VIEWS FROM THE FIELD
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GRANT MAKERS IN HEALTH

Linking Medical Services and Community-Based Care: A Step toward Aging with Dignity, Choice, and Independence

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As a physician, I have witnessed firsthand how difficult it can be for older people with chronic illness and daily living challenges to bounce back and forth through the health care system until they end up in the hospital, against their wishes. The biggest challenge, however, is not the disorganized process that brings them to the hospital's door; it is what lies ahead as they try to make their way home again. Awaiting them is a maze of unknown services and confusing payment structures that have little or no communication with their care providers. Lost in this confusing mix and often left with no place to turn for help with everyday living needs, vulnerable older adults can easily wind up back in the hospital again when it all goes wrong. This situation does not have to be the norm. With the right balance of health care and supportive services, this desperate scenario can be avoided.

For years, my health care colleagues and I have lamented about this revolving door. Now health systems are beginning to take notice given the new payment penalties they will incur for avoidable rehospitalizations. Filling the care gap between a hospital (or skilled nursing) discharge and re-entry at home often means connecting individuals with services that live outside traditional health care settings. Key issues and questions that emerge during this critical period include:

- Can the person safely walk into their home, especially if steps are involved?
- Is there food in the refrigerator?
- Who will fill prescriptions, and did they get filled within 24 hours of discharge?
- How will a middle-aged son or daughter struggling with back problems safely get Dad from the recliner to the bathroom?

If families are in the know, they seek out a range of community-based organizations (CBOs) to help make necessary arrangements for a loved one to transition home safely. These organizations include aging and disability resource centers, faith-based groups, assisted living facilities, and others. They address these serious questions and others by providing care outside of the medical walls, including home and family assessments, care coordination, home care, medication assistance, nutrition guidance, transportation, and caregiver support, to name a few. When people need help with everyday living, from around-the-clock care to some basic assistance such as getting groceries, these organizations provide a critical component to helping people manage their lives. However, the unfortunate reality is that, more often than not, families do not even know where to turn to get this kind of help for their loved ones.

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Given the evolving policy focus on health care quality versus volume and continuous reductions in state and federal funding for supportive services, now is the time to help CBOs and health care providers build effective partnerships with each other to meet the quality and cost goals undergirding the Affordable Care Act (ACA). Beyond hospital readmission penalties, the ACA also instituted other policies and demonstrations aimed at making health care providers responsible for the total episode of care. For CBOs, this means that the daily living and care management services they offer are of increasing value to a health care sector that stands to gain more than ever from their availability and use.

Many CBOs already possess the experience, care delivery models, linkages to the community, and trained staff that

focus on quality of daily living. Also, they specialize in serving precisely those groups most at-risk for rehospitalization, such as individuals eligible for both Medicare and Medicaid. By aligning with hospitals, post-acute care providers, physician networks, and insurers, CBOs can leverage their expertise to meet the needs of this neglected component of the full continuum of care. In California alone, there are over 500 hospitals that discharge over 1 million people each year, a large majority of whom are sent home, making effective care transitions essential. CBOs can provide a suite of essential services and supports for those most vulnerable to experience transition difficulties, but this will require fundamental changes to the way they do business.

Traditionally, CBOs are charitably-oriented, nonprofit entities predominantly funded through grants, private donations, and/or government funds, and to a much lesser degree, revenue generated from providing these services. Their business practices and procedures have been shaped by their major funding sources, holding them accountable for numbers of people served rather than particular quality outcomes. With these funding sources declining in recent years due to the economic downturn, CBOs must develop new revenue streams to survive and thrive, which means fostering new contractual partnerships and striving for a new level of quality monitoring and improvement. Given this new way of doing business, CBOs must develop the business acumen to create, facilitate, and maintain effective partnerships, either with the health care sector and/or other CBOs. The SCAN Foundation supported research that has identified three important phases of business development to make this transition successful: planning and promoting the services and making a strong business case, delivering those services successfully and profitably, and evaluating their effectiveness.

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BRINGING PROMISING PROGRAMS TO SCALE

As part of the foundation's work to bring promising programs to scale in California, we provided support to six CBOs in order to establish contractual relationships with local health care providers. Over the next two years, Camarillo Health District, Silicon Valley Independent Living Center, St. Paul's Retirement Home Foundation, Bay Area Community Services, Institute on Aging, and Jewish Family Service of Los Angeles will partner with a health care entity to leverage the opportunities created through California's integration demonstration for dual eligibles, as well as others through the ACA. Grantees will work toward identifying opportunities in their local markets, potential customers, and the root causes of readmission and failed communication transmissions. They will need to provide a specific set of services; price them effectively; and then contract with health plans, hospitals, and other health care organizations that are "at-risk" for poor medical outcomes. These CBOs will also need to provide data demonstrating the outcomes resulting from their care. Ideally, health care staff will be able to access community-based care transition services in real time, particularly in the home, to assure a safe and successful landing. CBOs will benefit from these new relationships with health care through new revenue streams. Most importantly, vulnerable older adults and their families will benefit from these more integrated linkages between health care and supportive services.

If this initiative is a success, we envision that these types of partnerships can be replicated throughout the state and serve as a national model for linking health and supportive services in organized systems of care. Along with creating care delivery efficiencies, this work ultimately puts the needs of individuals and their families at the center of the decisionmaking process.

As care needs grow among aging baby boomers in the coming years, successful transitions will be ever more critical to providing services offered at the right time by the right provider and in the right place. This is the standard of care that should be available to our loved ones, and ultimately us, so that everyone can age with dignity, choice, and independence.

For more information about the work discussed in this article, contact Erin Westphal, program manager, at EWestphal@TheSCANFoundation.org.

For Further Reading

Bridging Medical Care and Long-Term Services and Supports: Model Successes and Opportunities for Risk Bearing Entities: bit.ly/ZTdWby

California's Coordinated Care Initiative: Background and Overview: bit.ly/15Mrcac

Promising Programs funded by The SCAN Foundation: bit.ly/YZqZJs

Victor Tabbush: Overview of Preparing Community-Based Organizations for Successful Health Care Partnerships: bit.ly/17mK6m0

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