Aging and Disability BUSINESS INSTITUTE

Connecting Communities and Health Care

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Successful Partnerships between Community-Based Organizations and Health Care Partners

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VAAACares®

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Aging and Disability Business Institute
National Association of Area Agencies on Aging

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Session Objectives:

I. Current Status of Community-Based Organization (CBO) Engagement with Health Care Entities

II. Overview of Traditional Approach to Aging Services Delivery

III. Prospect for Growing Traditional Funding Streams

IV. Models for Engaging Healthcare Providers and Payers

The Business Institute

Vision: To improve the health and well-being of older adults and people with disabilities through improved and increased access to quality services and evidence-based programs.

Mission: To build and strengthen partnerships between aging and disability CBOs and the health care system.

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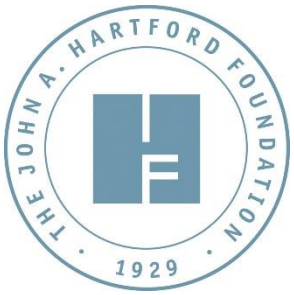
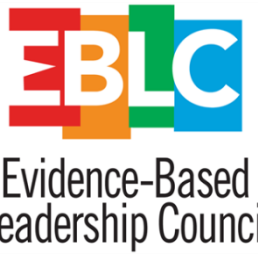
Business Institute Funders

- The John A. Hartford Foundation
- The Administration for Community Living
- The SCAN Foundation
- The Gary and Mary West Foundation
- The Colorado Health Foundation
- The Buck Family Fund of the Marin Community Foundation



Business Institute Partners

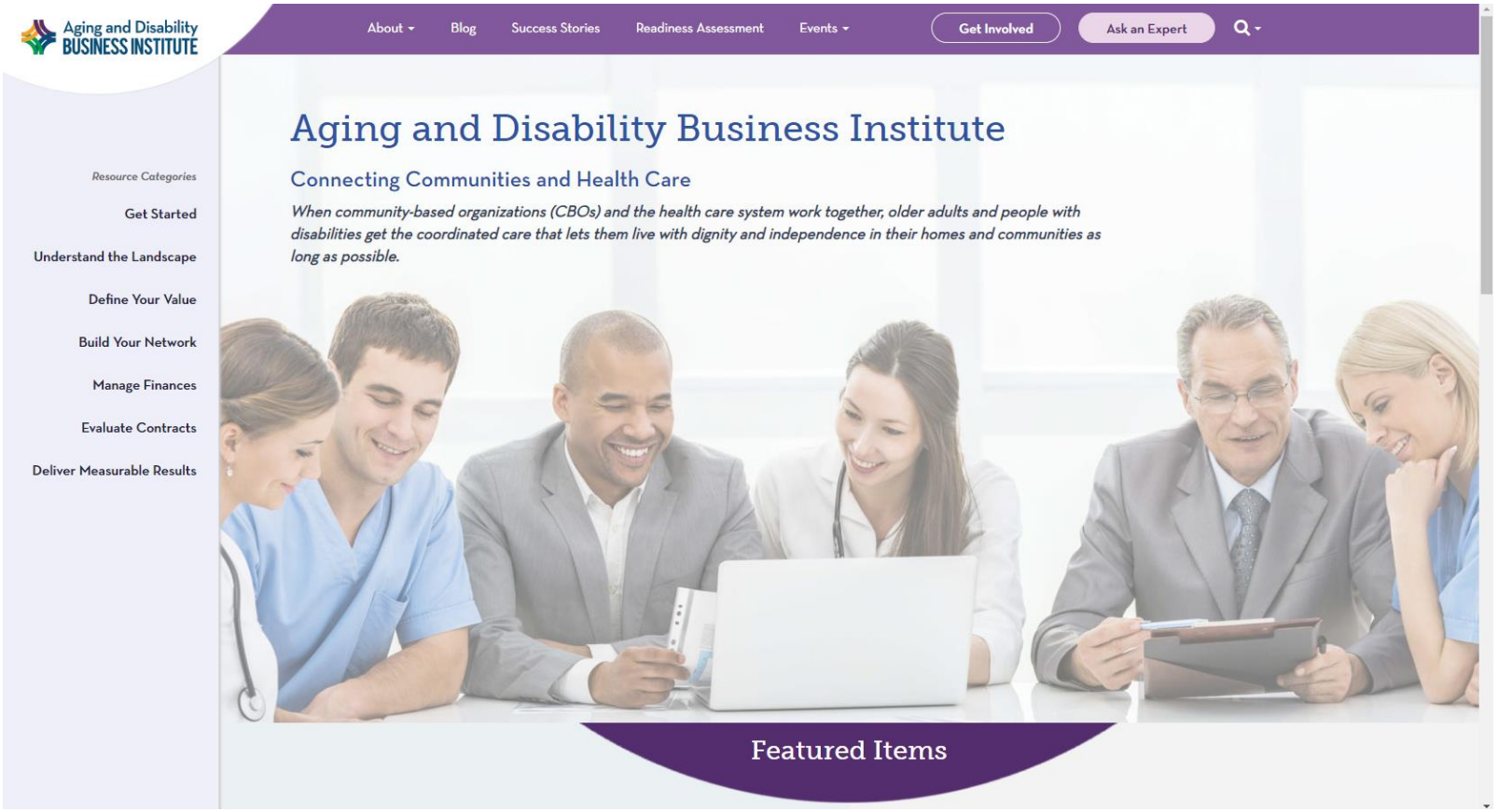
- National Association of Area Agencies on Aging
- Independent Living Research Utilization/National Center for Aging and Disability
- American Society on Aging
- Partners in Care Foundation
- Elder Services of the Merrimack Valley/Healthy Living Center of Excellence
- National Council on Aging
- Meals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



Goals & Activities

- Build a national resource center
- Develop an assessment tool to determine the capacity of CBOs
- Provide training and technical assistance
- Conduct an outreach and educational campaign targeting the health care sector
- Systems Change Through Stakeholder Engagement

www.aginganddisabilitybusinessinstitute.org



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Readiness Assessment Modules

Internal

- Change Readiness
- Strategic Direction Readiness
- Operational Readiness
- Management Readiness
- Leadership Readiness

External

- External Market Readiness
- Partnership Development Readiness

Training and Technical Assistance

- ❑ Monthly Webinar Series
- ❑ Conferences
- ❑ State & Regional Business Acumen Trainings
- ❑ Case Studies
- ❑ Learning Collaboratives
- ❑ Targeted Technical Assistance
- ❑ Consulting Services

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Common TA Requests

- Network Development
- General contracting
- Developing a value proposition
- Information technology infrastructure
- Pricing and return on investment (ROI) analysis
- Accreditation, metrics and quality systems
- Medicare billing

