Community Care Connections (CCC)
Integrates Lifespan’s community-based aging services with health care systems to breakdown siloes.

Final Report, Contract # C030146, August 2015 – December 2019

Lifespan of Greater Rochester

Lifespan "*helps older adults and caregivers take on the challenges and opportunities of longer life.*"

Lifespan is a community-based organization serving over 40,000 people in the Greater Rochester and Finger Lakes Region annually, including older adults, people with disabilities and caregivers.

Agenda

Project Objectives

The Community Care Connections (CCC) Model

Achievements

Results & Evaluation

Lessons Learned

Payers Priorities

Barriers

Sustainability Plan

Current Initiatives Underway

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Community Care Connections Pilot

With support from the New York State Department of Health, Lifespan created Community Care Connections (CCC) because of an acute need for an integrated care approach for older adults.

From August 1, 2015 through the last quarter of 2019, CCC assisted 2,397 older adults who were referred by medical systems of care.

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Strategic Vision

Prove that integrating traditional community-based aging services with medical systems of care positively affects the triple aim of cost, quality and patient satisfaction.

We sought to change the paradigm by breaking down the silos between community-based aging services and medical systems of care to help an increasing population of older adults access the right care, at the right time, at the right place.

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Community Care Connections Goals

- Provide a proven model for replicability of integrated care for older adults in NYS.
- Reduce inappropriate hospitalizations and ED use.
- Determine which community-based aging services make a difference in health outcomes.
- Evaluate Physician response to integration of Lifespan intervention.
- Reduce family caregiver stress.

Breaking Down Silos

Historically,
community-based services
&
healthcare systems
operated in silos.

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Addressing the Social Determinants of Health

"Four in five physicians say patients' social needs are as important to address as their medical conditions.

"This is health care's blind side:
Within the current health care system,
physicians do not have the time or sufficient staff support to address patients' social needs."

Robert Wood Johnson Foundation, 2011

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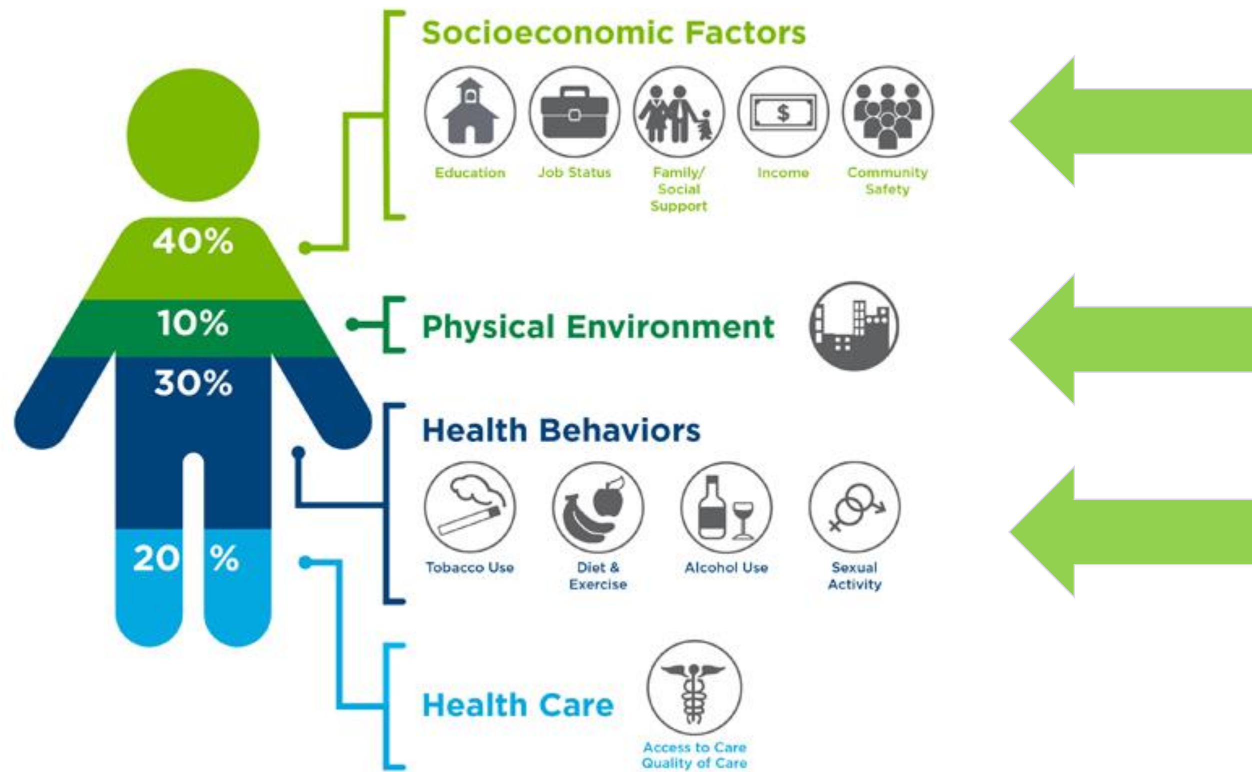
Building an Integrated Delivery System - Addressing Health AND Social Determinants of Well-Being



