Business Acumen Update

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May 25, 2016
Marisa Scala-Foley is our lead for business acumen and she sends her regrets.

You have ME instead!
Why are we doing this?

Why does business acumen matter?

“Stay with me now, people, because in Step C, things get a bit delicate.”
High risk, high cost individuals = those with chronic conditions **AND** functional needs

![Bar chart showing the distribution of high risk, high cost individuals among all enrollees, top 20% of Medicare spenders, and top 5% of Medicare spenders.](chart)

- **All Enrollees**: 15% chronic conditions & functional limitations, 48% 3 or more chronic conditions only, 31% 1-2 chronic conditions only, 7% No chronic conditions
- **Top 20% of Medicare Spenders**: 46% chronic conditions & functional limitations, 41% 3 or more chronic conditions only, 12% 1-2 chronic conditions only, 1% No chronic conditions
- **Top 5% of Medicare Spenders**: 61% chronic conditions & functional limitations, 32% 3 or more chronic conditions only, 7% 1-2 chronic conditions only, 7% No chronic conditions

*Source: H. Komisar & J. Feder, Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services, The SCAN Foundation, October 2011.*
More likely to use hospital inpatient and ED services

![Bar chart showing usage of hospital inpatient and ED services]

- **Inpatient Hospital**
  - Enrollees with chronic conditions & functional limitations: 34%
  - Enrollees with 3 or more chronic conditions only: 20%
  - Enrollees with 1-2 chronic conditions only: 9%

- **Emergency Department**
  - Enrollees with chronic conditions & functional limitations: 31%
  - Enrollees with 3 or more chronic conditions only: 23%
  - Enrollees with 1-2 chronic conditions only: 13%

*Source: H. Komisar & J. Feder, Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services, The SCAN Foundation, October 2011.*
Concerns:
Funding, sustainability & managed care

Source: Aging and Disability 2015 Information & Referral/Assistance National Survey, National Association of States United for Aging and Disabilities (NASUAD) in partnership with the National Council on Independent Living (NCIL)
Integrated Care Opportunities

- Accountable Care Organizations (ACOs)
- Community-Based Care Transitions Program (CCTP)
- Bundled Payments
- Duals Financial Alignment Initiative
- Health Homes
- Medicaid Managed LTSS (MLTSS)
- State Innovation Models (SIM)
The critical role of community-based organizations

Managing chronic conditions

- Chronic disease self-management
- Diabetes self-management
- Falls prevention
- Oral health
- Nutrition programs (counseling & meal provision)
- Socialization opportunities
- Education about Medicare preventive benefits

Preventing hospital (re)admissions

- 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

Activating beneficiaries

- Evidence-based care transitions
- Person-centered planning
- Chronic disease self-management
- Information, referral & assistance/system navigation
- Benefits outreach and enrollment
- Employment related supports
- Community beneficiary/caregiver engagement

Diversion/avoiding long-term residential stays

- Transitions from nursing facility to home/community
- Person-centered planning
- Assessment/pre-admission review
- Information, referral & assistance/system navigation
- Environmental modifications
- Caregiver support
- LTSS innovations
If we DON’T do this, someone else WILL!

IF we do this....we can HELP more people!

"Success is where preparation and opportunity meet."
--Bobby Unser

"Opportunities are like sunrises. If you wait too long, you miss them."
--William Arthur Ward

"If a window of opportunity appears, don't pull down the shade."
--Tom Peters
In partnership with foundations, ACL is providing aging & disability organizations with the tools they need to partner and contract with health care payers and providers in delivery system reform.

