Kaiser Permanente Partnership with Life-Eldercare

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Agenda

I. Introductions
II. Caring Moment
III. Background
IV. Current State
V. Future State - Project
VI. Performance Outcomes
VII. Conversation

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Caring Moment –Why focus on our senior members

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Alameda County

- Population = 1,648,556
- Aging population – 245,000 Seniors – 14.9%
- Several chronic conditions impairing physical and mental ability to self-manage
- Limited financial capacity – 9.4% poverty rate
- Food insecure and malnourished
- Reduced sensory ability
- Prone to falls
- Language – 45.68% speak other languages
- Education – 49.6% without college education
- Unsure about access to care
- Confused about self-care, including medications management
- Live alone
- Limited ability to use technology

**United States Census Bureau 2022*

Background - Hospital Readmissions

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California Average Rate
= 14.9% (2019)

Alameda County Rate
= 15.6%

Preventable Admissions
= $25 Billion

Examples of Avoidable Readmissions Drivers

Patient Adherence / Non-Compliance	Care Coordination	Social Determinants of Health (SDOH)	Medications / Pharmacy	Psychosocial / Behavioral Health	Clinical Status Change
• Misunderstanding of the disease, diagnosis, or therapeutic protocol • Culture or social beliefs of the treatment or disease leading to non-adherence • Lack of adherence to medication plan post-discharge • Language Barrier leading to poor self care or adherence • Level of motivation, self-efficacy, or knowledge of the disease and therapy • Literacy level and education • Member failed to keep scheduled appointment post-discharge • Member left Against Medical Advice (AMA) from Index Admission • Negative feelings like stress, hopelessness, or anxiety towards the treatment or condition leading to poor self care • Non-adherence to the overall discharge plan of index admission • Perception of therapeutic expectations, effects, efficacy, or need for treatment	• DME did not arrive or arrived too late • DME vendor not notified • Home health not notified • Home health SOC >72 hours • Patient has no PCP • PCP appointment not scheduled • PCP difficulty scheduling timely visit	• Home safety situation • Homeless • Housing insecurity • Lack of access to a healthy diet • Lack of access to medication • Lack of family / caregiver support • Lives alone • Mobility issues • Poverty or employment status • Transportation issues	• Contraindicated pharmacy issues • Lack of knowledge about medications and/ or side effects • Medication reconcilliation gap post discharge • Polypharmacy	• Comorbid BH and medical condition • Exacerbation of mental health condition • Relapse of addiction contributing to readmission	• A medical readmission for a continuation or recurrence of the reason for the initial admission, or for a closely related condition (e.g., a readmission for diabetes following an initial admission for diabetes) • A medical readmission for an acute decompensation of a chronic problem that was not the reason for the initial admission, but was plausibly related to care either during or immediately after the initial admission (e.g., a readmission for diabetes in a patient whose initial admission was for an acute myocardial infarction) • A medical readmission for an acute medical complication plausibly related to care during the initial admission (e.g., a patient with a hernia repair and a perioperative Foley catheter readmitted for a urinary tract infection 10 days later) • A readmission for a surgical procedure to address a complication resulting from care during the initial admission (e.g., a readmission for drainage of a post-operative wound abscess following an initial admission for a bowel resection)

