advocacy | action | answers on aging

# Finding Champions and Building Partnerships between CBOs and Health Care Entities

Part of the National Aging and Disability Business Center Series – a collaboration of n4a and ASA.

**June Simmons , MSW**
**President and CEO, Partners in Care Foundation**

**Rob Schreiber MD, AGSF, CMD**
**Medical Director of Evidence based Programs, Hebrew SeniorLife**
**Medical Director of Healthy Living Center of Excellent**



## The "Business Center"

The mission of the National Aging and Disability Business Center (Business Center) is to successfully build and strengthen partnerships between community-based organizations (CBOs) and the health care system so older adults and people with disabilities will have access to services and supports that will enable them to live with dignity and independence in their homes and communities as long as possible.

**www.n4a.org/businesscenter**

## Partners and Funders

**Partners:**

- National Association of Area Agencies on Aging
- Independent Living Research Utilization/National Center for Aging and Disability
- American Society on Aging
- Partners in Care Foundation
- Elder Services of the Merrimack Valley/Healthy Living Center of Excellence

**Funders:**

- Administration for Community Living
- The John A. Hartford Foundation
- The SCAN Foundation
- The Gary and Mary West Foundation
- The Colorado Health Foundation
- The Marin Community Foundation



# The Opportunity: Awakening in the Healthcare Sector

Completing the healthcare continuum with home and community-based services

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

Partners in Care FOUNDATION

the healthy living Center of Excellence

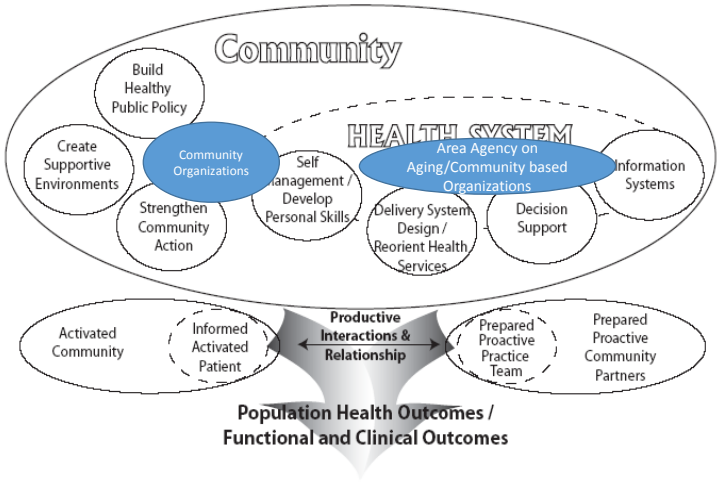
Part of the National Aging and Disability Business Center Series – a collaboration of n4a and ASA.

# Shift toward Value-Based Payment

- Transformation from Volume-based to Value-based payment
  - Generally, Value = Outcomes per $ invested (satisfaction, too)
  - Affordable Care Act base on the Triple Aim
- Potential for both Rewards & Penalties
  - All sectors – hospitals, health plans, community partners
- Tying fee-for-service Medicare payments to quality, value and alternative models of care
  - 50% of Medicare payments by 2018
- Medicare Access and CHIP Reauthorization Act of 2015
  - MACRA legislation provides direct incentives to Physicians and Hospitals to move towards a system that pays for outcomes
- Discharge Planning (CMS Rule, tied to IMPACT Act)
  - Consider access to caregivers and community-based care, including home and physical environment, assistive technologies, transportation, meals/household services and housing for homeless patients



## THE EXPANDED CHRONIC CARE MODEL: INTEGRATING POPULATION HEALTH PROMOTION

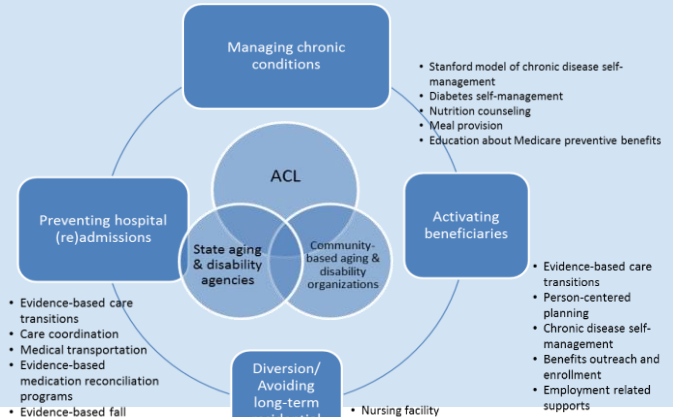



Barr, Robinson, Marin-Link, Underhill, Dotts, Ravensdale, & Salivaras, 2003.

