Integrated Care Resource Center

Exploring Community-Based Organizations' (CBOs) Role as a Delivery System Partner to Support Vulnerable Populations

March 10, 2017

2:00-3:00 pm ET

The Integrated Care Resource Center, an initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office, provides technical assistance for states coordinated by Mathematica Policy Research and the Center for Health Care Strategies.

Agenda

- Welcome, Introductions, and Roll Call
- Overview of ACL's Business Acumen Initiative for CBOs
- The Value-Add of CBOs to Delivery Systems
- Health Plan/CBO Partnership and Clinical Outcomes
- Questions and Answers
- Concluding Remarks

Integrated Care Resource Center

Participants

- Stephanie Gibbs and Leah Smith, Integrated Care Resource Center (ICRC)
- Marisa Scala-Foley, Director, Office of Integrated Care Innovations, Administration for Community Living (ACL)
- Joan Hatem-Roy, Assistant Executive Director, Elder Services of the Merrimack Valley
- Keith Peifer, President, Senior Whole Health, Massachusetts

ICRC
Integrated Care Resource Center

ICRC Study Hall

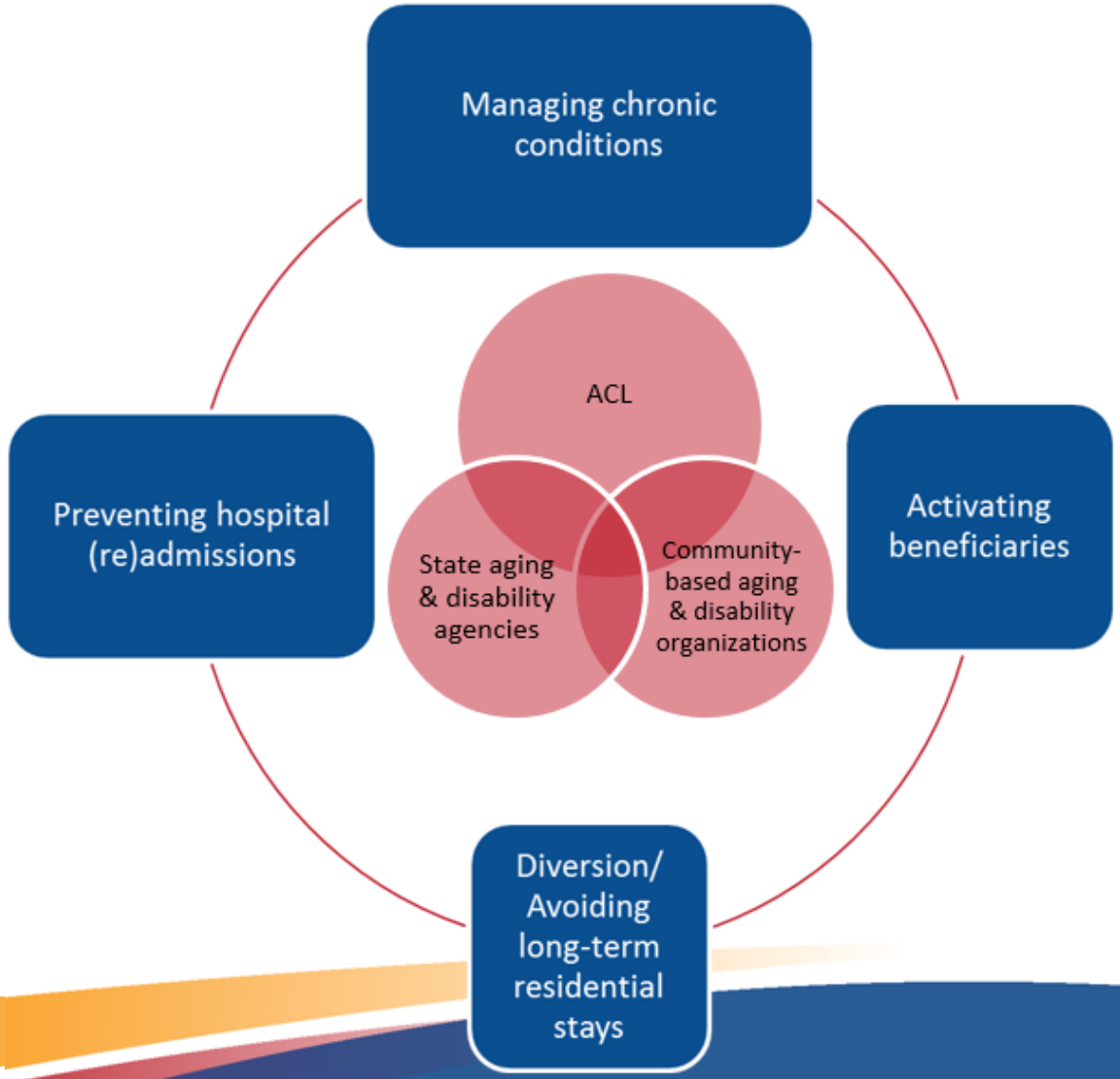
Exploring Community Based Organizations' (CBOs) Role as a Delivery System Partner to Support Vulnerable Populations