RFI Survey

To Take the Pulse of CBO-Health Care Partnerships

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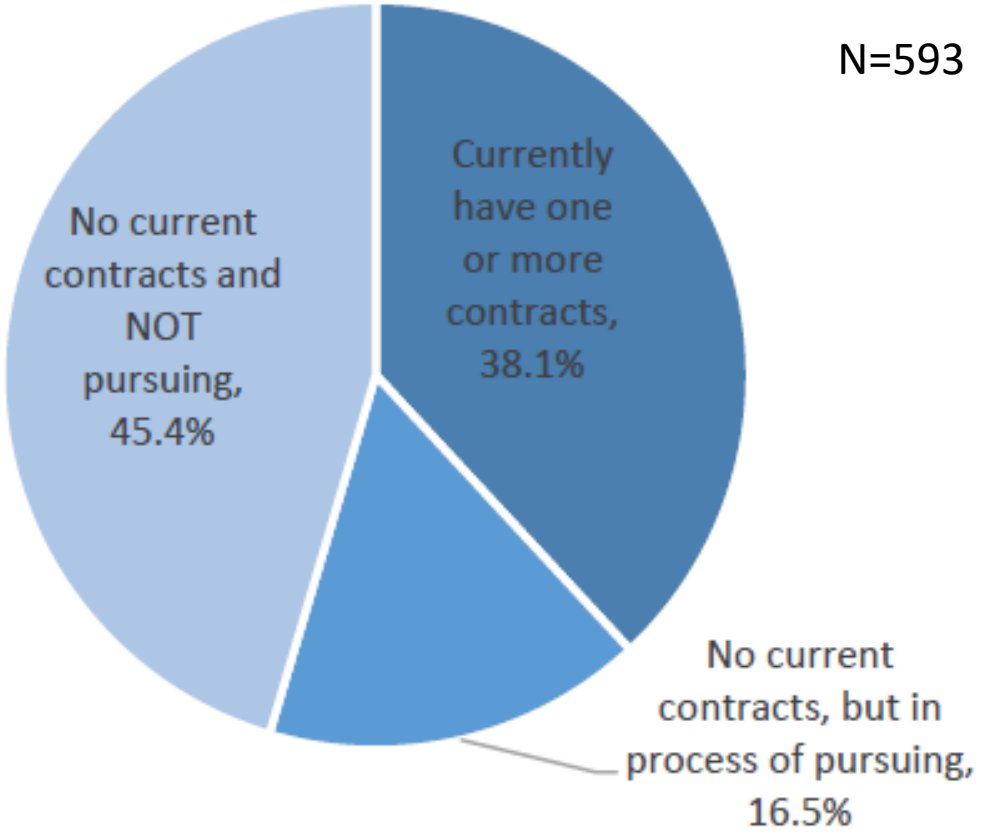
Survey Methods

- Partnered with Scripps Gerontology Center at Miami University
- Disseminated via email directly to 623 AAAs and 313 CILs
- Key national agencies shared the survey with other CBOs (THANK YOU!)
- Survey was in the field for 5 weeks between July and August of 2017 with a total of 593 respondents

RFI Survey Results

N=593



Data source

2017 data: Kunkel, S.R., Straker, J.K., Kelly, E.M., & Lackmeyer, A.E. (2017). Community-based organizations and health care contracting: Research brief. Scripps Gerontology Center, Oxford, OH.

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Contracting Status by Agency Type

	Yes	No, pursuing	No, not pursuing	Total
Area Agency on Aging (AAA)	144 (41.0%)	63 (17.9%)	144 (41.0%)	**351**
Center for Independent Living (CIL)	39 (32.8%)	15 (12.6%)	65 (54.6%)	**119**
Other CBO	41 (38.7%)	20 (18.9%)	45 (42.5%)	**106**

Data source

2017 data: Kunkel, S.R., Straker, J.K., Kelly, E.M., & Lackmeyer, A.E. (2017). Community-based organizations and health care contracting: Research brief. Scripps Gerontology Center, Oxford, OH.

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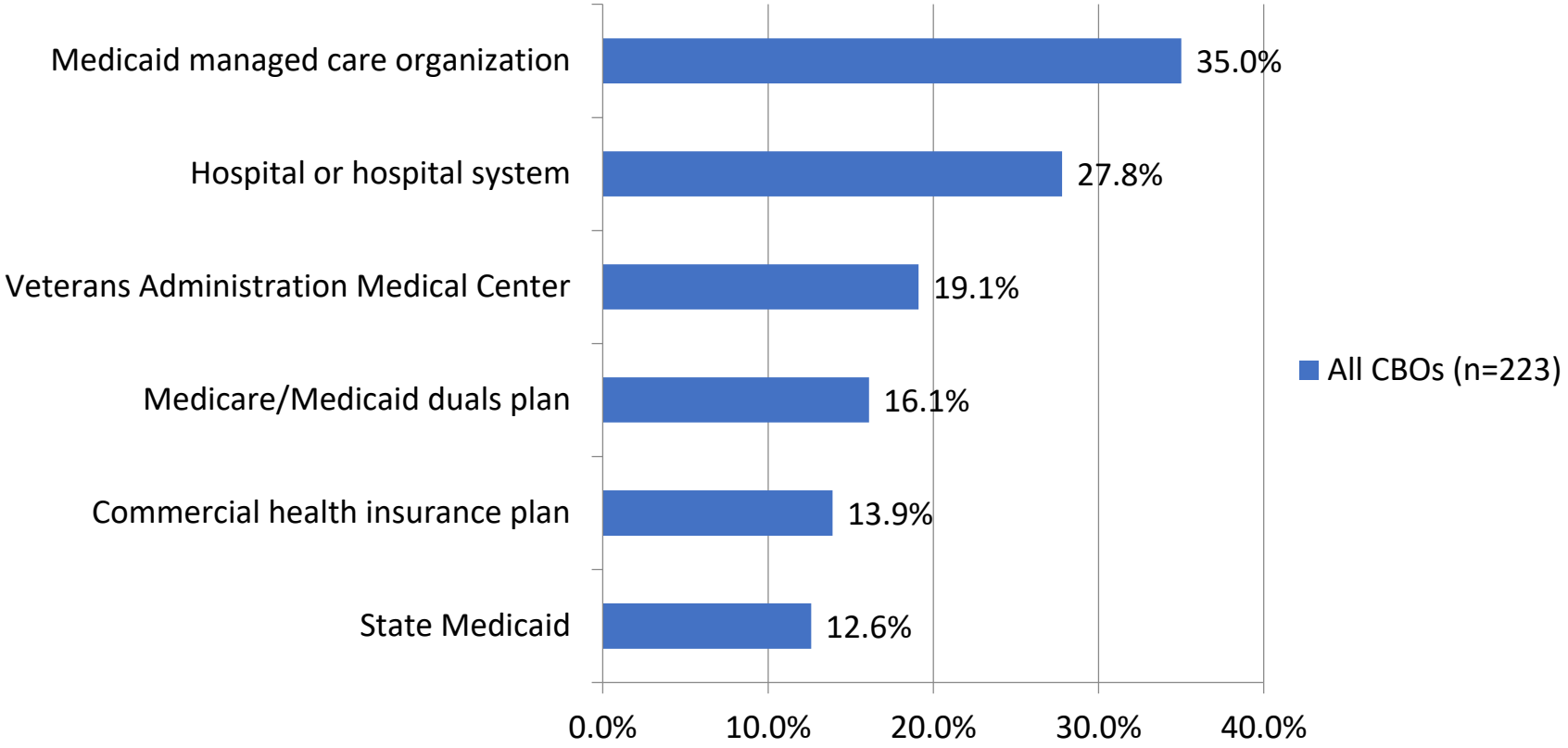
Most Common Health Care Partners for Organizations Contracting with Health Care Entities