# Integration of *Community Based Organizations* into Healthcare: Optimizing Health Outcomes

**Traditional <u>Scope of Long Term Services & Supports</u>**

- *Home-delivered/ congregate meals*
- *Transportation*
- *Medication review*
- *Respite/Caregiver support*
- *Falls/Home risk assessments*
- *Information and assistance*
- *Personal care*
- *Employment-related supports*
- *Housing*
- *Homemaker*
- *Shopping*
- *Money management*




- Stanford model of chronic disease self-management
- Diabetes self-management
- Nutrition counseling
- Meal provision
- Education about Medicare preventive benefits

- Evidence-based care transitions
- Care coordination
- Medical transportation
- Evidence-based medication reconciliation programs
- Evidence-based fall prevention programs/home risk assessments
- Caregiver support
- Environmental modifications

- Evidence-based care transitions
- Person-centered planning
- Chronic disease self-management
- Benefits outreach and enrollment
- Employment related supports

- Nursing facility transitions (Money Follows the Person)
- Person-centered planning
- Assessment/pre-admission review
- Environmental modifications
- Caregiver support
- LTSS innovations

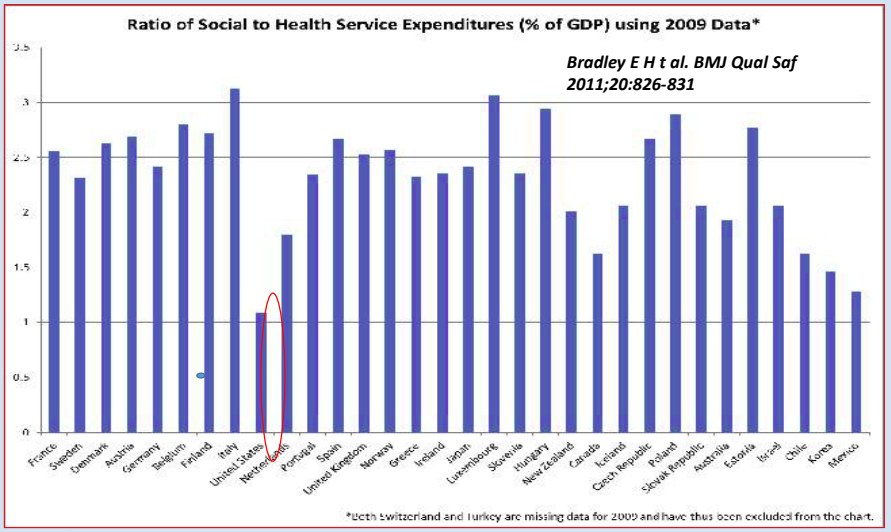
Elder Services of the Merrimack Valley, Inc. Choice for a life-long journey

the healthy living Center of Excellence

Part of the National Aging and Disability Business Center Series – a collaboration of n4a and ASA.

# Ratio of Social to Health Service Expenditures

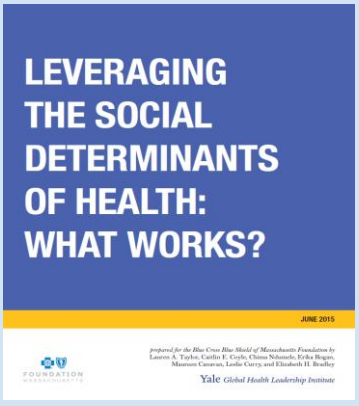
**for Organization for Economic Co-operation and Development (OECD) countries, 2005.**




Partners in Care FOUNDATION

Part of the National Aging and Disability Business Center Series – a collaboration of n4a and ASA.

## New Focus on the Social Determinants of Health (SDOH)


Partners in Care FOUNDATION

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



## CBOs & Healthcare: New, challenging partners

- Social sector challenges the notion of excellence in the status quo – it is not acceptable to ignore whole person
- We seek:
  - **to move money from old paradigms to our new sector**
  - **behavior change in stable settings**
  - **to expand the role of the person (AKA "patient") in their own health – *health happens at home***
  - **HCBS/community partnerships as new standards of care and an integral part of the healthcare system**
- We must align the powerful models and skills we bring – identify the system deficiencies we can impact
- Align with the payers who reap the savings