Marisa Scala-Foley

March 10, 2017

Administration for Community Living

The Critical Role of Community-Based Organizations in Delivery System Reform



Examples of Supports Provided by CBOs

- **Managing Chronic Conditions**
  - Chronic disease self-management, diabetes self-management, nutrition programs (counseling, education & meal provision), education about Medicare preventive benefits, peer supports, telehealth/telemedicine
- **Activating Beneficiaries**
  - Chronic disease self-management, community/beneficiary/caregiver engagement, community training, employment related supports, evidence-based care transitions, financial management services, independent living skills, information, referral & assistance/system navigation, nutrition education, person-centered planning, peer supports, self-direction/self-advocacy tools and training, benefits outreach and enrollment, supported decision-making, assistive technology, behavioral health services
- **Diversion/Avoiding Long-Term Residential Stays**
  - Transitions from nursing facility to home/community, person-centered planning, self-direction/self-advocacy, assessment/pre-admission review, information, referral & assistance/system navigation, environmental modifications, caregiver support, LTSS innovations, transportation, housing assistance, personal assistance
- **Preventing Hospital Admissions**
  - Evidence-based care transitions, care coordination, information, referral & assistance/system navigation, medical transportation, evidence-based medication reconciliation programs, evidence-based fall prevention programs/home risk assessments, nutrition programs (counseling & meal provision), caregiver support, environmental modifications, housing assistance, personal assistance

ACL & Business Acumen

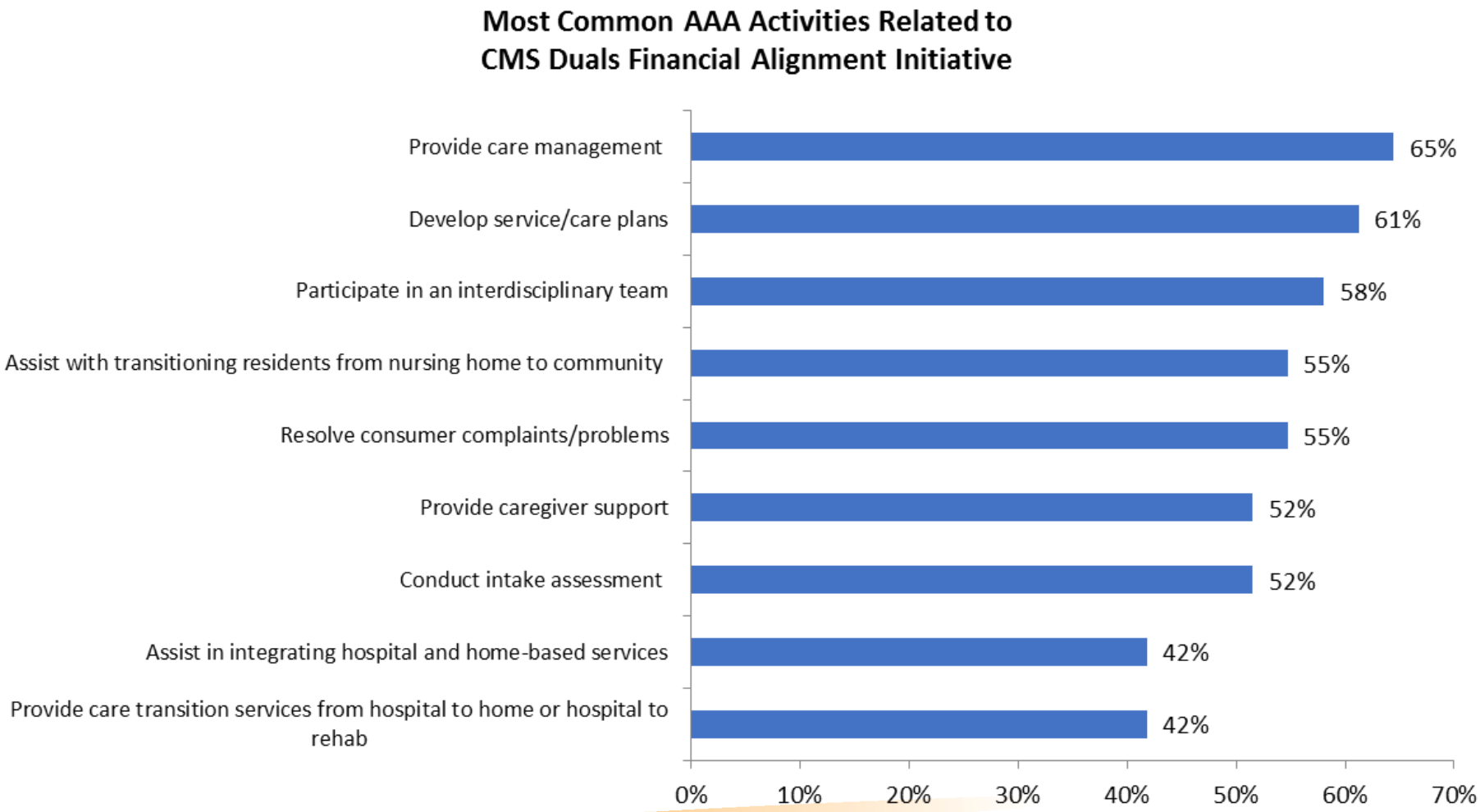
ACL, in partnership with foundations, is providing aging & disability organizations with the tools they need to partner and contract with health care payers and providers in delivery system reform.