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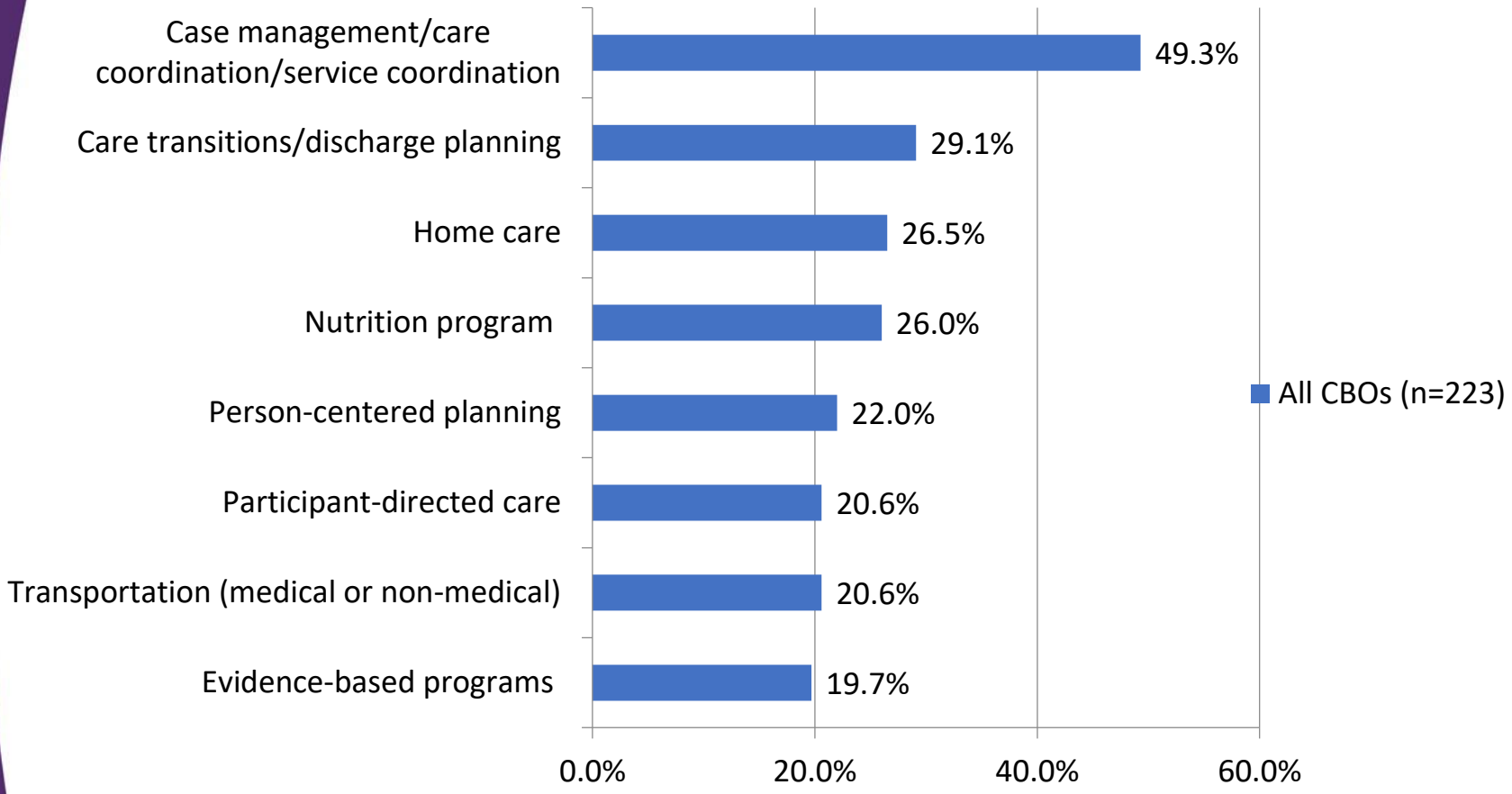
Most Common Services Provided through Contracts by Organizations Contracting with Health Care Entities



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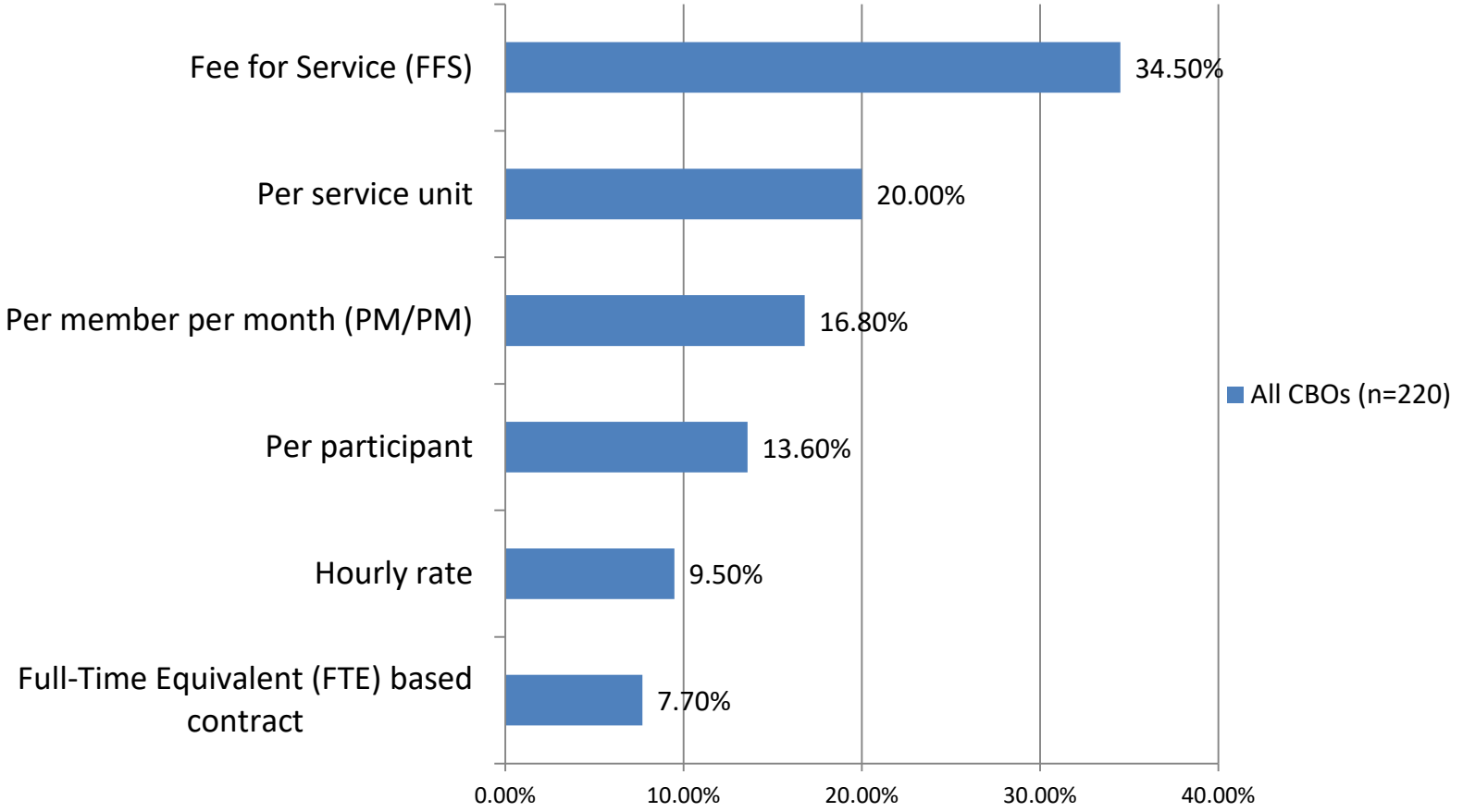
Most Common Payment Models in Contracts



