Key Steps to Successful Partnerships with Health Care Providers

- Robert Schreiber, Healthy Living Center of Excellence, Hebrew SeniorLife
- Sue Lachenmayr, Living Well Center of Excellence, MAC, Inc.
- Dawnavan S. Davis, MedStar
- Peggy Haynes, Partnership for Healthy Aging, MaineHealth
- Anna Guest, Southern Maine Agency on Aging

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The Healthy Living Center of Excellence

Rob Schreiber MD
Medical Director, Healthy Living Center of Excellence
Healthy Living Center of Excellence

Vision: Transform the healthcare delivery system. Medical systems, community-based social services, and older adult will collaborate to achieve better health outcomes and better healthcare, both at sustainable costs.

Key Features:

* Statewide Provider network of diverse community based organizations
* Seven (7) regional collaboratives
* Centralized referral, technical assistance, fidelity, & quality assurance
* Multi-program, multi-venue, multicultural across the lifespan approach
* Centralized entity for contracting with statewide payors
* Diversification of funding for sustainability
* EBP integration in medical home, ACO and other shared settings
Massachusetts by the Numbers

- 90+ member CBO provider network
- 7 regional collaboratives
- 600+ program leaders
- 16 evidence-based programs
- 16,000+ participants since 7/2013
- 20,000+ older adults since 2008

HLCE website traffic
- Over 1,000,000 annually
- 2,600 visits per month
- 1,300 unique visitors per month

www.healthyliving4me.org
Thank You To Our Partners
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
Benefits to a Carrier: Why Did SWH Get Involved

• **Improve Outcome 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 a higher satisfaction with carrier
  - Not all carriers are participating. Helps SWH to set themselves apart from others
  - Member might lose program if they leave SWH

• **Provides a Marketing opportunity:**
  - Helps attract potential members
  - Helps SWH to differentiate themselves from others
Steps to a Successful Partnership
MedStar Health and MAC, Inc. Living Well Center of Excellence

Dawnavan Davis, Vice President – Community Health
Sue Lachenmayr, State Program Coordinator
MedStar Health

- MedStar’s **Mission**: to serve our patients, those who care for them, and our communities.
- The largest healthcare provider in Maryland and the Washington, D.C. region, serving more than half a million patients annually.
- Working to reduce health disparities by addressing social determinants of health in Maryland’s and D.C.’s urban settings.
Empower individuals with chronic conditions to manage their health through Stanford Chronic Disease, Diabetes and Cancer Self-Management and a Hypertension Session.

Identify high risk zip codes, identify partnering sites/organizations in those zip codes.

Recruit community individuals residing in high risk zip codes to be trained as workshop leaders.

Provide hospital-based liaisons to connect sites and leaders, set up workshops, and conduct pre-/post- BP, BMI, Body Fat and weight.
Referral criteria embedded in Electronic Medical Record

Started in late April to generate referrals for OUTPATIENT – Primary Care and Urgent Care facilities; inpatient referrals to follow

Physician clicks on Community Health Programs tab in EMR (MedConnect)

E-mail to the MedStar Call Center (Care Connect)

Screening for unmet social needs at point of intake/enrollment and linkage to social services

Call Center has patient information, uses motivational interviewing to enroll them in a class.

Patient attends CDSME (30, 60, and 90-day post f/up)
Targeted Outcomes

- Participant program-specific
  - Behavioral- dietary, physical activity, self-management
  - Clinical- BP, weight/BMI, % fat
- Participant healthcare utilization, readmissions, costs
- Process variables
  - Lay leader and participant recruitment and retention
  - Number of + social screens/linkage to services
Statewide License for Stanford CDSME programs (Chronic Disease, Diabetes, Pain, Cancer, Spanish DSMP), Hypertension Session O

- Training and technical assistance
- Centralized referral, certified workforce, community-based locations, quality assurance measures, HIPAA compliant
- Statewide workshop calendar and registration
- Quarterly reporting to partners on patient activation, engagement and long-term goals
Four CDSMP/DSMP/CTS/Hypertension Leader Trainings February-March 2017 – 65 leaders; 3 Leader Trainings scheduled for September 2017 (45-60 new leaders)