Success on Contracting

20 Business Acumen Learning Collaborative Networks
28 signed contracts
More under negotiation

Services under contract	Populations served	Payers
• Care transitions • In-home assessment • Care coordination • Medication reconciliation • Evidence-based programs (EBPs)	• EBP targets Medicare-Medicaid enrollees • Other high-risk populations	• Medicare-Medicaid plans • Accountable Care Organizations • Physician groups • Medicaid health plans • Marketplace plans

Snapshot: AAAs and the Financial Alignment Initiative

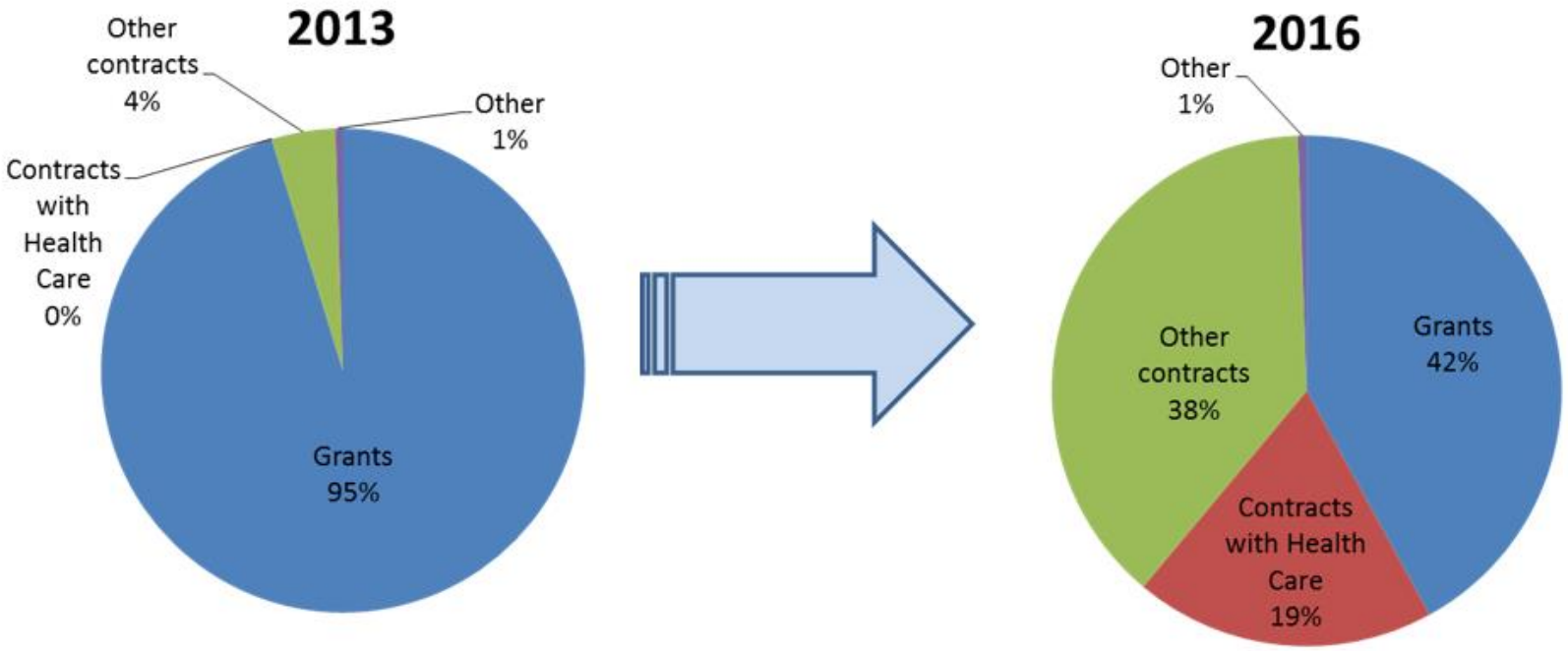


What We've Learned

- Culture is critical
- Networks need to match their strengths with a payer's needs
- Contracts take TIME
- Flexibility is key…but so is selectivity
- Relationships (and champions) are critical to the process
- Policy shifts offer new opportunities (and challenges)
- Still issues needing more work: Continuous quality improvement, generating and managing volume, network infrastructure, information technology, outcomes data, & more

Progress!

(An example from a CBO in one of our Business Acumen Learning Collaborative Networks)



Source: Elder Services of the Merrimack Valley and the Healthy Living Center of Excellence

Potential Roles for State Agencies Related to CBOs and Business Acumen

- Advocacy for CBO networks (and for the populations they serve)
- For state aging & disability agencies: working with State Medicaid Agency on development and implementation of these programs
- Relationship building (“Matchmaking”) with health plans and other integrated care entities
- Convening and technical assistance related to business acumen and financial sustainability
- Benchmarking and performance management

Moving Forward

- Two new ACL grants related to business acumen - awarded on September 30, 2016.
- *Business Acumen for Disability Organizations* - Awarded to National Association of States United for Aging and Disabilities (NASUAD), $2.25 million over 3 years:
