Opening the Door to Partnerships with Healthcare Organizations

AZLWI WEBINAR
JANUARY 16TH, 2014

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Arizona Living Well Institute
Advancing Evidence-Based Programs for Arizona

Partners in Care Foundation
changing the shape of health care
Bringing medicine, patients and community-based services together.
Opening the door to partnerships with healthcare organizations

Part 1: Augmenting/replacing public funding by contracting with health care systems

Part 2: Using the ACA-required Community Health Needs Assessment and evidence-based programs as a key to unlocking the door between CBOs and healthcare

Sandy Atkins, MPA
VP, Institute for Change
Partners in Care Foundation
National Strategic Direction

Augmenting/replacing public funding by contracting with health care systems
Healthcare’s Blind Side

- 2011 RWJF survey of 1,000 primary care physicians
  - 85%: Social needs directly contribute to poor health
  - 4 out of 5 not confident can meet social needs, hurting their ability to provide quality care
  - 1 in 7 prescriptions would be for social needs
  - Psychosocial issues treated as physical concerns

- *This is the gap we fill...our value to patients and the healthcare system*
The Upstream Approach: What would happen if we were to spend more addressing social & environmental causes of poor health?
Healthcare + HCBS = Better Health, Lower Costs

- We address social determinants of health
  - Personal choices in everyday life
  - Isolation, Family structure/issues, caregiver needs
  - Environment – home safety, neighborhood
  - Economics – affordability, access
Building Infrastructures for Health

- Medical care systems need to connect to community resources to build health
- Creation of widespread community-based programs to address lifestyle change are needed – especially to manage risks like diabetes progressing, heart disease and falls
- Pro-active care is emerging – the whole person
- Evidence-based programs are essential
Targeted Patient Population Management with Increasing Disease/Disability

- Well – No Chronic Conditions or Diagnosis without Symptoms
- Chronic Condition with Mild Symptoms
- Chronic Condition(s) with Mild Functional &/or Cognitive Impairment
- Complex Chronic Illnesses w/ major impairment
- End of Life

- Home Palliative Care
- Post Acute and Long Term Supports and Services
- Evidence Based Self-Management, Home Assessment and HomeMeds

Hot Spotters!
HCBS in Active Population Management – Value Propositions: Who Pays and Who Saves?

- EOL
- LTSS & Caregiver Support
- Care Transitions
- HomeMeds/Home Safety Assessment
- EB Self-Management: CDSMP/DSMP; MOB; Healthy IDEAS; EnhanceFitness; PEARLS; Fit & Strong
- Senior Center – meals, classes, exercise, socialization

25% of all Medicare is Last Year of Life: Duals Plans; Medicare Advantage SNP; ACO/MSSP

Nursing Home Diversion for Duals Plans

ED/Hosp: Capitated Providers/Plans
Readmission penalties: Hospitals

Chronic Disease Management: Duals Plans; MA SNP

Prevention: MA Plans; Capitated Med Groups
Local Imperative

LTSS Competition for the Duals:
Why regional networks are the only way to fly
Case Study: Los Angeles County

- 370,000 dual eligibles – only 2 states (PA & TX) have more than L.A. county
- Speed of application process led to choice of large national company to provide LTSS (APS).
- Why choose a national for-profit?
  - IT already developed and deployed
  - Single contracting entity
  - Experience
  - Capital
Choices for survival...pick one

• Organize agencies into a regional network
  – Single IT system
  – Local experience and cultural competence
  – Single point of entry for health plans, providers & consumers
  – Centralized billing, QA, contracting
  – Individualized pricing

• Or Compete with each other to become vendors to the for-profit contractor
Prototyping Aging/Disability Service Networks – thanks Hartford & ACL!!

