 4 critical public health issues.
  - Social Determinants of Health
  - Food as Medicine
  - Social Isolation & Loneliness
  - Opioid Epidemic and how the Chronic Pain Self Management Program can be used as a component of an Opioid Management program
- Pitch your creative public health innovations to varying audiences based on their needs.
- Develop partnerships with organizations providing supplemental services to be used with evidence-based health and wellness programs.
- Develop grant proposals integrating a group of evidence-based programs.

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Partners in Care Foundation

Our Mission

Partners shapes the evolving health system by developing and spreading high-value models of community-based care and self-management

Our Focus on Innovation

- We shift the emphasis from illness care to preventive care, reducing costs and improving quality of life for those with chronic conditions
- NCQA accredited for Complex Care Management as defined by CMS

Our Partnership

- Partners collaborates with hospitals, physician groups, health plans, community-based organizations, and government agencies to deliver services that support adults with complex health and social services needs and their caregivers and families
- Evidence-based programs demonstrated to significantly reduce costly hospital readmissions, ED visits, and nursing home placements

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Changing the Shape of Health Care

- A think-tank and a proving ground
- Changing the shape of health care by creating high-impact, innovative ways of bringing more effective clinical and social services to people and communities
- Partners' direct services test, measure, refine and replicate innovative programs and services, and bring needed care to diverse populations

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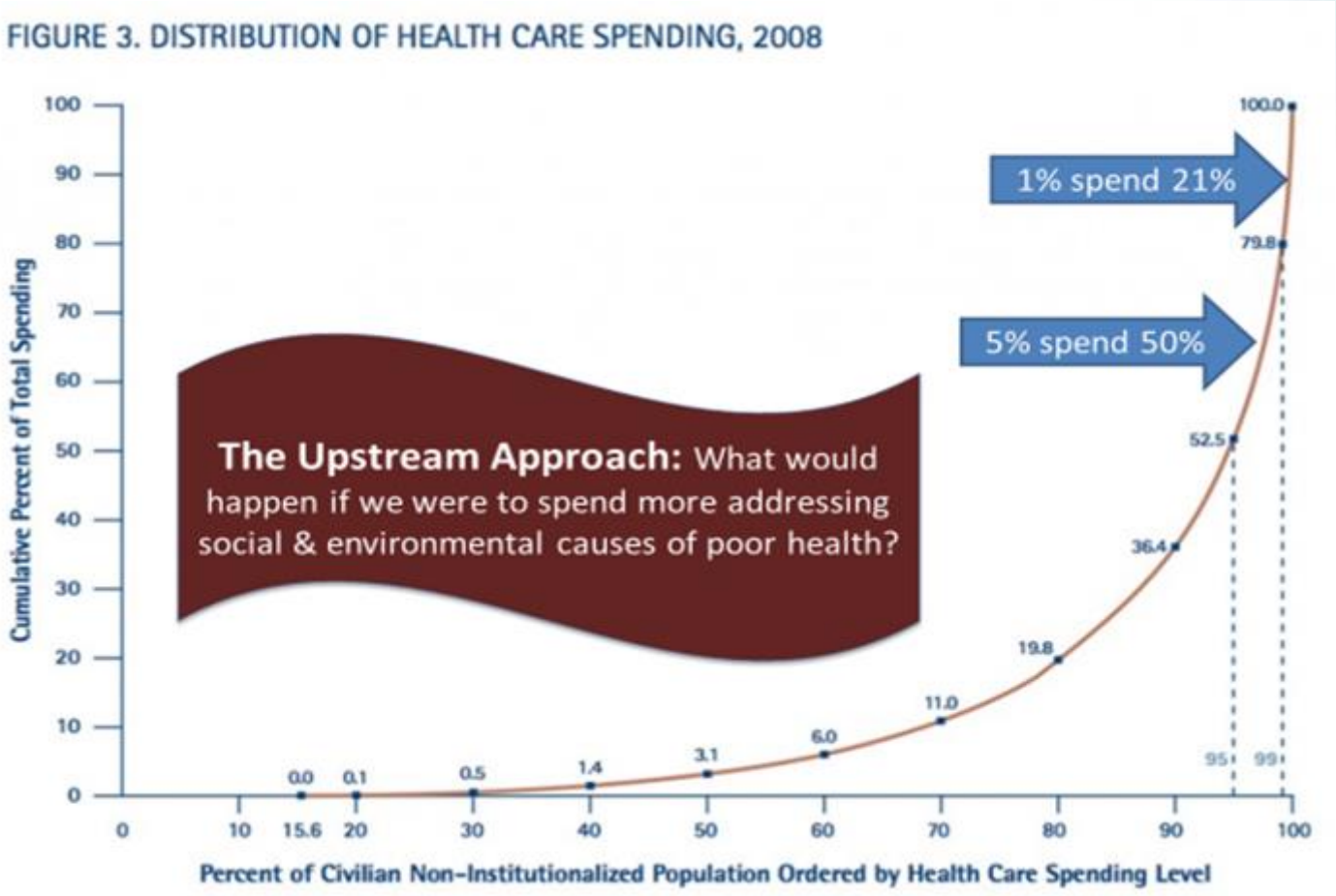
The Choice:

