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Coordination, Education, and Integration: Enhanced Roles For Home Care Workers in Theory and Practice

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ADVANCED ROLES FOR HOME CARE WORKERS

In this time of health care transformation, we believe the home care workforce has an important role to play in the delivery and coordination of vital health-related long-term services and supports. Together we are building innovative models of service delivery that improves individual health and experience, lowers healthcare costs, better supports family caregivers, and strengthens the overall quality of home care jobs. We hope you will join us in this effort.

Independence care system

SEIU Healthcare United for Quality Care

Commonwealth Care Alliance

CLTCEC
CALIFORNIA LONG-TERM CARE EDUCATION CENTER

St. John's Well Child & Family Center
CELEBRATING 50 YEARS 1964-2014

The Role of the Senior Aide in Care Management

Home and Community Based Services Conference

Regina M. Estela
Independence Care System, Inc.
September 18, 2014
Arlington, VA

Independence care system

Independence Care System, Inc.

- Nonprofit Organization
- Affiliated with Cooperative Home Care Associates and the Paraprofessional Health Institute
- Started in April, 2000
- Currently serve approximately 5,200 members
  - 50% adults with physical disabilities
  - 50% frail senior adults
- Serve Bronx, Brooklyn, Manhattan and Queens counties in NYC

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Social-Medical Program Model

- Support to live independently
  - Agency model of personal care and consumer directed personal assistants.
  - Wheelchair evaluation, purchase and repairs.
- Focus on avoiding potential medical complications
  - Prevention and management of urinary tract infections and pressure ulcers
  - Behavioral health support

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Interdisciplinary Care Management

- Person-centered care planning
  - Choices
  - Flexibility
- Care coordination and problem solving
  - Care transitions
  - Unstable home care
- Stratification of Members
  - Specialized Units: Multiple Sclerosis, Spinal Cord Injury
  - Independent-Stable-Complex Care

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Home Care Aide Services at ICS

- Members receive an average of 8.5 home care hours per day and 28% of members receive 24 hours of home care services per day.
- Home Care Services represent 70% of our medical expense budget
- Home Care Aides have frequent contact with members which gives them a unique advantage to help members improve their health since they are usually the first to know if a member is experiencing a change in their health.

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Senior Aides & Interdisciplinary Care Teams

- Pilot Program launched in 2011 with several goals:
  - To develop an interdisciplinary care model focused on leveraging the skills and talents of all team members, including the Senior Aide to support person centered care coordination.
  - To benefit the ICS member by providing an in-depth view of an individual's case from the vantage of a seasoned home care aide, in order to help the team more efficiently and effectively identify the member's underlying health issue and improve the quality of care being delivered.
  - To improve the member and the staff experience.

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Senior Aide Training

- All Senior Aides at ICS come from our affiliate organization Cooperative Home Care Associates.
- Eight Home Care Aides were trained to become Senior Aides at ICS.
- Training consisted of 8 learning modules delivered over 21 days and included classroom time, job shadowing and on-the-job orientation with the IDT.
- Training was designed in collaboration with PHI & CHCA to be highly interactive and focused on complex problem solving and peer coaching.

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Senior Aides and Interdisciplinary Teams

- Pilot Goals continued
  - To support the various aides in each member's home, as an experienced mentor trained in problem solving and peer coaching, in order to strengthen communication in the home and improve the skill level of the home care aide.
  - Promote job satisfaction and home care aide retention.

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Challenges

- New Role represented challenges to the Senior Aide, Members and the IDT.
  - Home Care Aides are accustomed to functioning independently within a member's home.
    - Needed support to speak up during team meetings and to fully contribute in that setting.
  - Members did not want someone watching them and reporting back to IDT.
    - Needed to get member buy-in and provide education on how the Senior Aide was there to help both the aide and the member.
  - IDT members were not always sure about how best to leverage the expertise of the Senior Aide and when to refer a member issue to the Senior Aide.
    - Needed to provide guidance to Team Members on how to best collaborate and use the Senior Aide.

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Successes

- Senior Aides are full participants of the IDTs and they are regularly called on by team members to support care plan goals.
- Senior Aides interventions have led to better outcomes for members and the senior aides express satisfaction with their work. “What I see matters”

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Further Development of Senior Aide Role

- Strengthened Care Transitions
- Supporting Reductions in ER Use
- Expansion of Tele-health
- Improvement of Care Giver Burnout
- Continued improvement of the linkage between the HCA and the IDT

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From the Front Lines

"As a member of the interdisciplinary care team, you are no longer alone in confronting a challenging situation. You get the bigger picture: seeing the member's care history and outcomes, and hearing different points of view from your colleagues. It's a much better perspective."