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Community Collaboration

- Steering committee informed the development of CCC:
  - Representatives from the two local health systems.
  - Office for the Aging.
  - Health insurers.
  - Monroe County Medical Society.
  - Finger Lakes Performing Provider System (FLPPS)/DSRIP.
  - Rochester Regional Health Information Organization (RHIO).
  - Accountable Care Organizations (ACOs).

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Intervention components:

- Social Work Care management
- LPN Healthcare Coordination
- A combination of both

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Individuals Served

Demonstrated difficulty navigating health care system.

- 60 years +
- History of missed medical appointments
- Aging/Stressed caregiver
- Lives alone
- 2 or more ED visits or hospitalizations in the past year
- Low health literacy
- History of non-adherence with treatment plan
- Co-morbidities, especially those that limit ADL's

A need for assistance with benefits, housing and/or socialization.

CCC Participant Demographics

- Female (62%)
- White (78%)
- Low-income (less than $1000/mo.) (41%)
- Lives alone (44%)
- Lives with a spouse or others (48%)
- Two or more chronic health conditions (80%)
- Medicare only beneficiary (68%)

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Referral partnerships: 85 + physician practices

- Patient is referred to CCC by Primary Care Provider.
- Referrals made via HIPAA compliant on-line form or by calling a dedicated phone line.
- CCC social work care manager (SW CM) conducts home assessment.
- Care Plan created and shared with Primary Care Provider.
- CCC SW CM connects client and caregivers to social services and LPN health care coordinator (HCC), if necessary.