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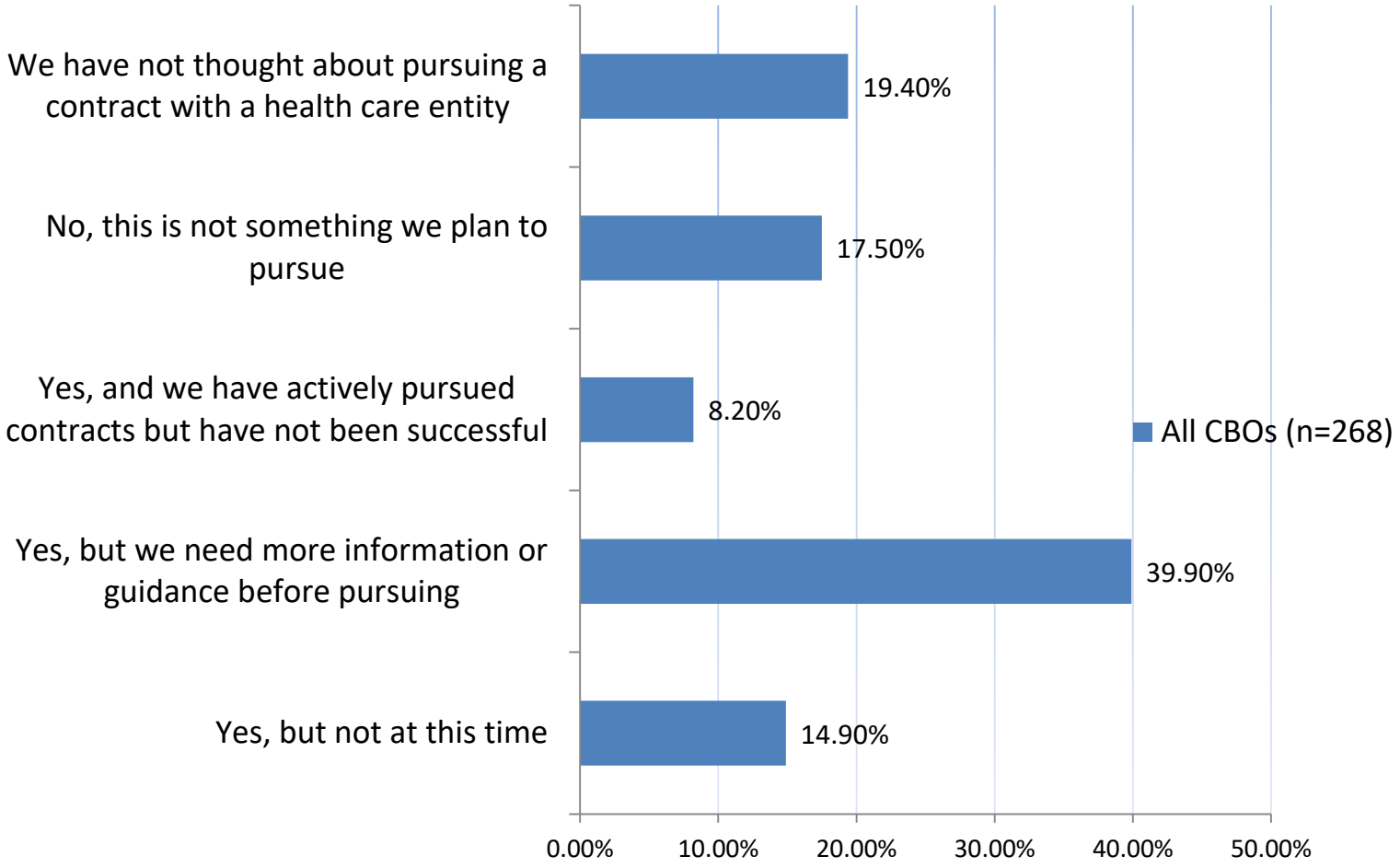
2017 data: Kunkel, S.R., Straker, J.K., Kelly, E.M., & Lackmeyer, A.E. (2017). Request for information: Community-based organizations and health care contracting. Scripps Gerontology Center, Oxford, OH.

Interest in Contracting of Respondents without Contracts



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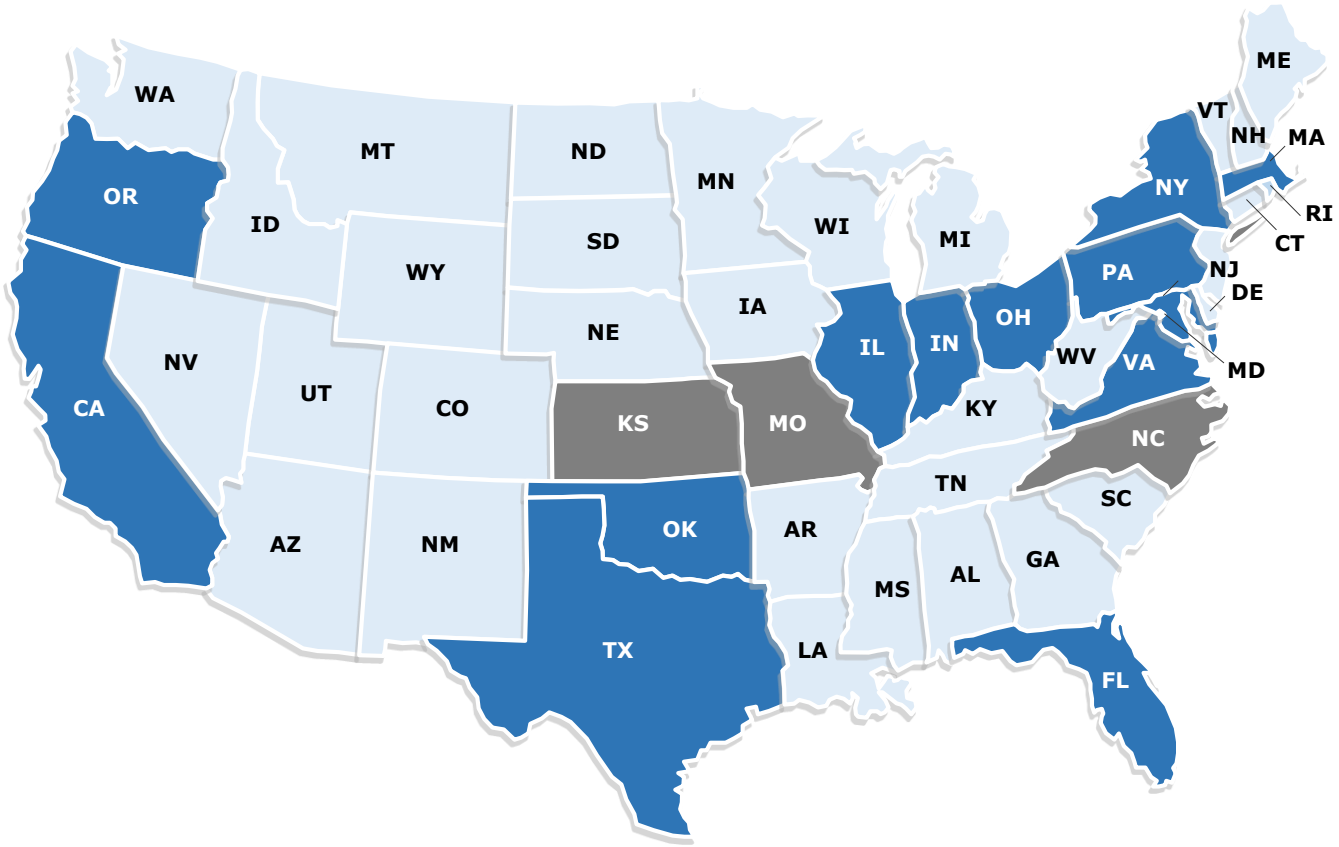
CBO Networks