Spend Upstream on SDOH on Top 5%



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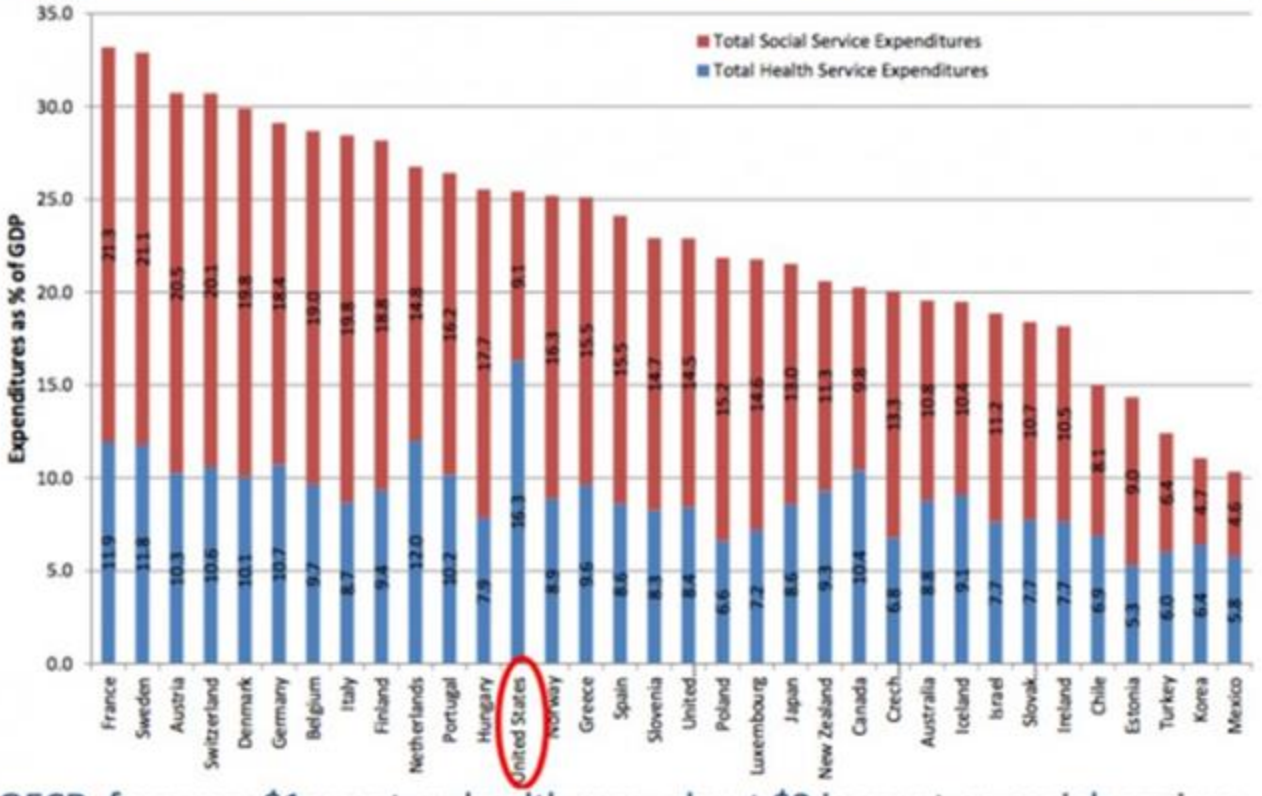
Social + Medical = Health

Total health care investment in US is *less*



In OECD, for every $1 spent on health care, about $2 is spent on social services
In the US, for $1 spent on health care, about 55 cents is spent on social services