Lillian Torres, Senior Aide

Independence care system

Thank you.

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CLTCEC
CALIFORNIA LONG-TERM CARE EDUCATION CENTER

WHO IS CLTCEC?

- The California Long Term Care Education Center (CLTCEC) is a 501(c)3 that was founded by SEIU ULTCW and provides educational opportunities of empowerment to long-term care workers

- CLTCEC is the largest trainer of IHSS workers in California, serving 5,000 workers per year

- SEIU United Long Term Care Workers (ULTCW), the 2nd largest SEIU local in the nation, represents 180,000 IHSS & nursing home workers in California

THE CALIFORNIA MODEL

- Over 400,000 IHSS providers
- All Independent Providers
- IHSS services in 8 counties are part of Managed Care as of April 2014, through a duals demonstration project called the Coordinated Care Initiative
- By 2020, there will be over 700,000 IHSS providers in California

CARE TEAM INTEGRATION OF THE HOME-BASED WORKFORCE

In 2012, CLTCEC received a Health Care Innovation Award from CMS for our Homecare Integration Training program.

- Train 6,000 IHSS Consumer-Provider Pairs over 3-Year Period
- Consumer-directed
- Integrate provider into consumers' care team

Better care

Improve health

- Reduce ER visits
- Reduce LOS in nursing homes
- Reduce hospitalizations

- Achieve $25 million in savings
- $10.2m Medicaid; $14.7m Medicare

Lower costs

PROJECT PARTNERS

- CLTCEC, Lead Agency
  - Overall project management and program development
- Partner Agencies:
  - SEIU United Long Term Care Workers (ULTCW)
  - Contra Costa Employment and Human Services Department
  - Contra Costa Health Plan
  - St. John's Well Child and Family Clinics
  - UCSF Center for Health Professions
  - SEIU UHW
  - Shirley Ware Education Center
  - SynerMed
  - IEHP (Inland Empire Health Plan)
  - Molina Healthcare
  - LA Care

INTERVENTION – BETTER CARE

- **TRAINING** the In-Home Supportive Services provider with a curriculum that enhances the training given to them by the consumers and to serve as health monitors, coaches, navigators, communicators and care aides.

- **INTEGRATING** into the healthcare system as a member of the consumer's integrated care team.

- **CONSUMER CHOICE** where participation and engagement in the intervention strategy is the consumer's choice.

TRAINING PROGRAM

- 17 week training
- 3.5 hours per session
- CPR session is 5 hours
- Consumer **and** provider attend second and last session together
- At home assignments
- Competency checks and skills demonstration
- Attendance policy

CORE COMPETENCIES

- Soft skills
  - **Communicating** about changes in health or any healthcare issues
  - **Monitoring** health conditions or medication adherence
  - **Coaching** to support overall improved quality of life for the patient (e.g., eating healthy foods, getting exercise)
  - Working as a **Care Aide** to help support the patient's overall care in the home
  - **Navigating** through the healthcare system with the patient

- Hard skills
  - CPR and First Aid
  - 10 Core Competencies

CORE COMPETENCIES

1. Infection Control and Standard Precautions: Tracheostomy and Nasogastric tubes, PPE's, Catheters and Colostomy	6. Body Systems and most common diseases: Arthritis, Cancer, Kidney Disease, Multiple Sclerosis, Parkinson's Disease, and Stroke
2. Oral Care and Dental care	7. Fall and Fire Prevention
3. Grooming and Personal Hygiene	8. Diet and Nutrition
4. Body Mechanics in lifting objects	9. Medication Management and Introduction to Vital Signs: measure or record vitals, but no diagnoses
5. Body Mechanics in transferring individuals	10. Communication and working relationship with patient's health care providers on chronic conditions, such as: heart and lung, diabetes behavioral health conditions, dementia.

