Developing a Network Hub

- **Alexandra Cisneros**, United Way of Tarrant County in Texas
- **Dianne Davis**, Health Self-Management Services, Partners in Care Foundation
- **Jennifer Raymond**, Healthy Living Center of Excellence, Hebrew SeniorLife
- **Melissa Weakland**, Blair Senior Services, Inc. and Comprehensive Care Connections, Inc.

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**National Council on Aging**

*Improving the lives of 10 million older adults by 2020*
Getting Started

- Texas responded to ACL solicitation for targeted technical assistance in 2014
- Reviewed Medicaid plan performance metrics
- Met with Medicaid officials and managed care organizations (MCOs) to raise awareness and knowledge
- A consultant (Tejas Management) was engaged in 2015 to provide guidance on building a provider network
- Seed funding for consultant was provided by the Texas State Unit on Aging
- Negotiations started with Cigna HealthSpring and plan provided administration funds to build capacity
- First contract executed in December 2015 with Cigna HealthSpring for modified Care Transition and HomeMeds (5 areas)
Challenges

• Texas is too big – 254 counties/ 28 AAAs
• 25 of 28 AAA are Councils of Government (COG) – which lacked the authority to contract with for-profit entities
  • Required a contract amendment from the State Unit and COGs board resolution
• Accreditation and provider # process- decided to use an Administrative Service Organization
• Standardizing one contracted cost for very diverse communities- its all in the analysis
Lessons Learned

Healthcare Payers want:
- To contract with one organization rather than several - one point of entry
- Return on Investment
- Value-added services to increase member retention and satisfaction

Organizations need:
- Standardization of processes
- Infrastructure to support growth
- Build relationship with the Healthcare Sector
- Prove the value of their services
- Know health plans network adequacy standards

This led to creation of Texas Health at Home!!
MISSION
We provide a comprehensive array of wellness and social services that support community living, resulting in lower healthcare costs.

VISION
To be recognized by healthcare payers:
- as a provider of choice for home and community based services
- for improving healthcare outcomes
- in preventing unnecessary hospitalizations and avoiding premature nursing home placement.
About Us

- Nonprofit organization incorporated in 2016
- Provide comprehensive array of wellness and social services that support community living, resulting in lower healthcare costs
- Building statewide network of:
  - Area Agencies on Aging (AAA)
  - Local Mental Health Authorities
  - Local Intellectual & Developmental Disability (IDD) Authorities
  - Aging and Disability Resource Centers (ADRC)
- Certified counselors and coaches
- Piloting evidence-based programs in targeted geographic areas to meet priority needs
What our network can do for Managed Care Organizations

- Network Adequacy: credential and monitor nutrition, personal assistance, emergency response, home modification, and durable medical equipment
- Enhance service coordination
- Member Retention: help complete members’ annual re-certification and apply for non-medical public benefits (e.g., SNAP, and VA benefits)
- Value-Added Services: Diabetes self-management, care transition, medication reconciliation, falls prevention, caregiver education and support services
Moving Forward

AAA of Tarrant County was awarded an ACL 2015 Evidence-Based Falls Prevention Grant

• In partnership with 8 other AAA created the Falls Reduction and Education Empowerment (FREE) Project
• As part of FREE’s sustainability Texas Healthy at Home began negotiations for A Matter of Balance contract with WellMed Medicare Advantage
  • Plan requested a Return on Investment analysis for their member population
  • Negotiations are in process and we are in the final stages of contract development
• Texas Healthy at Home is currently in conversations with:
  • Humana, Aetna, Molina, Superior, and Care N’ Care
Thank You!

Contact Information

**Don Smith**
United Way’s Area Agency on Aging of Tarrant County
donsmith@unitedwaytarrant.org
817.258.8128

**Alexandra Cisneros**
United Way’s Area Agency on Aging of Tarrant County
alexandra.cisneros@unitedwaytarrant.org
817-258-8111
Partners Network Hub

Network in Action
Partners in Care Foundation
Changing the Shape of Healthcare

• Partners mission is to shape the evolving health system by developing and spreading high value models of community-based care and self management.

• Partners’ direct services test, measure, refine and replicate innovative programs and services, and bring needed care to diverse populations.
Evolution from Coalition to Network Hub

- 13 years as statewide Healthier Living Coalition Technical Assistance Center
- CA Dept. of Aging, CA Dept. of Public Health, Partners in Care, Dignity Health, Kaiser Permanente, and many others
- Established value proposition with healthcare payer(s)
- Won contract with managed care plan
- Built a statewide network with CBO providers to scale delivery capability
Program Timeline

Summer 2014 - Begin planning process for outreach and engagement

Fall 2014 - Partners at Home Network established w/in Partner in Care Foundation – develop state-wide CDSME network of contracted providers over a 12 month period

Fall 2014 - BSC contract signed

January 2015 – Contact Center goes live

April 21, 2015 - Contact Center goes live

May 2017 – Refining Quality Assurance, developing new contracts, expanding pilots with BSC (DSMT, Falls Prevention, etc.), contracting with other entities to provide outreach and engagement through Contact Center
Partners at Home Statewide Network...Growing