- CA Partners At Home Network
- FL Florida Health Network
- IL Illinois Community Health and Aging Collaborative & Coordinated Care Alliance
- 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)



Networks in Development

[1] Not a full statewide network

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https://www.healthaffairs.org/do/10.1377/hblog20180130.620899/full/

HEALTH AFFAIRS BLOG

RELATED TOPICS:
DISABILITIES | OLDER ADULTS | COSTS AND SPENDING | MEDICAID | LONG-TERM SERVICES AND SUPPORTS | NURSING HOMES | MEDICARE ADVANTAGE | CHRONIC DISEASE | VALUE | MEDICARE

Health Care And Community-Based Organizations Have Finally Begun Partnering To Integrate Health And Long-Term Care

Nora Super, Mary Kaschak, Elizabeth Blair

FEBRUARY 2, 2018 10.1377/hblog20180130.620899

TOOLS SHARE

Community-based organizations such as area agencies on aging (AAAs) and centers for independent living (CILs) have served for decades as cost-effective, trusted, and proven resources for addressing the health-related social needs of older adults and people with disabilities, including long-term care needs. Yet, until recently, the health care sector has had little awareness of the value of these home and community-based resources. AAAs and other community-based organizations have typically relied on traditional funding sources such as the Older Americans Act of 1965. However, these funds have remained flat or declined, despite upward growth

Related

CONTENT
- Long-Term Services & Supports

TOPICS
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- Older Adults
- Costs And Spending
- Medicaid
- Long-Term Services And Supports
- Nursing Homes
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"Health Care And Community-Based Organizations Have Finally Begun Partnering To Integrate Health And Long-Term Care," Health Affairs Blog, February 2, 2018. DOI: 10.1377/hblog20180130.620899

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Next Steps

- RFI 2 Survey closed in July
- New questions added on challenges in contracting, data collection, and impact of contracting on the organization
- Will provide cross-sectional data and longitudinal comparisons to RFI 1

A Case Study

VAAACares®

A "subsidiary" of Bay Aging

Eastern Virginia Care Transitions Partnership (EVCTP) is the regional division of VAAACares®

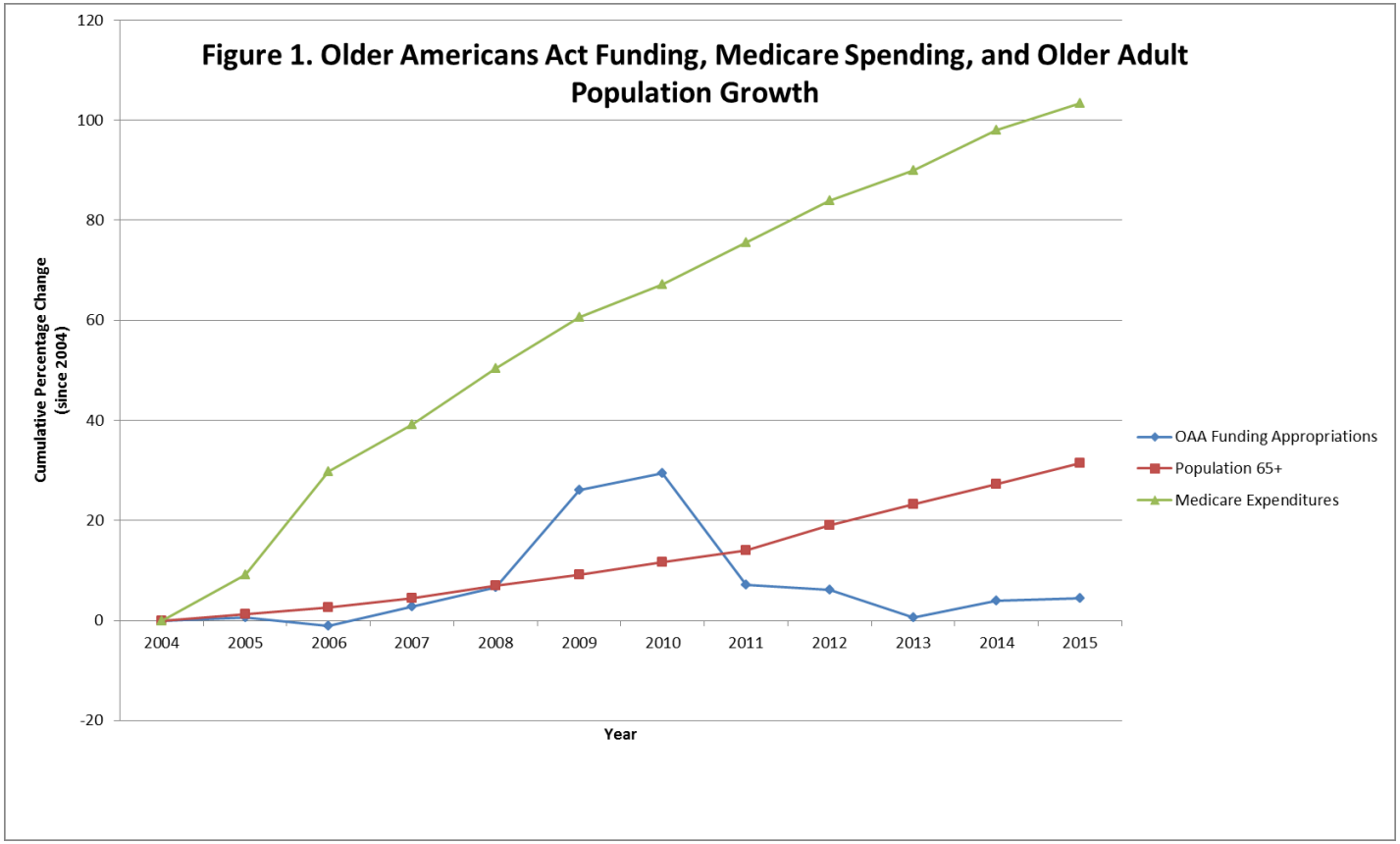
Traditional Approach: Older Americans Act of 1965