INTEGRATION

- Bottom Up and Top Down Approach
  - IHSS Providers
    - Tool for 1st visit
      - Empower the consumer and provider
      - Consumer asks for provider to be included as part of his/her care team
      - Recorded in the EMR
    - Educates the “traditional” care team members about the training program
  - Health Plans and Medical groups
    - Partner on our program
    - CLTCEC educates health plans / medical groups about the program
    - Communication methods and best practices developed

INTEGRATION

- Working with each health plan to concretize their vision for Integration:
  - Training for Integrated Care Team (ICT)
  - Training for IHSS workers
  - Method for training: curriculum, team meetings
  - Observations, Reporting and Communications:
    - Hotlines
    - Web Portals
    - Office visits
  - Awareness and consideration of literacy levels
  - Eye towards multiple languages

MEASURING INTEGRATION

Working with Health Plans and Medical Groups to track frequencies of interactions and method of interactions

- Telehealth
- Physical visit
- Web portal

Focus Groups to understand real life application

- IHSS provider on the care team
- Use of FAQ tool in curriculum

MEASURING INTEGRATION

- Internal research and evaluation partner: University of California, San Francisco (UCSF)
  - Pre and post surveys
    - Consumer and Provider
    - Quality of Life, Frequency, Relationship
    - Workforce: tenure, satisfaction, skill use
  - Utilization Data
    - Medicare
    - Medicaid
- CMS appointed NORC out of the University of Chicago as the external project evaluator

PROJECT STATUS - SEPTEMBER 2014

- Los Angeles
  - 1246 providers have completed the training, impacting 1350 consumers
  - Current cohort of over 979 provider and consumer pairs currently enrolled in 43 classes
  - Spanish, English, Mandarin, Armenian, Korean
  - Will train 4200
- San Bernardino
  - First cohort of 53 consumer and provider pairs enrolled in 2 classes
  - Will train 390
- Contra Costa
  - 69 providers have completed the training, impacting 65 consumers
  - Current cohort of 38 students enrolled in 2 classes
  - English and Spanish
  - Will train 210

CONSUMER AND PROVIDER STORIES

"Before I took this class I did not know as much about how to understand different conditions and what do to about them. My father (consumer in his 70's) suffered a stroke. If I had not taken the class I would have thought that he was just sleepy. Because I learned about stroke and the details about what to look for and how to deal with that emergency, I was able to call the ambulance. They took him to the hospital and later the doctor told me that it had been a minor stroke but because I took quick action it helped him in minimizing the effects." (Cantonese provider)

CONSUMER AND PROVIDER STORIES

- **Provider: "It has not been just one thing, it has been many. Diet, exercise and Diabetes were the best. It has helped me in how I work with my consumer."**

- **Consumer: "Yes, he tells me everything he learns after every class and tries it on me. It has helped me with my diabetes because he has changed the menu now he includes a lot more vegetables. I did not like it at first but I knew it was for my health and now I feel better. He also continually asks me to do exercise, and he puts stationary pedals on the floor for me to exercise. Sometimes I tell him I do not want to do it but I end up doing it because he encourages me. It has helped me because I have grandchildren and that allows me to still play with them and it also helps me with my Diabetes."** (English speaking, African American couple)

OBSERVATIONS AND PATH FORWARD

- Challenges of training on scale
- Multiple health plans and medical groups
- Data transfer for analysis
- Consumer reporting better quality of life
- Provider feeling more empowered in their role
- Excited about the future of this work

THANK YOU.

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COMMONWEALTH CARE ALLIANCE

INNOVATIVE APPROACHES TO ENHANCING THE ROLES OF HOME CARE WORKERS: AN ESSENTIAL ELEMENT IN PRIMARY CARE TRANSFORMATION

LOIS SIMON, PRESIDENT
COMMONWEALTH CARE ALLIANCE

NATIONAL HOME AND COMMUNITY BASED SERVICES CONFERENCE
NASUAD SEPTEMBER 18, 2014

HEALTHY IS HARDER FOR SOME. That's why we're here.

Commonwealth Care Alliance

WHAT IS COMMONWEALTH CARE ALLIANCE (CCA)?

- A Massachusetts, consumer governed, not-for-profit, comprehensive, prepaid care delivery system created in 2003
  - A hybrid of care delivery and payer roles
  - Accountable Care Organization Prototype for Complex Populations
  - Redesigns care by investing in and transforming primary care; enhances primary care and care coordination capabilities through deployment of Interdisciplinary Primary Care Teams
- Mission driven concentration – focuses exclusively on the care of Medicare and Medicaid's most complex and expensive beneficiaries
- Proven track record for providing high quality care while bending the health care cost curve
- One of the few organizations nationally with depth, longevity of experience and demonstrated success in integrating primary, acute, and long term care services financed by a risk adjusted global capitation