- Southern California – ACL Targeted Technical Assistance
  - Start with CCTP providers to avoid duplication and inability to bill
    - AAAs, OAA contractors (meals, EBP, etc.), retirement home w/ home health/hospice, large FQHC/PACE & waiver provider
  - Move to subcontracting with each other for patients living in each geographic area
  - Seek contracts with non-CCTP hospitals
  - Build business office & capacity, MOU/Agreements
  - Add in the other services each can provide
  - Win Contracts!!!
# Building Our New Business Model: Focus Areas

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<th>Evidence-Based Self-Management</th>
<th>Assessments, Care Coordination &amp; Coaching</th>
<th>Provider Networks For Efficient Delivery System</th>
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<td>Brief Assessment/Care Coordination/SNF Diversion Networks</td>
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## Building Relationships & Contracts

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<th>HC Entity</th>
<th>Foot in the door</th>
<th>Contract Services</th>
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<td>Medicaid Health Plan</td>
<td>Health risk assessment; board member; CMMI</td>
<td>CTI private contract; ADHC FTF assessment</td>
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<td>Health System</td>
<td>Consulting on community strategic plan; CMMI</td>
<td>Root cause analysis; CCTP; Home visits</td>
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<td>ACO/MSSP</td>
<td>Primary Care Redesign Team; CMMI</td>
<td>Home Palliative Care</td>
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<td>Medical Group 1</td>
<td>Evaluation; consulting; EOL</td>
<td>HomeMeds, Home Safety Eval, Care Transitions</td>
</tr>
<tr>
<td>Medical Group 2</td>
<td>Board member</td>
<td>DSMP; evaluation; waiver pilot</td>
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Cracking the door open...and then strutting your stuff

A beginning guide for building partnerships, and eventually contracts, with hospitals and other medical providers

Sandy Atkins, VP
Partners in Care Foundation
Case Study: CHNA

- Community Health Needs Assessment
- Hospitals in many states (including California) have required CHNAs under various regulations
- The Patient Protection and Affordable Care Act (ACA) includes a CHNA requirement
  - Hidden in the IRS Form 990 and Schedule H
  - First time requirement related to tax filings
  - **Failure to file** under new rules **results in a $50,000 excise tax**
CHNA Essentials

IRC Section 50010 (r)(2)(A)(i)-(ii)

- CHNA must be filed “at least once every three taxable years”
- Assessment should “solicit input from persons who represent the broad Interests” of the community
  - Includes three groups whose views must be addressed:
    - Public health specialists
    - Other agencies with Current Community Data
    - Representatives/Leaders of low-income/minority populations
- Hospital must “create and adopt an Implementation Strategy” to address identified needs
- Hospital must widely publicize the results
How CBOs Can Participate

- Provide specialized experts
- Connect hospitals with low-income/minority group representatives
- Provide expertise on community drivers of “frequent flyer” syndrome
- Enhance community relations for hospitals through local credibility of nonprofit CBOs
- Offer needed services cost-effectively
Hospital Staffs are juggling many ACA requirements (This one seems small)

Potential for Pain if existing requirements not met, but greater risk as data becomes public

“Bending the Cost Curve” depends on smart adaptations, or rationing

Communities have answers – it’s getting the hospitals to ask the questions.
Know your local nonprofit hospitals

• Community benefit officer — often in development department
• Community Benefit Committee — become a member
• Often have health education outreach that can benefit CBO clients – invite them to your site
• Join the Bioethics Committee
• Attend fundraisers…and bid!!
• Hold meetings at the hospital – use space
• Join Rotary, etc.
Understand the Hospital Context

• Part of Health System?
  – Work on relationships with primary care/patient-centered medical home or rehab
    • Train staff in community resources

• Part of ACO?
  – Present the value of your programs on the social determinants of health
  – Ask to be part of the ACO

• Ancillary services (e.g., senior care group)
  – What part of patient base do you represent?
  – Market opportunities

• $$$, Data, PR, mission
Review Past Needs Assessments

• Usually public documents
• Often tied to Healthy People goals (2010, 2020)
• Find issues CBO can help with
• See if your constituency/population was represented
• Check dates for next three-year cycle
• Find out who organized/implemented and work with them on mutual benefit project
Get involved in the next CHNA

• Know when it’s due and who they hired to do it
  – You may know the company
• Ask to be included in planning
• Attend public meetings
• Respond to surveys & provide your ID
• Offer to help consumers participate – bus, promo
• Be involved in prioritization step
• And of course, be in the implementation plan
• Partner with partners
Typical Problems Identified

• In children, youth, adults and seniors:
  – Obesity
  – Diabetes
  – Alcohol/Substance Abuse
  – Cardiovascular/Cholesterol/Hypertension
  – Mental Health
  – Smoking
  – Oral Health
  – Chronic Respiratory Disease
  – Access to Care
Prioritization

• Typical criteria to choose:
  – Severity of the issue and size of affected population
  – Ability of hospital to affect/effect change
  – Community and System resources available to make a difference
  – Ability to evaluate outcomes
  – Extent to which others are addressing the problem already

• SUGGESTION – match priority weighting to % of revenue from MEDICARE
Implementation Plan

• Intentionally left blank!!! Weakest link.