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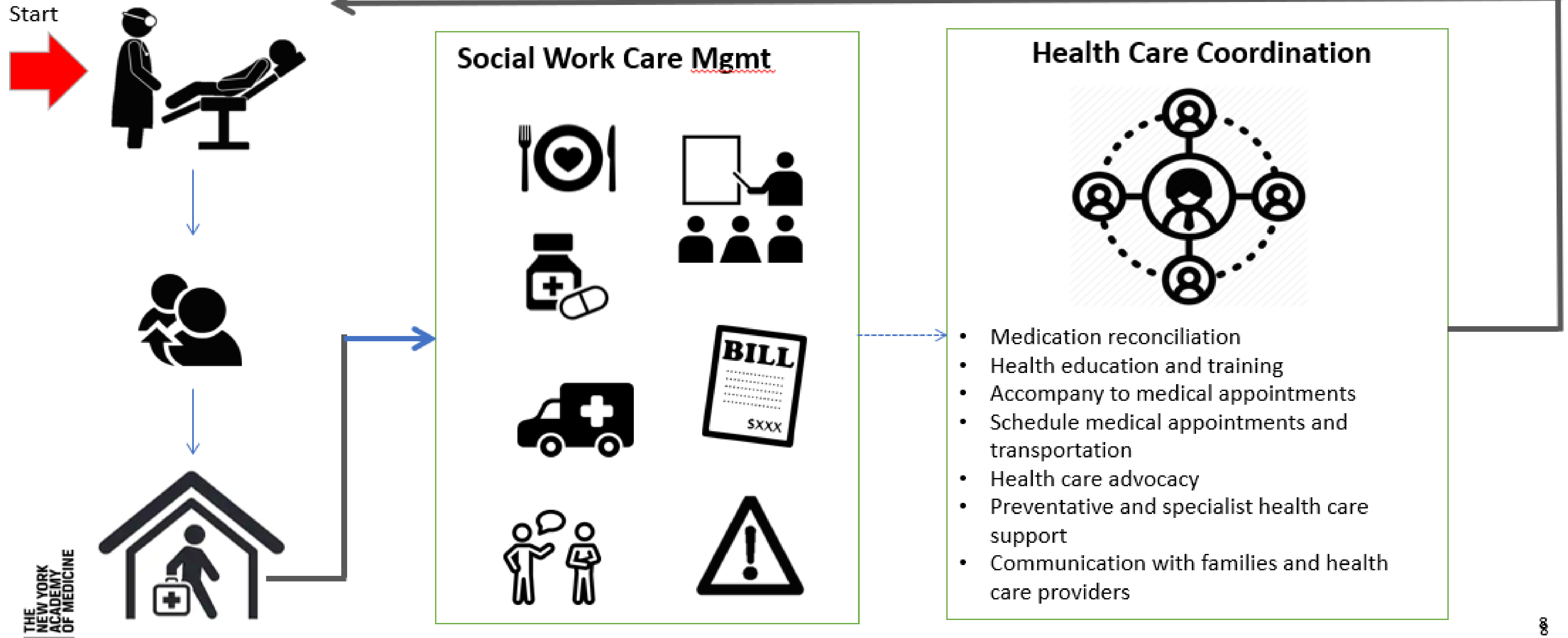
Closed Loop of Communication

SW CMs and HCCs communicate regularly with PCP to manage health-related medical and social needs.



Achievements

Healthcare access point testing (PCP, EMS, ER, Certified Home Care agencies) led to a well-established integration of CCC with Primary Care Physician practices.

Case in Point:

The COO of Accountable Health Partners (ACO) recently asked his team if they need CCC or if they could live without us.

Their response: “We need them! They are part of our workflow and how we manage the needs of our patients.”

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Achievements

Lifespan has established the key components of the CCC program that make it work:

(1) The CCC program offers medical providers and patients a central, trusted point of contact for addressing nonclinical health issues.

(2) The CCC program closes communication gaps: patients, providers, and Lifespan staff describe multiple ways that the CCC program contributes to improved communication with patients and across care settings.

(3) The CCC program offers Lifespan staff the time and flexibility to provide holistic and comprehensive care.

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Achievements

Evaluation results led to additional demonstration grants and contracts from foundations, an Accountable Care Organization, a Federally Qualified Healthcare Center, 2 insurers and others:
Accountable Health Partners, Excellus Blue Cross Blue Shield, United Healthcare, Rochester Primary Care Network, Greater Rochester Health Foundation, Western and Central NY Health Foundation, New York State Health Foundation, Monroe County DHHS, and the Finger Lakes Performing Providers System (FLPPS)/DSRIP.

CCC won national recognition for innovation with awards from:

- Mather Lifeways in 2017
- Archstone Foundation in November 2019
- Administration for Community Living - John A. Hartford Foundation 2020 Business Innovation Award (runner up)

Achievements - Dissemination Activities

Health Affairs Grant Watch Blog post: Working Across Sectors To Improve Health For Older People: The Community Care Connections Program.
https://www.healthaffairs.org/do/10.1377/hblog20200129.627279/full

Aligning social and health care services: The case of Community Care Connections, Preventive Medicine, 143 (2021) 106350, February 2021

