The Lewin Group
Building Partnerships: Health Plans and Community-Based Organizations
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Jessie Micholuk: Good afternoon, everyone. Welcome to the Disability-Competent Care webinar, *Building Partnerships: Health Plans and Community-Based Organizations*. My name is Jessie Micholuk, and I'll be getting us started today.

If you have any questions now or throughout the presentation, please feel free to enter them into the Q&A feature on your platform. We will be addressing your content-related questions during the discussion portion of this webinar.

The Lewin Group, under contract with the CMS Medicare/Medicaid Coordination Office, partnered with Christopher Duff and other disability practice experts to develop the 2018 Disability-Competent Care webinar series. This webinar series builds on the 2017 DCC webinar series but introduces the model of care and its seven foundational pillars. You can view this series and other related resources at the Resources for Integrated Care website.

As I mentioned, this webinar will be interactive, with 45 minutes of presenter-led discussion followed by a 15-minute presenter and participant question-and-answer session. Video replay and the slide presentation will be available after the session, and you can find those at our website, ResourcesForIntegratedCare.com.

This webinar is supported through MMCO to help beneficiaries enrolled in Medicare and Medicaid to have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to Medicare and Medicaid enrollees, MMCO is developing technical assistance and actionable tools based on successful innovations in care models, such as this webinar.

To learn more about current efforts and resources, again, you can visit our website, the link on your screen.

We are also pleased to be able to offer credits for continuing education units and continuing medical education for this webinar. For information about how to obtain the credits, you can access the CMS Continuing Education Credit Guide, which is located on the left-hand side of your platform in the Resource Library. To receive credit, the post-test must be completed through the CMS learning management system with a score of 80% or higher by midnight on April 23, 2018. Again, further information is available at the Resources for Integrated Care website.

I'll now hand the presentation over to your moderator, Chris Duff.

Chris Duff: Thank you, Jessie. I would also like to welcome everyone to this seventh and last webinar in this series. I'm a disability practice and policy consultant who has been working with

the Lewin Group to develop a disability-competent care model and related webinars and materials. I will be joined today by three speakers.

First will be Lori Peterson. Lori's expertise ranges from building community-based networks to strategic partnerships, cross-sector collaborative development to multi-stakeholder facilitation and new service design to change activation and implementation. She has extensive experience helping organizations position for growth in a value-based environment. She received her Bachelor of Science from Kansas State University in physiology and her Master of Arts from Sonoma State in psychology.

The second presenter will be Paul Castro. Paul is currently an organizational and executive consultant, having recently retired as president and CEO of Jewish Family Services of Los Angeles, where he had worked for over 35 years in a variety of roles. JFS is a multi-faceted, multi-service social service organization serving more than 100,000 individuals and families annually in the L.A. area. Paul graduated from California State University at Fullerton with a B.A. in ethnic studies and holds a Juris Doctorate from Loyola Law School.

Last but not least is Patricia Yeager. Patricia began her career in the Center for Independent Living movement, providing turnaround services for centers in Denver and San Diego, and later served as the director of the California State IL Association. In 2011, she started at The Independence Center, where she is currently serving as the CEO. The Independence Center quickly came to see that due to their long history of providing LTSS services, they could help health care entities provide better care to their joint clients. Through participation in business acumen training provided by the Colorado Healthcare Foundation, she found a way to start a partnership with a local hospital. Patricia has a PhD in rehabilitation administration from the University of Northern Colorado.

As these objectives show, today's presentation will be on collaboration and partnerships between health plans and health system and community-based organizations, which will be referred to hereafter as CBOs. Today's webinar will start by focusing on the population of persons with disabilities and their potential to benefit from these partnerships. We will learn of strategies for building partnerships between health care organizations and CBOs. Lastly, we will hear of the experiences of two CBOs.

I will be handling the first section myself, talking about social determinants and the contributions of the different stakeholders in these newly emerging partnerships.

Of the 11.4 million persons simultaneously enrolled in Medicare and Medicaid, 27% receive institutional LTSS services, and they accounted for 52% of the total Medicare/Medicaid enrollee expenditures. On top of these costs, there are additional ones that are not expended through Medicare and Medicaid, such as housing, food subsidies and others. Persons with disabilities, especially dual-eligible beneficiaries, often live their lives on the edge or at the precipice of instability. They commonly experience increased health care needs due to disability-related illnesses, multiple chronic conditions, social isolation due to community access, financial challenges due to limited income, unstable housing, unreliable transportation to access care, and others.

