Strategies to Achieve Alignment, Collaboration, and Synergy across Delivery and Financing Systems

Battle Creek Community Complex Care Response Team to Improve Geriatric Public Health Outcomes

Research In Progress Webinar

Wednesday, August 24, 2016   12:00-1:00pm ET/ 9:00-10:00am PT

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Agenda

Welcome: **Anna G. Hoover, PhD,** Co-Director, RWJF *Systems for Action* National Coordinating Center*;* Assistant Professor, U. Kentucky

Battle Creek Community Complex Care Response Team to Improve Geriatric Public Health Outcomes

Presenter: **Carolyn E. Z. Pickering, PhD, RN**, Assistant Professor, School of Nursing, Dep't. of Health Restoration and Care Systems Management, University of Texas Health Science Center at San Antonio *pickeringc@uthscsa.edu*

Commentary: **Ruth Coffman, MPP, MDiv,** Executive Director of Health Lab, University of Chicago Urban Labs *rcoffman@uchicago.edu*

Questions and Discussion

RWJF Systems for Action Program
to build a national Culture of Health
http://www.systemsforaction.org/

Overview

Mission: Widen the lens beyond health care & public health systems

Rigorous research to identify novel mechanisms for aligning delivery and financing systems in ***medical care, public health,*** *and* ***social & community services*** in ways that improve ***health*** and ***wellbeing,*** achieve ***efficiencies*** in resource use, and reduce ***inequities***.

www.systemsforaction.org

A Robert Wood Johnson Foundation program

Systems for Action
Systems and Services Research to Build a Culture of Health

Research Agenda
Delivery and Financing System Innovations for a Culture of Health

