Innovations in the Community –
Improving Health and Cost Outcomes for Older Adults

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Summary

• Non-clinical, community-based interventions can improve outcomes and reduce total cost of care for Maryland’s older adults.

• Multiple chronic diseases faced by the majority of older adults lead to significant health care expenditures.

• Opportunities in non-clinical realms include engaging individuals in their own health – health literacy, education on self-management, patient activation – to positively influence outcomes and costs.
Learn & Explore…

• Leverage community resources to achieve better health and cost outcomes - *examples of clinical and non-clinical partnerships*.

• A traditional long-term care provider adjusts to the current environment and prepares for the future, *expanding mission impact* to engage community-dwelling older adults in improving health and managing chronic conditions.

• *The context*: rapidly aging population, chronic disease prevalence, influence of non-clinical social determinants of health… and Maryland’s All Payer Model
Examples

• Bringing clinical service to non-clinical settings
  – Wellness suites within senior communities – shift the location of the service to improve access to care

• Connecting clinical team member with non-clinical partner
  – Nurse Practitioner-Service Coordinator Models

• Extension of clinical provider into non-clinical realm
  – A traditional long-term care community extends its mission impact into the community to enhance the health and quality of life of older adults.
What is Keswick?

• Keswick is a 130 year old traditional long-term care community also offering subacute care and medical adult day services.

• The board and leadership recognized the need to further serve older adults living in the larger community.

• In the past three years:
  ▪ Action in Maturity (AIM) Senior Center and Transportation Service joined Keswick’s campus.
  ▪ The AIM-GEDCO-Keswick Provider Collaborative was created bridging transportation, housing and services.
  ▪ Keswick Community Health, Inc, a 501(c)3, was established.
Evolution of Keswick’s Role

- Keswick invited the community to health/aging education events on campus
- Hosted aging services provider meetings on campus
- KCH Executive Director 1/2015
- AIM joined Keswick campus
- Provider Collaborative MOU with AIM, GEDCO, Keswick
- HUBS Service Coordinator Grant secured by Collaborative

- Implemented Care at Hand Transition Coordination software
- Developed Healthy Eating Active Living HEALS series with Action in Maturity
- MOU w/Notre Dame for joint programming, services
- Summer Gardening series
- Hosted partner programs: American Diabetes Association Fabulous You; MedStar DPP and Cardiac Fitness

- New KCH Executive Director July 2016
- Legal incorporation of KCH
- Expanded Evidence-based Programs
- Developed Experience Corp relationship
- MOU with Maryland’s Living Well Center of Excellence
- MOU Extends Virtual Senior Center pilot
- Repurposing space on campus
- Implementing Notre Dame Nursing partnership
- Offering five Evidence-based Programs, plus Artful Minds, BrainWise, Men’s Health
- New/Expanded Offerings: Petite Retreat, Music & Memory
What is Keswick Community Health?

**Home & Healthy**
- Transition coordination
- *Post-discharge from Keswick*

Sub-acute guests receive care coordination for a successful transition to **Home**... and to support long term success.

**Engagement & Education**
- Evidence-based health education and supports – by KCH, AIM, other partners

Each week, over 150 older adults come to Keswick’s campus... to stay well and to continue living at **Home** in their community.

**Service Coordination**
- Linkages to home repair/rehab, services & benefits

Older adults are supported in how to make **Home** safer and life easier... to stay in their community as long as possible.

**Medical Adult Day Services**
- Supports individuals w/ dementia & other chronic conditions

Older adults are engaged daily, medication mgmt, OT/PT/ST available, and caregivers gain respite and support... to remain at **Home**.
Keswick Today & Into the Future

Senior Centers

Hospitals

Volunteers and Service Organizations

Academic Institutions

Senior Living Communities/Providers

Primary Care Providers

Community Partnerships

On Campus

In the Community
Context: What’s driving our work?

• Impact of social isolation on health
• Chronic disease prevalence/aging trends, related costs & demand on system (workforce)
• Potential for a more activated patient population to improve outcomes and reduce costs

Health Promotion, Disease Prevention & Chronic Disease Self-Management is critical for older adults, families, providers and payers.
Context: What’s driving this work?

Approximately 92% of older adults have at least one chronic disease, and 77% have at least two.

Four chronic diseases—heart disease, cancer, stroke, and diabetes—cause almost two-thirds of all deaths each year.

-National Council on Aging
COSTS OF CHRONIC DISEASE

CHRONIC DISEASES ACCOUNT FOR $3 OF EVERY $4 SPENT ON HEALTHCARE OR $7,900 FOR EVERY AMERICAN WITH A CHRONIC DISEASE.

SINCE THEY ARE FREQUENTLY LONGSTANDING, PEOPLE WITH CHRONIC CONDITIONS ARE ALSO AT HIGH RISK FOR DEPRESSION, ANXIETY, MENTAL AND FAMILY DISORDERS AND FINANCIAL BURDEN.