I thought it was important to start with an understanding of the concept of partnerships used in this webinar. Within this context and the overall, evolving health care delivery system, partnerships are a collaboration of two or more organizations to create a system of care for the population being served. These are generally formal and directed by a contract between the parties.

Persons with disabilities, as we have discussed throughout these webinars, are highly susceptible to falling through the cracks of the delivery system that serves them and commonly experience avoidable episodes of illness. These cracks occur because of the silos between and within the social service and health care delivery systems. These silos are the basis for the partnerships we will be discussing today.

This slide illustrates the social determinants of health. As you can see, the health care system addresses the issues identified in the far right or light-blue column. In order to make an impact on health outcomes, represented by the orange row on the bottom, partnerships are needed to address the other factors that contribute to health outcomes, namely those listed in the first five columns of this chart. Those partnerships are the focus of the remainder of this webinar.

Partnerships are used as a strategy to build upon the competencies of these diverse organizations. There's no single model for partnerships. While the focus is always on the participant, these partnerships include a range of stakeholders, providers, health plans, health systems and CBOs. For any partnership to be successful, they need to be built on the capability, capacity and need of these partners.

CBOs and health plans or health systems have highly divergent cultures. Though their visions may be similar, their lines of business are very different, and they can have varying goals and values. On top of that, both types of organizations are challenged by operationalizing these partnerships, such as payment relationships, contracting, service documentation, claims and others.

Throughout the next series of slides, I will highlight one or two contributions or needs of each stakeholder group and leave it to you all, the audience, to read the remainder of the content on the slides.

Throughout all the partnerships being discussed here, it is vital to understand the participants' unique contributions and needs. Perhaps most importantly, participants bring an understanding of their disability and what works and what doesn't work for them. At the same time, they need help maneuvering the health care system and the LTSS delivery system, and they need someone who they can call whom they trust, when needed.

When looking at providers, they generally bring established interdisciplinary teams with care coordinators prepared to manage the complexity of health care and LTSS systems. To refocus their work without the constraints of fee-for-service systems, providers need to learn to focus on outcomes and quality of care. Additionally, providers need to transition from the medical model to the person-centered model.

Health plans and health systems bring experience with acute and primary care. As the payment models evolve, they need to develop a network of high-quality providers to more efficiently and effectively transition participants through the care continuum and back into the community.

CBOs are often in the best position to address the social determinants of health experienced by participants. They bring relationships and trust with the participants and are often the place where they feel most comfortable. Knowledge of the community, including services, supports and gaps, are also a strength of CBOs.

CBOs tend to operate in a very different sphere with very different systems and levels of organizational capacity. Thus, they often need infrastructure and capacity to grow and mature.

At this point, I will turn it over to Lori Peterson, who has actually worked directly with both of the other presenters.

Lori Peterson: Thanks, Chris. I am thinking I do not need to convince anybody that is sitting in on this webinar that the space between what is in the system of health and health care and what could be has room to narrow. These transitions, that I have listed here, move from better to better to better, starting with organizational incentives to system incentives, and from my patient to our population. Regardless of how you identify with that individual, whether it is a patient, member, beneficiary, client or consumers, transition the style from control to influence, especially as we start talking about partnerships. These transitions need to be accelerated if we are really going to be working in this intersection between what is and what could be.

So from our work, we've been working in that intersection for about the last eight years and specifically focused on the design and implementation of effective cross-sector partnerships, and I'm using the word "effective" intentionally. And what we've witnessed is that these partnerships have the potential to activate a better system of health, and they're an especially effective conduit in addressing the social determinants, which are really widespread in numerous communities.

Two big takeaways here. One is a reminder that partnership is not the goal; it's the strategy to reach the goal. And I think sometimes with all the information, everything in the literature these days about the need to partner, we get confused that that's not the end goal. The end goal is actually improvement to the health and health care delivery system, and that partnership is a strategy.

Second takeaway is that there is, unfortunately, no big playbook that exists for partnership development. There's lots of toolkits. There's case studies. There's inspiration to pull from. But there is not a standard playbook, and what we've seen the reason is is because the class of challenges that these partnerships are coming together to address, they move beyond a complicated problem to one that's complex. And you can't really solve a complex problem by using the same kind of strategy that you would to solve a complicated problem, regardless of how we would like to do that.

In the nature of complex, you're working with multiple factors, multiple relationships, the interplay between those factors, how they influence each other. And they're constantly changing. Think about it for a minute. Improving the health of a population, yes, it takes access to high-quality health care, but it's also significantly influenced by economic conditions, housing or lack thereof, psychological wellbeing, nutrition, all of the buckets that we're calling the social risk factors or social determinants of health. And those are changing all the time, constantly.