September 2015

Wide lens: implicated sectors

- Public health

- Medical care: ACOs, PCMCs, AHCs

- Income support

- Nutrition and food security

- Education and workforce development

- Housing

- Transportation

- Criminal justice

- Child and family services

- Community development and finance

Study **novel mechanisms** for aligning systems and services across sectors

- Innovative alliances and partnerships

- Inter-governmental and public-private ventures

- New financing and payment arrangements

- Incentives for individuals, organizations & communities

- Governance and decision-making structures

- Information exchange and decision support

- New technology: m-health, tele-health

- Community engagement, public values and preferences

- Innovative workforce and staffing models

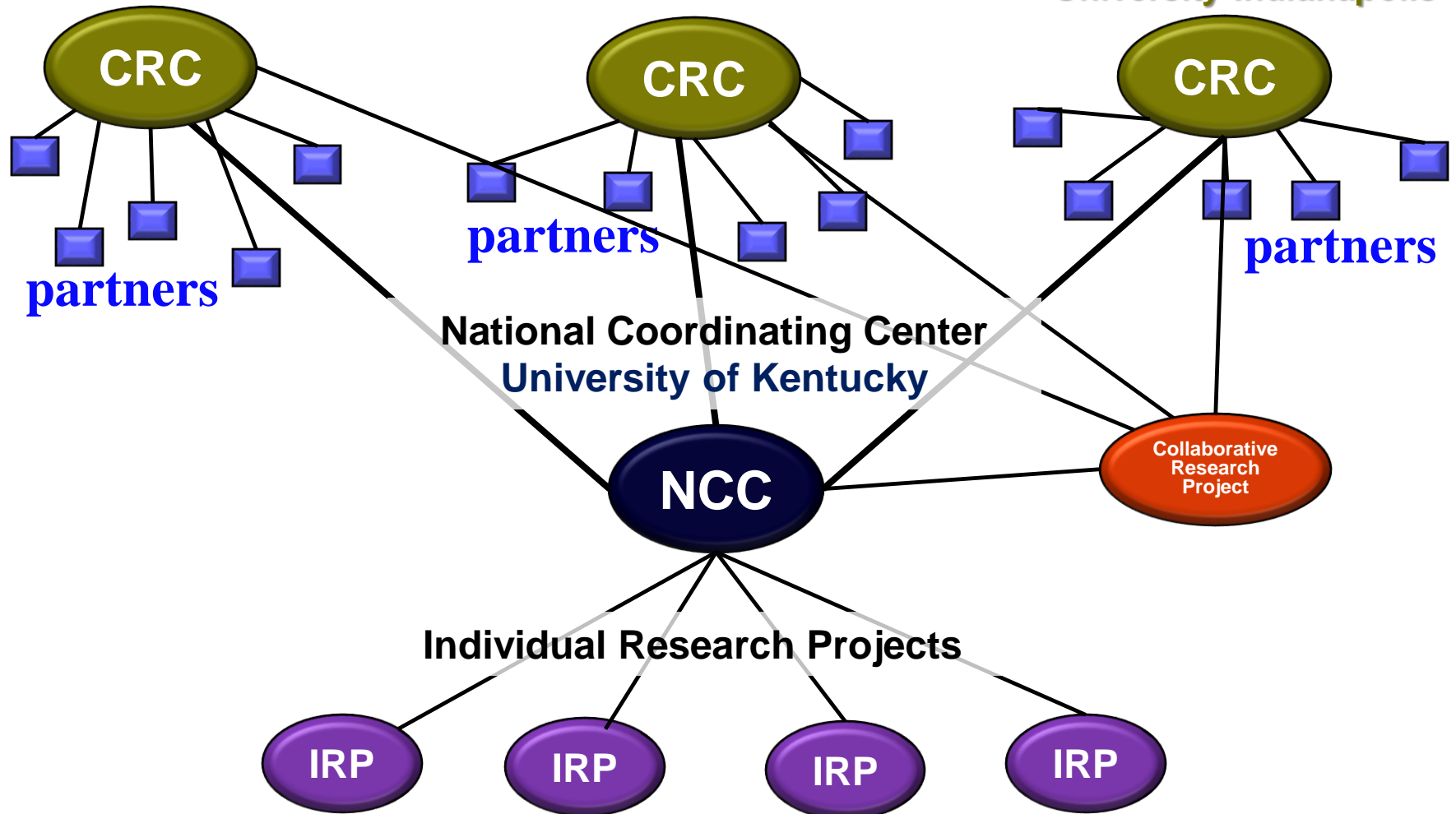- Cross-sector planning and priority-setting

S4A Program Structure

Collaborating Research Centers

University of Chicago

Arizona State University

Indiana University – Purdue University Indianapolis

CRC

CRC

CRC

partners

partners

partners

National Coordinating Center
University of Kentucky

NCC

Collaborative Research Project

Individual Research Projects

IRP   IRP   IRP   IRP

Collaborating Research Centers

- *University of Chicago:* Randomized trial of a Comprehensive Care, Community and Culture program

- *Arizona State University:* Analysis of medical, mental health, and criminal justice system interactions for persons with behavioral health disorders

- *IUPUI:* Evaluating integration and decision support strategies for a community-based safety net health care and public health system

- *University of Kentucky:* Measuring multi-sector contributions to public health services and population health outcomes.

Individual Research Projects

- *Michigan State University:* **Randomized trial of Community Complex Care Response Team**

- *Los Angeles Department of Health:* Evaluation of Housing for Health initiative, which provides permanent housing and supportive services for vulnerable populations

- *University of Delaware:* Randomized trial to test the efficacy of using the team approach to leverage different financing systems and services

- *Drexel University:* Evaluation of Building Wealth and Health Network within anti-poverty programming

Presenter

Carolyn E. Z. Pickering, PhD, RN

Assistant Professor

School of Nursing

Dep't. of Health Restoration and Care
  Systems Management

University of Texas Health Science Center
  at San Antonio

pickeringc@uthscsa.edu

Battle Creek Community Complex Care Response Team

Christopher Maxwell, PhD – Michigan State University, School of Criminal Justice

Carolyn Pickering, PhD, RN – U. Texas Health Science Center San Antonio School of Nursing

Fuad Abujarad, PhD – Yale University Dept. Emergency Medicine

ELDER ABUSE & NEGLECT

- 11.4% of older adults reported past year prevalence of abuse or neglect
  - Victims experience physical injuries, mental health problems, financial strain, disrupted family relationships, 300% increased risk of mortality
  - Elder financial abuse alone cost victims an estimated $2.9 billion in 2010
- Currently no rigorously tested interventions either to prevent abuse/neglect or help victims

