CHaSCI Community webinar

June 26, 2018

Cross-Sector Partnerships & Contract Development

www.chasci.org

CHaSCI
The Center for Health and Social Care Integration

Welcome to the CHaSCI Community!

What is CHaSCI?	The **Center for Health and Social Care Integration**, housed at Rush University Medical Center in Chicago
	A platform to translate and elevate learnings from care provided at Rush and by various local & national partners
What does CHaSCI do?	Develop and evaluate care models and innovative practices
	Spread care models to health systems, managed care, accountable care and community-based organizations
	Educate and train interprofessional trainees, educators, and practitioners on best and promising practices
	Run a peer learning community open to public: *the CHaSCI Community*
	Influence policy and reimbursement mechanisms

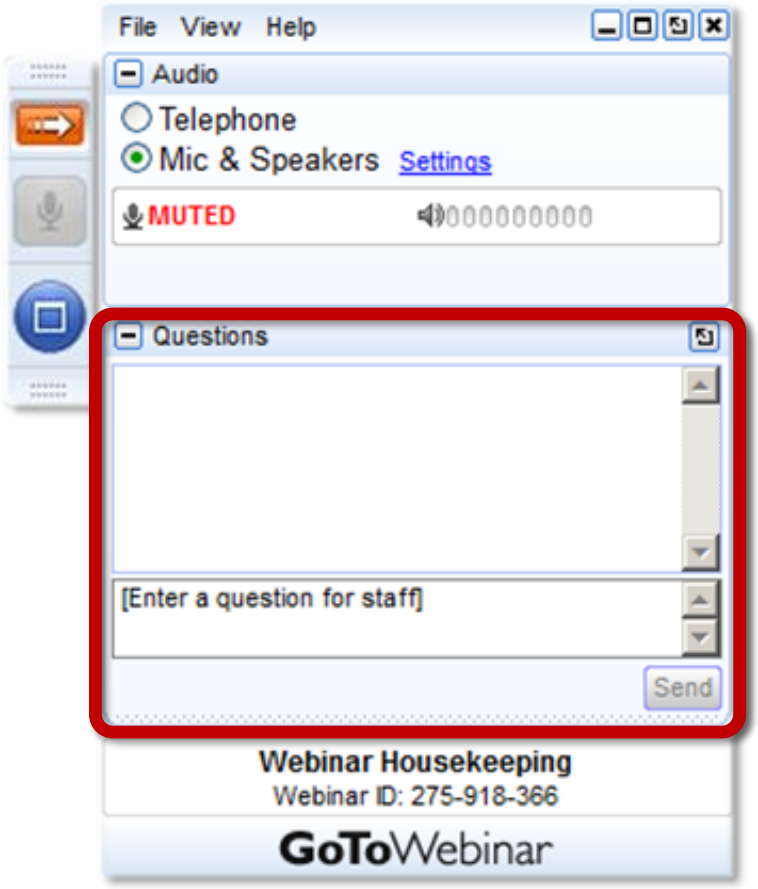
Source: Flourish Index, Publication In Progress, 2018, University of Louisville http://www.optimalaginginstitute.org/about-the-institute.

CHaSCI
The Center for Health and Social Care Integration

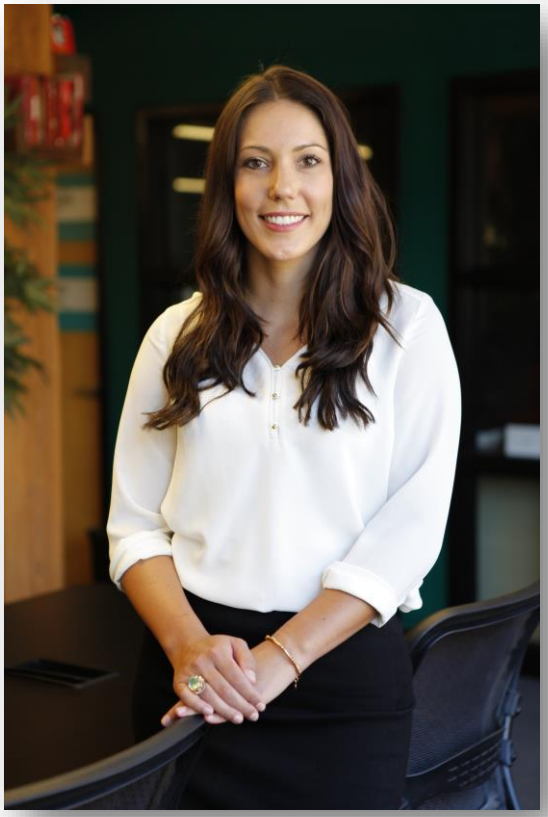
How to ask questions during the webinar

- To submit a question or comment, please type your questions into the question box (right)

- If at any point during the webinar you experience technical difficulties, please call Citrix tech support at 888-259-8414



Today's speaker



Jessica Grabowski, AM, LCSW

Executive Director, Coordinated Care Alliance

Conflict of interests

I do not have any significant financial interest/arrangement or affiliation with any organization/institution whose products or services are being discussed in this session or publication.