So there's no real bypassing the work that's required and understanding your own environment, your own local market, what might work within your organization but also across a network of organizations, and the willingness to experiment. I say that because it really needs to be considered as you start the design and implementation of these partnerships.

But we have seen in our work over the last several years themes, or some people might call these conditions, that you can start to consider as you think about your partnership work, the first one being leadership. Everybody leads with this, but I'm really talking about leadership that's way beyond being a champion for partnership, but leadership that's willing to take a very active role in numerous phases of partnership development, all the way from launch to implementation and design to sustainability.

I'm also talking about a leadership that adopts the style—and this goes back to influence versus control. So, understanding the awareness of the entire system and the relationships at every layer that are involved, and have ability to activate and maintain change not only within their own organization but across a network of partner organizations where the typical hierarchy for getting work done doesn't exist. We find that the system leadership is a nice framework.

The second one is financial, and a lot of these partnerships are being funded by grants to get them off the ground and started, but if you think about a grant, that's a short-term financial mechanism and the work of partnering is a long-term endeavor. So really looking at the finance mechanism early on, early in the design phase, and also the case, what's the financial case for partnership. Who has the most to benefit? Who bears the risk? How does the partnership get designed to align multiple incentives across multiple stakeholders?

I'm going to rush through some of these. Design, that's another piece, and this is often an underestimated area of focus. If you think about your own organization has an org chart, your partnership organization has an org chart. You also need an org chart for the partnership. How is work going to get accomplished among multiple organizations? How is communication going to happen? And so forth.

And then market conditions, and then I'm just going to pause here on the capacity. Capacity building that we've seen has been very focused at the community-based organization level. There's numerous foundations, the SCAN Foundation, the Colorado Health Foundation, the Marin Community Foundation. You're going to hear from a couple of those grantees in just a moment that are funding capacity building for community-based organizations to build skills and assets to partner more effectively with the health care sector.

Because we work on the other side of the equation as well, that capacity building goes both ways. If you think about the capacities to deliver effective cross-sector partnership, they don't really come naturally to organizations that have been accustomed to working in what we call silos. As one health care executive put it to me, a hospital CEO said, "We, too, need to work on our capacity to partner with organizations that we don't know and understand a lot about." So that capacity building, the capacity building to partner, very important for success of the partnerships. Last slide, please, and this will be my final one here.

Where do you get started? This is in the assessment, so assess first. And if you take yourself through a comprehensive assessment, you're likely going to address all of those conditions that I just started to briefly talk about.

We developed an organizational readiness assessment that's been used in a variety of ways. It has the six domains—so, adaptability and change readiness, leadership and governance, operations and management, financial and business acumen, program and service redesign, technology systems and data literacy—and this has been utilized in many of the foundation work that we've done to assess readiness at the community-based organization level. We've also now started to use it as health plans as hospitals and health systems start to look at who's in the market at the community level and how do we start to assess their readiness for partnerships, and to deliver, especially as volume most likely increases.

Then we also, which there is an example here, did a redesign of this assessment for the Aging and Disability Business Institute, which is on the public domain.

So, assess first in getting started. Assess your population. Assess and understand the market. And then probably the most important, which I just spent a little bit of time on, is your organizational self-assessment to really pinpoint do you have the desire and the skills and capacities to be a capable partner.

I'm going to turn it over. There's two other slides here. I would recommend taking a look at one more last slide here. If you get an opportunity, these are very notable results that we've seen from some of the partnerships. Two of the community-based organizations that I've highlighted here were actually part of the foundation work that you're going to hear from the next two presenters, but these I think are pretty notable and speak to the opportunity for partnerships to really start to make a difference in improving the system of health and health care.

Thanks, everyone.

Jessie Micholuk: Thanks, Lori. We'd like to turn it over to Paul Castro now.

Paul Castro: Thank you. This is Paul. I wanted to talk a little bit about Jewish Family Services. Chris did a little bit in the introduction. JFS is the first organized charity in Los Angeles. 1854 was the founding. As you can see, we've been in the community a very, very long time. Our mission is to strengthen and preserve individual, family and community life. For most of our history, we were a fairly traditional, social-work-focused organization, but after the Older

Americans Act was passed, we began to expand and move into areas of older adults and persons with disabilities.

As an organization, we receive referrals, particularly with regard to the work that we're talking about, from health plans and health providers, really focused in on our delivery of social services to participants who have complex needs. We utilize a case management staffing structure where we assign cases to our social workers, and the social workers typically see clients in the homes or in other institutional settings.