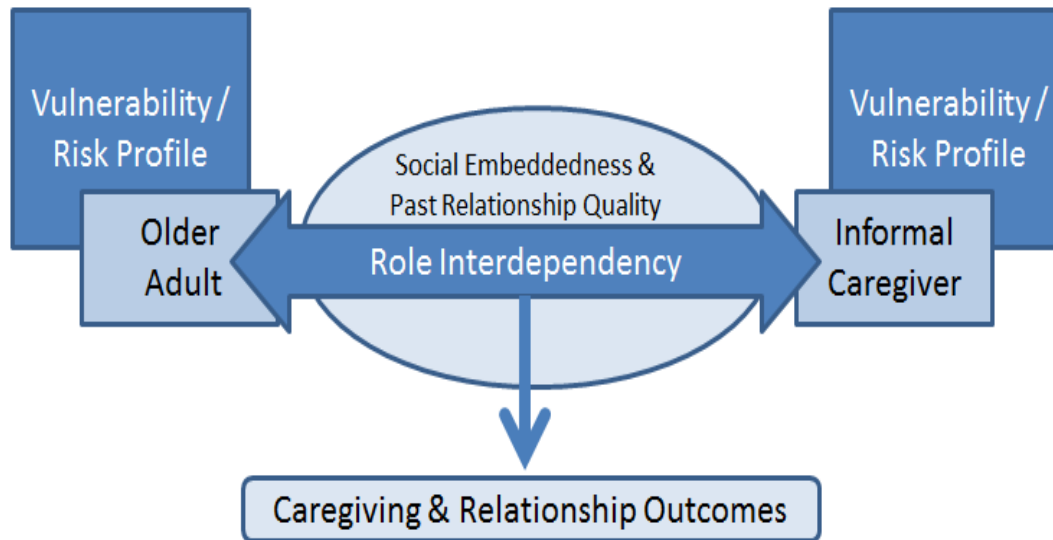# THEORETICAL FRAMEWORK FOR ELDER ABUSE/NEGLECT [EA/N]

Fig. 1 Relationship Dynamics in EA/N

Community Complex Care Response Team aka CCCRT Model

- The goal of the CCCRT model intervention is to decrease vulnerability of older adults by promoting and supporting independence and capacity for self-care.

- The idea behind the CCCRT is that by working together through a care model based on shared communication and information exchange that the various agencies in Battle Creek that provide services to older adults can (1) maximize service/resource availability for clients (2) maximize resources within the agency.

PROJECT BACKGROUND

2012 OVW

- Calhoun County Elder Abuse Prevention Network Formed
  - Identified need to share information between health & human service agencies
  - Developed uniform consent form and informal coordinated community response team

2015 Hartford Action Award

- Formalized CCR model protocol for coordinated case management
- Developed & piloted electronic case management system along with model protocol & uniform consent form
- Expanded stakeholders to become CCCRT