- Training and technical assistance for hospital liaisons, regional coordinators on data collection and recruitment
- Onsite assistance at all workshop session 1, fidelity/quality assurance monitoring of workshop delivery/data collection
- Expansion of database to include clinical pre-/post-measures (BMI, Body Fat, Weight)
LWCE’s Role in MedStar 10 Hospital Rollout

- Data entry and quarterly reporting
  - Demographic data,
  - Satisfaction surveys
  - Change in clinical pre-/post- measures
  - 3-6 month participant Action Plan goals
- Quality assurance monitoring (on site visits, participant retention, workshop size, leader performance, participant self-efficacy
- Leader reimbursement
- Ongoing technical assistance as required
Key Steps to Successful Partnerships with Health Care Providers

Peggy Haynes, Senior Director, MaineHealth
Anna Guest, Falls Prevention Project Director, Southern Maine Agency on Aging
SMAA Info

Founded in 1973, under the authority of the federal Older Americans Act, SMAA is a non-profit organization dedicated to planning and implementing social services for adults age 60 and older.

• Our Mission

The Southern Maine Agency on Aging's mission is to improve the quality of life for older adults, adults with disabilities, and the people who care for them.

Our Vision
We envision a community in which older people are able to live to their fullest potential. We will provide older adults in southern Maine with useful information, resources, and services to help them meet their changing needs. We will promote effective learning, social connections and healthy lifestyles that maximize independence and security. We will provide extra help to those who are challenged by unusual health, social and/or economic circumstances. We will offer older adults meaningful volunteer opportunities so they, and their families, will experience productive and fulfilling lives while benefiting their communities. We will promote partnerships throughout the community to enhance our reach and effectiveness for the benefit of older adults.
MaineHealth and MaineHealth ACO

MaineHealth Mission: MaineHealth and its members, reflecting the needs of our communities, acting within available resources and consistent with agreed upon strategic priorities, will:

• Maintain an integrated not-for-profit, community-owned, comprehensive delivery system providing the continuum of care from prevention and health maintenance through tertiary services, rehabilitation, chronic care and long-term care.
• Have as its primary goal, the continual improvement of the general health of the communities served.
• Provide high quality, safe and accessible health services delivered with care and compassion in a cost effective manner.
• Consist of regionally organized providers operating in concert.
• Provide care regardless of ability to pay.
• Maintain financial viability.
• Accept and manage financial risk.
• Lead health professions' education and research efforts.
• Take a leadership role in healthcare public policy

MHACO Mission: We engage and support providers, payers and community partners in advancing integrated, value-based patient care.

MaineHealth Vision: Working together so our communities are the healthiest in America.

MHACO Vision: To be a nationally recognized network of providers delivering high quality, affordable care.
Target Consumer

- Who are we targeting?

  » Target demographics:

    ▪ Older Adults (Age 60+)
    ▪ Positive Fall Risk
    ▪ Healthcare Patients
      ▪ Low-Income Subsidy (LIS) recipients and/or Medicare and Medicaid Dual-Eligible (DE)
      ▪ High Risk, High Utilizer
      ▪ At risk of losing function and independence
Partnership Milestones

2000
MaineHealth Partnership for Healthy Aging created (MH & SMAA)

2003
Chronic Disease Self Management Program (MH, SMAA & PHO)

2006 – 2011
Choices for Independence AoA grant to Maine (PFHA administers)

2006
Care Transition Intervention (PHO & MH)

2006 – 2011
Choices for Independence AoA grant to Maine (PFHA administers)

2009
N4A Innovations Award Community Links

2003 - 2006
A Matter of Balance translational grant (PfHA, MMC, USM & SMAA)

