Building Partnerships: Health Plans and Community-based Organizations

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April 4, 2018

Resources for Integrated Care

Resources for Plans and Providers for Medicare-Medicaid Integration

The 2018 Disability-Competent Care Webinar Series:

Building Partnerships: Health Plans and Community-based Organizations

Webinar Overview

- 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 is the seventh webinar in the series.
- This webinar series builds on the 2017 Disability-Competent Care webinar series, that introduced the model of care and its seven foundational pillars. To view this series, please visit:

  https://www.resourcesforintegratedcare.com/DisabilityCompetentCare/2017_DCC_Webinar_Series/Series_Overview
- Each session will be interactive (e.g., polls and interactive chat functions), with 45 minutes of presenter-led discussion, followed by 15 minutes of presenter and participant discussions.
- Video replay and slide presentation are available after each session at: https://www.resourcesforintegratedcare.com

Support Statement

- This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare and Medicaid Services (CMS) to help beneficiaries enrolled in Medicare and Medicaid 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-Medicaid enrollees, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar.

- To learn more about current efforts and resources, visit
  Resources for Integrated Care at:
  https://www.resourcesforintegratedcare.com

Continuing Education Accreditation

- The Centers for Medicare & Medicaid Services is accredited by the International Association for Continuing Education and Training (IACET) for Continuing Education Units (CEU) and by the Accreditation Council for Continuing Medical Education (ACCME) for Continuing Medical Education (CME, AMA PRA Category 1 credit for physicians and non-physicians).

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Introductions

Christopher Duff
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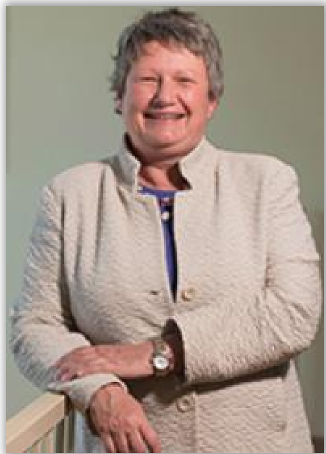

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Webinar Learning Objectives

This webinar will emphasize:

- Integrating community-based resources to address the social determinants of health for participants with disabilities and complex needs.
- Partnerships between health organizations and how these can more adequately meet the full range of needs for complex participants with disabilities.
- Strategies to prepare your organization for partnerships in the health system.

Agenda

- Understanding the population and partnerships
- Strategies for building health care partnerships
- Community-Based Organization (CBO) partnerships in action: Jewish Family Services of Los Angeles
- CBO partnerships in action: The Independence Center
- Audience questions

Understanding the Population and Partnerships

Christopher Duff
Disability Practice and
Policy Consultant

Understanding the Population

- Of the 11.4 million dually eligible beneficiaries, 27% receive institutional LTSS services, accounting for 52% of total Medicare-Medicaid enrollee expenditures.
- Persons with disabilities, especially dually eligible beneficiaries, live their lives "at the edge", e.g., at the precipice of instability, commonly experiencing:
  - Increased health needs due to disability-related illnesses and multiple chronic conditions
  - Social isolation due to community access limitations
  - Financial challenges due to limited income
  - Unstable housing
  - Unreliable transportation for accessing care and social activities
- These participants rely on multiple systems of support, including health care, social services, housing and financial supports. Rarely can one organization meet all these needs.

Source: 1) Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office Fact Sheet. February 2018.

Defining Partnerships

- A partnership is a collaboration between two or more organizations; creating a system of care to better meet the needs of the population being served.
  - Partnerships are facilitated by a formal contract or memorandum of understanding (MOU) between the organizations.
- Dually eligible beneficiaries can particularly benefit from well coordinated partnerships due to their susceptibility experiencing avoidable episodes of illness and other crises that result in the loss of independence and community participation.
- Partnerships between providers, health systems, health plans and community-based organizations (CBOs) can address:
  - The needs of the population through a comprehensive system of care
  - The social determinants of health that are foundational to improving health outcomes

Using Partnerships to Create a System of Care

- Addressing social determinants of health involves looking beyond the health care system to other factors that affect health outcomes. Partnerships can help to address these factors of the population being served.