  - Develop baseline knowledge about the content and infrastructure needs of community-based disability organizations through surveys and feasibility studies;
  - Provide broad-based training and technical assistance for the disability networks; and
  - Utilize a learning collaborative model to provide targeted technical assistance to 10 to 15 state networks of CBOs serving persons with disabilities of all ages and all types that seek to build their business capacity to contract with integrated care entities.

Moving Forward (Continued)

- *Learning Collaboratives for Advanced Business Acumen Skills* - Awarded to National Association of Area Agencies on Aging (n4a), $1.5 million over 3 years:
  - Organize and conduct 3-5 topically based action learning collaboratives to address “next generation” issues such as continuous quality improvement, infrastructure and technology, generating and maintaining volume, data pooling, and more; and to provide targeted technical assistance to networks of community-based aging and disability organizations.
  - Create knowledge and capture insights through these collaboratives to incorporate into future curriculum for national dissemination.

Moving Forward (Continued)

- 2016 grant from John A. Hartford Foundation, The SCAN Foundation, Colorado Health Foundation, Gary and Mary West Foundation, and Marin Community Foundation to n4a and partners – to form the *Aging and Disability Business Institute* (*http://www.aginganddisabilitybusinessinstitute.org/*)

For More Information:

Marisa Scala-Foley
Marisa.scala-foley@acl.hhs.gov
202-795-7433

http://www.acl.gov/Programs/CIP/OICI/BusinessAcumen/index.aspx

Integrated Care Resource Center

Joan Hatem-Roy, LICSW
Assistant Executive Director
Elder Services of the Merrimack Valley, Inc.

Keith Peifer
President
Senior Whole Health, LLC

SWH
SENIOR WHOLE HEALTH
Simple. Secure. Independent.

