Connecting People Dually Eligible for Medicare and Medicaid with Non-Medical Service Providers: Promising Practices for Health Plans

Health plans that contract to provide comprehensive care to dually eligible individuals may find it beneficial to collaborate with community partners that provide services beyond direct medical care, such as housing, transportation for non-medical needs, and food. Leveraging existing non-medical services could improve your plan's ability to coordinate the care needs of dually eligible individuals, increase overall health status, and ensure better outcomes for specific episodes of care.

This document provides a checklist of promising practices to help your plan strengthen existing partnerships and form new collaborative relationships with providers of non-medical services. The checklist includes specific suggestions for how to accomplish the following goals:

1. Identify relevant community partners

2. Collaborate with relevant community partners

3. Prepare for challenges

The Appendix provides four examples of health plan collaborations with non-medical service providers that have successfully improved members' health outcomes. These case studies may give your plan some helpful ideas for how to connect with non-medical, community-based service providers to improve care coordination for dually eligible individuals.

1. Identify Relevant Community Partners

Steps to identify community partners in your area:

☐ Connect with the following state and local entities for databases and information on providers of non-medical services.[1] In most cases, these entities were created to serve the purpose of better connecting members to needed resources:

    ☐ Aging and Disability Resource Centers (ADRCs)

    ☐ Area Agencies on Aging (AAAs)

    ☐ Community health centers (CHCs) or Federally Qualified Health Centers (FQHCs)

    ☐ Centers for Independent Living (CILs)

    ☐ Social service agencies/local Departments of Social Services (DSS)

    ☐ Public health departments

    ☐ Community Service Boards (CSBs)

    ☐ Advocacy networks

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[1] The Greater New York Hospital Association is one example of an advocacy network that has already developed a provider database. The database, called the Health Information Tool for Empowerment (HITE), contains a large repository of providers, organized by service type: http://www.hitesite.org/.

☐ Free and charitable clinics, which also provide or coordinate many non-medical services

☐ Local United Way organizations

☐ American Network of Community Options and Resources

☐ Public transit associations

☐ Public housing authorities, such as the U.S. Department of Housing and Urban Development (HUD)

☐ 211.org (operated by the Alliance of Information and Referral Systems and the United Way), which provides comprehensive local information on community resources

☐ Search for health coalitions in your service areas that have existing partnerships with providers.

☐ Attend meetings, health fairs, community events, and support groups.

☐ Sign up for provider newsletters.

☐ Investigate being a part of referral systems that are used by state and local agencies, advocacy groups, and the faith-based community.

☐ Reach out to community organizations that can communicate with members who have limited English proficiency or have different cultural backgrounds.

☐ Contact religious, ethnic, and cultural organizations that can help align supports and services for your members.

☐ Outline desired criteria to help you identify ideal providers. For example, when searching for housing options, your plan should consider the facilities (e.g., ADA compliant, meet safety standards), equipment (e.g., meets the needs of your members), staff (e.g., staff are trained), and capabilities (e.g., dietary options, housekeeping).

In addition, national directories of service providers are listed by service type in the companion tool, Community Resources Guide for Health Plans (available at: https://www.resourcesforintegratedcare.com/general/care_coordination/tool/community_supports). Add services relevant to your member population that are not currently found in the Community Resources Guide for Health Plans and remove services that are not relevant.

> **"We want to tell plans that we can help them produce the outcomes they desire."**
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> **- Housing services organization (Ohio)**

2. Collaborate with Relevant Community Partners

Your health plan may want to form a partnership or formally contract with one or more community partners. The following steps outline helpful strategies to build these relationships:

Outreach

☐ Join or organize a learning collaborative or coalition of advocacy groups, community partners, and state or local governments dedicated to identifying and meeting the needs of your members. The Appendix provides examples of successful coalitions that have improved member health outcomes.

☐ Encourage health plan employees responsible for outreach to meet with community leaders, members, and members' families face-to-face. This will increase communication efforts between plans, providers, and members.[2]

☐ Gather a team of program champions to lead communication with community partners. Program champions are advocates who manage and promote the plan's efforts to partner with providers of non-medical services.

☐ Consider operating a store-front with "boots on the ground" at local businesses and community centers to reach providers and inform members about available services.

☐ Establish lines of communication with advocacy groups to help your plan understand the needs of member populations and demonstrate to providers that your plan is committed to meeting their clients' needs.

☐ Reach out to state governments and attend state-hosted focus group calls, stakeholder meetings, and outreach events to connect with providers. If your plan operates in a larger state, regional meetings might be appropriate to more easily identify available community partners.