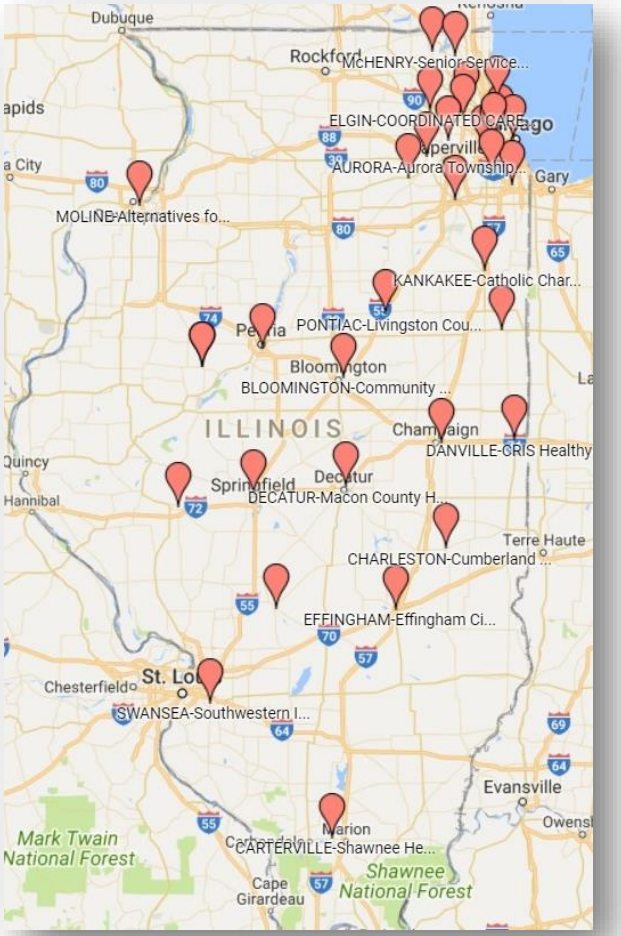
The planners, editors, faculty and reviewers of this activity have no relevant financial relationships to disclose. This presentation was created without any commercial support.

Objectives

- Identify opportunities for contractual partnerships between healthcare entities and community-based organizations
- Summarize considerations for community-based organizations as they launch new initiatives in partnership with healthcare entities
- Describe specific examples from Illinois of facilitators and challenges to successful contract development

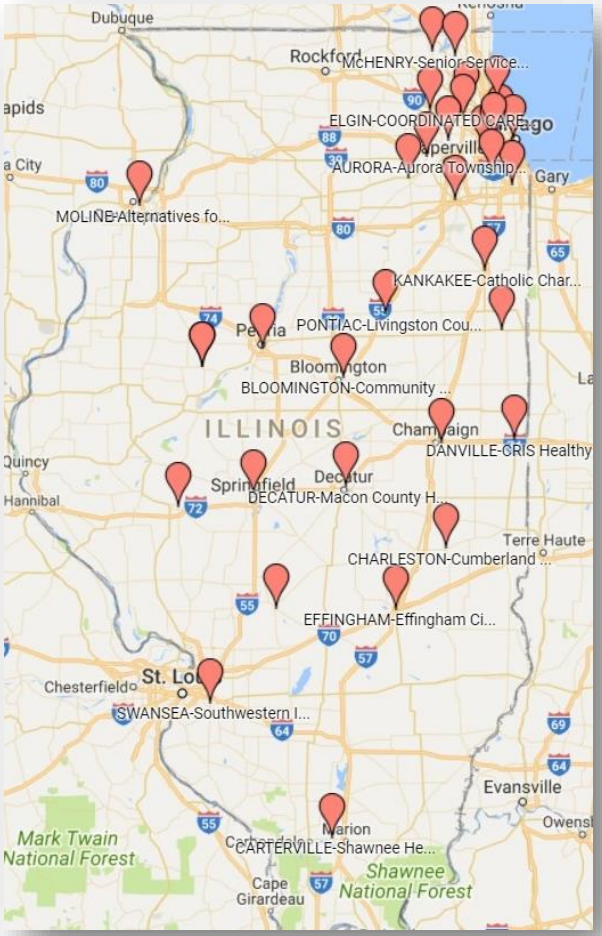
COORDINATED CARE ALLIANCE (CCA)

- Statewide network of community-based organizations in Illinois that provide coordination and care transition support to at-risk populations
- Focus 60+ y/o population and individuals with disabilities
- 25+ community-based member organizations
- Offer a single point of entry to statewide services
- Partner with payers, hospitals, and skilled nursing facilities