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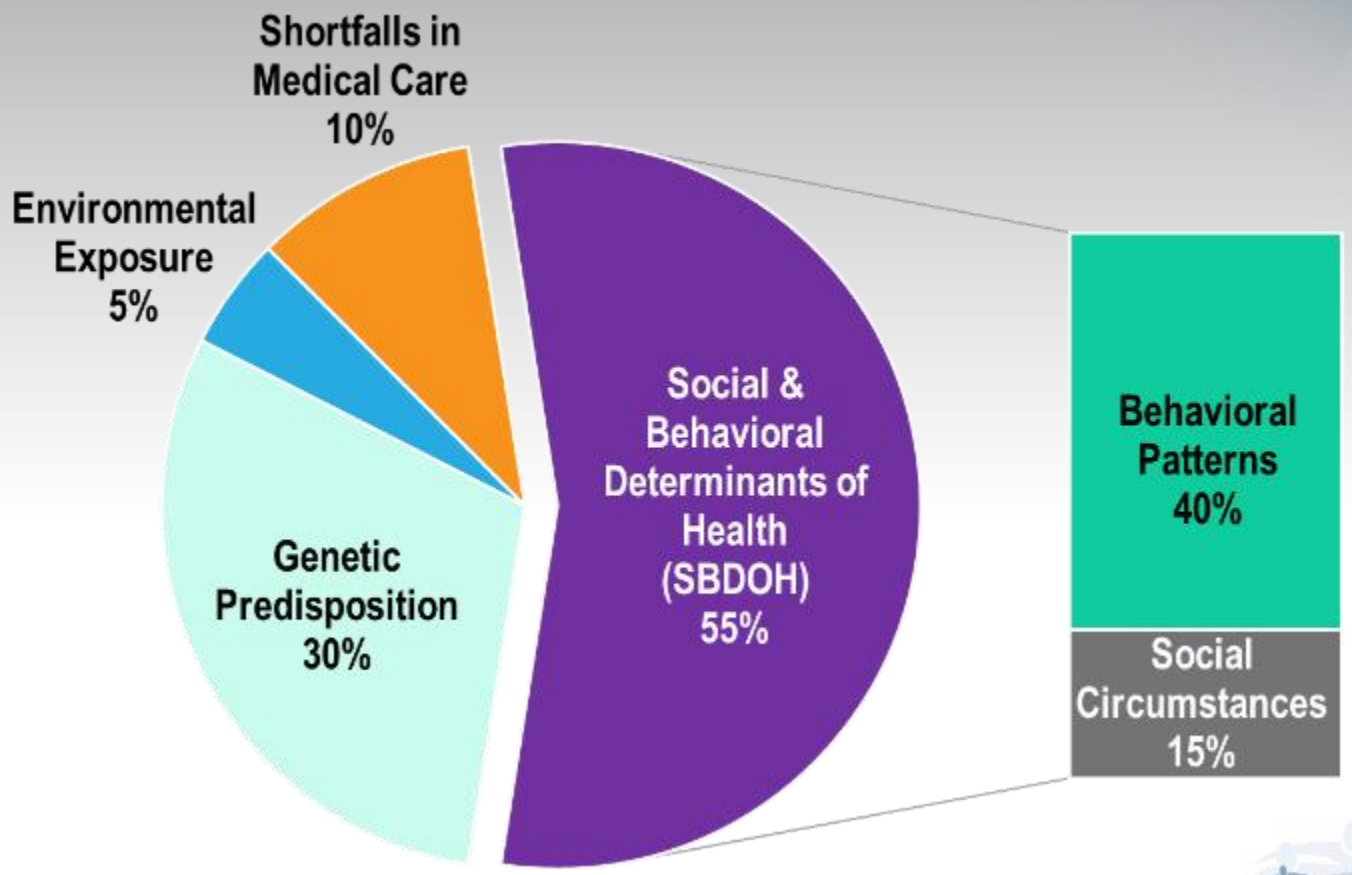
Factors in Premature Death - USA



Adapted from McGinnis JM, Williams-Russo P, Knichman JR. The case for more active policy attention to health promotion. Health Affairs (Millwood) 2002;21(2):78-93

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Focused on the Social Determinants of Health (SDOH)

Home and Community-Based Services

Healthcare's Blindside

The Robert Wood Johnson Foundation survey of 1,000 PCPs

- 80% not confident in their capacity to address their patients' social needs
- 86% said unmet social needs are leading directly to worse health
- 76% wish the healthcare system would cover cost of connecting patients to services to meet health-related social needs
- 1of 7 prescriptions would be for social supports, e.g., fitness programs, nutritious food, and transportation assistance

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CMS to Pay for Special Supplemental Benefits for the Chronically Ill

(2019 CMS Call Letter)

"To enable MA plans to better tailor benefit offerings, address gaps in care, and improve health outcomes for the chronically ill population."

Medicare Advantage plans can now provide supplemental benefits based on member need – no longer one size fits all.

Definition of chronically ill:

1. Has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;
2. Has a high risk of hospitalization or other adverse health outcomes; and
3. Requires intensive care coordination.

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List of Covered Chronic Disorders

Chapter 16b, 20.1.2

1. **Chronic alcohol and other drug dependence**;
2. **Autoimmune disorders limited to**: • Polyarteritis nodosa, • Polymyalgia rheumatica, • Polymyositis, • Rheumatoid arthritis, and • Systemic lupus erythematosus;
3. **Cancer**, excluding pre-cancer conditions or in-situ status;
4. **Cardiovascular disorders limited to:** • Cardiac arrhythmias, • Coronary artery disease, • Peripheral vascular disease, and • Chronic venous thromboembolic disorder;
5. **Chronic heart failure**;
6. **Dementia**;
7. **Diabetes mellitus**;
8. **End-stage liver disease**;
9. **End-stage renal disease (ESRD) requiring dialysis**;
10. **Severe hematologic disorders limited to**: • Aplastic anemia, • Hemophilia, • Immune thrombocytopenic purpura, • Myelodysplatic syndrome, • Sickle-cell disease (excluding sickle-cell trait), and • Chronic venous thromboembolic disorder;
11. **HIV/AIDS**;
12. **Chronic lung disorders limited to:** • Asthma, • Chronic bronchitis, • Emphysema, • Pulmonary fibrosis, and • Pulmonary hypertension;
13. **Chronic and disabling mental health conditions limited to:** • Bipolar disorders, • Major depressive disorders, • Paranoid disorder, • Schizophrenia, and • Schizoaffective disorder;
14. **Neurologic disorders limited to:** • Amyotrophic lateral sclerosis (ALS), • Epilepsy, • Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia), • Huntington's disease, • Multiple sclerosis, • Parkinson's disease, • Polyneuropathy, • Spinal stenosis, and • Stroke-related neurologic deficit; and
15. **Stroke**.