As an organization, our funding sources are fairly varied. We receive government funding from all levels. We do a lot of private philanthropy. We have a strong fundraising capacity. And then of course, third-party payers.

The population, we serve about 100,000 individuals annually through a variety of service intervention. About a third of that number are older adults and people with disabilities, and the majority of the older adults are dual-eligible beneficiaries. Some of the services we provide, we have senior centers, adult daycare centers. We do case management, as I mentioned, for the persons with disabilities and seniors with complex chronic conditions. We do a lot of health and wellness evidence-based work that helps people maintain independence and stay in their homes, etc. We also provide counseling and support for participants, their families and for their caregivers as well.

We were part of the first class that the SCAN Foundation had of their Linkage Lab learning collaborative. We were there from 2012 to 2014. We joined the collaborative because we were looking to see how we could engage in this environment that was changing, particularly around health care relationships to community-based organizations, as a strategy to build long-term sustainability for the organization and to help us prepare for a landscape that was rapidly changing and really gave us the opportunity to evaluate our current model, an organizational model of not only service delivery but in terms of how we structured our leadership.

Part of what we were looking for was to build partnerships with managed care entities to better meet the needs of our populations, as there was a thrust in California to begin to move our clients into more managed-care environments.

To be successful, there were a few things that we needed to recognize. One is that there needed to be a full commitment from executive leadership, so all the executive leadership participated in the learning collaborative and every meeting was required and attended by the entire executive team. Also, a willingness to take an introspective look at the organizations and particularly the gaps and the vulnerabilities. An organization that has a history that we've had, 163 years, you kind of build obviously over decades a certain model of how you do things. This was an opportunity for us to rethink where we were at that particular time and hopefully adapt going forward.

Then we needed to really evaluate and make investments, both financial and human capital, to support the work that we were trying to accomplish.

As we looked at our core competencies and the populations that we wanted to identify as being our focus, we looked at the populations that we had a history of really having, in our minds, an effective intervention [program]. Older adults with complex case management needs, including adults with functional limitations. Participants who were currently in the hospital or recently discharged to the community and at risk of readmission. Older adults with disabilities needing linkages to community resources. Dual-eligible beneficiaries. Then a population that had not been traditional; we started to focus on participants who were homeless as well.

One of the things that we realized is we needed to maintain a results-focused approach in order to really have serious conversations with health providers. And so, we really zeroed in on a few areas. One is that we were focused in on how we would be able to reduce readmission rates, reduce length of stay, connect participants to community resources once they left hospitals or other higher levels of care. Really, utilize our core competency and expertise providing case management. Then provide care transition for participants who identified a particular choice and do so in a timely and cost-effective manner.

In the last few years, California has been really focused in on integrating services to support older adults and persons with disabilities. The coordinated care initiative that emanated from the governor's office mandated that all the programs that have been siloed out previously would be integrated into one service strategy.

So, along these lines, we began to really become active in terms of trying to influence the policy that occurred and, with some legislative support, we were able to really have the opportunity to sit down with health plans and other health entities and really talk about partnerships.

Once we had identified our population and really had zeroed in on some of the results we were trying to accomplish, then these conversations with health plans and hospitals really were more fruitful than we had originally anticipated. Obviously the legislative support was really part of that equation. Once we had conversations, which we were able to connect with health plans, we were able to sit down, work through, and develop contracts with several of them and MOUs in over a two-to-three-month period.

Our selling point was the competencies that JFS brought to the partnership with our ability to handle complex case management cases in a cost-effective manner, and to help identify people who were at risk of rehospitalization or reinstitutionalization. The ability to provide mandated assessments to determine eligibility. Our ability to provide information and facilitate referrals to appropriate services and supports if we couldn't provide those directly.

So based on the needs of the health care plan, we developed a menu of services, and it varied from plan to plan while not fundamentally in terms of the nuances for participants' complex care needs. Essentially we ended up doing psychosocial assessments, care plan development and implementation of case management. We did eligibility assessments of community-based adult services and health risk assessments.

What we were able to do in these relationships is provide a warm handoff and anchor for the participants of the community. We had an understanding of the needs of the hospitalized

participants with complex needs as they were experiencing mental health disorders, disabilities, homelessness and others without financial resources as they were going back out of the hospital into the community.

Based on the needs of a specific hospital, we delivered transition support for persons with behavioral health needs and complex case management needs. Care navigators to support the participants in accessing services and supports they needed, particularly those who were at risk of re-hospitalization or re-institutionalization.