☐ Connect with organizations that provide options counseling such as Area Agencies on Aging, which can give valuable insight about services that are most important to your members. Area Agencies on Aging may also provide some non-medical services and have existing relationships with providers.

> **"We're seeing the plan's members every day, so we can be its eyes and ears."**
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> **- Comprehensive services provider for elderly populations (Minnesota)**

Program Planning

☐ Consult with providers for ideas on how to coordinate care, streamline processes, and create an efficient partnership. For example, providers that already have regular face-to-face contact with your members could complete comprehensive member needs assessments required by the state, as well as provide valuable insight into developing the assessment.

☐ Consider putting in place a memorandum of understanding or formalized contract between your plan and your community partners. Be clear about service expectations for meeting member

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[2] Heath, Sara. "More Face-to Face Interaction is Key to Patient Engagement," accessed April 1, 2019 at https://patientengagementhit.com/news/more-face-to-face-interaction-is-key-to-patient-engagement.

needs; for example, agreements with transportation providers should address how much time in advance members need to request a ride and whether the trip is direct or will have stops.

☐ Assign certain staff members to manage outreach to community partners, monitor contracts, or execute care management for members' non-medical needs.

☐ Consider bringing services to congregate housing properties, which may allow for a greater range of interaction with members. For example, on-site care managers can provide care coordination, comprehensive assessments, health education, and medication management.[3]

☐ Take advantage of having multiple enrollees living in one housing site. For example, your plan could work with the service coordinator at the property or fund one, if necessary. If there aren't enough members living in one site, you can develop a network of housing organizations.

☐ Partner with home-delivered meals providers, as they can present another opportunity for face-to-face contact with your members. For example, their home visits could be expanded to include tailored nutrition education, assessing the home for fall risk, medication management, and observing signs of dementia in elderly members.

☐ Consider developing a pilot program, if applicable, before implementing a full-scale program throughout the health plan.

☐ Identify particular health conditions or member populations that may warrant special attention and consider structuring a program around these members.

Financial Relationships

☐ Consider providing cash advances to community partners to alleviate their concerns about service provision. Small community-based organizations may experience greater difficulties with delays in payment if they bill incorrectly or if the plan misses a payment as a result of switching to a new managed care arrangement.

☐ Make donations to community partners and foundations for specific health and wellness-related activities. This will help demonstrate your plan's interest in the health of their clients.

☐ Explain current billing, contracting, and other reimbursement processes to community providers who may be unfamiliar with and concerned about managed care arrangements.[4]

> **"One plan provides financial support by sponsoring our largest fundraising event of the year. This is a huge help to us."**
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> **- Meals provider (Ohio)**

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[3] For more information on building a supportive housing program, visit the Substance Abuse and Mental Health Services Administration's Permanent Supportive Housing Toolkit: http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510

[4] The Commonwealth Fund, "Forging Community Partnerships to Improve Health Care: The Experience of Four Medicaid Managed Care Organizations," accessed on March 29, 2019 at https://www.commonwealthfund.org/publications/issue-briefs/2013/apr/forging-community-partnerships-improve-health-care-experience

Ongoing Communication

☐ Create opportunities to learn about current and potential community partners, openly exchange and clarify information about the partnership, and reinforce your plan's intent.

    ☐ Invite partner community organizations regularly to the plan's staff meetings.

    ☐ Host social events, such as community support mixers or coffee meetings, and sponsor provider fundraisers, health fairs, and other events at local community centers.

    ☐ Encourage your plan's employees to sit on the boards of provider organizations.

Performance and Oversight

☐ Track quality measures to assess health outcomes and monitor progress. It is useful to have a control group to compare to your intervention member population, or conduct pre- and post-intervention comparisons with the same population.

☐ If your plan has a sufficient number of enrollees, compare quality measures with available national or regional benchmarks, such as the Healthcare Effectiveness Data and Information Set (HEDIS).[5]

☐ If your plan has a sufficient number of enrollees, implement surveys to track members' and providers' satisfaction with the program. Surveys should also allow members to report incidents of abuse, neglect, or exploitation. If appropriate, surveys may ask members' families and caregivers to report on members' experiences. Some survey resources that plans may find helpful include:

    ☐ Consumer Assessment of Healthcare Providers and Systems (CAHPS) – https://www.ahrq.gov/cahps/surveys-guidance/index.html

    ☐ Health Resources and Services Administration's (HRSA) Health Center Patient Survey - https://bphc.hrsa.gov/datareporting/research/hcpsurvey/index.html

    ☐ Participant Experience Survey (PES) - http://nasuad.org/hcbs/article/participant-experience-survey-pes-tools

☐ Collect qualitative data from case managers who can help ensure that provider organizations and individual staff comply with members' needs and preferences. Case managers can also ensure that the plan includes alerts for any quality concerns about specific providers or individual workers.