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Source: 2) Heiman and Artiga, The Kaiser Commission on Medicaid and the Uninsured. Issue Brief.

Building Partnerships in Health Care

- Partnerships can be an extremely valuable tool and mechanism used in the delivery of specialty services.
- Partnerships aim to combine complementary services from different organizations in an effort to deliver the best and most specialized care possible by building upon each other's competencies.
- While the focus is always on the participant, stakeholders of the partnership also generally include:
  - Providers
  - Health plans and systems
  - Community-based organizations (CBO)
- Successful partnerships are built on the contribution of the partners and a focus on the results they hope to gain from the partnership.

Building Partnerships: Participant Perspective

Each partner plays an integral role in the partnership; bringing their own unique contributions, perspective and skills.

- Participants bring the following:
  - An understanding of their disability, including what works and what doesn't work for them
  - Providers with whom they have trust and confidence
  - An understanding of the access and systemic barriers they face

Partnerships are designed to be complementary in nature. One partner's needs can generally be addressed by the contributions other partner brings to the partnership.

- Participants need the following:
  - Help navigating the health care and long-term services and supports (LTSS) delivery systems
  - Help in addressing social determinants of health
  - Someone to call whom they trust when needed
  - Access to primary care in a timely manner
  - Access to specialists who understand their disability

Building Partnerships: Provider Perspective

- Providers bring the following:
  - An established relationship with the participant
  - An understanding of the unique needs of persons with disabilities
  - Established interdisciplinary teams (IDTs) within the disability-competent care (DCC) model, with care coordinators prepared to manage the complexity of the heath care and LTSS systems
  - Relationships with CBOs that can deliver improved outcomes with fiscal responsibility
- Providers need the following:
  - To increase their focus on participant outcomes and quality of care
  - To learn how to transition from the medical model to person-directed care
  - Systems support, including referral flexibility, clinical support systems, quality performance data, and electronic health records (EHR)

Building Partnerships: Health Plan and Health System Perspective

- Health plans and systems bring the following:
  - Experience with acute and primary care provider networks
  - Contracts with providers, particularly those transitioning to value-based purchasing strategies, and a focus on a range of quality indicators and outcomes
  - Knowledge of claims payments, incentives, and managing risk
- Health plans and systems need the following:
  - To understand the broader continuum of services and supports that are increasingly being incorporated into their contracts
  - To learn how to establish relationships and trust with their members
  - To develop a network of high-quality providers to more efficiently and effectively transition participants through the care continuum and back to the community

Building Partnerships: CBO Perspective

- CBOs bring the following:
  - Relationships and trust with participants; CBOs are often a place where participants are comfortable
  - A knowledge of the community, including services, supports, and gaps
  - Understanding of the LTSS systems and benefits, and the ability to manage them accordingly
  - Staff to deliver home-and community-based services (HCBS) and supports
- CBOs need the following:
  - Infrastructure and capacity to grow
  - Support to prepare for value-based purchasing models
  - Retraining and refocusing of their staff and services to focus on the desired outcomes of all the parties

Strategies for Building Health Care Partnerships

Lori Peterson, MA
Collaborative Consulting

Transitioning Care Delivery

Health and social services delivery systems are transitioning from silos of care to systems of care to improve the continuity of services for participants with complex needs.

- From “more is better” to **“better is better.”** Transitioning from fee-for-service (FFS) payments to payments for outcomes.
- From organizational incentives to **system incentives**. Transitioning from rewarding the organization to integrated health system incentives.
- From “my patient” to **“our population.”** Transitioning focus from an individual to a population.
- From a leadership style of control to **influence**. Transitioning leadership from organizational control to health system influence.

Partnership is not the goal, it is a strategy to reach the goal.

No Playbook Exists for Developing a Partnership

- Those interested in developing a cross-sector partnership won't find a playbook or guide to direct them. The parameters that drive the design and development of a partnership are unique for each.
- Organizations seeking partnership already operate in a complicated system within their own organization and culture, but introducing a cross-sector partnership requires the challenge of shifting to a complex system that involves multiple organizations and cultures.
- No system or market is the same – the characteristics, conditions and resources vary.
- The challenges and motivations that drive the goals of the partnership are unique.
- Multiple variables, dynamics and desires will be involved.
  - Just as no relationship is the same, no partnership is the same.