Partners in Care FOUNDATION

## CBOs Offer High Value to Healthcare Sector

- New home and community-based specialty EB **models of care**, a critical component across the care continuuim
- Depth of experience, with deep **local** knowledge and connections for essential life resources
- Full **regional coverage** with consistent tools, IT and results
- **Evidence-based** programs for chronic conditions, caregivers, medication safety and post-acute coaching and support
- Careful targeting who we should serve

**Powerful Outcomes**
- Reduce hospitalizations, readmissions, SNF & ER visits
- Improve quality scores
- Improve patient experience
- Better clinical outcomes

**Together, we are achieving the Triple Aim!**



# Solution #1: Build Partnerships

How CBOs can begin bridging the gap between home and lifestyle and healthcare payers and providers: health plans, provider groups, and new payment models

## Relationship Building: Strategies for CBOs

- *Board* membership from healthcare sector to open doors:
- Health care leader branding:
  - Top level agency leadership to represent community (CEO)
  - Join healthcare sector organizations
  - Attend, sponsor, exhibit and speak at conferences
- Form alliances with key players- QIO's, Readmissions
- Hire staff to *translate* between social services & healthcare.
- Honor outstanding healthcare leaders
- Join networking groups – e.g., female healthcare executives – at all levels (finance, exec, CMs, etc.)
- Take first champion with you to create the next
- CEO to CEO, MD to MD, RN to CNO, etc.

Partners in Care FOUNDATION



## Building Partnerships: Health Payers

- Competitive and Consolidating Marketplace
- What populations are they serving?
- What are their challenges?
- What is their marketing strategy?
- Measures of Effectiveness and Evaluation
  - Star Ratings for Health Plans
  - HEDIS (Healthcare Effectiveness Data and Information Set)
  - PQRS (Physician Quality Reporting System
  - HCAHPS(Hospital Consumer Assessment of Healthcare Providers and Systems)

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

the healthy living Center of Excellence

# Solution #2: Engage Champions

For all stages of contracting: Introductions, negotiations, planning, & implementation



## Finding Health Care Champions

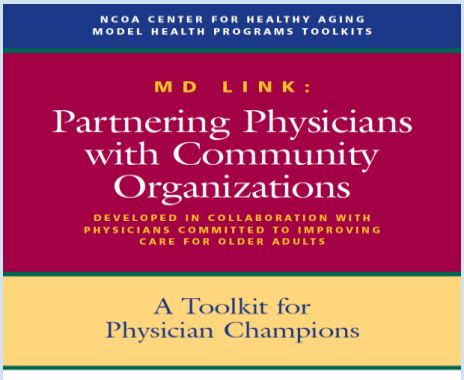
- Continue to cultivate
- Use Patient and Provider Stories
- Use a spotlight on the champions
- Can be Physicians, **Nurse Care Managers,** Social Workers, Care Coordinators, Secretarial Staff
- Can be **Medical Assistants/Medical Office Staff**
- Administrative Leadership
- Foundation Leadership: Tufts Health Plan Foundation, John A. Hartford Foundation, the SCAN Foundation

# Making the Pitch to Medical Care

- What Keeps You Up at Night?
- What Is In It For Me (WIIFM) concept
- Showing Value, Know the Return on Investment
- Making their job easier
- Sharing stories
- Have a physician speak to other physicians
  - Necessary but not sufficient
- Nurse Care Managers speaking with their peers
- Need administrative buy-in to operationalize the process



# Find a Physician Champion




- MD education about the benefits and practicalities of collaborating with social workers and community-based organizations (CBOs) that serve older adults.