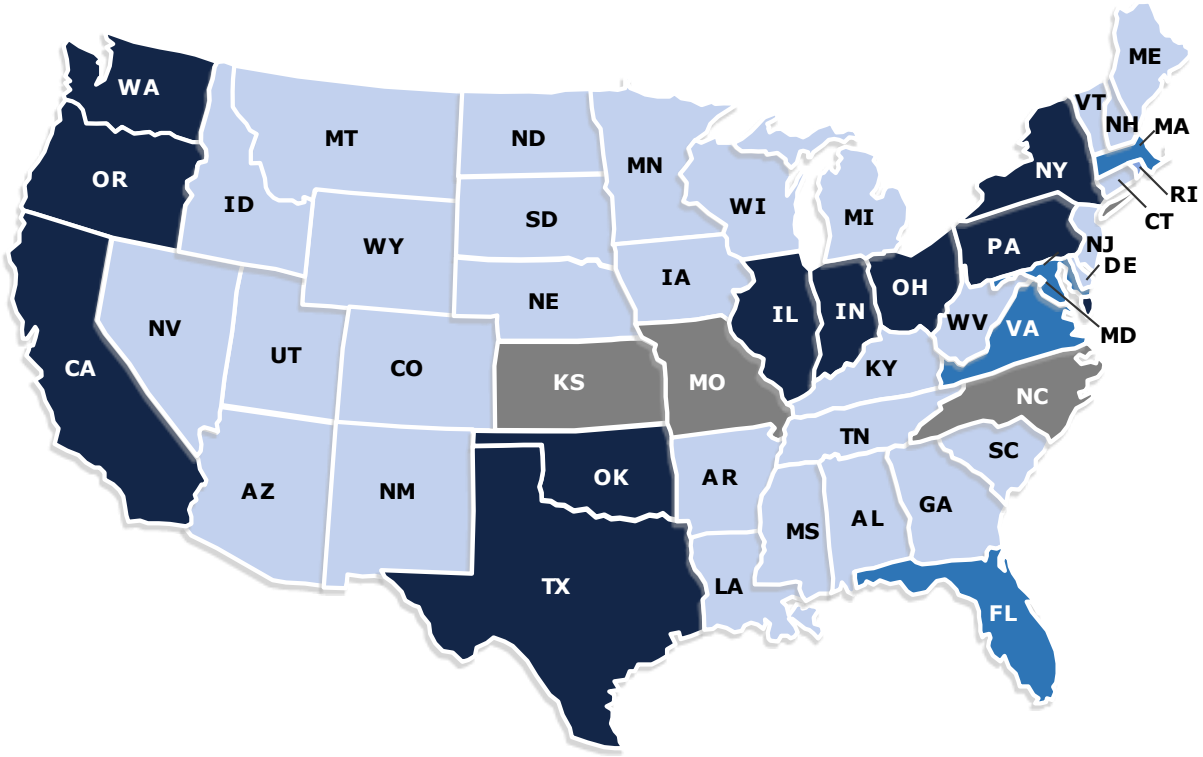


MEMBER ORGANIZATIONS

- Autonomous Case Management (ACM Care)
- Alternatives for the Older Adult
- Aging Care Connections
- Catholic Charities of the Archdiocese of Chicago
- Catholic Charities, Diocese of Joliet
- Community Care Systems
- DuPage Senior Services
- Kenneth Young Center
- North Shore Senior Center
- Oak Park Township Senior Services
- PLOWS Council on Aging
- Senior Services Associates
- Senior Services of Will County
- Solutions for Care
- Care Horizon (Cumberland And Associates)
- CRIS Healthy-Aging Center
- Ford County
- Iroquois County
- Livingston County
- Montgomery County Health Dept
- Prairie Council on Aging
- Senior Services of Central IL
- Starting Point (Macon County Health Dept)
- Southwestern IL visiting Nurse Association
- Shawnee Health Service
- Senior Services of Effingham County



MANY STATES HAVE STATEWIDE NETWORKS OF CBOS IN PLACE OR IN DEVELOPMENT



Networks in Development

[1] Not a full statewide network

CA Partners At Home Network
FL Florida Health Network
IL Coordinated Care Alliance; Illinois Community Health and Aging Collaborative
IN Indiana Aging Alliance
KS Kansas Association of Area Agencies on Aging
MA Healthy Living Center of Excellence
MD Living Well Center of Excellence
MO Kansas City Integrated Care Network, MO[1]
NC Community Health Partners[1]
NY Western New York Integrated Care Collaborative[1]
NY NYC Department for the Aging[1]
OH Direction Home
OR Oregon Wellness Network
OK Oklahoma Aging & Disability Alliance[1]
PA Aging Well, LLC & Comprehensive Care Connections (C3)
TX Texas Healthy at Home
VA Virginia Area Agencies on Aging – Caring for the Commonwealth (VAAACares)
WA Conexus Health Resources[1]