Conditions for Successful Partnerships

- **Leadership** that understands the value of having awareness of the entire system, and applies a style of influence to activate change across multiple organizations
- **Financial** case for partnerships and an understanding of how risk can be shared between organizations
- **Collaborative design** to integrate operations, systems, communications, and sharing of information
- **Thoughtful selection of partners**, following research and exploration to ensure alignment
- **Capacity building** across sectors
- **Results-focused** with mechanisms incorporated for tracking, analyzing, and sharing progress
- **Convergence of incentives** increases motivation for cross-sector partnerships
- **Participant-centered focus**

Building Partnerships: Assess First

Crucial steps for building a successful partnership include understanding the needs of your population, and their competencies and gaps.

- Complete an in-depth organizational readiness assessment to better understand individual and cohort-level readiness. Assessments can be completed before, during, and upon completion. Areas of assessment include:
  - Adaptability and change readiness
  - Leadership and governance
  - Operations and management
  - Financial and business acumen
  - Program and service redesign
  - Technology systems and data literacy
- Identify the primary challenges to be addressed by the partnership.
- Assess the external market for potential opportunities.
- An example of a readiness assessment tool is available here: https://www.aginganddisabilitybusinessinstitute.org/assessment-intro/

Partnerships Currently in Practice

Examples of partnerships and programs currently being provided to communities include:

- **Medically-Tailored Meal Services:** may be delivered for a specified period of time following a hospital discharge to participants with a diagnosis of congestive heart failure, diabetes or other chronic conditions.
- **Community-Based Care Management Services:** providing high-risk participants with community-based support for an extended period of time to ensure all needs are addressed.
- **Transportation Services:** might include options to transport to medical appointments and services or to conduct everyday tasks, such as grocery shopping.
- **Medical Respite Programs:** providing shelter, care management, and nursing care to homeless individuals when care is needed but hospital-level care is unnecessary.
- **Nursing Home Diversion Programs:** support delivered to participants able to transition to the community with necessary supportive services, such as housing, meals or home care.

Notable Results

- A hospital implemented a community care network:
  - 0.8 day reduction in average length of stay for skilled nursing facility (SNF) participants
  - Over $2.2 million in savings
  - Improved efficiency in door-to-bed times for admitted participants
- A hospital partnered with a CBO on a short-term respite program:
  - 85 percent readmission reduction
  - 2 week reduction in average length of stay
  - Serving over 200 homeless participants annually
- A health plan engaged a CBO to create a community care settings program:
  - 50 percent reduction in total cost of care per member per month
  - 60 percent reduction in hospital average length of stay
  - 95 percent retention rate in community placement at 6 months

CBO Partnerships in Action: Jewish Family Services of Los Angeles

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Jewish Family Service of Los Angeles

- Jewish Family Service (JFS) of LA is the city's first organized charity.
- Mission: to strengthen and preserve individual, family, and community life by providing a wide range of needed human services to people in the community at every stage of the life cycle, especially those who are low income and disadvantaged.
- JFS receives referrals from both health plans and providers to deliver social services to participants with complex needs.
  - Case managers at JFS are assigned to work directly with participants.
- Funding sources for JFS include:
  - Government (local, state and federal)
  - Philanthropy (individual and foundation)
  - Third party payers

Jewish Family Service of Los Angeles

- Population: currently serves over 100,000 individuals annually with over one third of those individuals being older adults and people with disabilities, who are dually eligible beneficiaries.
- Programs and services include:
  - Senior centers and adult day centers
  - Case management for participants with disabilities and complex chronic conditions
  - Health and wellness services with adaptive equipment for participants with disabilities and trainers to meet their specific needs
  - Counseling and support for participants, their families, and care partners