- 1973 Amendments created AAA Network
- Funding
  - Federal
  - State Match
  - Local
  - Grants
- Prohibited direct service delivery
- Targeted older adults in the greatest economic and social need
- Means testing prohibited

Prospects for Growth:

- OAA Funding has been flat for almost thirty years
- State budgets are stretched thin covering Medicaid costs
- Local government is struggling to meet budget demands
- Population continues to age at a rapid rate

Older Americans Act Funding, Medicare Spending, And Older Adult Population Growth

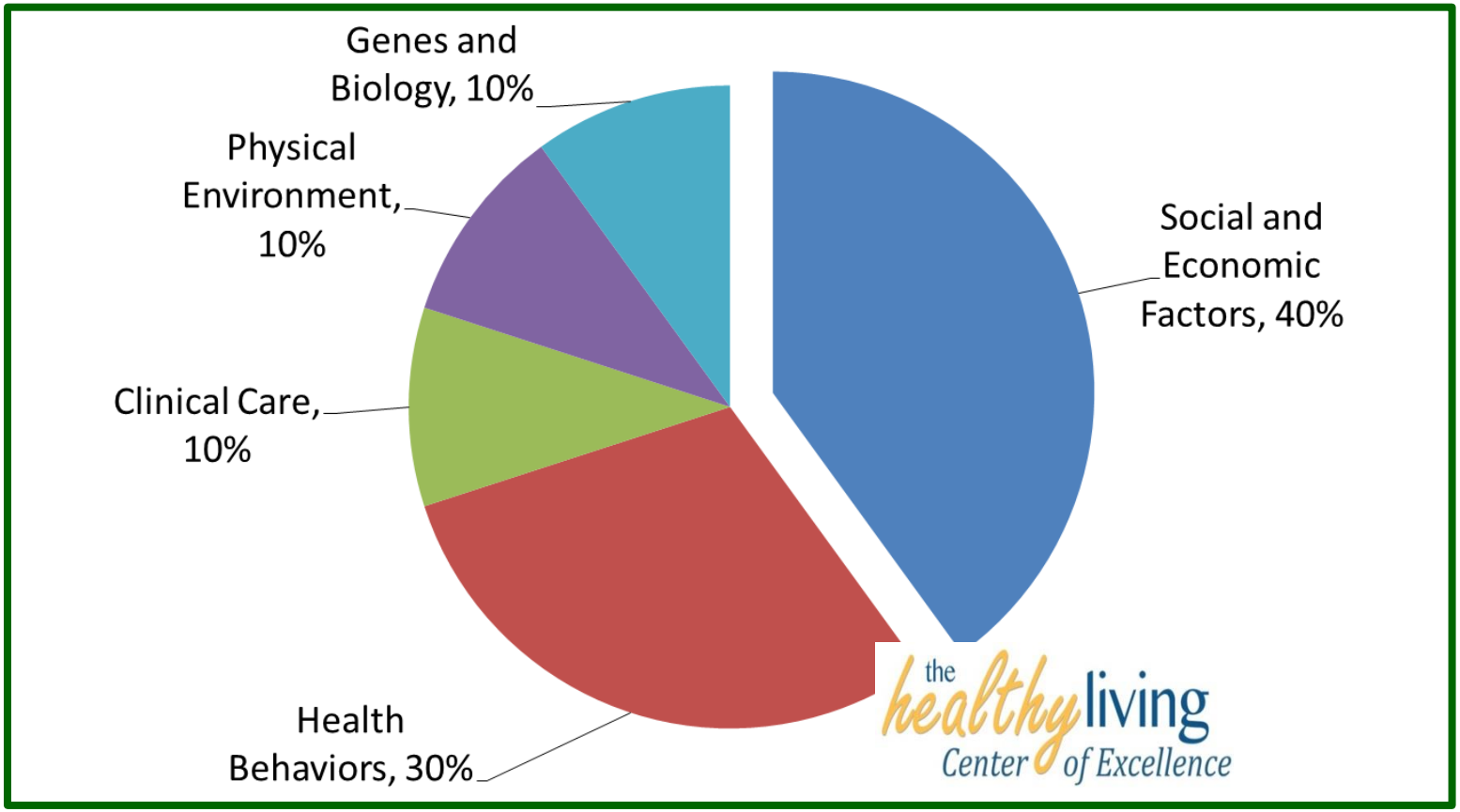


Source: Adapted from Parikh RB, Montgomery A, Lynn J. The Older Americans Act at 50—community-based care in a value-driven era. N Engl J Med. 2015;373(5):399-401. Values have not been adjusted for inflation.

Evolution of the EVCTP to VAAACares®

- CMS CCTP Pilot partnership with Bay Aging and Riverside Health System developed EVCTP.
- EVCTP's full launch for CTI with 5 health systems, 69 skilled nursing facilities, and 5 Area Agencies on Aging – covering 20% of the state
- Bay Aging Initiated development of VAAACares® statewide for contact opportunities with Duals Demonstration - CTI and Care Coordination.
- Based on Medicare savings and improved health outcomes, the VA General Assembly awarded funding to Bay Aging/EVCTP to demonstrate impact in Medicaid.
- Success in Duals Demo led to MLTSS contracts for CTI and Care Coordination

Public Policy Framework for Improving Population Health



Tarlov AR. Public policy frameworks for improving population health. *Ann N Y Acad Sci* 1999; 896: 281-93.

HEALTH

Synergy deemed 'unprecedented'

Warner impressed by plan to reduce readmissions of Medicare patients

By Prue Salasky
psalasky@dailypress.com

NEWPORT NEWS — More than half of hospital readmissions of Medicare patients within 30 days result from socio-economic factors and the physical environment, compared to just 10 percent for medical reasons, Kathy Vesley-Massey, CEO of Bay Aging, said at a forum hosted by the Eastern Virginia Care Transitions program.

Bay Aging is the lead agency in the program, which is a collaboration of five agencies on aging, four health systems, 11 hospitals and multiple other health providers. The group is two years into a five-year Medicare pilot project to bring down patient costs and reduce 30-day readmissions for vulnerable seniors.

Its primary methods are encouraging close collaboration between medical providers and community services, and using "coaches" with social work backgrounds (rather than case managers) specially trained to smooth transitions and teach self-reliance to patients leaving the hospital. The coaches make one hospital visit and one in-home visit, then use follow-up phone calls to teach those at risk for readmission how to look after themselves, said Kyle Allen, vice president of clinical integration for Riverside.

Nationwide, the eastern Virginia program is ranked sixth in performance for reducing all-cause readmissions and is one of 44 Medicare pilots out of more than 100 initially that has met its enrollment goals and realized significant savings. The Centers for Medicare and Medicaid Services estimates those at $9,600 per patient, or more than $20 million in savings since its inception, Vesley-Massey said at the roundtable presentation with two dozen stakeholders and U.S. Sen. Mark Warner, D-Va., at Riverside Regional Medical Center.

JUDITH LOWERY/DAILY PRESS PHOTO

Sen. Mark Warner, D-Va., asks a question about the Eastern Virginia Care Transitions program on Tuesday in Newport News. About two dozen stakeholders attended the event at Riverside Regional Medical Center.