2016 RWJF S4A

- RCT to evaluate impact of CCCRT care model as primary prevention strategy

PROJECT STAKEHOLDERS

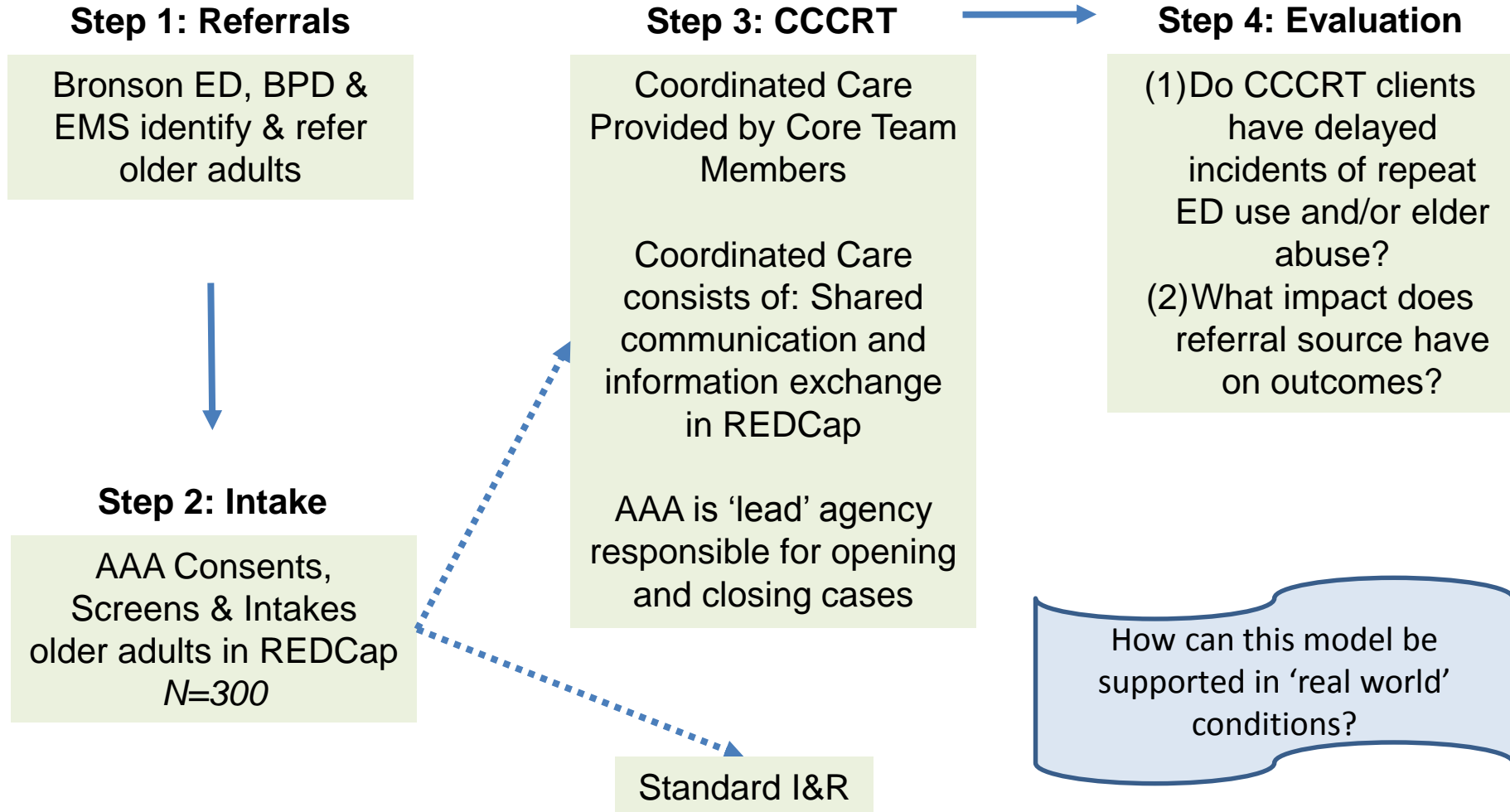| Referral Partners	CCCRT core team
Battle Creek Police Department	Region 3B Area Agency on Aging [AAA]
Bronson Health System ED	Senior Health Partners (GEMS, prevention)
LifeCare Ambulance Services	Community Healthcare Connections (access for un/underinsured)
	Bronson Primary Care
	Integrated Health Partners (PCP)
	Grace Health (FQHC)

Elder Law of Michigan   Michigan State University

CCCRT CORE TEAM SERVICE PLANNING

- Holistic, patient-centered, single-point-of-entry, wrap-around services, involves CHWs
    - basic needs (i.e. meal delivery, transportation),
    - consumer services (i.e. debt and financial counseling)
    - criminal justice (i.e. legal outreach)
    - public health & safety (i.e. public health nursing, walk-in clinics)
    - healthcare (i.e. geriatric mental health assessment, medication adherence programs)
    - income support (i.e. health insurance navigators),
    - individual/family life services (i.e. caregiver support, housekeeping assistance)
    - organizational/community services (i.e. senior centers)

CCCRT PROJECT CASE FLOW

Step 1: Referrals

Bronson ED, BPD & EMS identify & refer older adults

Step 2: Intake

AAA Consents, Screens & Intakes older adults in REDCap *N=300*

Step 3: CCCRT

Coordinated Care Provided by Core Team Members

Coordinated Care consists of: Shared communication and information exchange in REDCap

AAA is 'lead' agency responsible for opening and closing cases

Standard I&R

Step 4: Evaluation

(1) Do CCCRT clients have delayed incidents of repeat ED use and/or elder abuse?
(2) What impact does referral source have on outcomes?