MARKET LEADER IN INTEGRATED CARE FOR DUAL ELIGIBLES

Senior Care Options Program

- Fully Integrated Dual Eligible Medicare Advantage Special Needs Plan (FIDESNP)
- 6100 elder members in Greater Boston, W. Mass and North Shore
- $300M + in annualized blended premium
- 74% of members meet nursing home criteria yet live in the community
- 40+ primary care sites affiliated with 9 hospital systems with integrated, multi-disciplinary primary care teams

OneCare Program

- Implemented Oct 1, 2013 – first in the nation capitated duals demonstration
- Of three OneCare Plans, CCA has the broadest service area, enrolling beneficiaries in nine counties
- Expected enrollment by end of 2014 of approximately 10,000 One Care enrollees
- Serves dual eligibles under 65 with chronic illness and disabilities, 70% of whom have a behavioral health diagnosis
- Served through a platform of primary care and human service partners, as well as an expanded medical and behavioral health provider network

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CCA PROVEN SUCCESS

HIGHEST RATED FIDESNP AND DSNP IN THE NATION 2011 - 2013

Performance Metrics

CCA - Senior Care Options – launched in 2004:
2 years into program, an independent evaluation (JEN Study) showed SCO enrollees enter nursing facility less often and for shorter durations than control population

Ongoing study and experience shows:

- 66% less likely to enter nursing facilities
- 45-50% reduction in hospitalizations
- Decreasing readmissions and increasing percent of patients dying at home

In a very early (circa 1999-2008) demonstration for complex under 65 Medicaid beneficiaries, avg. PMPM for the most expensive individuals decreased from $9,000 under FFS to $2,500 under CCA capitated system

Quality Metrics

- Overall Plan Rating: 
- Health Plan Rating (Part C): 
  - Staying Healthy: Screenings, Tests & Vaccines
  - Managing Chronic Conditions
  - Rating of Health Plan Responsiveness & Care
  - Health Plan Member Complaints & Appeals
  - Health Plan's Telephone Customer Service
- Drug Plan Rating (Part D): 
  - Drug Plan Customer Service
  - Drug Plan Member Complaints, Members Who Choose to Leave, and Medicare Audit Findings
  - Member Experience with Drug Plan
  - Drug Pricing and Patient Safety

Medicare Star Ratings – Highest rated FIDESNP and DSNP in the nation 2011 – 2013 (2014 not yet available)

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WHAT DIFFERENTIATES COMMONWEALTH CARE ALLIANCE (CCA)?

An Enhanced Primary Care Model

- Clinical model of enhanced primary care involves hands on care by our clinical teams – well beyond “remote” care management
- Robust home visiting program by CCA interdisciplinary teams enhances ability to respond to episodic care needs and averts trips to emergency rooms, prevents hospitalizations and readmissions
- Teams responsible for transitions of care and continuity of care across ALL care settings (home to hospital to sub-acute/SNF to home)

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WHAT DIFFERENTIATES CCA?

Member Engagement

- Commitment to engaging members in multiple ways:
  - Governance
  - Program Development, Design and Improvement Strategies
  - Individual Care Planning and Self-Management

- Growth and care delivery approach:
  - Enrollment process aimed at diligence in ensuring continuity and comprehensiveness of care
  - We work with providers who are interested in our model of care

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WHY DO WE EMBRACE PARTICIPANT DIRECTION?

- Philosophy
  - Honors individual autonomy/control
  - Grounds us in person-centered care
  - Cultural and linguistic competency
  - Allocates resources to households & families
  - Supports continuity in care
- Practicality
  - Workforce availability
  - Workforce flexibility
  - Market expectations

THE CHALLENGE

- How do we integrate participant direction into a fully-integrated, team-based model of managed care?
- Organization/Team
  - Responsible for comprehensive assessment
  - Responsible for developing individualized care plan w/ member input
  - **Accountable for fulfillment of care plan**
  - *Direct care is the key element in community-based long-term supports & services*

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THE SOLUTION

- Create a hybrid that offers the best features of participant-directed and agency approaches to direct care

HYBRID MODEL

- **Self-Direction: Consumer Role/Responsibilities**
  - Identifies direct care worker(s)
  - Informs and approves individualized care plan
  - Retains control over hiring/firing
  - Directs worker
  - Elects/declines PCA training & education opportunities
  - Elects/declines PCA communication w/ team