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What Are the
Possible Range of Covered Benefits?

A reasonable expectation of improving or maintaining the health or overall function of an individual as it relates to their chronic condition or illness:

- Home Delivered Meals (beyond what is currently allowed), food and produce
- Transportation for non-medical needs
- Pest control
- Indoor air quality equipment and services
- Permanent ramps
- Widening of hallways and/or doorways
- ***Others as needed***

What does this mean for plans and us?

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New Roles for the Medical System

- Risk ***Stratification*** — Active screening and targeting
- Continual ***Monitoring*** for "trigger events" that could change a risk category
- ***Build*** comprehensive partnerships between community-based organizations and health systems/insurers as a continuum of care for the delivery system, for population health
  - Health systems assist with building out provider networks by contracting with community providers; referral alone is not enough

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Addressing the Social Determinants

Across Settings and Populations

- ***Partner*** with hospitals, physicians & heath plans
- ***Focus*** – The home and the community
- ***Payers*** – Medi-Cal
  - Medicare
  - Private health plans
- ***New Directions*** transforming Medicare and Medi-Cal

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THE TIME IS NOW!

Partners' focus is on older adults and adults with chronic conditions

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Food
as
Medicine

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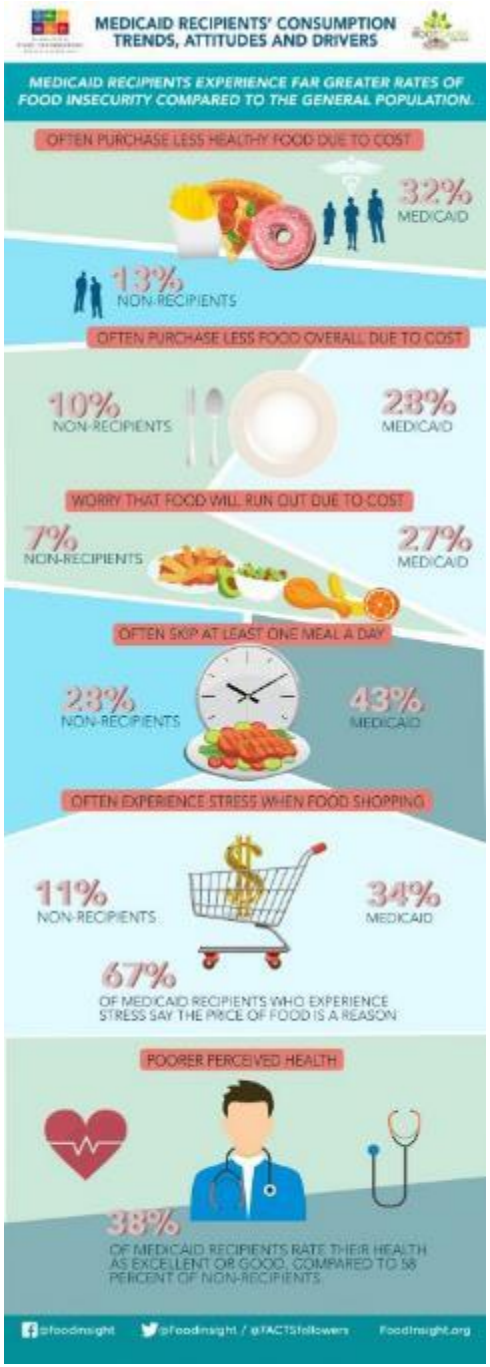

Medicaid Recipients Experience Greater Rates of Food Insecurity Compared to General Population

- Purchase less healthy food
- Purchase less food
- Worry that food will run out due to cost
- Often skip at least one meal
- Often experience stress when food shopping
- Report poorer perceived health

International Food Information Council (IFIC) Foundation's Food and Health Survey (oversample of Medicaid beneficiaries)
http://www.rootcausecoalition.org/e_news/new-research-collaboration-yields-insights-into-food-insecurity-among-medicaid-beneficiaries/

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Let Thy Food be Thy Medicine and Medicine be Thy Food. *Hippocrates**

Goldring Center for Culinary Medicine
at Tulane University

- Teaching medical students/residents, patients and other practicing clinicians how to shop for and cook tasty healthy meals
- Research to prove positive outcomes
- ***Movement to include culinary education in all medical school curriculum***
- https://www.youtube.com/watch?v=L0vWLn0lU5k

CulinaryMedicine.org

*400 BC

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Food as Medicine

- **Kitchen Divas**
  - Celebration at end of workshop
  - Cooking demonstration of food sourced in neighborhood
  - Samples and recipes
- **Vouchers for Veggies**
  - Provide healthy food vouchers accepted at local grocery stores
- **COVIA**
  - Farmer's Markets brought to sites

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Social Isolation

and

Loneliness

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Loneliness or Isolation?