☐ Share data with community partners and discuss with them ways to improve care coordination, service delivery, and member outcomes.

☐ Develop oversight mechanisms to prevent fraud and abuse. For example, your plan may require use of electronic visit verification systems to ensure that services are scheduled, authorized and delivered in accordance with your guidelines.

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[5] More information on HEDIS measures can be found here: http://www.ncqa.org/HEDISQualityMeasurement.aspx

3. Prepare for Challenges

Other health plans' experiences may help your plan prepare for challenges. Recommended strategies to improve your chances for success include the following:

☐ Develop strategies beyond telephone calls for initial outreach and ongoing engagement with members, and consider visits to members' homes or popular gathering places. As much as one-third of phone numbers that health plans receive from state records may be disconnected.

☐ Prepare for paper-based means of data collection from community partners that may lack necessary information technology resources.

☐ Prepare your health plan to allocate additional staff time to train providers and provide technical assistance. Developing a provider manual that outlines billing, payment, and communication protocols may also help providers understand new rules and procedures.

☐ Build in sufficient time (e.g., six to nine months) between approaching a community organization and formalizing a partnership.[6]

☐ Be aware that there are waiting lists for many needed resources, especially housing. Therefore, your plan may want to prioritize this service when seeking community partners.

☐ Simply referring members to community resources may not be enough to connect them with the services they need. Your plan should be prepared to offer advice, discuss specific steps, and have follow-up discussions with members to ensure they are adequately receiving these services.

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[6] Agency for Healthcare Research and Quality, "Community Coalition Connects Medical Practices to Community Resources, Leading to Improved Asthma and Diabetes Outcomes in At-Risk Populations," accessed on March 29, 2019 at https://innovations.ahrq.gov/profiles/community-coalition-connects-medical-practices-community-resources-leading-improved-asthma

Appendix: Health Plan Collaborations with Non-Medical Service Providers to Improve Health Outcomes

This appendix provides four examples of health plan collaborations with non-medical service providers that have successfully improved members' health outcomes. The following case studies may provide some helpful ideas for how to connect with non-medical, community-based service providers to improve care coordination for dually eligible individuals.

Addressing Comprehensive Care Needs – Case Study I

Program Name: Senior Care Options

Lead Organization: Commonwealth Care Alliance, Massachusetts

The Problem: Chronically ill and disabled individuals often lack adequate transportation and access to social services, which may directly affect health outcomes.

Collaboration Strategy: Commonwealth Care Alliance is a non-profit health plan and provider organization. Under the Senior Care Options program, the Alliance partnered with multidisciplinary teams that included geriatric social workers, community health workers, and clinicians that assessed patients, developed care plans, and assigned appropriate health and social arrangements. Social services became a focus in meeting the comprehensive needs of the patients. For example, a patient who was deeply religious and suffered from depression received not only treatment for her clinical diagnosis, but the care team also arranged for regular transportation to church services, which helped her cope with depressive symptoms.

Lessons Learned: The Alliance allowed its care teams to have independence in making necessary arrangements for social needs to improve health outcomes. The Alliance also experienced some challenges with finding primary care physician practices to "serve as the foundation of the program," as well as recruiting multilingual care teams to serve the diverse patient population.

Program Results: Enrollees in the program experienced a 55 percent drop in their hospital length of stay compared to a comparable group of individuals in a fee-for-service program. In addition, the rate of nursing home placements for program participants was 30 percent the rate of the comparable population receiving care through a fee-for-service arrangement. For more information, visit the following resources:

- http://content.healthaffairs.org/content/30/3/412.full?ijkey=9267deecce017345c68c850fa0ef38ddd630845c&keytype2=tf_ipsecsha

- http://content.healthaffairs.org/content/32/3/544.full

Addressing Comprehensive Care Needs – Case Study II

Program Name: The Action Program

Lead Organization: The Hudson Health Plan, New York

The Problem: New York's high-need Medicaid fee-for-service enrollees often lack housing and other basic necessities that are important to their overall health.

Collaboration Strategy: The Action Program provided comprehensive care management to Medicaid enrollees with complex health and social needs. The program used a multidisciplinary team of case managers, nurses, social workers, and peer specialists to link enrollees to a number of services beyond direct medical care such as housing, food, and transportation. The plan's primary collaboration strategy was to join a coalition of 25 organizations, collectively called the Hudson Valley Care Coalition, which could address the full range of enrollee needs.