- **Agency: Team Role/Responsibilities**
  - Assesses ability of consumer to direct care
  - Provides support/surrogate if needed
  - Assesses function/care needs
  - Develops care plan with member
  - Monitors implementation of care plan
  - Completes Individualized Preference Plan (IPP)
  - Offers training/education
  - Offers communication w/ team

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ENHANCED ROLE OF HOME CARE WORKERS IN THE SENIOR CARE OPTIONS PROGRAM: PERSONAL CARE ASSISTANT PROJECT SUMMARY

- Grant received from NRCPDS* at Boston College in 2011: Managed Care and Participant Direction
- Objective: Better understand and address policy issues related to emerging field of participant directed services within a managed care context

*National Resource Center for Participant Directed Services

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FOUR COMPONENTS TO PROJECT:

- Establish a surrogate resource to support SCO members who were challenged to manage their PCA services
- *Based on needs and preferences of SCO members*, develop education and training opportunities for participant directed PCAs
- *Based on needs and preferences of SCO members*, strengthen links between PCAs and SCO primary care team
- Develop PCA Project Coordinator to oversee and develop project components

PILOT PROJECT AT BRIGHTWOOD HEALTH CENTER

- 600+ SCO members; approximately 85% NHC eligible
- Those with functional support needs most often choose participant directed services (PCAs)
- Based on comprehensive assessment, SCO primary care teams (NP, RN, GSSC) refer members needing PCA management assistance to PCA Project Coordinator for further follow up

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PROGRAM ELEMENTS

- Individual Preference Plan (IPP): PCA Project Coordinator *elicits each member's preferences* with respect to PCA education and training and PCA communication with SCO primary care team
- Surrogate Program: CCA collaborates with community organization to recruit and train a pilot group of surrogates to support, represent and assist SCO members in managing their PCA services

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PROGRAM ELEMENTS (CON'T)

- Based on IPP information, respond with menu of options for members to choose from:
  - Offer information on SEIU sponsored trainings
  - Offer local community based PHCAST* curriculum
  - Offer individual follow up with members requesting specific primary care team assistance (e.g. PT/OT training on getting in/out of tub)
  - Offer CDSMP, DSMP and other Stanford group based peer led evidence based program opportunities sponsored by CCA
  - Offer opportunities for PCA(s) to join PCP/team joint integration sessions at Brightwood

*Personal and Home Care Aide State Training

WHERE WE ARE

- Over 50 IPPs have been completed with SCO members referred to program
- PHCAST curriculum has been offered in local community (Spanish); a second, restructured offering is in discussion
- SEIU trainings have been offered in local community (Spanish and English)
- Approximately 50 SCO members referred to the program are receiving surrogacy services to assist with management of the PCA program
- Fall 2014 start anticipated for PCA integration with the PCP/SCO joint primary care session; 5 members identified for initial focus

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St. John's Well Child and Family Center

In-Home Support Service Integration Pilot Programs

Becca Sussman, MPH

Associate Director of Programs & Grants Management

St. John’s Well Child and Family Center

St. John's Well Child and Family Center (St. John’s) –

- an independent 501(c)(3) network of Federally Qualified Health Centers in Los Angeles, California
- serves patients of all ages through eleven independent and school-based health centers spanning Central and South L.A. and Compton
- provides primary medical, dental, mental health, and social support services to uninsured, underserved and economically disadvantaged people in Los Angeles
- served 53,286 patients through over 185,233 visits

Healthcare Delivery System for Seniors/Persons with Disabilities (SPD)

- SPD – Medi-Cal designation
- Eligible for In Home Support Services (IHSS)
- 2011 – Transition of Medi-Cal SPD patients from FFS model to Managed Care
  - Assignment to primary care medical homes
- IHSS Providers hired and employed by the patient
  - 60% of IHSS providers in L.A. County are family members (SEIU-ULTCW)
- No required training or experience for IHSS providers

In-Home Support Service Integration Pilot Program

The St. John's Well Child and Family Center was awarded an innovation challenge grant from the Tides Foundation/Center for Care Innovations jointly funded by SEIU United Long-Term Care Workers to improve integration of care and health outcomes for seniors and individuals living with disabilities who use long-term services and supports.

This project, one of the first of its kind to test such an intervention, equipped home care providers to play an enhanced role in the areas of communication with key members of the care team, participate in the coordination of certain health and related services, become included in the health services plan, and gain additional skills relating to paramedical tasks and chronic disease management.