Thanks to Carla Perissinotto, MD, UCSF for slides.

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Intersection of Loneliness and Isolation

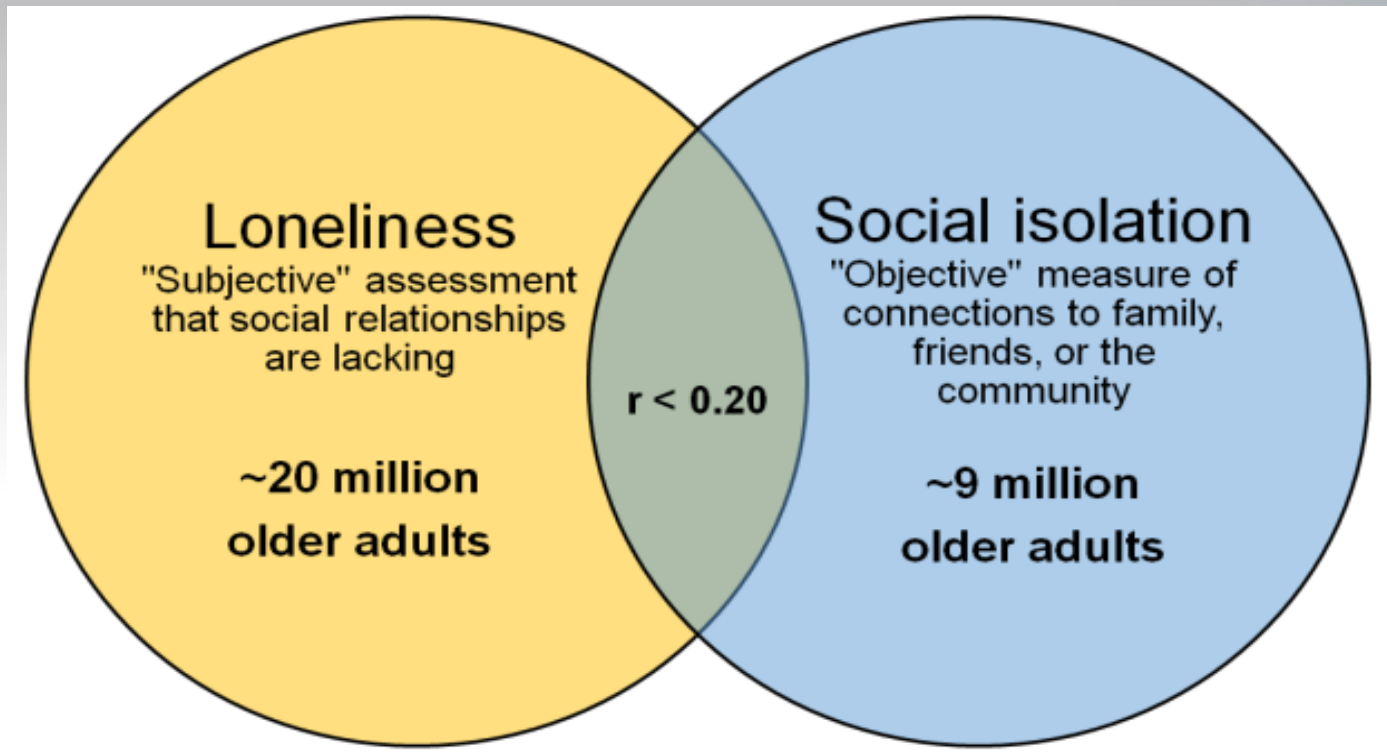

Figure from Dr. Ashwin Kotwal
Cornwell EY, Waite LJ. 2009;64(suppl_1):i38-i46

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Health Outcomes

Outcomes:

- Death – 45% increased risk
- Decline in Function - 59% increased risk
- Increased risk of:
  - Dementia, Diabetes, Cardiovascular disease
  - Longer hospitalizations