Learning Collaborative: Building Partnerships

- JFS participated in the first class of the SCAN Foundation Linkage Lab learning collaborative from 2012 through 2014.
- JFS goals for participating in the learning collaborative were to:
  - Build long-term sustainability for the organization
  - Prepare for a new, evolving landscape of care in the region
  - Build partnerships with managed care entities to better meet the needs of their population
- To be successful in this work there needed to be:
  - Full commitment from executive leadership (all executive leadership from JFS participated in the learning collaborative)
  - A willingness to take an introspective look at organizational gaps and vulnerabilities
  - The ability to make investments of financial and human capital to support the work

Target Population

- JFS identified the following vulnerable populations as positioned to benefit from the outcomes of a partnership:
  - Older adults with complex case management needs, including adults with functional limitations
  - Participants currently in the hospital or recently discharged to the community and at risk of readmission
  - Older adults and adults with disabilities needing linkages to community resources
  - Dually eligible beneficiaries
  - Indigent and homeless participants

Results-Focused

- To maintain a results-focused approach, JFS also identified the following areas of improvement for the population of persons with disabilities and the elderly:
  - Reduce readmissions
  - Reduce length of stay
  - Re-link participants to community resources and health supports to address social determinants of health
  - Provide case management
  - Provide care transitions to the participant's setting of choice within a timely and cost-effective manner

Identifying Organizations for Partnerships

- California at the time was encouraging health plans to increase community engagement and partnerships with CBOs. Health plans in the area were open to working with JFS (and other CBOs) to improve health services for the population.
- Once the target population and desired results were identified, JFS identified several different settings of care that could help to achieve these results:
  - Health plans in the Los Angeles area
  - Hospitals and health systems
  - A California hospital that was involved in a CMS transitions demonstration
- JFS executives held meetings with the organizations over two months to identify objectives, goals, and services to be provided prior to signing contracts / MOUs.

Partnerships with Health Plans

- Competencies JFS brings to the partnership:
  - Ability to handle complex case management in a cost-effective manner and to identify participants ‘at-risk’ of re-hospitalization or re-institutionalization
  - Ability to provide mandated assessments to determine eligibility for LTSS services within required time frames
  - Ability to provide information and facilitate referral to appropriate services and supports
- Based on the needs of the specific health plan, JFS is delivering the following services for participants with complex care needs and socio-economic challenges:
  - Psycho-social assessments, care plan development and implementation, and case management
  - Eligibility assessments for community-based adult services
  - Health risk assessments

Partnerships with Hospitals

- Competencies JFS brings to the partnership:
  - Ability to provide a warm handoff and anchor the participants in the community
  - Understanding the needs of hospitalized participants with complex socioeconomic needs, including those experiencing mental health disorders, disabilities, homelessness, and those without financial resources
- Based on the needs of the specific hospital, JFS delivered the following services:
  - Transition support for persons with behavioral health needs and complex care management needs
  - Care navigators to support the participant in accessing the services and supports they needed in a timely manner, particularly for those who are at-risk of re-hospitalization or re-institutionalization

Building a Partnership with the California Hospital

- The California hospital partnered with JFS to facilitate a short-term demonstration program to transition participants out of inpatient care.
  - The program ended, but the partnership endured and evolved to target the population identified by JFS.
- Competencies JFS brings to the revised goals of the partnership:
  - Ability to connect with a very high-utilizing population to reduce their persistent readmissions to the hospital
  - Knowledge of the community-based safety net services available
- JFS primarily focused on participants with behavioral health needs, those who have experienced homelessness on a long-term basis, and / or have been discharged and are missing follow up.
- JFS delivered the following targeted services:
  - Finding and establishing a relationship with the participants, wherever they may currently be in the service area
  - Intensive community-based case management for participants with psychiatric diagnoses who need connections to community resources

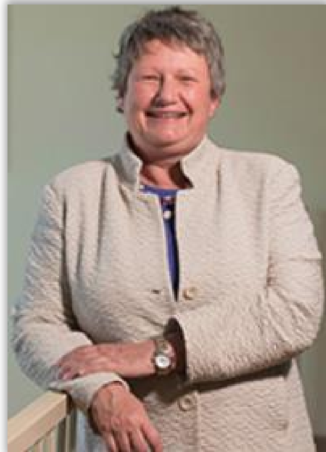
Improving the Lives of Participants through Partnerships