Warner has launched a bipartisan working group for the Senate Finance Committee with U.S. Sen. Johnny Isakson, R-Ga., to explore how to improve outcomes for Medicare patients with chronic conditions, which he dubbed a major factor in driving the national debt.

Warner expressed particular interest in how the coalition had effected coordination between competing health systems, characterizing it as "unprecedented," and how technology and telehealth could be used to improve care and reduce costs. He asked for hard numbers. "Medicare and Medicaid have a very complicated formula, and it's not very accurate. We need to drill down to see how much does it save the hospital. ... You need more transparency in pricing," he said, suggesting that the savings could then pay for the program.

The project's funding is part of innovation grants provided through the Affordable Care Act, which also provided the impetus by instituting penalties on hospitals for readmissions. Most who qualify for coaching are "dual-eligible" — receiving both Medicare and Medicaid — and have multiple medical conditions.

Several people at Tuesday's forum said these patients are not noncompliant by choice but simply don't have the means or understanding to follow their health care plan.

"It's a unique situation where they took away the carrot and added the stick and it worked," said Jimmie Carter Jr., board chairman for Bay Aging. He characterized the area agencies on aging as the perfect neutral participant, or "Switzerland," with already established connections to community care and the services — Meals on Wheels, transportation, caregiver support, home care — that address those social factors that contribute to readmissions.

The transitions program covers 25 percent of Virginia, and there's a plan in place to extend it statewide, according to Allen, who worked earlier with a similar program in Ohio.

Roundtable participants noted that the eastern Virginia program still leaves gaps, particularly in addressing mental health readmissions. These form a high percentage and are more complex and more difficult to resolve as the patient self-reliance model isn't applicable. "That's an area where this model needs to be built out," Warner said.

Vesley-Massey said that in an inexplicable turnabout, CMS had recently threatened to dismantle the eastern Virginia project a year early, despite lauding its outcomes.

Warner said he was impressed by the use of less expensive community resources and would support the partnership's full implementation. He said it was "more focused" than other efforts he's observed. The senator also supported the suggestion that the program be extended to become proactive rather than reactive, pointing out that it would be more cost-effective to intervene before a hospitalization if those with several chronic conditions could be identified early.

Salasky can be reached by phone at 757-247-4784.

Past Performance

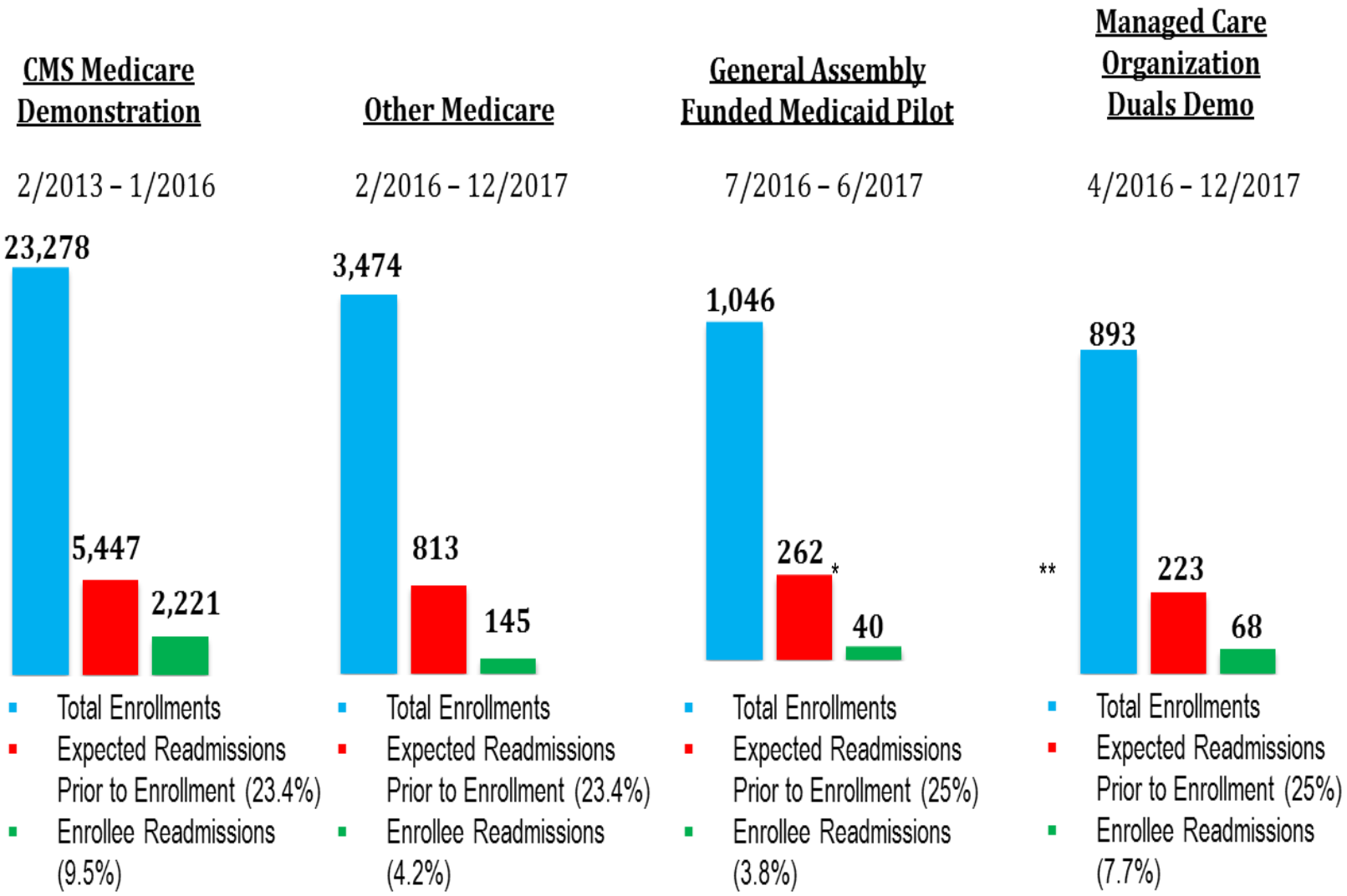
CMS – CMMI funded Community Care Transitions Provider: Eastern Virginia Care Transitions Partnership (EVCTP)

EVCTP: Year 2 Performance Analysis:

- Visited 90% of chronically ill target group (high utilizer) patients from partner hospitals in their homes
- Total Home Visits to all Hospital Patients 25,655
- Target Group Readmission Reductions (Hospital Data)
  - **2010 Baseline 23.4%**
  - **Enrollee Readmission Rate 9.1%**
  - **Reduced ED Utilization of "Self Insured"**
  - **Increased PCP Utilization**

In-home environmental assessment is key to identifying needs: beyond 'health' and discharge plan; what is needed for "well-being."