Perissinotto C. JAMA (Archives) Internal Medicine 2012

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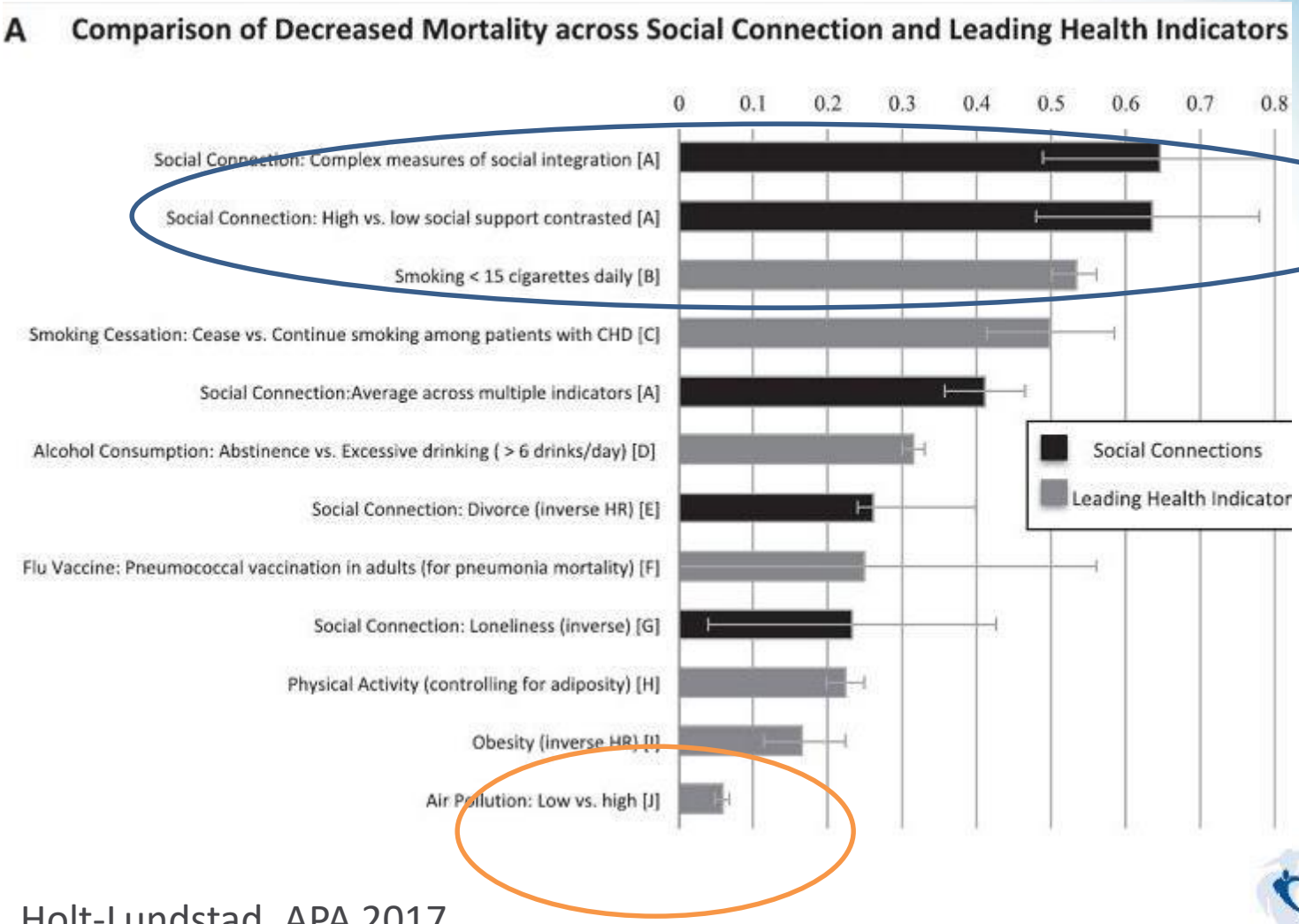
The Facts: What We KNOW



Holt-Lundstad, APA 2017

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AARP Study on Social Isolation

Real Possibilities

It's Deadly,
But Is Social Isolation Costly?

Research Question: The health consequences of social isolation among older adults are well known, but is social isolation **costly for Medicare?**

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To Learn the Answer, They….

- Linked nationally representative data from the **Health and Retirement Study** (to derive social isolation) to **Medicare claims** data (showing actual beneficiary spending)

- We followed spending over an average of **five years.**

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To Learn the Answer, They….

Controlled for factors known to influence Medicare spending:

- demographics
- health and functional status
- socio-economic status
- region
- living arrangement
- supplemental coverage

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Major Finding

Real Possibilities

Social isolation increases Medicare costs by an estimated

$6.7 billion every year

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Why Does Social Isolation Cost Medicare More?

Socially isolated older adults were:

- More likely to use skilled nursing facility care and when they did, they cost Medicare more.
- Not more likely to use more inpatient hospital care, but when they did, they cost Medicare more.

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Costs to Medicare Could Be Even Higher

Total costs to Medicare **could be higher,** if you consider:

- Medicare prescription drug spending (Part D)
- Spending on younger Medicare beneficiaries with disabilities
- Spending on Medicare beneficiaries enrolled Medicare Advantage private plans

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Millions of Medicare Beneficiaries are Isolated

We estimate that there were approximately **4 million** socially isolated older adults in traditional fee-for-service Medicare.

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Who's Isolated?

Isolated older adults more likely to be:

- men
- depressed
- dually eligible for Medicare and Medicaid
- experiencing difficulties performing activities of daily living (bathing, dressing, etc.)