Aligning Healthcare and Social Services to Reduce Hospitalizations and Emergency Room Visits, An Evaluation of the Community Care Connections Program, Medical Care, 59: 671–678, August 2021

National Conference Presentations:
American Public Health Association conference, November 4th, 2019
American Society on Aging conference, May 4th, 2021

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STUDY (1) New York Academy of Medicine, Ongoing Analysis

Pre-Post Analysis

Updated Results, February 2021

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NOTES – STUDY (1)

- Analyses include all CCC clients who have intakes between 6/1/2016 and 6/1/2020 (this allows for 90 days of data in the post period)
- **"Client enrollment"** is defined as 30 days after the initial CCC program intake was completed
  - During this time, it is assumed that connections are made to necessary programs and clients begin to receive services
- Findings are preliminary and subject to change

PROGRAM STATS – STUDY (1)

- **1,750 clients** joined CCC and provided consent for data sharing between June 1, 2016 and June 1, 2020.
- 109 cases open, 1,641 cases closed
- Of those with closed cases, the median program length was 114 days (mean 158 days)
    - 25th percentile: 59 days
    - 75th percentile: 195 days
    - Range: 0 - 1,180 days

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Data Flow – Study (1) and (2)

- **Peer Place Customized Platform:** Demographics, diagnoses, community services needs and referrals and standardized wellness assessments, conducted at intake and case closure.

- **Rochester RHIO Data:** Hospital inpatient and emergency encounters from health systems in Greater Rochester Region.

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90-DAY PRE/POST ANALYSIS: HEALTH CARE UTILIZATION

Rochester Regional Health Information Organization (RRHIO) provided ED & hospitalization encounter data for pre- and post-intervention comparisons.
New York Academy of Medicine evaluated the effectiveness and ROI. * Study (1)

Average number of hospitalizations, emergency department visits, and observations per client decreases after 90 days of CCC program participation.

	# of CCC Clients (N)	Pre CCC	Post CCC	% Change
Hospitalizations	1,750	.109	.077	-29%*
ED Visits	1,750	.389	.280	-28%*
Observations	1,750	.162	.125	-22%*

* = significant at $p < .01$

RETURN-ON-INVESTMENT

Every dollar spent on the CCC program is associated with an estimated **$1.75** in reduced costs related to hospitalization and ED visits (using a 90-day analysis)

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90-DAY PRE/POST ANALYSIS:
PERCENT CHANGE IN HEALTH CARE UTILIZATION BY SERVICE CONNECTION – STUDY (1)

Service	N	Hospitalizations	ED visits	Observations
Case Management	1446	**-35%***	**-30%***	-21%*
Financial Benefits Counseling	390	**-53%***	**-40%***	-11%
			-10%	-25%
Health Care Coordination	337	-5%	**-27%***	-26%
				-18%
Medicaid	229	**-56%***	-15%	-17%
Health insurance counseling	222	44%	**-44%***	-26%
Durable medical equipment	221	-11%	-25%	-13%
PERS	221	10%	-2%	52%
Housekeeping		**-58%***	**-45%***	-27%

Services presented here are those to which clients were most frequently referred.
* *p<.05*

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Return on Investment (ROI) analysis 90-day pre/post analysis – Study (1)

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- Notes:
  - ROI calculations rely on several assumptions, all of which impact the final ROI estimate.
    - Complete data is available for 1,750 clients. This is the number of clients who enrolled in CCC before June 1, 2020 who provided consent for data sharing.
    - Program costs are assumed to be $375 per client for 3 months of intervention.
    - Average cost for a hospitalization or ED visit was calculated using data from the 2017 Medical Expenditure Panel. Average cost for an observation was extrapolated from a 2013 US Surgeon General Report on Health Care Cost and Utilization Project. All data are adjusted to 2020 dollars using the Consumer Price Index for Medical Services for all Urban Consumers.
    - Healthcare costs are estimated by multiplying the average cost of an encounter (hospital/ED/observation) by the average number of that type of encounter per CCC program participant in both the pre and post periods. Pre-post cost differences are calculated by subtracting the estimated costs in the post-period from the estimated costs in the pre-period.