How can this model be supported in 'real world' conditions?

CCCRT OBJECTIVE 1

(1) Examine the impact of coordinated multi-sector service delivery offered by the CCCRT on two geriatric public health outcomes: elder abuse and neglect, and emergency department utilization

- experimental explanatory mixed-methods approach
- RCT design, quantitative data will be used to test the hypothesis that the CCCRT intervention will delay incidents of EA/N and repeat ED visits for participants in the intervention group
  - Survival analyses
- Qualitative data from focus groups will be used to explore whether the intervention effects occur as theorized
- "mixing" - New pathways identified will tested

CCCRT OBJECTIVE 2

(2) Explore which institutions are best positioned to perform integrator roles in connecting vulnerable older adults to needed medical care, public health, and social and community services and supports provided by the CCCRT

- experimental exploratory mixed-methods approach
- moderator analyses to examine impact of referral source on observed treatment effects
- Open ended surveys with staff and interviews with site leadership to understand perceived impact of CCCRT intervention
- "mixing" thematic analysis produced will provide context into why or how certain agencies may be better positioned to be integrator; additional statistical modeling as required / to the extent data is available

CCCRT PROJECT GOALS

(3) Identify implementation and translational issues of data sharing across health, human and civil service sectors to ensure generalizability and successful dissemination.

– Product: Patient Care Record Central Framework "Blue Print"

PILOT RESULTS

- 27 clients received CCCRT services
- 21 continue to be supported at home
- 8 with prior hospital admissions, none have been readmitted
- 25/27 improved self-management of chronic condition
- 6 patients with DM-2, 3 had a decrease in A1C and 2 maintained over a 3 month period
- 6/7 clients with medication adherence issues are now compliant

System for Actions Portfolio

- We will evaluate the **impact of service alignment and integration** facilitated by electronic communication and data sharing on our target outcomes.

- We will investigate a novel community-based organizational model for the **integration of preventative services** for older adults.

- We will explore the **integrator roles** of the different community referral sources.

- In the completion of this project's objectives we will develop a framework for translation of the model for other communities which has the potential to impact the '**electronic medical record linkages**' measure identified by the culture of health framework.

PERCEVIED BENEFIT TO STAKEHOLDERS

Referral Partners	CCCRT core team
Battle Creek Police Department	Region 3B Area Agency on Aging
Bronson Health System ED	Bronson Primary Care
LifeCare Ambulance Services	Integrated Health Partners (PCP)
	Grace Health (FQHC)
	Community Healthcare Connections (access for un/underinsured)
	Senior Health Partners (GEMS, prevention)

IMPACT & SIGNIFICANCE

- CMS Bundled Payment Models

Mediscape Medical News:

"If CMS doesn't relent on making the bundled payment models mandatory, then the agency needs to implement them more gradually than proposed, said Dr. Lewin, who was formerly CEO of the American College of Cardiology and the California Medical Association….**For bundled models to succeed, he said, hospitals and physicians need to tap into a variety of patient-data sources, not just the hospital's EHR, and get that information quickly to manage care effectively. The necessary digital infrastructure isn't in place yet, said Dr Lewin.** "Maybe the move toward (value-based care) is moving faster than the system can accommodate it," he said.

IMPACT & SIGNIFICANCE

- Findings from this work will contribute to the development of replicable and reimbursable service models utilizing community health workers.

- First RCT of an EA/N intervention – first tested primary prevention strategy for EA/N

- As the goal of CCCRT is to improve capacity for self-care and independence, likely positively impacting other geriatric syndromes

PROJECT MILESTONES

- Referral partner training – mid-September
- **RCT Launch – October 1st 2016**
- Qual strands data collection begins – Jan 2017
- Preliminary analyses – Summer 2017
- Final analysis – April- July 2018

Project Updates

go to: http://systemsforaction.org/projects/testing-community-complex-care-response-team-improve-geriatric-public-health-outcomes

Testing of a Community Complex Care Response Team to Improve Geriatric Public Health Outcomes

Testing of a Community Complex Care Response Team to Improve Geriatric Public Health Outcomes

This study evaluates Michigan's Community Complex Care Response Team, a collaboration of three community agencies that provide services across the medical care, public health, and social and community services to decrease potential vulnerabilities and promote health, wellness, and independence in older adults. The research team will use a pragmatic randomized controlled trial to examine the impact of coordinated service delivery on emergency department utilization; will explore which institutions are best positioned to perform integrator roles that connect vulnerable older adults to needed services and supports; and will identify data sharing and storage challenges across health and human service sectors.

