CARING FOR PATIENTS AND
THE VENTURA HOSPITAL
TO HOME ALLIANCE

A Community Collaborative
In Person Centered Care

Our Organization
History and Profile

- Community Memorial Hospital was established as a single hospital site in 1901
- Community Memorial Health System is the only community owned, independent, not-for-profit hospital organization in Ventura County, established in 2005 through the merger of Community Memorial Hospital and Ojai Valley Community Hospital
- The System also consists of a Skilled Nursing Facility, sixteen ambulatory clinics, four urgent care centers and three imaging centers
- Recent and Ongoing Construction
  - 338,000 square foot, 250-bed replacement facility Community Memorial Hospital, Parking Structures
  - Full renovation of 25-bed Critical Access Hospital Ojai Valley Community Hospital
  - 75-Bed Skilled Nursing Facility
Our Organization

- CMHS Hospitals
- CMHS CFH Ambulatory Care Centers
- CMHS Rural Health Clinics
- CMHS Imaging/Diagnostic Centers
- CMHS Skilled Nursing Facility
- Urgent Care Centers
Discussion Points

- Provide an overview of the Hospital to Home Alliance
- Explore care redesign that emphasizes referral partners rather than referral sources
- Highlight the role of person-centered care across the continuum and efforts thus far at integration within the Alliance

CURRENT ALLIANCE MEMBERSHIP

- Three Health Systems (six hospitals)
- A Managed Care Organization
- Health Services Advisory Group
- Ten Home Health Agencies
- Seven Skilled Nursing Facilities
- A Large Multiservice CBO
CHANGING DEMOGRAPHIC

- 1.85 million Californians age 60-64
  2.45 million by 2030  32%
- 607,000 Californians age 85+
  2.49 million by 2050  310%

Significantly higher rate of severe chronic health conditions + Greater functional limitations = More health and supportive services

LACK OF INFRASTRUCTURE

The impact of an aging population, described by some as an “age wave” and others as an “aging tsunami,” will be felt in every aspect of society.

The economic, housing, transportation, health, and social support implications of this phenomenon must also be viewed in the context of the State’s tremendous population growth, which continues to challenge the State’s overall infrastructure planning.

Demographers project that California's population, now nearly 38 million, could reach 51 million by 2050
HEALTHCARE REFORM AND CHANGING REIMBURSEMENT

Value Based Purchasing

- Readmission Reduction
- Medicare Spending Per Beneficiary

Alternative Payment Programs

- ACOs
- Bundled Payments

Shared Risk Contracting and the need for Population Health Management
TRANSITION BREAKDOWN

- Multiple providers and programs
- Poor communication and collaboration
- Fragmented and siloed care
- Redundant efforts
- Frustrated patients and families
- Less than desired outcomes

ALLIANCE EVOLUTION

- Began in 2014 as a hospital driven effort in partnership with Health Services Advisory Group (HSAG) Readmission Reduction Program

- Participation was based upon a required scope of service and insurance contracts including Medi-Cal and a charity care program
EVOLUTION CONTINUED

- Initial focus started with home health around a best practice homecare model and required data submissions

- CMHS sponsored the development of a web based data collection tool

- We began with over 50 agencies. By the end of the first year that number was reduced to 17 and ultimately to 10

EVOLUTION CONTINUED

- A similar process was started separately with Skilled Nursing Facilities

- Emphasis with SNFs on returns to the hospital with a focus upon: tracking returns using a version of the tool developed for the home health agencies, length of stay and clinical competencies

- This group began with 15 and narrowed to 7 by the end of the first year
PROCESS IMPROVEMENT EFFORTS
HOME HEALTH

• Enhancing The Role Of The Liaison
• Care Coordination
• Data
• Criteria for Good Standing
• Communications
• Strategic Planning
• Scan Foundation Grant

PROCESS IMPROVEMENT EFFORTS IN SKILLED NURSING

• Data
• Competency
• Criteria For Good Standing
• Quarterly Community Quality Assessment
ALLIANCE OUTCOMES

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<tr>
<th>All Cause Readmissions</th>
<th>CMH - HSAG</th>
<th>Alliance Members</th>
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<tr>
<td>Home Health</td>
<td>18.2</td>
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<td>Skilled Nursing</td>
<td>16.8%</td>
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<table>
<thead>
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<th>Skilled Nursing Average Length of Stay</th>
<th>Medicare</th>
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LESSONS LEARNED

- Collaboration is key – moving from a hospital dictated process to a collaborative built on trust partnership and shared accountability has produced results
- Social determinants of health need equal if not more of our attention
- **REFERRAL SOURCES NEED TO BECOME REFERRAL PARTNERS**
- Data is essential and continues to be a challenge
INTEGRATING PERSON CENTERED CARE INTO ALLIANCE EFFORTS

Small Tests of Change:

- Focus Groups
- Identification of Test Population
- Development of a Risk Assessment Tool
- Creation of PCC Assessment Tool
- Roll Out Design – Education and Communication

THOUGHTS? COMMENTS? QUESTIONS?

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