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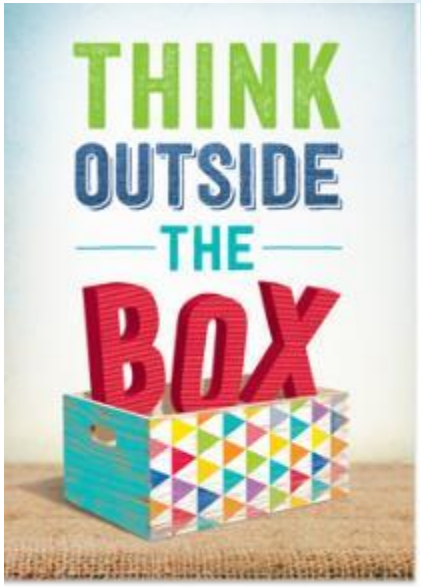
It’s Counter Intuitive!

You might think that people who **live alone** or **are single** are more likely to be the socially isolated.

That’s not what we found!

That’s why its important to **not exclude** certain populations from screening.



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Policy Recommendations

AARP Real Possibilities

Step One: Identify the Isolated

Develop a valid and reliable tool to screen for isolation.

- Short
- Easy to use
- Usable in a variety of settings

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Step Two: Develop Evidence-Based Interventions

- Private-public **partnerships** are highly desirable
- Interventions need to be **culturally competent**
- Explore feasibility and desirability of using **technology**

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Step Three:
Require Screening in Medicare

- Use Welcome to Medicare and Annual Wellness Visits to identify people who are socially isolated.
- Screeners should connect people to evidence-based interventions.
- The private sector will likely follow Medicare's lead.

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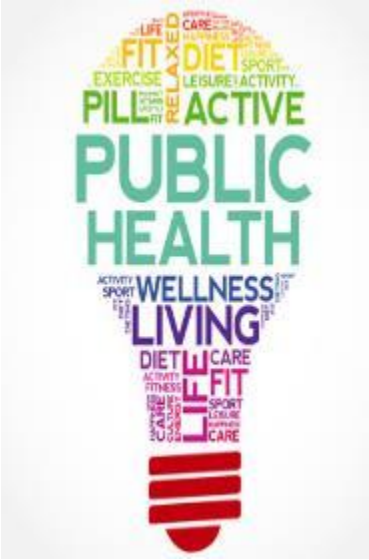
Step Four: Engage Public Health

- Recognize social isolation as an **important social determinant** of health
- Work towards population-level **surveillance**
- Disseminate public health messages to **overcome possible stigma**



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What Partners is doing . . .

Wellness Club SM

A Program of
Partners in Care Foundation

- Link multiple evidence-based programs together over time
- Free t-shirt and loyalty card upon sign-up
- Colored button for every workshop completed
- Free reusable grocery bag when a three-workshop series is completed
- Healthy snacks
- Kitchen Divas
- Incentives

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Celebration is Important!

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Chronic Pain Self-Management

as a

component of an

Opioid Management Program

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Opioid Epidemic

- Every day, more than 130 people in the United States die after overdosing on opioids.[1]
- The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare.
- The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse alone in the United States is $78.5 billion a year, including:
  - the costs of healthcare,
  - lost productivity,
  - addiction treatment, and
  - criminal justice involvement.[2]

National Institute on Drug Abuse, January 2019.

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National Institute on Health

In the summer of 2017, NIH met with pharmaceutical companies and academic research centers to discuss:

- Safe, effective, non-addictive strategies to manage chronic pain
- New, innovative medications and technologies to treat opioid use disorders
- Improved overdose prevention and reversal interventions to save lives and support recovery

National Institute on Drug Abuse, January 2019.

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Chronic Pain Self-Management

A component of an Opioid Management Program

- The program was developed for people who have a primary or secondary diagnosis of chronic pain.
- Examples of chronic pain conditions are:
  - chronic musculoskeletal pain (such as neck, shoulder, back pain),
  - fibromyalgia,
  - whiplash injuries,
  - chronic regional pain syndromes,
  - repetitive strain injury,
  - chronic pelvic pain,
  - post-surgical pain that lasts beyond 6 months,
  - neuropathic pain, or neuralgias
  - and post stroke or central pain.
- The program may also benefit those who have persistent headaches, Crohn's disease, irritable bowel syndrome, diabetic neuropathy, or multiple sclerosis.

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Subjects Covered

TECHNIQUES TO DEAL WITH PROBLEMS SUCH AS FRUSTRATION, FATIGUE, ISOLATION, AND POOR SLEEP

APPROPRIATE EXERCISE FOR MAINTAINING AND IMPROVING STRENGTH, FLEXIBILITY, AND ENDURANCE

APPROPRIATE USE OF MEDICATIONS

COMMUNICATING EFFECTIVELY WITH FAMILY, FRIENDS, AND HEALTH PROFESSIONALS

NUTRITION

HOW TO EVALUATE NEW TREATMENTS

PACING ACTIVITY AND REST

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Chronic Pain Self-Management

- CPSMP evaluated in two randomized clinical trials funded by Health Canada and the Canadian Institutes of Health Research (CIHR).

- The research studies found that, on average, people who have participated in the CPSMP have:
  - **more vitality or energy,**
  - **less pain,**
  - **less dependence on others,**
  - **improved mental health,**
  - **are more involved in everyday activities, and**
  - **are more satisfied with their lives compared to those who have not participated in the program.**

- The program has also been delivered and evaluated across 10 pain clinics in Ontario, Canada. Evaluation of the program found it to be beneficial for participants in terms of:
  - coping skills,
  - education, and
  - overall quality of life.