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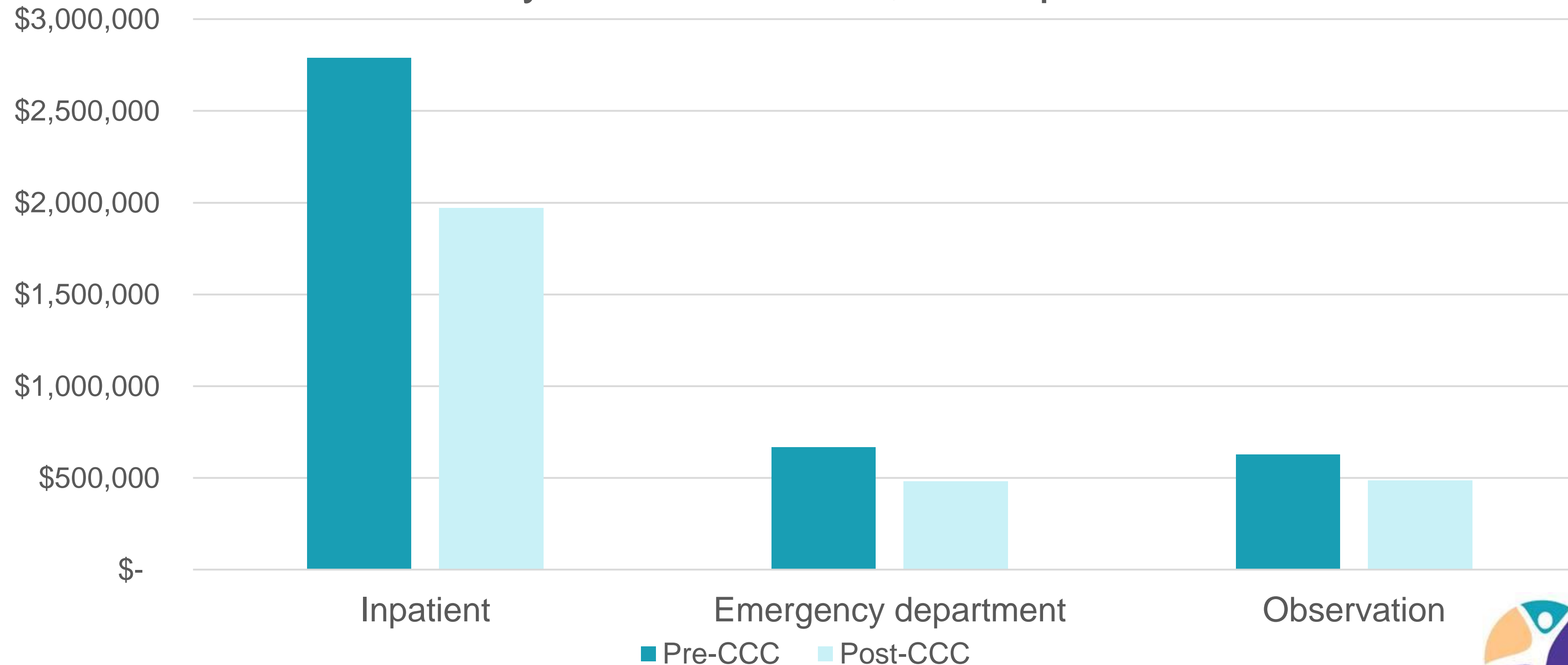
CHART: ESTIMATED HEALTHCARE* COSTS – STUDY (1)



*Healthcare costs include inpatient hospitalizations, emergency department visits, and observations.

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RETURN ON INVESTMENT (ROI) CALCULATIONS

		Pre CCC	Post CCC
Number of patients	1,750		
Average number per client			
ROI (%)	75%		

Interpretation: For every dollar spent on the CCC program is associated with $1.75 in return resulting from reduced heath care costs (a net gain of $0.75).