- When working within a single silo of the health care system, it is difficult to fully meet the needs of participants, particularly those with disabilities and complex care management needs.
- By building partnerships, CBOs, health plans, hospitals, and providers have access to increased resources and supports to accomplish a variety of participant goals in a timely and effective manner:
    - Reduce readmissions to inpatient or nursing home facilities
    - Reduce length of stay in facilities
    - Facilitate communication between the facilities and appropriate health care providers
    - Re-link the participants to community resources to address social determinants of health

Lessons Learned and Next Steps

- Lessons learned through ongoing partnerships:
  - Build partnerships around core competencies and make sure your work with health care partners is mission congruent
  - Do not assume your organizational culture is ready for these kinds of partnerships. Assess your organization early and periodically to determine readiness for partnering.
  - Be creative in aligning your service model with the needs of the healthcare partner
  - Keep key stakeholders engaged throughout the new business activity
- Next steps for JFS:
  - Based on the experience of the last five years, JFS is increasingly defining our niche in the market as serving the needs of high risk, “difficult”, and complex participants.
  - Maintain organizational focus on expanding relationships with healthcare partners.
  - Engage all levels of the organization in strategic planning.

CBO Partnerships in Action:
The Independence Center



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The Independence Center

- The Independence Center (IC) is a nonprofit organization based in Colorado Springs that provides traditional and self-directed home health care, independent living, and advocacy services for people with disabilities.
- These services range from providing peer support, skills classes, and employment assistance to individuals, and advocacy to affect change within and outside the disabilities system.
- The IC's mission is to work with people with disabilities, their families, and the community to create independence so all may thrive.
- Generally, the participants in the IC Home Health program are under 65 and qualify for Medicaid services. About 15-20 percent of participants are dually eligible beneficiaries.

Serving Participants

- The IC focuses on:
  - Person-centered plans of care
  - Participant and family at the center of decision making
  - In-depth knowledge of eligibility and entitlement programs
  - Customized caregiver training for unique service plans
  - Internal and external collaboration to create better outcomes with the participant and the payer
- We listen to both the recipient of the service and the payer when working with healthcare systems.

Preparing for Partnerships

- 2011: The IC established focus groups to understand participants and the barriers they face in accessing health care. The results led to a comprehensive internal assessment of readiness.
- 2012: The IC made a strategic organizational decision to become a provider of health and social services under the Independent Living (IL) model. To successfully support IL through home health and health care, the IC needed partnerships in the community.
- 2015: The IC joined the SCAN Foundation's Linkage Lab Learning Collaborative to learn about and prepare for cross-sector partnership.
- 2018: The IC is developing two partnerships:
  1. Partnering with a hospital to develop the **Hospital-to-Home transition program**
  2. Partnering with the Rocky Mountain Health Services' (RMHS) PACE program to plan for the **Person-Centered, Community Care Model (P3C)**

Hospital Partnership: Hospital-to-Home Transition Program

- Goal: to significantly reduce the number of participants being discharged from the hospital and being directly admitted to a nursing home.
- This requires several wrap-around services to be available for participants in their home, including:
  - LTSS and home health services
  - Assessment of the participant's home and assistance with services for food/nutrition
  - Prescription services
  - Durable medical equipment services (DMEs)
  - Participant engagement in the community through peer support, recreation, assistive technology and employment
  - Benefit acquisition efforts, such as applying for Social Security and Medicaid, and qualifying for Medicaid waivers that pay for long term assistance in the home
- The IC developed a disability network from CBOs in the community that would be able to provider these services and presented this approach to the hospital to begin the partnership.

Hospital Partnership: Hospital-to-Home Transition Program

- The hospital's discharge plan includes evaluating the family's ability to keep the participant at home. Three barriers were identified that prevented a successful transition from hospital to home:
  - The participant's care being too complex for the home situation.
  - The family initially agrees; however, following rehabilitation, they discover that the care is too complex.
  - The participant is homeless.
- To promote a successful partnership, the IC wanted to understand the hospital's needs before presenting their plan.
  - A board member from the target hospital was invited to help identify gaps in the hospital's discharge process. This board member became a valuable stakeholder and helped to push the process through on the hospital's side.
- The IC approached the hospital with the plan to provide more intensive services to meet participant needs at home in the first month after hospitalization. Following the first month, the services will focus more on moving this participant into the community, with additional activities at the IC.