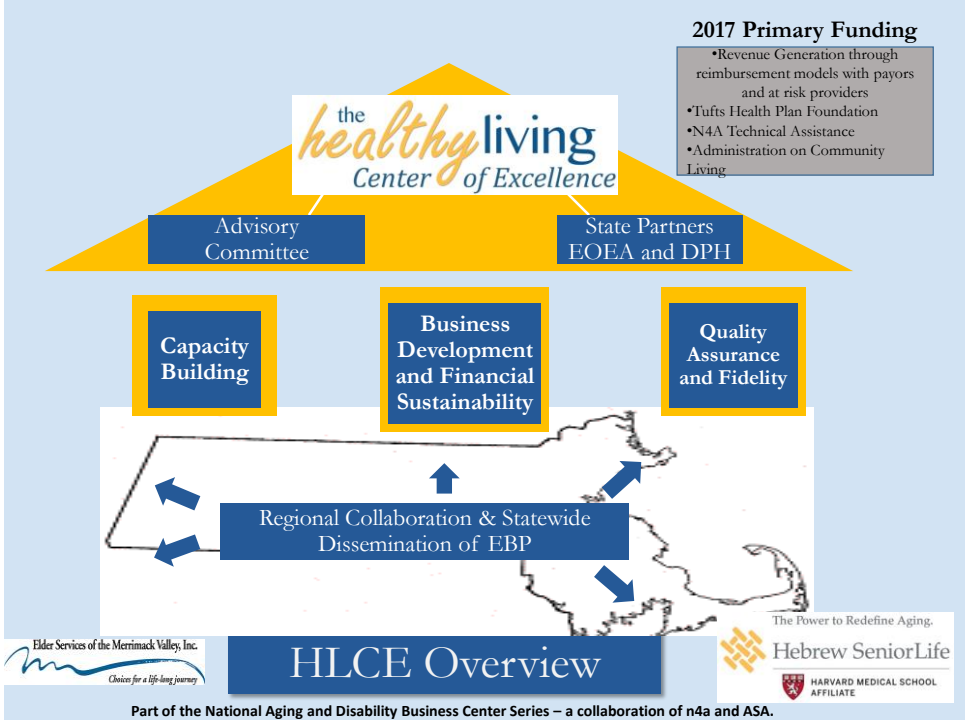
http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/MDLink_PartnerPhysicians.pdf

Part of the National Aging and Disability Business Center Series – a collaboration of n4a and ASA.

# Solution #3: CBO Networks

Follow the geography of plans, large provider groups, health systems & ACOs. They all need efficient, convenient, high quality services – one call does it all.





the healthy living Center of Excellence

http://www.healthyliving4me.org

1. Integration with Medical Care Providers and Insurance Carriers
2. Enhanced Quality and Efficiency through Centralized Infrastructure
3. Easy Access-one phone #, website access
4. Financial Sustainability through Reimbursement Models
5. Doorway for Integration of Long-Term Service Support AAA and other CBOs



## *Partners at Home Network* for an Integrated Community Care System

# Partners at Home Growing Footprint

***Expand Network footprint to cover added markets to meet our customer's needs***


Network as of June 2016

**Active Network Counties**

Alameda
Butte
Contra Costa
El Dorado
Fresno
Humboldt
Imperial
Kings
Kern
Los Angeles
Madera
Marin
Mendocino
Merced
Monterey
Nevada
Orange
Placer
Riverside
Sacramento
San Bernardino
San Diego
San Francisco
San Mateo
San Joaquin
San Luis Obispo
Santa Barbara
Santa Clara
Santa Cruz
Shasta
Solano
Sonoma
Stanislaus
Tulare
Ventura
Yolo

**Network Expansion in Progress**

Glenn
Napa
Sutter
Tehama

PARTNERS AT HOME
A Community Network of Partners in Care

Partners in Care FOUNDATION

**Part of the National Aging and Disability Business Center Series – a collaboration of n4a and ASA.**

## Our Community-Based Network

PARTNERS AT HOME
A Community Network of Partners in Care

California Health Collaborative
Camarillo Health Care District — For your health & wellness
County of San Diego HHSA — Health and Human Services Agency
Live Well San Diego
HealthTrust
Keiro
Vaa — Ventura County Area Agency on Aging
SeniorServ — Securing Home, Health & Heart
LIFE ElderCare
Saint Agnes Medical Center
Dignity Health
Community Housing Management Services
Riverside County Office on Aging
Meals on Wheels and Senior Outreach Services
AAOA — Area Agency on Aging Serving Napa and Solano — Assistance, Advocacy, Answers on Aging
ON LOK — Experience Matters in Senior Care
ssg — Special Service for Groups
VIC — Your bridge to help
WLCAC
Partners in Care FOUNDATION

**Part of the National Aging and Disability Business Center Series – a collaboration of n4a and ASA.**

# Solution #4: Build the Business Case

Addressing high-cost services and quality measures for payers



## Health Plans

- Look at quality ratings – areas for improvement
- Get to know the competition – big case management, behavioral health, & disease management companies
- Find a population or risk niche
- Look for nontraditional service opportunities
  - HRAs & eligibility determination for ADHC
- Play to risk aversion for home visits