Confidential – For Internal Use Only

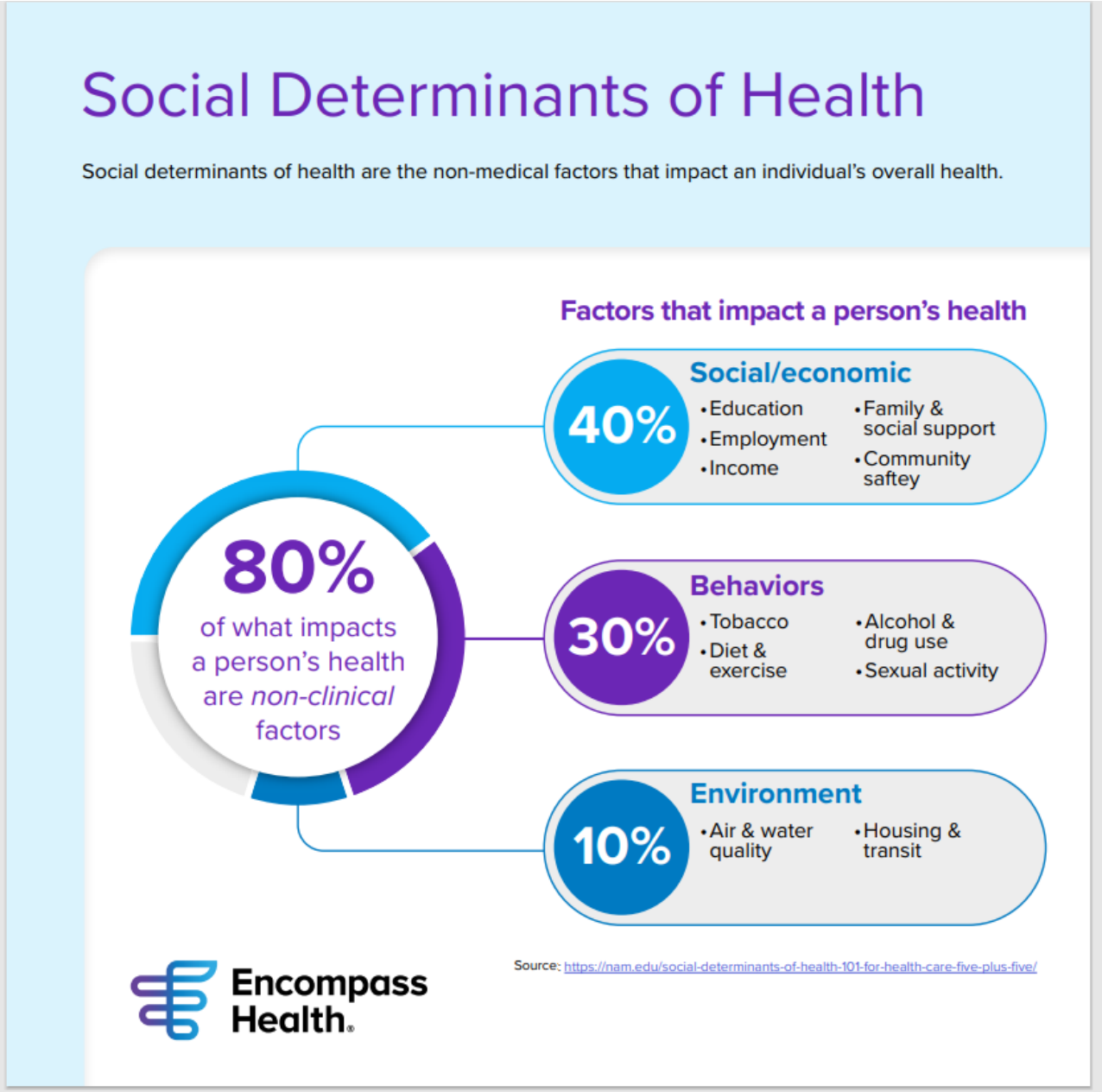
Social Determinants of Health

Multi-prong Impact

- Hunger – Food insecurity
- Access to care – Health benefits
- Housing – Homelessness/Unhoused
- Mental Health – Addictions/Behaviors
- Transportation
- Education
- Income and Jobs
- Isolation – Family/Network support
- Environment and Safety

Background – Impact of SDOH

SDOH
80% of what impacts
a person's health
are non-clinical factors!



SDOH Impact

Social determinants	Factors linked to lack of socioeconomic resources are associated with higher readmission rates for patients at minority-serving hospitals.[20,46] • Connect patients with community-based resources such as adult day health programs, personal care, home-delivered meals, and services that address social determinants of health (e.g., housing and food security, transportation, employment) and financial barriers that disproportionately affect racial and ethnic minorities.[20,47] • Connect uninsured and underinsured patients with supplemental health insurance, when possible.[48,49] • Encourage social support through community connections, use of health information technology, and community-based interventions that reduce social isolation and loneliness.[43,50]

*Guide to Reducing Disparities in Readmissions (cms.gov)

Background

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5. Systematically Respond to Social Determinants

Developing interventions to prevent readmissions, especially in vulnerable minority populations, requires focus in two areas— (1) creating systems responsive to the needs of diverse populations and (2) addressing the social determinants that put them at continued risk for readmissions. Identifying the specific social determinants that impact patients and their care processes is key to understanding how to support patients at greatest risk of readmission. Social determinants such as transportation to attend appointments; access to healthy, affordable foods; and housing status can be addressed with the support of navigators and links to community resources. Social isolation and a lack of social support are other key factors in readmission risk. Assuring that patients have the social supports and home and community-based services they need to manage their condition can be assessed and addressed by social workers and community health workers. Hospitals should provide easy-to-read patient information that is culturally and linguistically appropriate and reinforced by a multidisciplinary inpatient team of educators and interpreters. In the end, a patient's ability to engage in their care is influenced by their clinical, physical, and emotional status; the support system available to them; and their capacity to overcome the social obstacles present in their lives and environment.