Current Counties

- Alameda
- Contra Costa
- Fresno
- Kern
- Kings
- Los Angeles
- Napa
- Orange
- Riverside
- Sacramento
- San Bernardino
- San Diego
- San Luis Obispo
- Santa Barbara
- Sonoma
- Ventura
Regional Providers
Outreach for Population Health

• Contact Center
  – Partners and plan developed a new engagement strategy to reach out to and engage a significant managed care population
    • 117,000 referrals received in the first 24 months
    • 2.7% enrollment rate in one of the three modalities (in-person, on-line, toolkit)
    • Industry average is between 1% – 2%; contract goal was 2% enrollment

• Significant IT investment required
  – Customer Relationship Management (CRM) platform
  – Interactive Voice Response (IVR) system
  – Auto-dialer
  – Motivational Interviewing Script Development
THANK YOU
Building a Collaborative Community Network: The Massachusetts Experience
Overview of the HLCE

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
Our Partnership Path

April 2006: First CDSMP Master Training

2007: Statewide Community Coalition

2013: Building a Community Provider Network: Tufts Health Plan Foundation & Hartford

2016: First Contract – Senior Whole Health

2017: Sharpening Your Skills

22,265 Participants
HLCE Provider Network

- Statewide Provider Network: Beyond Aging
- AAA/ASAPs
- COAs
- ILCs
- Multicultural Organizations
- Faith Based Organizations
- YMCA
- QIN/QIO
- Community Health Centers
Value to Community Partner

- Multi-site license for CDSME (no cost, but …)
- Discounted or no-cost trainings in diverse programs
- Bi-monthly Fidelity / Best Practice Webinars
- Fidelity Committee
- Connections with Health Care
- Program reimbursement
- No membership fee
- Website with calendar and leader portal
- Annual Sharpening Your Skills Conference
Outcomes: Towards a More Sustainable Model

- **2013**
  - Grants: 95%
  - Contracts with Health Care: 4%
  - Other contracts: 1%

- **2016**
  - Grants: 42%
  - Contracts with Health Care: 19%
  - Other contracts: 38%

- John A. Hartford - Tufts HPF

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Elder Services of the Merrimack Valley, Inc.

The healthy living Center of Excellence
Key Learnings

• Start TODAY (or someone else will)
• Develop a shared mission and vision
• Look beyond usual suspects / aging network
• Consider including your competitors
• Provide Value to partners beyond $$$
• Be collaborative… until you can’t
• If you know 1 network …. 
• Communicate, Communicate, Communicate
• Celebrate Successes
Celebrate Your Successes
Governor Tom Wolf, in collaboration with the PA Department of Human Services & the PA Department of Aging introduced Community HealthChoices (CHC) in 2015, an MLTSS program aimed at ensuring that older Pennsylvanians receive the services they need, delivered where and when they want them.

Community HealthChoices will replace all current 1915c waivers in Pennsylvania for those aged 21+

Implementation will be January 1, 2018 in the SW, July 1, 2018 in the SE and January 1, 2019 for the remainder of the Commonwealth.
S (Strengths): 52 AAAs serve Pennsylvania’s 67 counties and have been operational for over 40 years

W (Weaknesses): 52 AAAs, not all of which provide service coordination under Pennsylvania’s current 1915c waiver, Aging Waiver. Currently service coordination is FFS (fee for service).

O (Opportunity): Community HealthChoices – Opportunity to contract with MCOs under a payment model that is PMPM and would combine Medicare and Medicaid care coordination = consumer focus

T (Threats):
- AAAs were not “carved in” legislatively. MCOs are not required to contract with the AAAs.
- 120 competing SCEs in the Commonwealth
- 52 disparate AAAs
By bringing together the AAAs, C3 will work collaboratively to give the agencies broader geographic reach, additional operational capacity, and efficiencies necessary to contract with and provide services to MCOs and their members.

C3 gives MCOs immediate access to trusted and knowledgeable experts who will deliver coordinated long-term services and supports in the community to meet consumers’ physical and underlying social needs.

With the collective resources and experience of member AAAs, C3 is well-positioned to develop innovative methods to deliver aging services that will help MCOs achieve higher quality and better value.

Will the AAAs join?
Inaugural Board of Directors seated on 10/24/16

Officially established a 501(c)3 as of May 2017

33 AAAs covering 52 counties

Projected ~420,000 participants across the Commonwealth, ~250,000 of which are 60+
C3: Uniquely positioned to meet the goals of Community HealthChoices

- Enhancing Opportunities for Community-Based Living
- Improving Coordination of Aging Services
- Ensuring Quality Services and Accountability
- Promoting Innovations in Service Delivery
- Increasing Efficiency and Effectiveness
Paul Cantrell, Executive Director  
  pcantrell@comprehensivecareconnections.org

Missy Weakland, RN, Program and Member Services Director  
  mweakland@comprehensivecareconnections.org

Angela Lucente-Prokop, PMP, Regional Project Director  
  alucenteprokop@comprehensivecareconnections.org

Jessica Machler, CHC Program Specialist  
  jmachler@comprehensivecareconnections.org
OPEN FOR DISCUSSION