# Health Plan: Massachusetts Senior Care Insurance Options

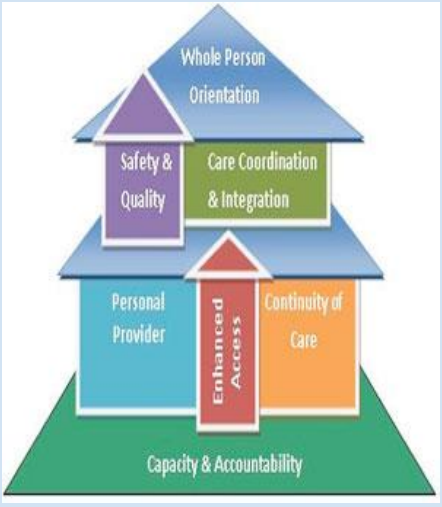
- Comprehensive Health Plan that covers all services reimbursable under Medicare and Medicaid through a managed care organization and its network of providers
- Improve Outcomes for our Members:
  - Improve on their daily lifestyle.
  - Reduce costs due to improved lifestyle.
  - Experience better quality of life.
- Improves Retention of existing members:
  - Participating members have higher satisfaction with carrier.
  - Not all carriers are participating, helps SWH to set themselves apart from others.
  - Members might lose program is they leave SWH.
- Provides a Marketing Opportunity:
  - Helps attract potential members.
  - Helps SWH to differentiate themselves from others



# How can CBOs help hospitals?

- "Throughput" and reducing length of stay
- Avoid/reduce readmission penalties/ER use
- Reduce minimally reimbursed or unpaid administrative days for hard-to-place patients – lack of caregiver, mental health, homeless, others
- Create alternatives to "soft" admissions from ED for people who need support at home
  - Aide to accompany patient, pick up meds, shop, and supervise
- Improve patient mix – tertiary & quaternary rather than chronic
- Improve patient satisfaction

# Patient Centered Medical Homes




- Model of Care strengthens physician-patient relationship
- Team based care with collective responsibility
- Goal is more personalized, coordinated, effective and efficient care
- Support patient self management and shared decision making



# Value Proposition to Medical Groups

- Self-Management is a criteria for PCMH
- P4P for outcomes: diabetes, hypertension
- Improve patient satisfaction with providers/practice
- Improve PCP satisfaction
- Increase referrals to practice
- Improve care transitions:prevent Hospitalizations and Readmissions
- Keep complex, frail patients in the community

Elder Services of the Merrimack Valley, Inc. Choices for a life-long journey
the healthy living Center of Excellence
Part of the National Aging and Disability Business Center Series – a collaboration of n4a and ASA.

## Value Proposition: ACO/Health System

- Reduce readmissions
- Reduce post-discharge ED use and inappropriate ED use
- Earlier/safer d/c home from hospital or SNF
- Improve quality scores and patient satisfaction
- Improve care through a full picture of each patient: preferences, functioning, and psychosocial strengths and challenges.
- Improve patient self-management for long-term reduction in utilization of high-cost services



# Solution #5: Successful Partnership Tips

You will encounter barriers and resistance – why? How can you succeed in spite of them?

## Developing Your Service Package and/or Pilots for Sustainability

- **Service Offerings --**
  - What problems need help solving?
  - How can you solve that problem?
  - What is unique about how you can solve that problem compared to others
  - Evidence Based programs, Social workers, Care Transitions, Regional Coverage, Distinctive Skills & Local Trust/Fit
- **Data --** Outcomes Driven and Measures of Success
- **Research --** Know the gaps and meet them



## Physicians, Hospital Groups & Plans

- Align with payment – whoever saves/gains should pay
- Target groups at full or partial risk for costly services (ER, inpatient) – check the DOFR
  - CAPG.org member, Hospital Association
- Build around key services paid by others
  - Waiver
  - LTSS
  - EB Programs
- Learn their quality metrics
- Pilot paid services for new pain points
  - Care transitions or new populations
  - Connect patient with PCP annual visit

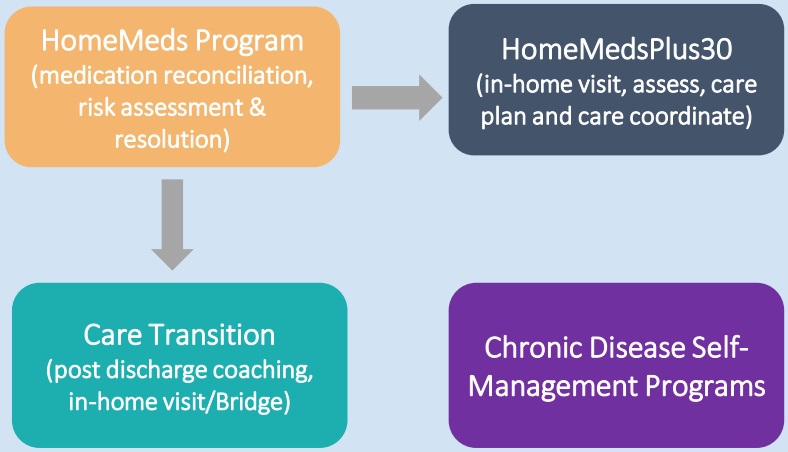
# Pilots – short-term risk for long-term relationships