Upstream Strategy

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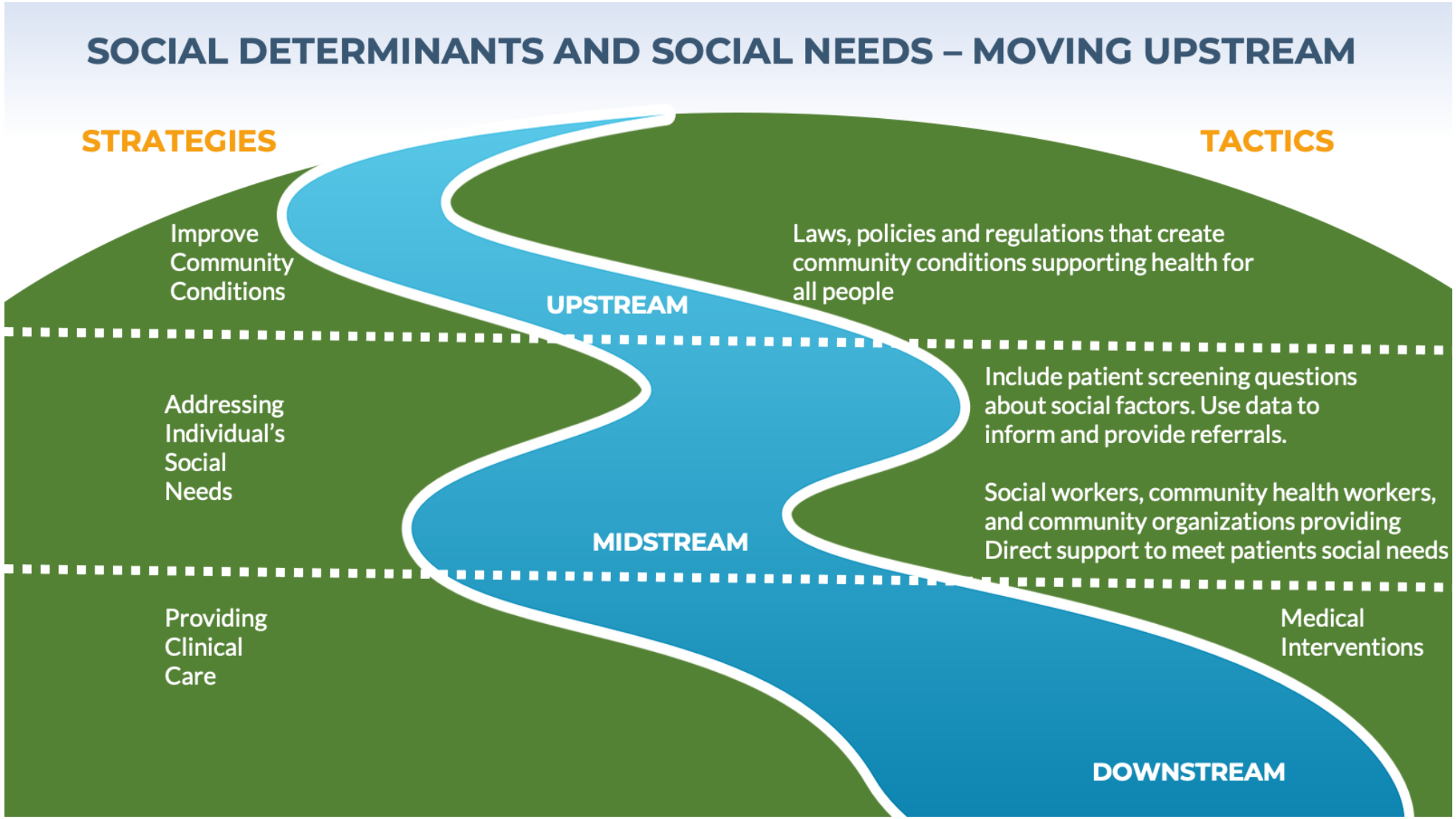