One quick little scenario. At one of our hospitals that we ended up having a contract with was a hospital called California Hospital. This hospital is one that serves the downtown skid row area of Los Angeles where there's a very, very substantial chronically mentally ill homeless population. The way we got connected to this partnership is that some of the staff at California Hospital knew us from our other partnerships at other hospitals, and when they moved to California, they invited us to sit down and talk about a strategy to deal with this population that was inundating their emergency rooms and other services. So they were looking to see whether the model that we had worked with them in another environment that was focused on older adults could actually work with a population that was chronically mentally ill.

We focused in on that population. Our social workers are on the streets, going to communities in downtown Los Angeles, and we're really looking at how we can create interventions with this population that would reduce their need to utilize services at California Hospital. It is an ongoing project. We have funding from a foundation to support it, but it is something that we are learning a lot about, and I think the data at the end of the three-year pilot will be very, very interesting.

One of the reasons why this work is important is that historically community-based organizations were in one silo, health care systems were in another silo, and while there was some connection in terms of referrals, there wasn't really an ability to really sit down and look at the full needs of the participants and the complex care management needs they may have. So building these partnerships with health plans and hospitals and having access to increased resources really gave us the opportunity to really have an impact on the health care side as well, coming in from the CBO side.

Our focus is on delivering services in a timely and effective manner. We're able to reduce readmissions to inpatients or nursing home facilities, reduce length of stay and facilitate communication between facilities and appropriate health care providers, and relink participants to community resources, which we find is really one of the more important aspects of the work that we do.

Lessons learned, just very briefly. It's important for a CBO to build the partnerships around their core competency. Make sure that your work with the health care partners is mission congruent. We are historically a charity. Do things for individuals out of the goodness of our hearts, really just there to do whatever a client needs. So moving into this work where there's a different framework and more constraints in terms of the kinds of work you might do, it's important that your board and your staff are clear about why you're doing it and how it fits into your culture.

So don't assume that the organizational culture is ready for these kinds of partnerships. You need to assess early and periodically to determine the readiness for the partnering. Be creative in aligning your service models with the needs of the health care partner. Meet them halfway. As they get to know you and you get to know them, you'll find that there are things that you can do to create a common ground in terms of how you operate and deliver services. And then keep key stakeholders engaged throughout the new business activity so everybody's aware of how you're doing it.

Next step for JFS is that we want to really build off the experience we've had the last five years in defining our niche in a market that's serving high-risk, difficult and complex participants. It's clear that for particularly the health plans, they're most interested in CBOs, from our experience, who can really take the high-risk individuals who are really, really costing them the most money. There are other entities that can do it with less-intensive levels of participants who don't necessarily need the interventions as deep as this.

It is something that's starting to emerge as being our niche. What comes with that is making sure that we can really put together a pricing structure that covers our cost.

Let me stop there. I know pretty much I've run out of my time. Anyway, thank you.

Patricia Yeager: Hello, this is Patricia Yeager. I'm going to talk about a different program of people. The Independence Center is a non-profit organization based in Colorado Springs that provides traditional, i.e., skilled and self-directed home health care services. Self-directed is often with family and friends. We also do independent living skills training and advocacy services for people with disabilities. We have 340 employees. We cover a six-county area, and we are not a residential facility.

The services range from providing peer support, skill classes, employment assistance to individuals and advocacy to effect change both within the disability community and the outside. Please see our website. There's so much more that we do that I don't have time to talk about.

Our mission is to work with people with disabilities, their family and the community to create independence so that all may thrive. In general, the participants in our home health division are under the age of 65, and all of them qualify for Medicaid services. Between 15% and 20% are dually eligible beneficiaries. We have been providing home health services for about 30 years in this area, so we have a lot of credibility and trust, and we have been serving individuals with disabilities between the ages of three and 105, so we have a lot of experience.

The IC focuses on person-centered plans of care. We live and breathe this. Most of us have disabilities in the family or at the center of decision-making. We bring in-depth knowledge of eligibility and entitlement programs as well as local services to the consumer.

Customized caregiver plan training for unique service plans. Each person in our home health division has a plan of care, and we teach and train the providers on how to do that particular service.

We value and we really work to promote and build internal and external collaborations to create better outcomes with the participants and the payer.

We sort of have a right-brain, left-brain. Part of us is medical, part of us is social. We have struggled with that. Because of it, we are able to listen to the health care provider and their patient, our consumer, and better address their issues.

I'm going to deviate a little bit from this timeline. In 1987 our home health Medicaid-only home health agency was established by a woman who was a quadrant. In 1994 The Independence Living Center, the civil rights part of this organization, came up. In 2011 I came in to modernize our organization, and through that modernization, we were getting ready. We improved our services and processes. I didn't know what we were getting ready for. I now know.