• Fill in the blank with your programs.
• Often aligned with Healthy People 2020
Examples – EB Programs

• Priority=Diabetes
  – Diabetes Self-Management Program

• Priority=Physical Activity
  – Senior Centers & EB Activity (EnhanceFitness, Fit & Strong, Arthritis)

• Priority=Alcohol/substance abuse
  – BRITE (Brief Intervention & Treatment for Elders)

• Priority=Hypertension, COPD
  – CDSMP
Healthy People 2020 – Older Adults

- Confidence in managing their chronic conditions
  - CDSMP and variants
- Receipt of Diabetes Self-Management Benefits
  - DSMP
- Leisure-time physical activities among older adults
  - EnhanceFitness, Fit & Strong, etc.
- Caregiver support services
  - Savvy Caregiver; Powerful Tools
- ED visits due to falls among older adults
  - HomeMeds, MOB, Healthy Moves

Resources on CHNA

- Community Commons Toolkit:
  - http://assessment.communitycommons.org/CHNA/

- CDC Resource Page
  - http://www.cdc.gov/policy/chna/

- IRS Code – for the intrepid

- Excellent IHI Podcast (WIHI):
  - http://www.ihi.org/knowledge/Pages/AudioandVideo/WIHICommunityHealthNeedsAssessments.aspx

- Google hospital name & “Community Health Needs Assessment” (in quotes)
Once you’re in the door, what else can you do?
Why aren’t we already there?
Hospital Disincentives!

- Not Reimbursed = Non-Existent
- “Heads in Beds” orientation
- No penalties for readmissions…until now, sort of
- Thought leaders have medical background
- Lifestyle/Community issues outside of “field of vision”
- They often see things in opposite direction – they help CBOs. Vice versa? Not so much!
Non-Traditional Opportunities for CBOs

➢ Develop focused services to address common causes of hospital readmissions
➢ Provide provider networks to perform services not offered by hospital
➢ Connect with existing healthcare providers
➢ Develop protocols for managing discharges to minimize re-admits
➢ Potential cost management tools
HomeMeds – they “get” it!

- Everyone in healthcare understands importance of medications & medication reconciliation
- Major cause of readmissions
- Show that much is lost in translation from hospital to home – 40% to 60% have problems
- Capitated medical groups & ACOs have incentives to prevent readmissions
  - Targeted home visit to do medication reconciliation, risk assessment, and psychosocial assessment
Why should non-healthcare agencies work on medication safety?

• To thrive, CBOs need to play a new role connecting the home with the healthcare system
  – Meds are major factor in readmissions (72%)
  – Home provides unique perspective otherwise unavailable to healthcare providers.
  – Quality measures for health plans and providers relate to issues such as medication use and fall prevention – HEDIS, Medicare Advantage Star Ratings
  – New focus on population health – identifying and proactively addressing health for high-risk patients
Fall Prevention & Care Transitions – they “get” that too

• Tarrant County, TX (Ft. Worth)
  – Local fall prevention collaborative
  – Fire Dept. mapping 911 calls for falls
  – Target Matter of Balance & HomeMeds for frequent fallers

• CareLink, Little Rock, AR
  – CTI plus HomeMeds = Action & Improvement
    • Eric Coleman approves as long as it doesn’t impede coaching
  – 27% of alerts resulted in med change
  – Pharmacist link empowering to patients
Take-home messages

• Don’t go it alone – regional networks are needed to play with the “big boys”
• Many ways to open doors – CHNA is a good example
• EBPs are excellent ways to create a shared vocabulary and provide value to healthcare
• Watch for more from the Hartford-funded initiative through Partners in Care.
Contact Information

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Thank You!

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