Future State – Kaiser Permanente Oakland Medical Center

Project

- Late 2021 - Collaboration with Senior Services Coalition of Alameda County
- Partnership with Life-Eldercare
- ED Team – Care Without Delay, Resource Management, Physicians
- Project – Draft agreement
- Goal Statement
- Cohort – 25 senior patients
- Workflows - Referrals to Life-Eldercare, communication, updates, etc
- Metrics – conversion rate, utilization
- Technology integration

- Launch date July 2022

Outcome Measurements

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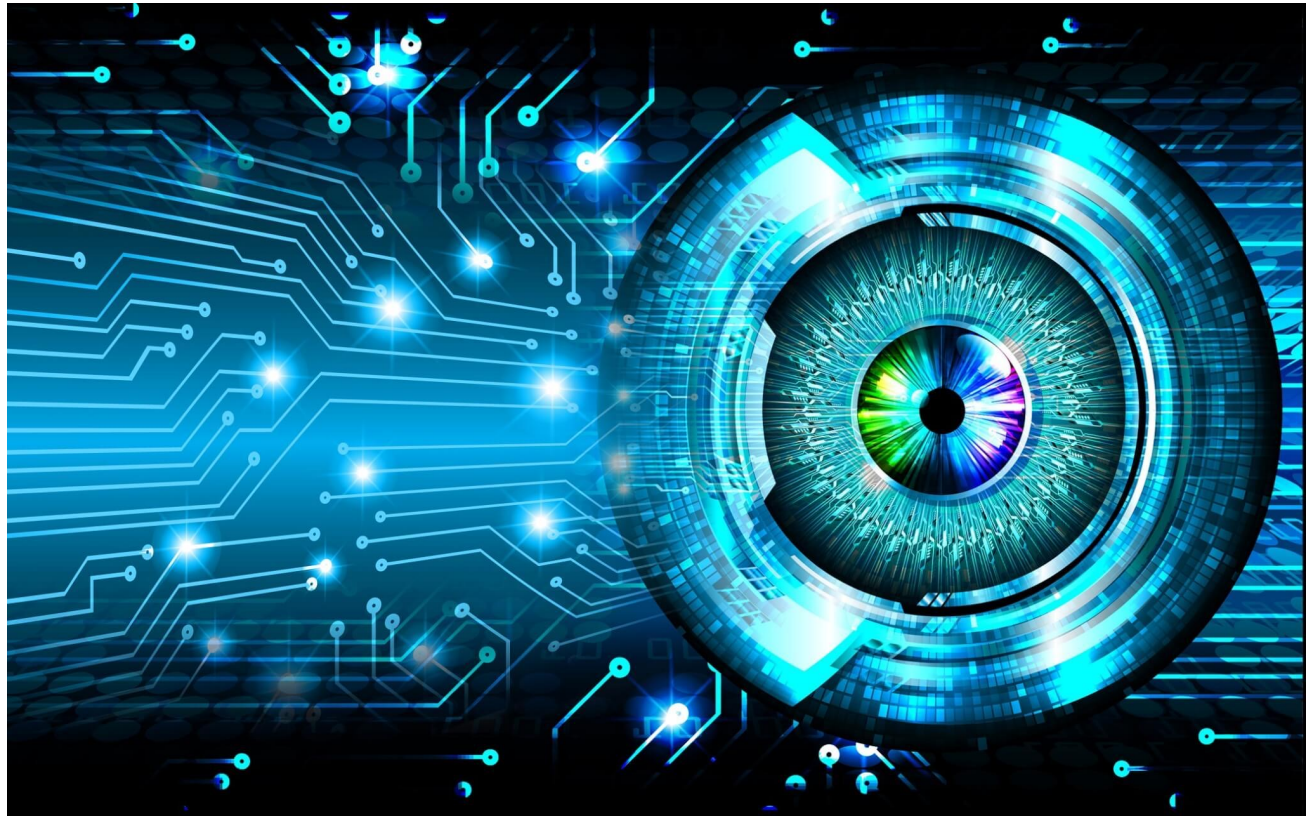
Data Trend

- Conversion – Patient willingness to participate
- ED Visits and Inpatient Days - 6 months prior vs 6 months
- Outcomes – Self-management, SDOH, Utilization

Vision

1. Develop a systemic approach to SDOH
2. Continue partnering with community based-organizations



Conversation

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