In 2012 the IC board and senior staff made an intentional decision that we wanted to bring these two programs, independent living and home health, together to become a provider of health and social services under the independent living model, consumer-controlled model. What we're hoping to do is show that The Independent Living Center could be financially and otherwise supported internally by our partnership with home health and externally with partnerships in health care. But we could not do this alone. We had to have partnerships in the community, and you'll see in our model how that worked.

In 2015, we joined the SCAN; actually, it was on the Colorado Health Care Foundation Linkage Lab session, which was modeled after the SCAN Foundation's program. We learned about business acumen, how to prepare for cross-sector leadership, and it was a fabulous experience, as shared by the previous presenters.

Currently we're working on two partnerships. The first is the hospital-to-home transition program, which actually started this week, and the second one is we're planning with the Rocky Mountain Health Services PACE program for the person-centered community care model, the P3C.

First, I'm going to talk about the hospital-to-home transition slide. Our goal is to significantly reduce the number of patients coming out of the hospital with disabilities going to a nursing home. We wanted to see if we could get them home for faster recovery and more integration into the community.

I want to tell a quick story here. A nursing home contacted us and said this person, for lack of a ramp, could live at home. It was a gentleman with a brain-stem injury, a brain-stem stroke. Had a young family. Wanted to be home, but they didn't have a ramp. We put a ramp in. He went home. We trained his wife as a CNA provider. We pay her to provide services to him, and he has an eye-gaze system that allows him to type on the computer with eye blinks so that he can communicate. His quality of life has gone through the roof.

Why can't we do that with other people coming out of the hospital? That was the beginning of the hospital-to-home transition. This requires quite a bit of wrap-around services, and you can see the list here. We wanted to be able to do the assessment, pick up the person from the hospital,

take them home. Their home mods are already in place. Their prescriptions are there. The family has some understanding of what's getting ready to happen. We have already started participant engagement through our peer support specialist who has been in to see and visit and build a relationship with this person. And we've already started whatever benefits process needs to happen.

This is a 30-to-60-day process, and the value to the hospital is that we get the person out faster, or at least they don't overstay their time. The consumer has a better experience. No hospital readmits. And they begin to create a life that they want to live.

To do this, we had to develop a network of CBOs in the community, and you can see we had to get medical transportation buy-in, food prep. We have a contract or an MOU with a Medicare provider who can back up our nurses and help us with OT and PT services.

In order to do this, in order to promote a successful partnership, we wanted to understand the hospital feed before presenting a plan. It was suggested to us that we get a staff person from the hospital to come to be on our board to help us figure this out, and we, in fact, did that. The director of the hospital's rehab program joined our board, gave us a crash course on what I call hospital cultural competency lingo, and gave us access to the discharge planners so we could start to identify the gaps that they might be having. We identified three.

Oftentimes care planners thought the patient was too complex to go home. We have not yet met a complex case. I know they're out there, but in our view, we think that we can work with just about anyone to get them home and accommodated.

We also saw that the family needed some support and needed to be assessed, would they be able to take care of that person at the home. Oftentimes they get halfway through the rehab process and throw up their hands and say, "Oh my god, I don't think we can do this. We need to put this person in a nursing home," and that would impact the hospital's bottom line. So we work with the family.

And the last one was a surprise to us. It shouldn't have been. The hospital has a number of homeless people stuck in the hospital. And so, one of our pilot projects is going to be working with a homeless respite care organization to help them to see if we can do this for the homeless population as well.

So we put a plan together. Our knight in shining armor from the hospital vetted the process, vetted the marketing. We presented it, and the hospital said, "Okay, we're going to try this." Therefore, we have a six-month pilot, and our goal is to show the hospital savings and a better outcome for the clients.

That's the hospital-to-home. That was an internally planning process. I'm going to briefly talk about this new project that we're engaging on, and this is an external partnership. As you might know, CMS is currently considering a pilot to look at allowing younger people to use the current PACE project, PACE program. They are looking at dually eligible beneficiaries with seven

mobility-disabling conditions. These disability folks, folks with these disabilities, are our friends, people we've worked with for years, so we know this population very well.

In 2015 the Rocky Mountain Health Services PACE program and the IC initiated discussions and began to meet. The PACE program here has a long history and experience working with the PACE program, the PACE population, but they're not really prepared to work with a younger population. The Independent Living Center, the ILC, has experienced working with younger populations and understands the needs and how to encourage integration into the community, but we do not have a lot of experience managing actual medical care and costs.