Eastern Virginia Care Transitions Partnership (now d/b/a VAAACares®) Outcomes and Cost Savings



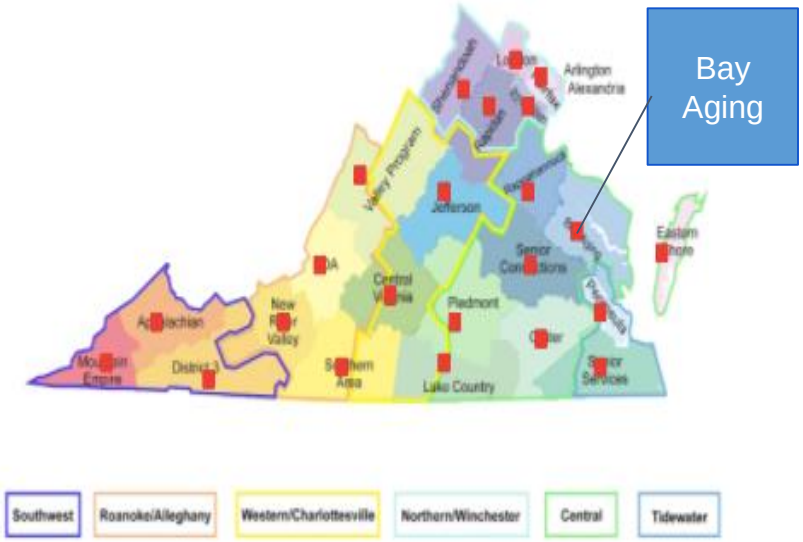
By partnering with AAAs, VAAACares® has the capability to scale and cover 100% of the service regions

VAAACares® is a partnership with Area Agencies on Aging (AAAs) to deliver Care Coordination and Care Transition services

AAAs have:

- 40 years of in-home experience;
- established relationships with hospitals and skilled and long term care nursing facilities in VA;
- tailored solutions for their unique population;
- the ability to leverage public and private resources for effective in-home services, and;
- the ability to deliver support services to maximize community living options.

Map of Area Agencies on Aging in Virginia



VAAACares® Model

- Lead agency is legal entity
- Cost to participate is minimal, $250.00
- Universal agreement across Virginia AAA Network
  - But – not all AAA's signed Business Affiliation Agreements
  - Participating AAA's also signed NDA's
  - VAAA Cares operates statewide
    - Traditional AAA service boundaries do not apply

VAAACares®

- Case Management delegation
- LTSS provider network contracting
- Care Transitions
- Initial health risk assessments
- Locating hard to reach members
- Waiver applications
- Waiver service coordination
- NF to community transitions

Nationally recognized, locally focused

Medicare Advantage Opportunities

In addition to a dedicated Care Transitions system, VAAACares also offers logistics management services including the following:

- In-home assessment to determine the needs of the consumer
- Person-centered planning to outline the needs and establish the required delivery of services
- Management and the delivery of a broad range of home and community based services provided by a credentialed network of direct services providers
- Just-in-time delivery of community based interventions to support the healthcare needs of targeted members in community settings
- Ongoing performance monitoring of network direct service providers
- Centralized invoicing and management of payment disbursement to the network of direct service providers.

Value Adds from AAAs

Assessment and home stabilization strategy

Components

- Assessment
- Medication Reconciliation and Self-Management
- PCP Appointment Adherence
- Red Flags
- Patient Centered Record

Incorporate

- Chronic Disease Self-Management Education
- Fall Prevention
- Diabetes Self-Management Education
- Healthy Ideas / PHQ9
- Advance Care Planning
- Telehealth / Tele-education

Other Services

- Transportation
- Nutrition / Meals on Wheels
- Personal and Companion Care
- Emergency Services i.e. fuel assistance
- Environment Home Modifications & Repair
- Friendly Caller Program
- Adult Day Services

Trailblazers Learning Collaborative (TLC)

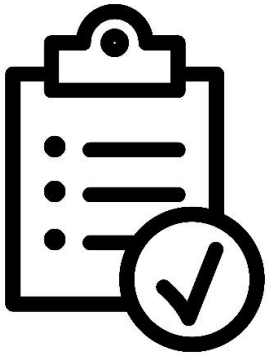
The “leading-edge” of the Aging and Disability Networks, the first group of community-based organizations (CBOs) to tackle next-generation CBO–health care partnership issues. The collective will serve as a “think tank” for prototyping, and work together toward solutions to address challenges and opportunities in contracting with health care entities.

TLC Objectives

- Develop comprehensive strategies (roadmaps) for approaching and engaging different health care payers and providers that they – and others within the aging and disability networks – can use to secure future contracts/agreements.
- Test and use these roadmaps to approach contracting organizations, and secure new or expanded contracts.

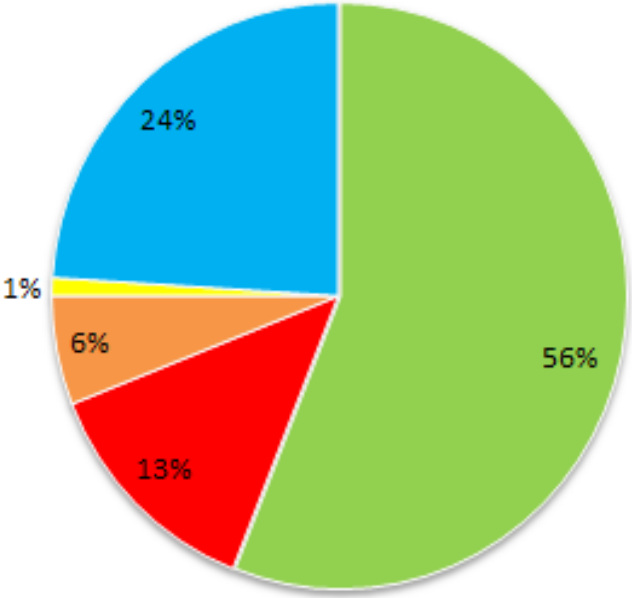
Health Plans Workgroup

- Creating standardized scope of work for care transitions to facilitate multi-state or national global contract covering multiple CBO networks
- Development of standardized client satisfaction surveys to help CBOs benchmark the quality of their programs, and enhance their ability to demonstrate the quality outcomes of their services.

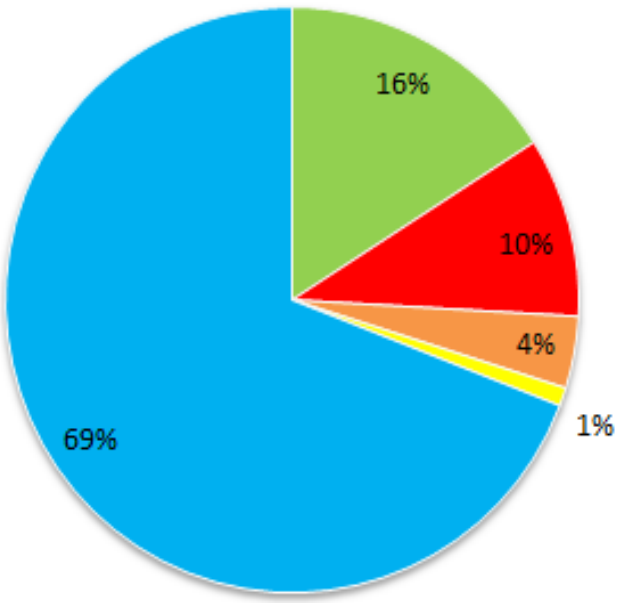


Revenue Trends

2012



2018



Federal
Local
Private Payers
State
Contributions

Federal
Local
Private Payers
State
Contributions

Thank you!

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Questions?

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