Project Details

Year:	2016
Status:	Active
Primary Investigator:	Carolyn Pickering

MICHIGAN STATE
UNIVERSITY

Commentary

Ruth Coffman, MPP, MDiv
Executive Director, Health Lab
University of Chicago Urban Labs
rcoffman@uchicago.edu

Co-Investigator,
S4A Collaborating Research Center:
[The Comprehensive Care, Community,
  and Culture Program](#)

Questions and Discussion

Webinar Archives & Upcoming Events

go to: http://systemsforaction.org/research-progress-webinars

| Upcoming Webinars |
|---|
| **Wednesday, September 14, 2016, 12 pm ET**
[Housing for Health: Assessing the Cross-Sector Impacts of Providing Permanent Supportive Housing to Homeless High Utilizers of Health Care Services](#)
***Ricardo Basurto Davila, PhD, M**S, Chief, Policy Analysis Unit, and **Corrin Buchanan, MPP**, Program Manager, Los Angeles County Department of Public Health Services* |
| **Wednesday, September 21, 2016, 12 pm ET**
[The Impact of Integrating Behavioral Health with Temporary Assistance for Needy Families to Build a Culture of Health](#)
***Mariana Chilton, PhD, MPH**, Associate Professor, and **Sandra Bloom, MD,** Associate Professor Department of Health Management & Policy, Drexel University Dornsife School of Public Health* |

Thank you for participating in today's webinar!
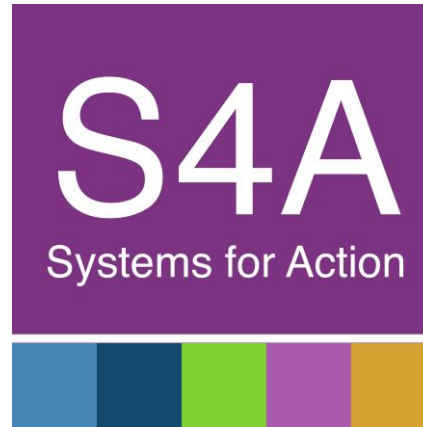
For more information about the webinars, contact:

Ann Kelly, Project Manager *Ann.Kelly@uky.edu*

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Speaker Bios

Carolyn E. Z. Pickering, PhD, RN, Assistant Professor, School of Nursing, Dep't. of Health Restoration and Care Systems Management, University of Texas Health Science Center at San Antonio *pickeringc@uthscsa.edu*

Dr. Pickering's program of research is on elder abuse and neglect prevention, and aims to understand the dynamics and development of abuse, neglect and high-risk caregiving in order to identify effective intervention strategies. Clinically, Dr. Pickering's expertise and training is in geriatric nursing with an emphasis on public health, with past experience as a Long Term Care Ombudsman. Dr. Pickering is former a member of the Michigan Elder Justice Task Force. Her research training includes expertise in qualitative methodology and a background in gero-feminism, mixed-methods and community-based research. Recently, Dr. Pickering completed a secondary-prevention project which taught abuse, neglect and caregiving assessment skills to in-home and community-based professionals through a virtual-reality training program. Currently, Dr. Pickering is leading a team of community agencies in the implementation of a coordinated community response team which provides preventative services to victims and older adults at-risk of victimization.

Ruth Coffman, MPP, MDiv, Executive Director of Health Lab, University of Chicago Urban Labs *rcoffman@uchicago.edu*

Ms. Coffman is Executive Director of the Health Lab, University of Chicago Urban Labs. She previously worked for the Cook County Sheriff's Office, where she started and led the Office's first Research Department. As Research Director, Ms. Coffman built analytical and data capacity within the Sheriff's Office, provided strategic direction, and led evaluations of programs and internal operations. Her previous experience includes working in a research capacity in a variety of organizations, including the Center for Global Development, and she also interned in the Social Office at the White House.