So we decided to try this, and our objectives in our first meetings were to map out a process, what would this look like. Develop examples of people who would come in and need services and how much that might cost. We've done a lot of research with our Medicaid and Medicare data in this county to see what are the usages, what health care usage does this cohort of seven disabling conditions use. We need to build a financial model and have a joint operating agreement in place.

It's very different, the two cultures are different, and how I'm going to explain this is they work with Excel charts and we work with flow charts and process maps. And when the two come together, it can be sort of difficult. We had to figure that out. And we also asked the question, Do we have to do this with that group? Is there somebody else? And the answer was no. The research that we did showed that 75% of the PACE's future population are people under the age of 55, so why wait to serve them? Let's get in there together and do it together.

Their strengths, they're a current PACE provider. Medical experience. And they're currently redoing their clinic so that they have accessible exam tables and equipment, which will be so helpful for the younger population.

Our strength is the social engagement that we do and our trust and knowledge of the younger population.

The initial meetings were chaotic. I didn't know if we were going to be able to do this. In the middle of all this, they got a new CEO. He and I clicked, and we work very well together, and the process began to open up.

How we solved the chart people versus the picture people is that we created what I call a sandbox for the dreamer group to be able to sit down and look at what this would look like, map out a process, and then we turned it over to the subject-matter experts, the medical people on their side, the independent living people and home health people on our side, to flesh out the details. We know how we're going to operate, and we just need to really concentrate on the communication and how are we going to integrate all of these services that we currently provide. We are waiting for that CMS proposal to drop.

Lessons learned. One organization cannot meet everyone's needs. Partnerships are key—see number one. You need to be flexible with partners, and you need to be flexible in your design because you in your research will find other things, other gaps that will come up.

Think big but start small. In our hospital-to-home, we have committed to doing one person per month. Now, we think we'll do more, but for now to get the processes together, we're going to do one person a month. In another program we work with the VA, we decided not to take too many people until their payment process was in place and we knew we would get paid, and then we let more people in.

We had an epiphany here that the customer is the hospital, not so much the consumer or the person with the disability. They are the beneficiary. So we are reporting to two bosses, in a way, and they have two different metrics and two different agendas, often the same but sometimes not.

And finally, having a project manager who could guide us through this process and ask the right questions and help us draw the picture and put it together was absolutely critical. All of the senior team had day jobs here at the Center, and taking this planning on was really quite difficult.

I hope that the hospital-to-home program works unequivocally. We will find that out in the next six months. We want to offer to Kaiser, and other managed care programs for seniors, to understand that Medicaid Advantage has just added in-home support services to their list of benefits. That will be hugely helpful. We want to provide this to Medicaid and to Workers' Compensation. Those are target areas for us.

Finally, Colorado is a fee-for-service state at the moment, and it's inching its way slowly but surely towards a managed care prospect, and we want to really be engaged and involved so that we can be a part of that movement and ensure that people with disabilities get great-quality health care.

And that's it.

Chris Duff: Thank you, everyone. Patricia, I especially love that story of the gentleman you worked with. And then also your ah-ha moment that you had two customers in that program with the hospital. I would not have thought about that, and I thought that was very interesting.

We have a few questions here. One I just want to acknowledge. It wasn't so much a question. Peggy thanked the IC for mentioning DME, which she says is an important wraparound service. It certainly is. And I just wanted to point out that if you go to the RIC website, Resources for Integrated Care, we've done several webinars back in some previous years around a range of DME and home and community-based services, wheelchair equipment and so on. So I encourage you to reference those resources also.

Then, Patricia Chapman from Aetna wanted to know, how do you get the prescriptions already at the home?

Patricia Yeager: Well, we are going to find out, but we have a relationship with a pharmacy here in town a long time, and if we can get the prescription from the doctor, we can run it over to him and he will deliver it, a two-dollar charge. He will deliver it that day or the day before. So we're going to see if we can get the prescription early enough to be able to make that happen.

Chris Duff: So that is still one of the things on your list to try to monitor and figure out.

Patricia Yeager: Right.

Chris Duff: Okay. This is a question from someone in management at a center for independent living, who says, We believe we bring value to our local health plans. How do we initiate working together with them? Maybe why don't we start this with Lori and then maybe go on to Paul.

Lori Peterson: Chris, I might bounce it back because you said this was an independent living center, correct?

Chris Duff: Yes.

Lori Peterson: Yeah, so probably hearing it from the horse's mouth, Patricia, please do not take that the wrong way, would be the best way. Then I can totally weigh in.

Chris Duff: Okay. Patricia, can you start with that?