2012: Grants to national partners to build business capacity of aging and disability organizations

2012 - Present: Engagement with public and private partners

2013-Present: Business Acumen Learning Collaboratives
2013-2014 Business Acumen Learning Collaborative

- Partners at Home/Partners in Care Foundation (CA)
- San Francisco Department of Aging and Adult Services (CA)
- Florida Health Networks (FL)
- Healthy Aging Center of Excellence/Elder Services of the Merrimack Valley/Hebrew SeniorLife (MA)
- The Senior Alliance and the Detroit Area Agency on Aging (MI)
- Minnesota Metro Aging and Business Network (MN)
- AAAs of Erie and Niagara counties (NY)
- Pennsylvania Partners in Care, LLC/PA Association of AAAs, Inc. & PA Centers for Independent Living (PA)
- Texas Healthy at Home/North Central Texas Council of Governments (TX)
2015-2016 Business Acumen Learning Collaborative

- County of San Diego Health and Human Services Agency and Aging & Independence Services
- Alameda County Aging, Disability, and Resource Connection
- Indiana Association of Area Agencies on Aging, Inc., and the Indiana Aging Alliance, LLC
- Greater North Shore (MA) Link/Aging and Disability Resource Consortium of the Greater North Shore, Inc.
- Gateway Wellness Network/St. Louis Metropolitan Integrated Health Collaborative
- Center on Aging and Community Living (NH)
- Oklahoma Aging and Disability Alliance, LLC/INCOG AAA, & Ability Resources, Inc.
- The Arc Tennessee
- Vermont Association of Area Agencies on Aging (v4a) and the Vermont Community-Based Collaborative
- Conexus Health Resources/Aging and Long Term Care of Eastern Washington
- Wisconsin Institute for Healthy Aging
ACL’s Business Acumen Learning Collaboratives

- **Primary**: Each network will have at least one new contract with an integrated care entity by the end of each collaborative.

- **Secondary**: To establish networks through which they can do business.
20 networks
24 signed contracts
7 more under negotiation

<table>
<thead>
<tr>
<th>Services under contract</th>
<th>Populations served</th>
<th>Payers</th>
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</thead>
<tbody>
<tr>
<td>• Care transitions</td>
<td>• Evidence-based program targets</td>
<td>• Duals plans</td>
</tr>
<tr>
<td>• In-home assessment</td>
<td>• Dual eligibles</td>
<td>• ACOs</td>
</tr>
<tr>
<td>• Medication reconciliation</td>
<td>• Other high risk populations</td>
<td>• Medicaid health plans</td>
</tr>
<tr>
<td>• Care coordination</td>
<td></td>
<td>• Physician group</td>
</tr>
<tr>
<td>• Evidence-based programs (EBP)</td>
<td></td>
<td>• State healthcare exchange</td>
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What we’ve learned

• Culture is critical – balancing margin and mission
• Networks need to match their strengths with a payer’s needs
• Flexibility is key...but so is selectivity (not all contracts are good contracts)
• Relationships (and champions) are critical to the process
• Policy shifts offer new opportunities (and challenges)
• Some issues still need more work:
  – Continuous quality improvement
  – Generating and managing volume
  – Network infrastructure
  – Information technology
  – Outcomes data

And...More!
moving forward

- Two new ACL Funding Opportunity Announcements related to business acumen
  http://www.acl.gov/Funding_Opportunities/Announcements/Index.aspx

- Letters of intent: June 1
- Conference call: June 6, 2 pm Eastern
- Closing date: July 11
FOA 1

• *Business Acumen for Disability Organizations*
  – Develop baseline knowledge about the content and infrastructure needs of community-based disability organizations through surveys and feasibility studies
  – Provide broad-based training and technical assistance
  – Utilize a learning collaborative model to provide targeted technical assistance to 10 to 15 state networks of CBOs serving persons with disabilities of all ages that seek to build their business capacity to contract with integrated care entities
FOA 2

- **Learning Collaboratives for Advanced Business Acumen Skills**
  - Organize and conduct 3-5 topically-based action learning collaboratives to address “next generation” issues
  - Create knowledge and capture insights through these collaboratives to incorporate into future curriculum for national dissemination
Eligible applicants (same for both FOAs)

• Domestic, public or private non-profit entities including state and local governments, Indian tribal governments and organizations (American Indian/Alaskan Native/Native American), faith-based organizations, and community-based organizations.
  – Consideration will be given to national public and private non-profit agencies and organizations including faith- and community-based organizations (FBOs and CBOs), and national Indian tribal organizations.
New Grant

John A. Hartford Foundation awarded a grant

• Building the Capacity of the Aging and Disability Networks to Ensure the Delivery of Quality Integrated Care

• TO:
  – n4a
  – American Society on Aging
  – Independent Living Research Utilization
  – Partners in Care Foundation
Vision: Transforming the healthcare delivery system, so that medical systems, community-based social services, and older adult collaborate to achieve better health outcomes and better healthcare, both at sustainable costs.