SOCIAL DETERMINANTS OF HEALTH

- The World Health Organization (WHO) defines the SDH as **"the conditions in which people are born, grow, live, work and age, including the health system."**

- The Centers for Disease Control and Prevention (CDC) **"the social environment, physical environment, health services and structural and societal factors."**

- The Robert Wood Johnson Foundation (RWJF) **"Health starts where we live, learn, work and play."**

SOCIAL DETERMINANTS OF HEALTH IMPACT

Social, behavioral, and environmental factors significantly impact specific health issues:

70% + of certain types of cancer

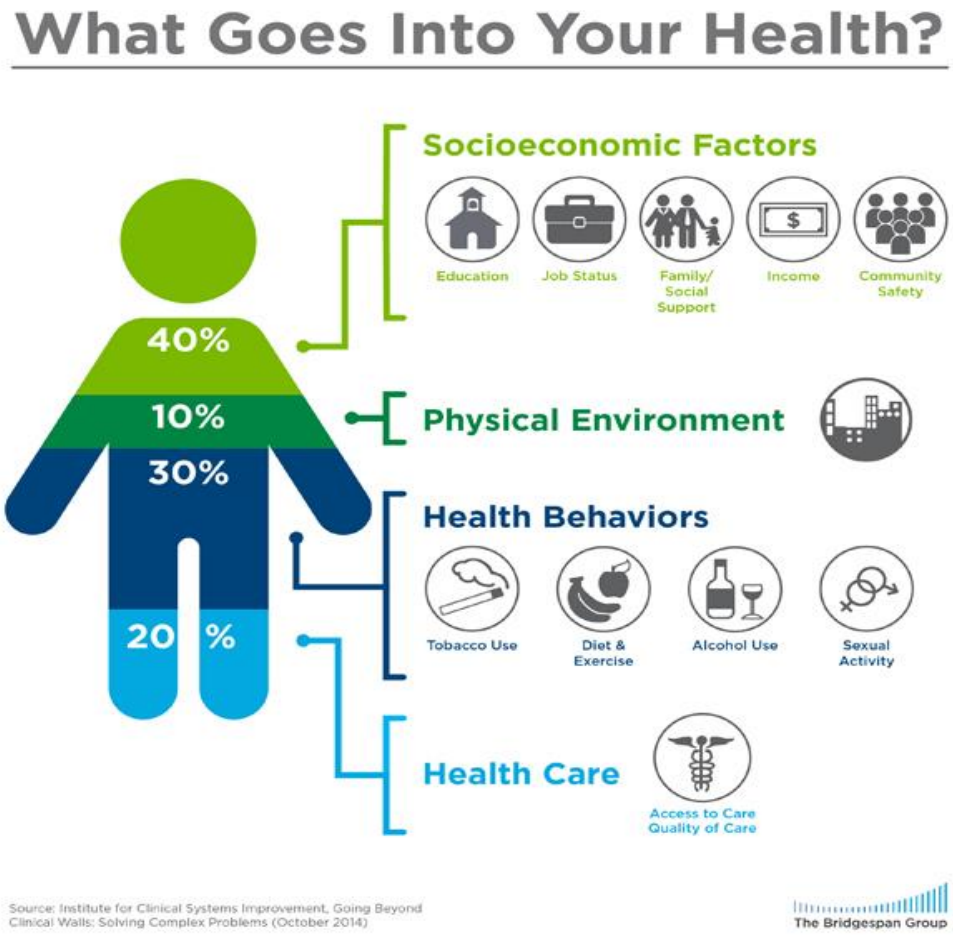
80% of heart disease

90% of stroke cases

(Bradley et al., 2016)

40-50% of readmissions are related to psychosocial problems and lack of community support resources.

(E.K. Proctor et al, 2000)