Partnership Planning in Action: RMHS PACE Program

- CMS is currently considering a pilot to evaluate the impact of expanding current Programs for All-Inclusive Care for the Elderly (PACE) to serve dually eligible beneficiaries over the age of 21 with seven mobility disabling conditions.
- In 2015, The Rocky Mountain Health Services' (RMHS) PACE program and the IC initiated discussions to develop a PACE-like program for younger adults under the CMS Person-Centered, Community Care Model (P3C).
- RMHS has experience working with the current PACE population, but is unprepared to develop a program targeting a younger population.
- The IC has experience working with the younger population, and understands the services needed to integrate them successfully into the community.

Partnership Planning in Action: RMHS PACE Program

- The RMHS and the IC are partnering to be able to respond to the anticipated request for proposals (RFP) from CMS.
- Objectives:
  - Map out the program in flow charts
  - Develop “straw people examples” of who might use our program at what costs
  - Understand the cost history of the projected membership
  - Build a financial model
  - Have a joint operating agreement in place

Partnership Planning in Action: RMHS PACE Program

- Initial considerations for building the partnership:
  - Can we work together with very different cultures?
  - Can either organization do it without the other?
- RMHS strengths:
  - Current PACE provider
  - Medical experience with the older population
- The IC strengths:
  - Social engagement and reputation with younger target population
- Initial meetings were chaotic and the fit did not seem viable. The two organizations had very different planning processes, which was solved by playing to individual strengths.
  - The big-thinkers formed the “dreamer group” for developing the picture
  - The detail-oriented people worked on operational pieces, such as assessment tools, developing the service plan, data collection and evaluation

Partnerships: Lessons Learned

- One organization cannot meet all the needs of complex participants. Bring in skills that complement yours and build a network.
- Partnerships can help to diversify funding of CBOs, and maintain long-term sustainability
- Be flexible with the partner organization; these partnerships can take time, e.g. a change in leadership can slow the process down.
- Think big, but start small: cash flow is very important. Make sure your reimbursement model is working before taking on too many customers/recipients.
- The customer (hospital) and the recipient (their participant) are not the same.
- A project manager who is adept at monitoring and evaluating processes is critical to the team's successful planning and launching of a partnership program.

The Independence Center: Future Plans

- Hopefully, the Hospital-to-Home program will be expanded and eventually offered to groups like Kaiser, other managed care programs for seniors, Medicaid, and workers' compensation.
- Changes to the health care system in Colorado will affect future partnerships. It's important to be aware of policy changes that may reflect changes in payments and changes to the players.

Questions

Thank You for Attending!

- The video replay, slide presentation, and a summary of the Q&A will be available at:

  https://www.resourcesforintegratedcare.com

- For more information about obtaining CEUs via CMS' Learning Management System, please visit: https://resourcesforintegratedcare.com/sites/default/files/DCCWebinar7_CMSCECreditGuide_Pre_Webinar.pdf

- Questions? Please email RIC@lewin.com

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Webinar Evaluation Form

- Your feedback is very important! Please take a moment to complete a brief evaluation on the quality of the webinar. The survey will automatically appear on the screen approximately a minute after the conclusion of the presentation.

Send Us Your Feedback

Help us diversify our series content and address current Disability-Competent Care training needs – your input is essential!

Please contact us with your suggestions at

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What We'd Like from You:

- How best to target future Disability-Competent Care webinars to health care providers and plans involved in all levels of the health care delivery process
- Feedback on these topics as well as ideas for other topics to explore in webinars and additional resources related to Disability-Competent Care

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Additional Resources

- The SCAN Foundation Linkage Lab
  - Case studies: http://www.thescanfoundation.org/linkage-lab-case-studies
  - The SCAN Foundation Innovation In Health Care Award: http://www.thescanfoundation.org/innovation-health-care-award
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