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STUDY (2) Robert Wood Johnson Foundation, Systems for Action Comparison Group Analysis

Aligning Healthcare and Social Services to Reduce Hospitalizations and Emergency Room Visits, An Evaluation of the Community Care Connections Program

~ *Medical Care Journal* Article, 59: 671-678, published August 2021

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Study (2) RWJF Quantitative Summary Results

CCC participants had fewer hospitalizations and ED visits in the 90 days post-enrollment:

- 40% fewer hospitalizations.
- 33% fewer ED visits.

CCC participants did not have fewer emergency room visits than a demographically matched comparison group.

CCC participants had fewer hospitalizations than a demographically matched comparison group.

- 39% fewer hospitalizations than a demographically matched comparison group.
- 55% fewer hospitalizations among CCC participants diagnosed with hypertension.

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Study (2) Methodology

- The CCC program enrolled 1,928 patients between June 10, 2016, and March 1, 2019, and 1,316 consented to participate in the research study.
- Lifespan staff recorded demographic, diagnosis, and service connection information on all CCC participants who enrolled and provided consent.
- Care Managers recorded clients as "connected" to service after confirming that the client accessed the program or resource.
- The RHIO linked CCC client information to clinical encounter data and identified a large group of adults with similar demographics as CCC participants with records in the exchange between January 1, 2016, and December 31, 2018.

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Study (2) Limitations

- The RHIO did not have or provide access to data on the social and economic circumstances, health characteristics, nor reasons for clinical encounters of potential comparison group adults.
- CCC program participants may have had higher or more complex health needs than non-CCC adults or been more likely to visit the ED for reasons related to underlying health conditions or unmet social or economic needs than non-CCC adults.
- Although both hospitalizations and ED visits are costly and often avoidable, they may also be attributable to different mechanisms. Health care providers determine whether a patient is admitted to the hospital, whereas ED visits are oftentimes a response by patients.

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Study (2) RWJF

Qualitative Interview Summary Results

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HEALTH CARE PROVIDER PERSPECTIVE

Health care providers view CCC as beneficial for both providers and patients. Providers report:

- Feeling more confident that patients are receiving help with the social, economic and contextual challenges that impact their health.
- More time to focus on providing medical care instead of trying to address social issues, which they are not trained to do.
- A better understanding of what patients are facing outside of their office that may be impacting their health.

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HEALTH CARE PROVIDER PERSPECTIVE

“I’m no longer spinning my wheels trying to help somebody.

…Just the idea that somebody who is skillful and understands the population – where they are, and where they’re living, and what life looks like for them – when that’s being handled, the benefit is that the patient can come in and talk to us about their health and to know that they have a [CCC social worker] for X amount of days, months, working on something with them.

It helps us to focus on good primary care when the patient’s in the office.”

~ Health Care Provider

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HEALTH CARE PROVIDER PERSPECTIVE

"Non-compliance is not synonymous with attitude. It's often impacted by the social determinants that create barriers a patient cannot navigate alone. Lifespan's intervention and advocacy for our most complex patients allows those social determinants to be identified and addressed so action can be taken to remove some of those barriers. Lifespan is an invaluable resource for our providers and patients to help our patients achieve their highest level of good health."

~ Health Care Provider

"I am so grateful for having Lifespan as a resource, especially during the pandemic. These unmet socioeconomic needs have become so overwhelming, and Lifespan does such a great job at addressing them."

~ Health Care Provider

PATIENT PERSPECTIVES

Patients report that the CCC program:

- Improves their physical and mental health
- Enables them to better access primary and preventative care and supports them in understanding and adhering to provider recommendations
- Reduces caregiver stress
- Provides social support and reduces social isolation

PATIENT PERSPECTIVE: HEALTH

"I just don't know what I would do without [my LPN Healthcare Coordinator]. She keeps me on target with my appointments and things, some of my appointments she actually goes there with me to make sure I understand what the doctor or therapist is telling me. I've not been in control of my diabetes for a long time. I am starting now to get much better control, my A1Cs are going down, so every service that they have provided to me have been very, very helpful."