Program Goal

- To improve integration of care and health outcomes for seniors and persons with disabilities in South Los Angeles who utilize services through the In-Home Supportive Services program (IHSS).

The Intervention:
IHSS Integration Program

Component 1: Training for IHSS providers

- 6 week training (25 hrs) + CPR/First Aid
- Formative research included IHSS providers, patients, clinicians

1. IHSS System	**6. Activities of Daily Living**
2. Life Quality	**7. Home Safety/Fall Prevention**
3. Paraprofessional Medical Services	**8. Mobility and Transferring**
4. Nutrition	**9. Medication Reconciliation**
5. Mental Health	**10. CPR/First Aid Certification**

The Intervention:
IHSS Integration Program

Component 2: Incorporate IHSS providers of elderly and disabled (SPD) patients of St. John's into clinic-based, patient-centered care

- IHSS providers present at medical visits
- Care coordination by the IHSS Coordinator
  - Regular contact
  - Linkage to necessary medical, ancillary and other health-related services
  - Ready access to clinic providers

Program Participants

- Number of Participants: 97 pairs of St. John's' SPD patients and IHSS providers (194 individuals)
- Recruited from St. John's patient population
  - Identified by: medical providers, IHSS Coordinator outreach
- Duration of Participation: 4 months

Evaluation

- The Triple Aim - Population Health, Patient Experience and Healthcare Cost
- What were the major objectives of this program?
  - Increase patient satisfaction
  - Improve health outcomes of patients
  - Reduce unnecessary healthcare utilization
  - Improve communication between providers of SPD patients (primary care, IHSS)

Domain 1 – Population Health

Measure: Health-related quality of life

- Measured at enrollment (baseline) and monthly thereafter until end of program participation
- Results: **67% of patients reported improvements in health-related quality of life** at the end of program participation

(Source: CDC HRQOL Questionnaire Unhealthy Days Index)

Domain 1 – Population Health, cont'd…

Measure: Health Related Quality of Life

Average number of reported Unhealthy Days versus Healthy Days in previous month (30):

UNHEALTHY DAYS:

Baseline: 25.3 days

Program End: 15 days

HEALTHY DAYS:

Baseline: 4.7

Program End: 15 days

(**Source:** CDC HRQOL Questionnaire Unhealthy Days Index)

Other Population Health Measures

- Self-rated health
- Patient health-status reported by IHSS provider
- Functional status (ADLs) – change in # ADLs performed

Domain 2 – Patient Experience

Measure: Patient Satisfaction with overall medical care

- Measured at enrollment and at program end
- Result: Patient satisfaction with overall care increased by 13.4%

(Source: PSQ-18 – RAND)

PATIENT SATISFACTION (SUBSCALES):

- General Satisfaction: + 12.8%
- Technical Quality: +18.0%
- Interpersonal Manner (Patient/Provider): + 7.7%
- Communication (Patient/Provider): +10.6%
- Financial Aspects : +10.9%
- Time Spent With Doctor: + 7.5%
- Accessibility and Convenience: +19.1%

Other Measures of Patient Experience

- IHSS provider participation in training
- Knowledge related to IHSS training
- IHSS presence in patient medical visits
- Contacts with IHSS Coordinator

Domain 3 – Healthcare Cost

Measure: Hospitalizations/ER Visits

Monthly Rate of Hospitalizations and ER Visits	Monthly Rate (Aggregate)	Change
Hospitalizations		
Baseline (previous 12 months)	4.3	
Outcome (4 months in program)	2	-53%
ER Visits		
Baseline (previous 12 months)	7	
Outcome (4 months in program)	3.25	-54%

Domain 3 – Healthcare Cost

Measure: Medication Adherence

- Measured at baseline and monthly throughout program
- 40.2% improvement in medication adherence among participating patients

(Source: Morisky, Medication Adherence Questionnaire)

Contributions of Training and Integration

- Improved IHSS providers' ability to identify and meet patient health needs outside of the clinic setting
- Improved patient experience and satisfaction with healthcare among SPD patients
- Improved health status and reduced unnecessary hospitalizations and ER visits for a complex population of elderly and disabled patients

Discussion

- Most important parts of program:
  - Training
  - Improved communication between IHSS and clinic-based care providers
- How do we know which program components made the difference?
- Making the evaluation more robust
  - Self-reported data (on small N) not validated with objective measures
  - Longer period of observation
  - Could we include more robust metrics?
  - Formal bio statistical analysis
  - More data remains that could be analyzed

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Thank You!