Patricia Yeager: Well, we have somewhat of a working relationship. The discharge planners all know about us, but they typically don't use us very much. They forget. And so, bringing on that staff member, director of rehabilitation, onto our board, he did a lot of keeping us visible and helped us really understand, as I say, hospital cultural competency so that we can work with them. So getting someone from the plan, your health plan, to work with you, to buy into this, show them the value of what you have to offer, how can you enhance their patients', your consumers', experience and be a better steward of their medical dollars, will go a long way.

Lori Peterson: Chris, I will just add, because this comes back to my point on the no playbook. What might work in that particular market with that particular organization could look very different than it does in, for example, where Patricia is in Colorado Springs. I think she makes a great point when she identifies multiple possibilities for relationship development within that system, all the way from a physician on the board to a case manager who is doing the day-to-day. The second piece that I'll just reinforce is the understanding of what it's like to live in their world, and so, making sure that there's been some research or some assessment or some other conversation to actually understand what is it that they're challenged with and what might be the opportunities, how do I need to open up that conversation with something that's going to resonate with them, not necessarily just what I think they should hear or know.

So those are the things I would add. I'm sure Paul has some more to weigh in here as well.

Paul Castro: Yeah, I think what Patricia and Lori said I think is important. Sometimes it just takes trying to find that person at the health plan or at the hospital that you think would take the time to really sit down and talk to you. Our experience has been that you've got to have the conversation move almost immediately to how you can save them money; otherwise, they really don't have the patience for the conversation.

Fortunately, for us because we had a contract with CMS doing the innovation work, care transition work, we have data that shows that we were able to reduce readmissions. We also had relationships with our board members who knew people in health plans and in hospitals. So we basically looked for any opportunity, any leveraged relationship that we could find in order to get in the door. And of course, again, there was some legislative mandate in California that required health plans in particular to have conversations with CBOs, and we maximized those to the extent that we could.

Chris Duff: Thanks, Paul. Elisa from Inland Empire Health Plan in California asked, how would a health plan go about identifying area CBOs that might meet the needs of the target population as far as wraparound services go? I'm not sure who would best do that. Why don't you take a start at that, Patricia, and then we'll see if either of the other two have comments.

Patricia Yeager: If I were in your shoes, there are a couple things. You could do a focus group with your participants who have disabilities for seniors or whatever community you're trying to improve services, and ask them, "What are the barriers? What do you need? What would be helpful?" And then once you've done that, then I would have an open house, a luncheon, some sort of a meeting and invite the agencies in your area that provide those services and open up a dialogue. If they have not worked with a health care plan before, they're a little scared about all this, you may have to provide some training and hand holding to help them figure out how to do it.

I believe they would be very interested, particularly if there is a reimbursement or financial arrangement. That's how I would approach it.

Lori Peterson: Chris, this is Lori. I'll jump in. I know we're short on time, but I think the question is categorized in, one, how do I identify who I want to work with, and then second, how do I select, what's the criteria for partnership selection, and how do I go about that? One in just the identification, you could do all the way from general market research to looking through the resource guide to an RFP, just to get a sense of who are the players in the market and what services are they offering. The organizational readiness assessment that I referenced, that gets more into, okay, we know who's in the market, we know what services, but do they have the skills and capabilities to deliver in a way that we will need them to deliver as we start to form the partnership.

So I would say in thinking about it, I would look at those three categories. One, how do I identify? Which can be done with some market research. Number two, how do I figure out what the criteria for partnership is? And then three, how do I assess if that is the right partner for what we're trying to achieve through the health plan's initiatives and goals?

Chris Duff: Thank you, all. I appreciate it. I think this has been a great webinar, and I'm afraid our time's up and I need to pass it back to Jessie for closure.

Jessie Micholuk: Thank you, Chris. Thank you, all, for attending today's webinar and for your contributions to our discussion, too. Please feel free to continue to send any additional questions via the chat on the platform or, of course, our email address is RIC@lewin.com.

I'd also like to thank our presenters, Lori Peterson, Paul Castro and Patricia Yeager, for all your help getting this webinar ready for today and of course for your discussions.

For more information about obtaining CEUs or CMEs and of course for additional resources, please visit our website, ResourcesForIntegratedCare.com. You can access the CMS Continuing Education Credit Guide, which is located on the left-hand side of the platform in the Resources Library, for additional information, too.

As always, your input is essential in developing new trainings and resources. Please answer our brief survey that will appear automatically on your screen when this webinar ends. Again, you can send additional comments that you have to our Inbox, RIC@lewin.com. Finally, you can follow us on Twitter at integrate_care.

Once again, thank you for attending today's webinar, and have a great rest of your day.