~ CCC participant

PATIENT PERSPECTIVE: CAREGIVER STRESS

Patients report that CCC reduces caregiver stress and burnout

- *"Just that I'm a lot happier, and I have more energy, and I'm sure that my husband is, probably, much better off too…it certainly helped our mental health. I mean, I was going absolutely crazy. So, you know, having this resources, and having someone I can call if I need something, has been a great thing. Because I just didn't know it was there and available, and I just am so thrilled that we have this."*

- *When this first started, you know, since he was in the hospital, I had to cancel my dental cleaning, I didn't make it to a doctor's appointment, and that sort of thing. And since I got respite care, and I was able to count on people that would be here, I've made appointments, I saw my primary care doctor, and I'm doing very well. And I got my dental appointments. ..You know, when you're a caregiver you put that stuff on hold because you don't think it's as important."*

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Lessons Learned

- For confidence in evaluation results, sample size matters.
- Data access — while an essential component of the evaluation — is often out of our team's control.
- Co-located CCC staff are no more effective than non-co-located.
- Relying on hospitalization and ED data as primary measures of success limits the understanding of the impact of CCC on the social determinants of health.
- Persistence is key for sustainability.

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Evolution of Payers Priorities

- Payers want dedicated resources and tailored reports.
- Payers are more interested in Social Determinant of Health interventions and service connections data than return on investment (ROI) analysis.
- Payers are not ready and/or are not interested in paying a "per member per month" rate.

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Barriers – COVID-19

- At the start of the pandemic, medical offices reduced in-person appointments.
- CCC staff became adept at facilitating tele-health and virtual appointments using Lifespan tablets for participants who lacked the technology.
- Lifespan adapted our home safety checklist to ensure safe home visits.
- The pandemic caused a delay in CCC participant enrollments for some funders' projects resulting in the need to obtain no-cost extensions.

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Barriers

Barriers we have experienced to further integration with healthcare are rooted in the “wrong pocket problem.” Simply put, Lifespan has been told by some in healthcare it is not their job to pay community-based organizations to address social needs.

A wrong pocket problem arises when one organization or sector is best placed to make an investment, but it is another sector—another pocket—that benefits from the investment. As any economist would point out, when a potential investor incurs the cost but cannot capture the generated value, there will be underinvestment. (Butler S. ‘How “Wrong Pockets” Hurt Health.’ JAMA Forum Archive. Published online August 22, 2018. doi:10.1001/jamahealthforum.2018.0033)

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Pathway to Sustainability

Results led to additional demonstration grants and contracts.

Continued evaluation will provide results and cost analyses broken down by funders' population of interest.

Working to transition demonstration partnerships to a sustained payment model including value-based contract agreements.

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Current Initiatives Underway

- A contract with Excellus Blue Cross Blue Shield continues. Excellus' preliminary analysis shows a greater reduction in hospitalizations among CCC participants than an Excellus member comparison group.
- A contract with Accountable Health Partners (ACO) continues.
- A new contract with the Finger Lakes Performing Provider System (FLPPS)/DSRIP will (1) support CCC's geographic expansion and (2) re-establish a Health Home Care Management program at Lifespan as a sustainable funding source.
- A new Administration for Community Living federal grant will test the integration of CCC and Adult Protective Services.

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Current Initiatives Underway

- A New York State Health Foundation grant is testing the integration of CCC with Lifespan's Geriatric Addictions Program.
- A United Healthcare grant is testing the impact of CCC on social isolation.
- A new contract with Monroe County DHHS to provide CCC LPN Healthcare Coordination to 10 Adult Protective clients.
- Engagement with Monroe Plan, a Managed Care Organization for a potential partnership.
- Engagement with CMS for a potential demonstration project.

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CCC is a Replicable Model

Lifespan is well positioned for opportunities to provide consultation and guidance to community-based organizations in other regions of New York State.

Lessons learned can be shared:

- Designing evaluations.
- Integrating with Primary Care offices.
- Value proposition presentations and contracting strategies.

Questions?

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