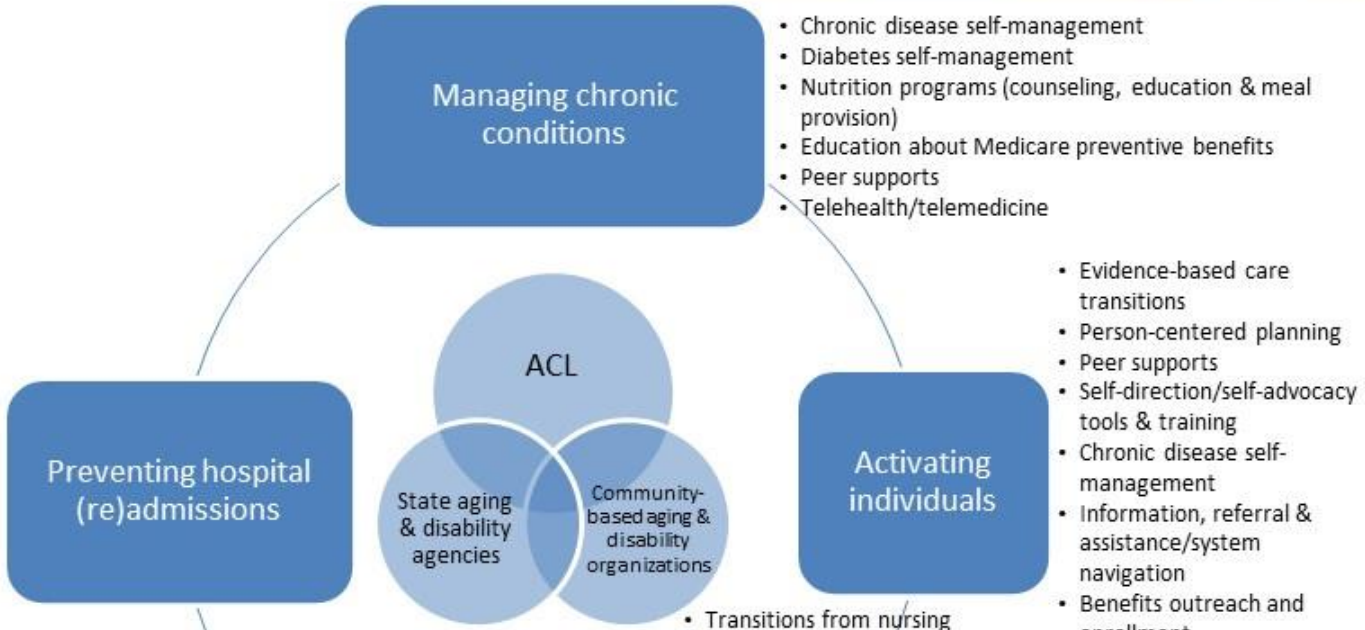
THE IMPACT OF WHAT YOU DON'T SEE IN A HEALTHCARE INSTITUTION






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

Administration for Community Living



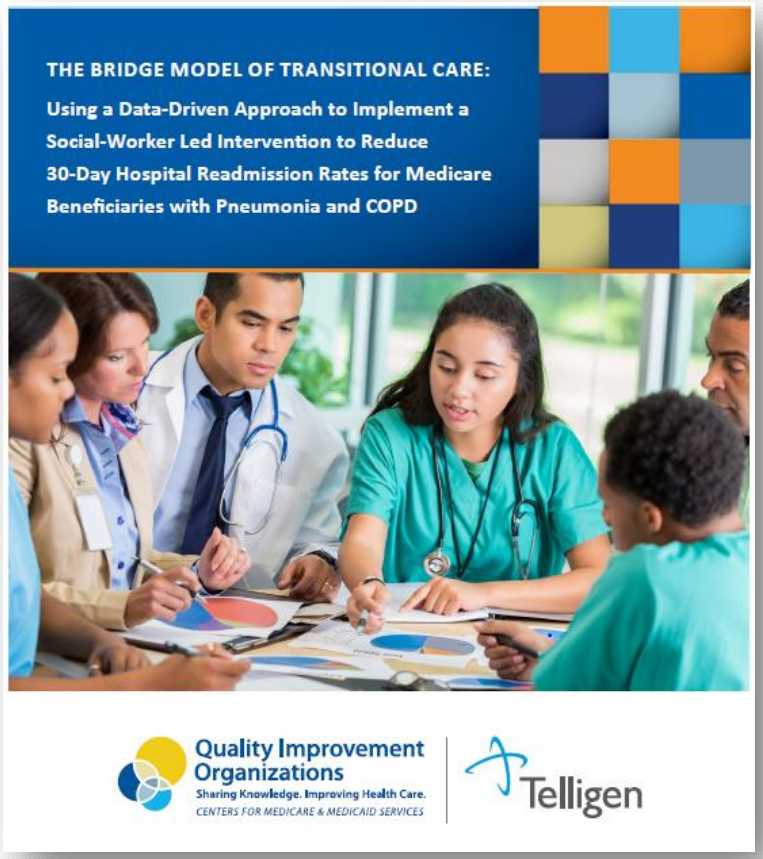
- Chronic disease self-management
- Diabetes self-management
- Nutrition programs (counseling, education & meal provision)
- Education about Medicare preventive benefits
- Peer supports
- Telehealth/telemedicine

- Evidence-based care transitions
- Person-centered planning
- Peer supports
- Self-direction/self-advocacy tools & training
- Chronic disease self-management
- Information, referral & assistance/system navigation
- Benefits outreach and enrollment
- Employment related supports
- Community/beneficiary/caregiver engagement
- Community training
- Supported decision-making
- Assistive technology
- Financial management services
- Independent living skills
- Behavioral health services
- Nutrition education

- 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

- 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

CCA MEMBERS IMPLEMENT A DATA-DRIVEN TRANSITIONAL CARE PROGRAM



Telligen (IL's Quality Improvement Organization, QIO) reports on a CCA's member transitional care program:

- "36 percent and 20 percent reductions in pneumonia and COPD readmissions, respectively, among Medicare beneficiaries"

"How They Did It: Quantifying the Benefits of Care Transitions." Telligen, 26 Apr. 2017, telligenqinqio.com/news/quantifying-benefits-care-transitions/.