Key Features:

* Statewide Disease Management Coalition with website and universal license
* Seven (7) regional collaboratives
* Centralized referral, technical assistance, learning, and quality assurance
* Multi-program, multi-venue, across the lifespan approach
* Diversification of funding for sustainability
* EBP integration in medical home, ACO and other shared settings
**2014 Primary Funding**
- Administration on Community Living
  - Tufts Health Plan Foundation
  - The John A. Hartford Foundation

**2018 Primary Funding**
- Revenue Generation through reimbursement models with payors and at risk providers

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**Healthy Living Center of Excellence (HLCE)**

- **Advisory Committee**
- **State Partners EOEA and DPH**
- **Capacity Building**
- **Business Development and Financial Sustainability**
- **Quality Assurance and Fidelity**
- **Regional Collaboration & Statewide Dissemination of EBP**

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**HLCE Overview**
Sustaining Linkages between Community and HealthCare

- Health Care reimbursement
- Non-health Payors
- Training and Technical Assistance
- Philanthropy and Community Partnerships
- Advocacy and Policy Change
Contracts and Services

Payors
Hospitals
Managed Care/SCO/ACO
PACE
Medicare Direct Billing
Behavioral Health Providers

Care Management & Long Term Support Services

Community Services (i.e. Consumer Directed, Medical Interpretation)

Behavioral Health Counseling

Care Transitions

Mass Health Redetermination

EBP
DSMP and Medical Nutritional Therapy

Technical Assistance (Non Health Care)
DPH NE States N4A/NCOA
Providing accessible, community-based and cost effective services that empower older adults to be healthy, active and well.
History

2012
- Business Acumen Movement
- Stakeholder interest in diabetes self management education

2013
- Build capacity in DSME using Stanford University program
- Explore Medicare Billing partners
- Continue meeting with stakeholders

2014
- OASIS hosted two learning sessions with healthcare and community providers
- Engage new OASIS board members
- Application for technical assistance submitted by OASIS

2015
- Participate in technical assistance activities
- American Association of Diabetes Educators accreditation for DSME
- Gateway Wellness Network formalized

2016
- Pilot Fall Risk Reduction Service Packages
- Implement DSME and CDSME
- Formalize partnerships with Payers
Service Packages

**Fall Risk Reduction**
- Home Hazard Assessment
- Balance Assessments
- A Matter of Balance
- Medication Review
- Exercise Programs*

**Chronic Condition Management**
- Stanford University Chronic Disease Self Management Program
- Medication Review
- Exercise Programs*

**Diabetes Prevention and Management**
- AADE Accredited Education Program
- Stanford University Diabetes Self Management Program
- Diabetes Prevention Program
- Exercise Programs*

**Other**
- Community-based Care Transitions
- Home Delivered Meals
- Depression Management
- Transportation

*Exercise programs include evidence-based and research-informed programs that are tailored for every ability. Programs improve strength, flexibility, balance, endurance and agility.
Falls Prevention Example

- When hospital services are complete, the healthcare team or insurance provider refers patient to Gateway Wellness Network for Fall Risk Reduction Package (details on back page).

- Gateway Wellness Network coordinates member organizations to provide continued services to reduce risk of a repeat fall and readmission.

- Patient receives a home-based assessment including home hazard evaluation, medication review/reconciliation and evaluation by an occupational therapist.

- Patient takes A Matter of Balance to incorporate behavior change strategies to reduce fall risk factors in daily activities.

- Patient engages in a physical activity program based on current abilities and individual goals for fitness and independence.

- Gateway Wellness Network reports back to referring provider on patient status.
Pilots and Scaling

- Pilots underway with independent physician and FQHC.
- Stratify patient population
  - Implications for scaling efforts and impact
- Use pilot results to obtain payer contracts
- Address challenges with patience and persistence