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Value Proposition, Grant Proposals, *and* Partnerships

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Value Proposition:

Understand what they need!

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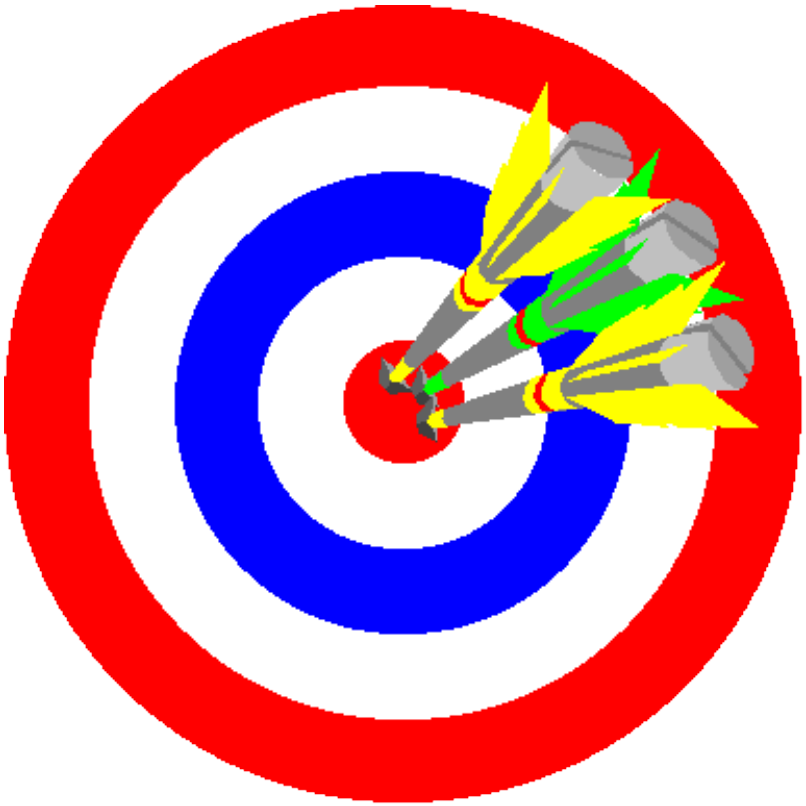
Organizational Research



- Websites—Mission Statement, Quality Improvement Plan, Quality Report, state/federal websites, etc.
- Accreditation/Industry resources, e.g., NCQA, Joint Commission
- Organization Charts, listing of key staff, job descriptions
- NCOA Road Map Toolkit-health care organizations
- Research the designated staff-Linked-In, etc.

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Value Proposition

- Are you able to demonstrate the capacity of your products/services to meet the organization's needs? Fulfill a gap? Provide a solution to a problem?
- Do you understand the perspective/responsibility for achieving organizational success for the person to whom you are *selling*?
- Match your organization presenters with staff with whom you'll meet; e.g., nurses, marketing, case manager.
- Multiple presentations over a period of time may be necessary; be prepared w/a variety of perspectives
- Each new presentation should foster a new champion/supporter!
- Avoid premature discussions on rates.

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Tailor Your Offering to Their Need

CHRONIC DISEASE SELF-MANAGEMENT

- Chronic Disease Self-Management
- Tomando Control de su Salud
- Chronic Pain Self-Management
- Diabetes Self-Management Program

PHYSICAL ACTIVITY

- Enhanced Fitness & Enhanced Wellness
- Healthy Moves
- Fit & Strong
- Arthritis Foundation Exercise Program
- Arthritis Foundation Walk With Ease Program

MEDICATION MANAGEMENT

- HomeMeds

FALL RISK REDUCTION

- Stepping On
- Tai Chi Moving for Better Balance
- Matter of Balance

DEPRESSION MANAGEMENT

- Healthy Ideas
- PEARLS

CAREGIVER PROGRAMS

- Powerful Tools for Caregivers
- Savvy Caregiver

NUTRITION

- Healthy Eating

DRUG AND ALCOHOL

- Prevention Management of Alcohol Problems

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Link Multiple Programs, Branding *and* Wrap Around Services

Wellness Club℠

A Program of
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- Free t-shirt and loyalty cards
- Colored button for every workshop completed
- Free reusable grocery bag when a three-workshop series is completed
- Grocery Store Vouchers
- Healthy snacks
- Healthy Cooking Demonstration
- Incentives
- Food Vouchers/Farmer's Market
- Celebration
- Measure for Changes in Social Isolation & Loneliness

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Building Partnerships

- Ambitious work
- Value proposition
  - (in marketing) an innovation, service, or feature intended to make a company or product attractive to customers
    - **WIIF-Them**
- The work doesn't end after the partnership is agreed on:
  - Value needs to be continuously proven
  - Need to keep partners' leadership & operations engaged
  - Transparency and communications are key

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QUESTIONS?

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