CBO SERVICES	MEMBER OUTCOMES	PLAN OUTCOMES
Care Coordination	Increase education	Decrease ED utilization
Home visits	*(discharge plan, chronic care mgt, nutrition, falls education, caregiver)*	Decrease OBS utilization
Home surveys and HRA	Decrease adverse effects *(medication mismanagement, falls from nonslip rugs, falls from doing household chores without support)*	Decrease Inpt admissions
Care transitions	Increase pt activation	Decrease readmissions
Chronic disease management	Decrease client and caregiver stress	Decrease LOS at hospital
Fall prevention	Decrease loneliness *(homemaker support, home visits)*	Decrease short and long term SNF utilization and LOS
Medication management		Decrease use of out of network providers
Nutrition		Increase member satisfaction and ratings
Transportation		
Home and family assessments		
Health benefits counseling		
Family Caregiver support & respite services		

POTENTIAL PARTNERS

- Hospital/Hospital System
- Skilled Nursing Facilities & Assisted Living
- Managed Care Organizations (MCOs)
- Accountable Care Organizations (ACOs)
- Medical Groups
- Primary Care Physicians Office
- Federally Qualified Health Centers (FQHC)
- Senior Housing/Retirement Centers

ARE YOU READY FOR A PARTNERSHIP?

- Aging and Disability Business Institute: Readiness Assessment Tool
- Nonprofit Finance Fund: Nonprofit Readiness for Health Partnership tool (excerpt):

Workflow Processes

Benchmark | *Our workflow processes allow the partnership to deliver services effectively and efficiently.*

Guiding Questions

- In what ways do partners interact with each other?
- To what extent has the way our interaction been formalized through written or verbal agreements or protocols?
- In what ways do partners communicate about challenges or opportunities in delivering services? How often?
- How do current processes and protocols support our ability to adapt to changing target population demands and service delivery needs?

Notes

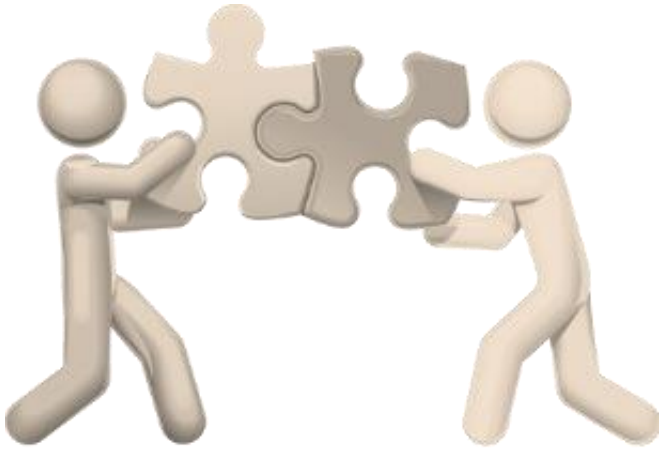
Assessment

Circle rating from 1-5: **1** *Needs development* **2** **3** *Developing* **4** **5** *Well-Developed*

5

DEVELOPING PROGRAM PACKAGES

- What do THEY need?
  - What outcomes are important to them? What about their potential partners?
    - What quality measures are relevant to them? (Think beyond readmissions!)
  - Service delivery model
  - Financial structure
  - Data collection processes



OUTCOME MEASURES BY ENTITY

Health Plans	Hospital / ACO	Medical Groups
• Quality Ratings • Member Satisfaction • Member Activation • Decreased unnecessary utilization • Connection with community resources (SDOH)	• Reduces length of stay • Reduced ER visits • Reduced readmission • Improved patient mix (tertiary rather than chronic) • Safe transition • Connection with community resources (SDOH)	• Improved satisfaction • Increased referrals • Decreased no-show • Time savings for providers • Improved safe transitions • Improved quality, value, accountability (Pay for Performance: MACRA, MIPS)

VALUE PROPOSITION

- What is your value add to a potential partner?
  - Program with x outcomes and therefore, ROI
  - Evidence-based
  - Trusted community organization
  - Home visits
  - Cost effective with affordable workforce
  - Efficient with short response time
  - Covers entire service area
  - Gather data that the partner currently doesn't have access to
  - Accreditation, Business Enterprise Program

RETURN ON INVESTMENT RESOURCES

The Commonwealth Fund
A Century of Advancing Health Care for All

Affordable, quality health care. For everyone.

Before You Start the ROI Calculator

Make your selections

You will see two menus. For each menu you should select only the options relevant for your specific planning scenario or non-medical intervention. The calculator subsequently will omit references to input and output fields that are not relevant.