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

Massachusetts

- Since 2004, Elder Services of the Merrimack Valley (ESMV) has contracted with Senior Care Options (SCO) plans to provide a range of services.
  - Geriatric Support Services Coordinator (GSSC)
  - Provider network management

Over Time…..

Plans began contracting with ESMV for additional services

-Care transitions

-Personal care attendant (PCA) program

-Evidence-based programs

-Money management programs

-Behavioral health counseling

-Medicaid redetermination

Factors Contributing to Success:

- Exemplary customer service
- Knowledge of resources and local community
- Relationships with hospitals, HCBS providers, and consumers
- Single contract for evidence-based programs through the Healthy Living Center of Excellence
- Outcomes and proof of value… Data!

n4a
advocacy | action | answers on aging

Aging and Disability BUSINESS INSTITUTE

Senior Whole Health Model of Care Structure

- The Interdisciplinary Care Team (ICT) coordinates the care of Senior Whole Health (SWH) members through a comprehensive, integrated and individualized care planning process
- Primary Care Provider focal point for clinical decision making

Senior Whole Health Nurse Care Manager	Senior Whole Health Member Support Representative	Community Geriatric Support Services Coordinator	Other Team Members
▪ Focus on care coordination ▪ 24/7 availability ▪ Relationship with PCP ▪ Relationship with member ▪ ICP development	▪ Verifies language needs ▪ Confirms PCP selection ▪ Facilitates visit to PCP ▪ Notifies Senior Whole Health Nurse Care Manager of clinical issues identified ▪ Coordinates transportation benefits	▪ Case worker through Aging Service Access Points (ASAPs)/Elder Services ▪ BA/BS or equivalent experience in social work/human services ▪ In-home assessments for nonmedical home services ▪ Identifies and organizes home-based support services ▪ Coordinates community-based services, i.e., Adult Day Health	▪ Specialists and other providers based on member needs ▪ Senior Whole Health Pharmacy consultants ▪ Behavioral health specialists ▪ Other as needed

SWH
SENIOR WHOLE HEALTH
Simple. Secure. Independent.

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

SWH Model of Care Works

- **SWH Inpatient Admissions Trend for SWH Massachusetts Members:**
  - Inpatient admissions/1000 declined 8.5% over 3 years
  - Inpatient days/1000 declined 18% over 3 years overall; Nursing Home Certifiable 12% decline in inpatient days from 2008 through 2013
  - 1.6% decrease in readmissions in the last 2 years; 1.8% for Nursing Home Certifiable
  - Inpatient costs decreased 5% in the last year and 22.75% for Nursing Home Certifiable over 4 years

SWH
SENIOR WHOLE HEALTH
Simple. Secure. Independent.

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

Performance & Health Outcome Measurement

SWH utilizes multiple approaches to evaluate the performance and effectiveness of the Model of Care.

- **Short Cycle: identification of process errors, opportunities for improvement in real time to develop action plans. Examples include:**
  - Clinical rounds
  - Regular review of medication adherence
  - Daily review of admissions and discharges
  - Care transitions

- **Long Cycle: regular collection of data on key indicators of care and services, identifying goals, reporting on regular basis, and developing corrective action plans. Examples include:**
  - HEDIS reporting
  - Quarterly indicator reporting (i.e. member grievances, claims processing, enrollment processing)
  - Annual Quality Improvement Program Evaluation

SWH
SENIOR WHOLE HEALTH
Simple. Secure. Independent.

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

SWH Partnership with ESMV

- Provides key resources with assistance from the **Geriatrics Support Services Coordinators.**
- Assist with identifying Social Determinants of our members.
- Providing an effective way of contracting and managing contracts with Adult Day Health, Adult Family Care, Group Adult Family Care, and Home Health Agencies.
- Also assist with "Meals on Wheels" and other LTSS services our members need.

SWH
SENIOR WHOLE HEALTH
Simple. Secure. Independent.

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

Additional Areas of Concentration with ESMV

- **Care Transitions**
- **Healthy Living Center**
  - Diabetes
  - Chronic Disease Management
  - Matter of Balance (Fall Prevention)

SWH
SENIOR WHOLE HEALTH
Simple. Secure. Independent.