- **Adapt and Flexibility** -- DON'T BE AFRAID TO TAKE A RISK!
  - Gauge level of buy-in at leadership & implementation level
    - Offer a no-fee pilot to prove yourself – get grant to pay for it!
    - Or reduced fee
    - Or full fee, if you can
  - Ask for 1 case, 1 cohort, 1 month. Show them what you can do and tell that story.
  - Define success for both parties
  - Trade measurement for payment
  - Track source of referrals to find CM Champion if it's not obvious
  - Meet often, speak openly – Joint Operating Committee
    - Find out where the partnership is causing pain for line staff



Provided through a full range of evidence-based programs and services complementing the clinical model

***Addressing the social determinants of health, a critical component across the interdisciplinary care team, improving health outcomes, the patient experience, and reducing costs***



## Successful Linkages for Elder Services of Merrimack Valley and HLCE

- Care Transitions Programs (CTP)
  - Contracts with two hospitals and two health plans
- Care Management and Long Term Service Support Care Programs
  - Contracts with five insurers all at risk
- Evidence based programs - two insurers, 2 ACOs
  - Targeted Patient Registry
  - Personalized Outreach
  - Motivational Interviewing
- Massachusett's Medicaid ACO-New Opportunity



# Solution #6: Addressing barriers & building long-term success

You will encounter barriers and resistance – why? How can you succeed in spite of them?

Lessons learned from contracting

# Common Dynamics and Drivers

- All are facing massive change – new populations and new payment structures
- Find clinical and financial alignment around populations who most need us -- chronic conditions/age/poverty
- Take a "right-sized" component – reduce ER, hospital and nursing home
- Assume we are an unrecognized essential provider – prepare to educate persistently on our value
- Address "buy vs. build"



# Bridging HCBS to new culture and regulations

- ***Payers often fear contracting with CBOs – to combat this we need to:***
  - Qualify for billing under Medical Loss Ratio/CPT codes, i.e., quality improvement &/or clinical care
  - Become accredited (NCQA, URAC, Joint Commission)
  - Become a Medicare Provider (ESMV)
  - Be able to respond in 24-48 hours
  - Cover entire service area with multiple languages
  - Meet IT security standards
    - Secure email, SFTP, annual testing/audit, etc.
  - Use certified EHR system
  - Provide evidence-based interventions
  - Jointly track/measure data demonstrating success/ROI

# Getting Through Other Roadblocks

- Social determinants – differentiate from the scope and skills of nurse case managers
  - Articulate unique skillset
  - Differentiate the home from telephonic CM
  - Demonstrate true partnership & support
  - Use stories
- Counter Myth that Social Services Are Free
  - Population data – who would actually qualify and how long would it take before services could begin?
  - Agency programs are different than a staff social worker
  - Regional delivery by multiple agency Networks bring local skills/trust, linguistic & cultural fit & new skills



# The Time is Now!!!

- Value based healthcare is transforming healthcare
- CBOs are essential for the system to meet the Triple Aim
- Need to be “bi-lingual/bi-cultural” healthcare and home and community
- We have a duty to complete an integrated system of care that builds on the realities of people’s lives
- The person is a key member of the healthcare team – their engagement is essential for best health outcomes
- Continuous reinforcement that “what happens at home” is key to health successes

# Questions & Answers:
# Please Submit Using the "Questions" Box

# Please join us for future webinars in the National Aging and Disability Business Center Series

**"Preparing Community-Based Organizations for Successful Health Care Partnerships: How to Make the Business Case"** – August 17

**"Leadership and Change Management for Community-Based Organizations"** – November 16

**Learn more and pre-register here:**

http://www.asaging.org/series/109/national-aging-and-disability-business-center-series

# Thanks to our funders for helping us be trailblazers

With gratitude to the
John A. Hartford Foundation,
Archstone Foundation, Tufts Health Plan Foundation, ACL & SCAN Foundation

**Part of the National Aging and Disability Business Center Series – a collaboration of n4a and ASA.**

## Questions about the National Aging and Disability Business Center?

Email us:

**BusinessCenter@n4a.org**