Social Services Menu

Select the specific social service or services that might be offered as part of the cross-sectional partnership

- Nutritional Support
- Transportation
- Home modifications
- Housing
- Counseling: Legal, Financial & Social Support
- Overall care management
- Other

Medical Utilization Menu

Select the medical utilization domain(s) from the list below that you anticipate the previously identified social service(s) in the Social Services Menu will affect. (If you believe that certain utilization domains will be influenced by addressing the social determinants of health, but that these changes will only affect third parties that are not part of the partnership agreement, we suggest that you do not select those domains.)

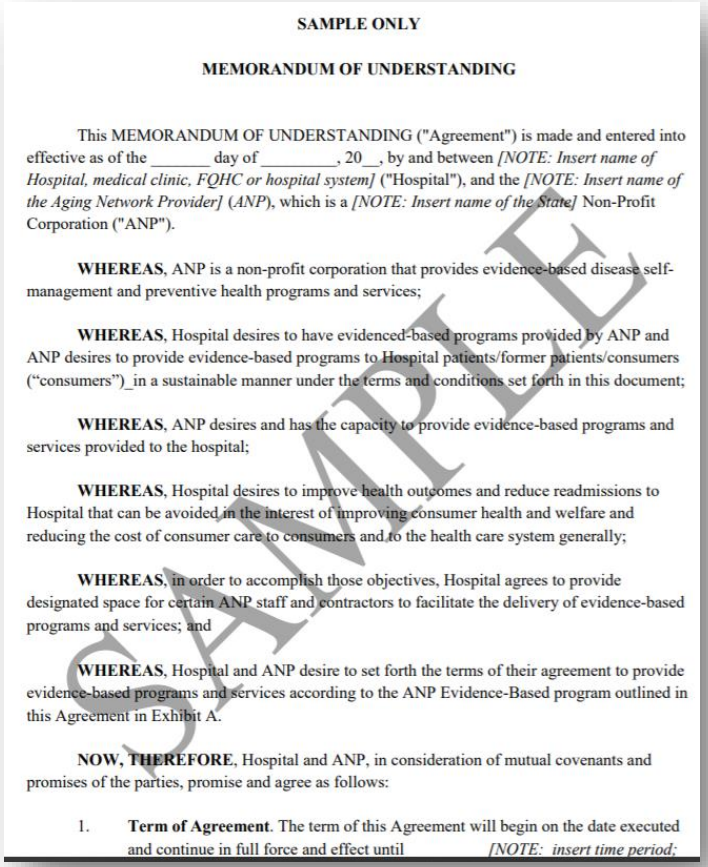
- Hospital Admissions
- Hospital Readmissions
- Skilled Nursing (SNF)/Rehab Facility Admissions
- Emergency Department (ED) Visits
- Falls

FROM FIRST CONTACT TO FIRST MEETING…

- Connecting with the right people
- What information are you providing?
- Follow up

DEVELOPING A CONTRACT

- Know your worth
  - Recognize strengths *and* weaknesses
- Know your costs
- Talk through the details of data sharing
- How will you evaluate your project?
- Compare with samples online (such as this one, shared by NCOA)



SAMPLE ONLY

MEMORANDUM OF UNDERSTANDING

This MEMORANDUM OF UNDERSTANDING ("Agreement") is made and entered into effective as of the _____ day of _____, 20__, by and between *[NOTE: Insert name of Hospital, medical clinic, FQHC or hospital system]* ("Hospital"), and the *[NOTE: Insert name of the Aging Network Provider]* (*ANP*), which is a *[NOTE: Insert name of the State]* Non-Profit Corporation ("ANP").

WHEREAS, ANP is a non-profit corporation that provides evidence-based disease self-management and preventive health programs and services;

WHEREAS, Hospital desires to have evidenced-based programs provided by ANP and ANP desires to provide evidence-based programs to Hospital patients/former patients/consumers ("consumers")_in a sustainable manner under the terms and conditions set forth in this document;

WHEREAS, ANP desires and has the capacity to provide evidence-based programs and services provided to the hospital;

WHEREAS, Hospital desires to improve health outcomes and reduce readmissions to Hospital that can be avoided in the interest of improving consumer health and welfare and reducing the cost of consumer care to consumers and to the health care system generally;

WHEREAS, in order to accomplish those objectives, Hospital agrees to provide designated space for certain ANP staff and contractors to facilitate the delivery of evidence-based programs and services; and

WHEREAS, Hospital and ANP desire to set forth the terms of their agreement to provide evidence-based programs and services according to the ANP Evidence-Based program outlined in this Agreement in Exhibit A.