ABOUT 25% OF PEOPLE WITH A CHRONIC DISEASE HAVE SOME TYPE OF ACTIVITY RESTRICTION, e.g., MOBILITY, PERSONAL CARE, WORK OR SCHOOLING.

EVEN WITH HEALTH INSURANCE, CHRONIC CONDITIONS CAN POSE A SIGNIFICANT FINANCIAL BURDEN, PARTICULARLY WHEN WORK IS AFFECTED.

PEOPLE WITH CHRONIC DISEASES ARE AT HIGHEST RISK OF MEDICAL ERRORS AND DUPLICATED OR UNNEEDED SERVICES.

MOST DISABILITY AND PREMATURE DEATHS IN U.S. ARE CAUSED BY CHRONIC DISEASES SUCH AS DIABETES, CANCER, AND HEART DISEASE.

Health care costs for a person with one or more chronic conditions ARE FIVE TIMES HIGHER COMPARED TO INDIVIDUALS WITHOUT A CHRONIC DISEASE.

CHRONIC DISEASES CAUSE 7 OUT OF EVERY 10 DEATHS.

#1 MEDICAL EXPENSES ARE THE #1 CAUSE OF BANKRUPTCIES IN THE U.S.

1 in 3 children born today will develop diabetes in their lifetime (1 in 2 Latino children).

OBESITY IN ADULTS HAS DOUBLED IN THE LAST 20 YEARS, TRIPLED IN CHILDREN AGES 2-11, AND MORE THAN TRIPLED IN CHILDREN AGES 12-19.

OVERWEIGHT AND OBESITY ARE THE BIGGEST PUBLIC HEALTH THREATS OF THIS CENTURY, CAUSING UNPRECEDENTED INCREASES IN THE RATES OF DIABETES, CIRCULATORY DISEASES, CANCER AND OTHER DISEASES.
Incentives under global payment can lead to continued innovations in bridging the non-clinical and clinical realms.

Scope, degree of integration, and the nature of the effort & outcome— Is it about Access, Services or Behavior Change?...
Figure 1
Impact of Different Factors on Risk of Premature Death

DEFINING POPULATION HEALTH

- **Population health is both:**
  - the health outcomes of a group of individuals, and
  - the distribution of such outcomes within the group

- **Improving population health requires both:**
  - clinical management of individuals in the group, and
  - addressing underlying determinants of health status across the group
Patient Activation

• Knowledge, skills and confidence to manage one’s health.
• Engaging an older adult… *activating a patient.*
  • *Relationship* - Readiness and trusted partners
  • *Evidence-based* - Health promotion, chronic disease prevention and self-management education
• *Removal of practical barriers* - putting knowledge into practice
The Stanford Chronic Disease Self-Management Program demonstrated significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations. They also spent fewer days in the hospital, and there was also a trend toward fewer outpatients visits and hospitalizations. These data yield a cost to savings ratio of approximately 1:4. Many of these results persist for as long as three years.

http://patienteducation.stanford.edu/programs/cdsmp.html
CDC-Diabetes Prevention Program demonstrated that people with prediabetes who take part in a structured lifestyle change program can cut their risk of developing type 2 diabetes by 58% (71% for people over 60 years old). This finding was the result of the program helping people lose 5% to 7% of their body weight through healthier eating and 150 minutes of physical activity a week… Research has found that even after 10 years, people who completed a diabetes prevention lifestyle change program were one third less likely to develop type 2 diabetes.https://www.cdc.gov/diabetes/prevention/prediabetes-type2/preventing.html
Reimbursement/Funding Models

• Bridging services between clinical and non-clinical realms via:
  o Community benefit funds
  o Privately funded pilot projects
  o Contracts for services – shared risk?
  o Global payment opportunities

• Buy, Build or Partner???

• A variety of operating and reimbursement models continue to develop…
How Community-Based Organizations Can Support Value-Driven Health Care
Anand Parekh and Robert Schreiber

Resources

Building the business case for community partnership
Lessons from the BUILD Health Challenge
Resource|December 12, 2016


Housing and Health Care: A Toolkit for Building Partnerships
CHPS | FEBRUARY 24, 2015

Speaker Biographies

• **Aileen McShea Tinney** has an MHS in Finance & Management, an MA in Management of Aging Services and a BS in Gerontology. Aileen became Executive Director of Keswick Community Health in July 2016. She previously served as Director of Catholic Charities Senior Communities and began her career at University of Maryland Medical System in Strategic Planning and Post Acute Services.

• **Eric Turnbaugh** is a Certified Public Accountant with an MBA in Finance who currently serves as the Chief Financial Officer of Keswick. Eric began his career in public accounting serving as a manager for PricewaterhouseCoopers. He has experience working in all facets of healthcare from post-acute and long-term care providers to continuing care retirement communities (Erickson) to acute-care, academic medical centers (Hopkins).