2006
N4A Aging Innovations and Achievement Award (SMAA, MH)

2008
Community Links (SMAA, MH w/Providers)
Partnership Milestones

2009
MaineHealth
Transitions of Care Program
(MH w/PHO)

2010
Aging & Disability Resource Center - Care Transitions Intervention Collaborative
(SMAA, PHO & MH)

2012
Community-based Care Transitions Program
(SMAA, PHO & MH)

2013
Advance Care Planning
(SMAA, MH, MHACO)

2013
MSSP ACO
MHACO

2015
MHACO Shared Savings With SMAA

2016
MHACO and MH nominate SMAA CEO for John A. Hartford Business Foundation Award

2016
SMAA awarded ACL Falls Prevention grant with MH as key partner

2017
MHACO Grant Award for ACP with PCP
## ACL 2016 Evidence-Based Falls Prevention Grant (EBFPP) - Summary

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<tr>
<td><strong>Mission</strong></td>
<td>• <strong>State-wide, integrated, sustainable network</strong> to offer increased options for Evidence-Based Falls Prevention Programs (EBFPP)</td>
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<td><strong>Vision</strong></td>
<td>• SMAA “hub”; regional centers for implementation; establish relationships with key medical providers; screen/assess/refer</td>
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<td><strong>Strategies</strong></td>
<td>• Develop workforce and system for Falls Prevention Screening and Referral</td>
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<td></td>
<td>• Develop workforce and systems to increase capacity and use of EBFPP</td>
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<td><strong>Outcomes</strong></td>
<td>• 270% increase in participants (from 630 to 1,700)</td>
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<td>• Partners who provide financial support</td>
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<td>• MaineHealth Safe Mobility Toolkit</td>
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<td>• Interdisciplinary EBFPP Education Workshop curriculum</td>
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Key barriers

• Different organizational structures
• Speak different languages – health care, social determinates of health
• Funding structures
• Reach and access
• Competing demands for time and resources (internal)

Key Opportunities

• Provide integrated care and services to our community
• Shared community vision
• Using resources and talent/skills to best level
• Achieving the Quadruple Aim
• Meet the needs of our target consumers
Key Steps to Successful Partnerships with Health Care Organizations: Interactive Session
Faculty

• Robert Schreiber, MD, Medical Director, Healthy Living Center of Excellence, Hebrew Senior Life

• Sue Lachenmayr, State Program Coordinator, Living Well Center of Excellence, MAC, Inc.

• Dawnavan Davis, Assistant Vice President of Community Health, MedStar

• Peggy Haynes, Senior Director, Elder Care Services, Partnership for Healthy Aging, MaineHealth and Southern Maine AAA

• Anna Guest, Project Director, Falls Prevention at the Southern Maine Agency on Aging

• Sharon Williams, CEO Williams Jaxon Consulting & NCOA Consultant
The Winds of Change Are Blowing

- Regulatory
- Consumer Need/Demographics
- Value Based Payment
- Access to Care
- Integrated Care
- Sustainability
I don’t think we’re in Kansas anymore...

Infrastructure/organizational changes

• How did you prepare your staff/other stakeholders for the cultural shift for your organization from a purely social services entity to a social entrepreneurial entity?
Lions and Tigers and Bears...Oh My!

Outreach

• What methods did you use to identify healthcare partners who would be conducive to partnering with you?
• How did you target decision makers in these organizations?
Unraveling the Riddle for Every *Individdle*

Stakeholder Buy in
- What did you do to educate internal/external decision makers regarding this initiative?
- What were your key selling points?
No one gets in to see the Wizard!! Not no one, not no how!!

Barriers
• Describe a critical barrier you encountered in preparation for this new business venture?
• What did you do to overcome it?
The Ruby Slippers

Vehicles for financing start up costs

• What challenges/opportunities did you encounter establishing your start up capital?
The Emerald City

Cultural Integration

• What/How did you prepare your organization for engagement with your partner CBO?

• Were there cultural alignment initiatives?
Follow The Yellow Brick Road

The Rationale

• What were some of the factors your organization considered in deciding to contract for EBP vs. managing it in-house?
We’re off to see the Wizard

One Stop Shopping

• Is there value for you in CBOs creating network hubs to provide single source contracting (one-stop shopping) for EBP services across a region/state? Why or Why not?
Somewhere over the rainbow...

Accomplishments/new opportunities
• What is your most significant achievement to date regarding your partnership?
• Are you considering expanding the program or adding additional services?
Thank You!

Bibliography: Please reference the NCOA website; including the RoadMap and Toolkit for more information on partnering with healthcare organizations!