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

Care Transitions

- Program modeled after the Coleman Model –
  - Four pillars focusing on review of red flags for discharge diagnosis, medication reconciliation, verify follow-up appointments, provide personal health record (PHR)
- Goals –
  - Improve transitions from the hospital to community
  - Increased patient activation and engagement
  - Increased communication, coordination and transfer of information to the SWH in CaseTrakker, increased care coordination for members
- Intervention – 30 days post discharge, initial contact within 72 hours of discharge, subsequent follow-up calls at 7, 14, 21 days
- Barriers to Intervention – Difficult to reach members, refusers, language barriers, family dynamics

SWH
SENIOR WHOLE HEALTH
Simple. Secure. Independent.

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

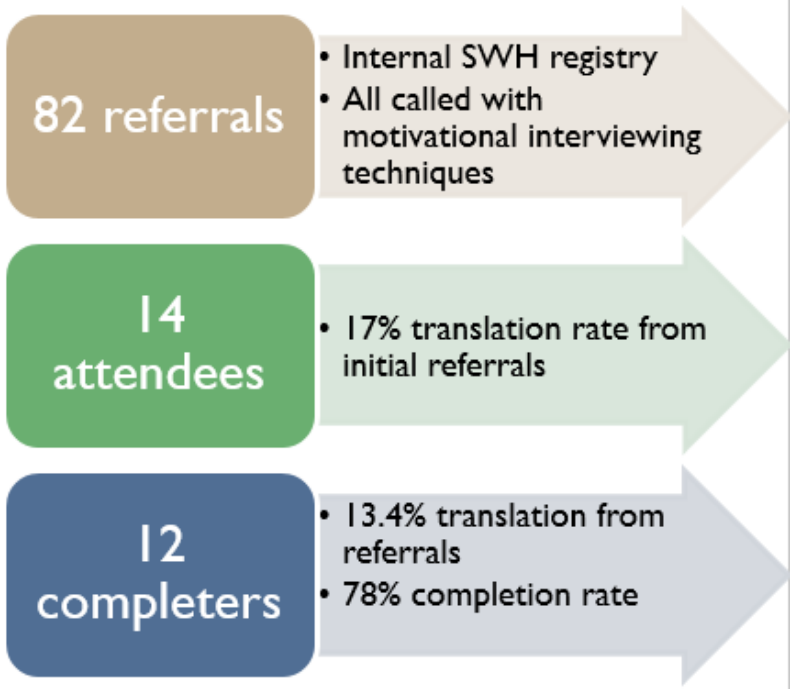
Healthy Living Center and Senior Whole Health

- First MCO to reimburse per participant
- Single contract for all regions/programs
- 14 Evidence-based programs
- Four-pronged referral approach
  - Registry of high-risk members identified through internal analytics
  - Geriatric Support Services Coordinator referrals
  - Referrals from case/care managers and other SWH providers
  - Self-referral
- Bifurcated rate (recognizes cost and value)
  - 50% when member contacted
  - 50% upon program completion
- Data collection and feedback

SWH
SENIOR WHOLE HEALTH
Simple. Secure. Independent.

Sample Workshop:

- A Matter of Balance (Boston)
- Low income housing
- Chinese Speaking



Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

Benefits to a Carrier: Why Did SWH Get Involved?

- **Improves outcomes for our members:**
  - Improve their daily lifestyle
  - Reduce costs due to improved lifestyle
  - Experience better quality of life
- **Improves retention of existing members:**
  - Participating members have higher satisfaction with plan
  - Not all health plans are participating, which helps SWH to set themselves apart from other health plans
- **Provides a marketing opportunity:**
  - Helps attract potential members
  - Helps SWH to differentiate themselves from others

SWH
SENIOR WHOLE HEALTH
Simple. Secure. Independent.

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

Your Value Proposition

Why did SWH buy vs. build?

- Problem solving, not just service providing
- Integration of care
- Community experience and presence
- Single contract for Healthy Living Programs
- Marketing and outreach
- Improved feedback and communication
- Quality & efficiency
- Improved health and retention outcomes

SWH
SENIOR WHOLE HEALTH
Simple. Secure. Independent.

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

Questions and Answers

Integrated Care Resource Center

About ICRC

- Established by CMS to advance integrated care models for Medicare-Medicaid enrollees
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica Policy Research and the Center for Health Care Strategies
- Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send additional questions to: ICRC@chcs.org

ICRC
Integrated Care Resource Center