NOW, THEREFORE, Hospital and ANP, in consideration of mutual covenants and promises of the parties, promise and agree as follows:

1. **Term of Agreement**. The term of this Agreement will begin on the date executed and continue in full force and effect until *[NOTE: insert time period;*

SAMPLE

PAYMENT MODELS IN CBO CONTRACTING

- Fee for service
- Case rate
- Capitation
- Gain-sharing

PAY STRUCTURE EXAMPLE

Table 1: Continued

Payer/ Provider	Criteria Used to Evaluate IOA	Contract Duration	Service Package	Population to Be Served	Pricing Structure	Implementation Status
Health Plan of San Mateo (HPSM)	Formal RFP process	11-month term, with option to renew for four additional years	• Intensive care management services (skilled nursing facility to home) • Coordination of services and waivers • Management of referrals and assessments	Estimated 120 persons in the first 11 months and 875 over 5 years; seniors and persons with disabilities in San Mateo County who have Medi-Cal only, as well as some with CareAdvantage/ Cal MediConnect; mostly persons transitioning out of nursing facilities, but also some who need services and supports to remain in their homes	Year 1: Cost plus margin; Years 2-4: Cost plus shared savings (model yet to be developed). In addition, incentives for reaching key performance indicators will be explored after a period of collecting outcome data.	In implementa-tion

PAY STRUCTURE EXAMPLE, CONT'D

Table 1: Summary of the District Contracts with California's Health Care Sector

Payer/ Provider	Criteria Used to Evaluate the District	Contract Duration	Service Package	Population to Be Served	Pricing Structure	Implementation Status
A national managed care organization	Ability and existence of established programs to support the reduction of emergency room visits and skilled nursing facility usage	12 months	Case management, care transitions, health promotion self management programs	Approximately 348 persons; older adults with chronic conditions, disabled persons, and any adult with a chronic condition	Fee-for-service	Current

PAY STRUCTURE EXAMPLE, CONT'D

Table 1: Summary of BACS Contracts with California's Health Care Sector						
Payer/ Provider	**Criteria Used to Evaluate BACS**	**Contract Duration**	**Service Package**	**Population to Be Served**	**Pricing Structure**	**Implementation Status**
Alameda Alliance Health Plan	Utilization of emergency services based on baseline and after treatment	One year with annual option for renewal	Medical respite, care coordination, and discharge meal program	100 clients in Alameda County; dual eligibles, homeless, high-utilizers	Fee-for-service	In implementation
Sutter Hospital/ LifeLong Medical Care	Utilization of emergency services first 30 days post-in-patient discharge	One year with annual option for renewal	Medical respite	50-100 homeless clients at Sutter Hospital Alameda County	Fixed price per bed for set number of beds per year	Fully implemented

YOU GET A CONTRACT… NOW WHAT?

- Data/IT needs
- Continued relationship building at all levels
  - Structured/Unstructured
    - Weekly Check-ins
    - Scheduled Meetings
- Mergers/Buy outs
- Staff turnover

LESSONS LEARNED

- Change/Adaptation from both sides
- Getting in the door & relationship building
- Being able to articulate why they should buy vs build
- Be flexible
- Data collection and analysis to obtain quantifiable outcomes
- Takes a lot of time and patience.. Plan for needing various revenue streams in the beginning

LESSONS LEARNED FROM COMMUNITY-BASED REPLICATION SITES

Recommendations resulting from qualitative study with 13 community-based organizations trained in Bridge

Identify champions from health care leadership

Aim for contractual agreements w/ partners *(help avoid obstacles due to staff turnover or acquisition)*

Make sure program leaders understand changes in payment models

Diversify funding

Develop plan for evaluation and quality improvement from beginning – and invest in data platforms to enable it

Nurture internal champions *(help grow program AND avoid staff turnover with innovative roles)*

Clinical supervision helps strengthen social work therapeutic skills as part of intervention

Source: Xiaoling Xiang, Sheria G. Robinson-Lane, Walter Rosenberg & Renae Alvarez (2018): Implementing and sustaining evidence-based practice in health care: The Bridge Model experience, Journal of Gerontological Social Work, DOI: 10.1080/01634372.2018.1445154

DON'T REINVENT THE WHEEL

- There are many resources out there for you to use and learn from!
  - Advisory Board
  - Aging and Disability Business Institute
  - American Society on Aging
  - The Commonwealth Fund
  - Health Affairs
  - National Council on Aging
  - National Transitions of Care Coalition
  - Nonprofit Finance Fund
  - Scan Foundation

Thank you for joining our first CHaSCI Community webinar!

QUESTIONS?
THOUGHTS TO SHARE?

JESSICA GRABOWSKI
630-915-620, JGRABOWSKI@COORDINATEDCAREALLIANCE.ORG

BONNIE EWALD
BONNIE_EWALD@RUSH.EDU

CONTACT TO LEARN MORE ABOUT CHASCI SERVICES & SUPPORTS

Coordinated Care Alliance

CHaSCI
The Center for Health and Social Care Integration