Lessons Learned: The health plan cited several challenges with the program, including lack of housing resources in the community, difficulties with information sharing between the plan and community partners, and issues with locating clients to enroll in the program. Although it was difficult to overcome many of these challenges, the plan learned some important lessons. For example, future projects should establish additional partnerships with local housing organizations before project launch, develop a standard consent form that allows community providers to share information while respecting federal patient privacy laws, and prepare to search the streets, homeless shelters, and drug clinics to locate enrollees.

Program Results: Despite the challenges, preliminary results show that clients of the Action Program experienced 45 percent fewer hospital admissions and 15 percent fewer emergency department (ED) visits after two years of the program. For more information on the Action Program, visit the program spotlight: http://www.chcs.org/usr_doc/NY_RCP_CIDP_Profile_122112.pdf

Targeting Specific Member Populations - Case Study III

Program Name: Chicago Housing for Health Partnership (CHHP)

Lead Organization: AIDS Foundation of Chicago (AFC)

The Problem: Approximately 3.5 million individuals are likely to experience homelessness each year. This problem is compounded by the fact that individuals who are homeless are more likely to have a chronic medical illness.

Collaboration Strategy: AFC led a citywide collaboration (CHHP) with two hospitals, 10 supportive housing agencies, and two programs providing medical respite care. CHHP followed the "housing first" model, an approach that places homeless individuals directly into permanent supportive housing and provides health care and social services. The three key components to AFC's successful collaboration included the following: leadership from each involved agency (i.e., hospitals, housing agencies, and medical respite care providers), who met frequently to coordinate their separate systems; one entity (i.e., AFC) to set contractual agreements and expectations for collaborative meetings among the stakeholders; and a small working group for closer inter-agency relationships, shared experiences of success, and quicker program evaluation.

Lessons Learned: The Director of CHHP highlighted four lessons learned for future collaborations:

1. Create a well-trained outreach team that can effectively track down the documentation needed to get homeless individuals enrolled in the program. For example, the outreach team should be able to gather the member's prescriptions, identification, medical records, and social security.

2. Share documentation and assessment information to allow all stakeholders in the coalition or network to coordinate with each other and know exactly what each member needs.

3. Hold frequent meetings among social workers, case managers, and others on the ground to discuss the needs and status of members, especially during the first six to 12 months of the program.

4. Adopt a "Housing First and Harm Reduction" approach, which moves homeless individuals directly into permanent, supportive housing. This approach also provides these individuals with a range of health and social support services tailored to the needs of the individual.

Program Results: AFC conducted a random assignment experiment to evaluate the effects of the intervention and found that after 18 months, participants who received CHHP's permanent, supportive housing were 29 percent less likely to be hospitalized, spent 29 percent fewer days in the hospital, and had 24 percent fewer emergency department visits. For more information, visit: https://shnny.org/uploads/CHHP_randomized_trial.pdf

Targeting Specific Chronic Conditions – Case Study IV

Program Name: The Asthma Disease Management Program

Lead Organization: The Neighborhood Health Plan (NHP) of Massachusetts

The Problem: Asthma is the most prevalent chronic disease among the plan's members and disproportionately affects low-income residents. These residents are often exposed to asthma triggers within their homes, but are unable to make needed environmental modifications.

Collaboration Strategy: Under the Asthma Disease Management Program, NHP collaborates with home visitors, asthma care managers, and providers to identify and address social and environmental triggers of asthma. Under the program, respiratory therapists, nurses, and asthma educators visit members' homes to assess and help control environmental triggers through non-medical home modifications. The plan's asthma care managers also help connect members to alternative housing options, tenant's rights programs, and educational counseling. NHP facilitates collaboration with community partners by hosting weekly "integrated care management rounds." During these meetings, teams of home visitors, asthma care managers, and providers discuss each member's situation and then develop or refine the care plan.

Lessons Learned: Partnering with other larger coalitions in the state allowed NHP to develop a high-performing collaboration. These coalitions included: The Greater Brockton Asthma Coalition, a group of community and environmental providers, insurers, and educators; the Massachusetts Asthma Advocacy Partnership, which helped link the plan to community organizations; and the Boston Asthma Home Visit Collaborative, which led the home visits. The plan also learned that establishing a process to collect the data for evaluation before the program's launch is critical for success and sustainability of the program.

Program Results: After 10 years, NHP found that annual ED visits and hospitalization rates had decreased by about 30 percent for their members with asthma. ED visits dropped from 15.3 percent to 10.5 percent, and hospitalization rates dropped from 3.5 percent to 2.5 percent. Measures of medication adherence and patient satisfaction also improved. For more information, visit the program at a glance: http://www.asthmacommunitynetwork.org/node/3554