Aging and Disability Business Institute's Integrated Care Boot Camp, Part II: Get the Integrated Care Game Plan & Learn How to Diversify Payer Partnerships

Presenters:

-*Mary Kaschak*, Deputy Director, Aging and Disability Business Institute, National Association of Area Agencies on Aging, Washington, DC
-*Kathy Vesley-Massey*, President/CEO, Bay Aging, Urbanna, VA
-*Joan Hatem-Roy*, CEO, Elder Services of the Merrimack Valley, Inc., Lawrence, MA
-*Erik Eaker*, Bold Goal, Director, Partnerships and Communications, Humana, Louisville, KY

Aging and Disability BUSINESS INSTITUTE

Sponsored by

Humana®

Integrated Care Game Plan Huddle

Kathy Vesley-Massey, President / CEO

Bay Aging dba

Aging and Disability Institute's Integrated Care Boot Camp II

Monday, July 31, 2017

Savannah, Georgia

VAAACares

Virginia's Evolution – Timeline *(1978-2010)*

1978-2008

- Bay Aging = Traditional
- Encouraged Entrepreneurialism
- Partnerships Valued

2009-2010

- Shrinking Government Grants
- New Business Model Needed
- New Discussion: Value in Health Care

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The AAA That Didn’t Know It Couldn’t

BayAging

- Bay Aging: AAA that delivers services to 10 rural counties in Eastern Virginia
- By 2020, all 10 counties will have >30% population 60+ and by 2030 the same cohort will be as high 42%
- High poverty rates and large percentage of medically underserved older adults
- Shrinking resources: 3-1/2% of state aging dollars
- Tried CMS CCTP 1st time – FAILED
- **VISION & DETERMINATION OVERCAME ALL**

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Virginia's Evolution – Timeline *(2010-2012)*

2010-2011

- CMS CCTP Opportunity
- Bay Aging Submitted Application
- Rejected!

2011-2012

- Go **BIG** or Go Home!
- Hospital Champions
- Est. Eastern Virginia Care Transitions Partnership (EVCTP) Covering 20% of Virginia
- **SUCCESS!**

Eastern Virginia Care Transitions Partnership 2012-2015: The Golden Years

Community partnership of 4 health systems, 5 area agencies on aging, independent physicians' groups & 69 skilled nursing facilities.

HEALTH SYSTEMS

Bon Secours
Mary Washington Healthcare
Riverside Health System
Sentara Health Care

AREA AGENCIES ON AGING

Bay Aging – Lead Community Based Organization
Eastern Shore Area Agency on Aging and Community Action Agency, Inc.
Peninsula Agency on Aging, Inc.
Rappahannock Area Agency on Aging, Inc.
Senior Services of Southeastern Virginia

Later Added MCOs / Duals' Demonstration

Evolved Into …

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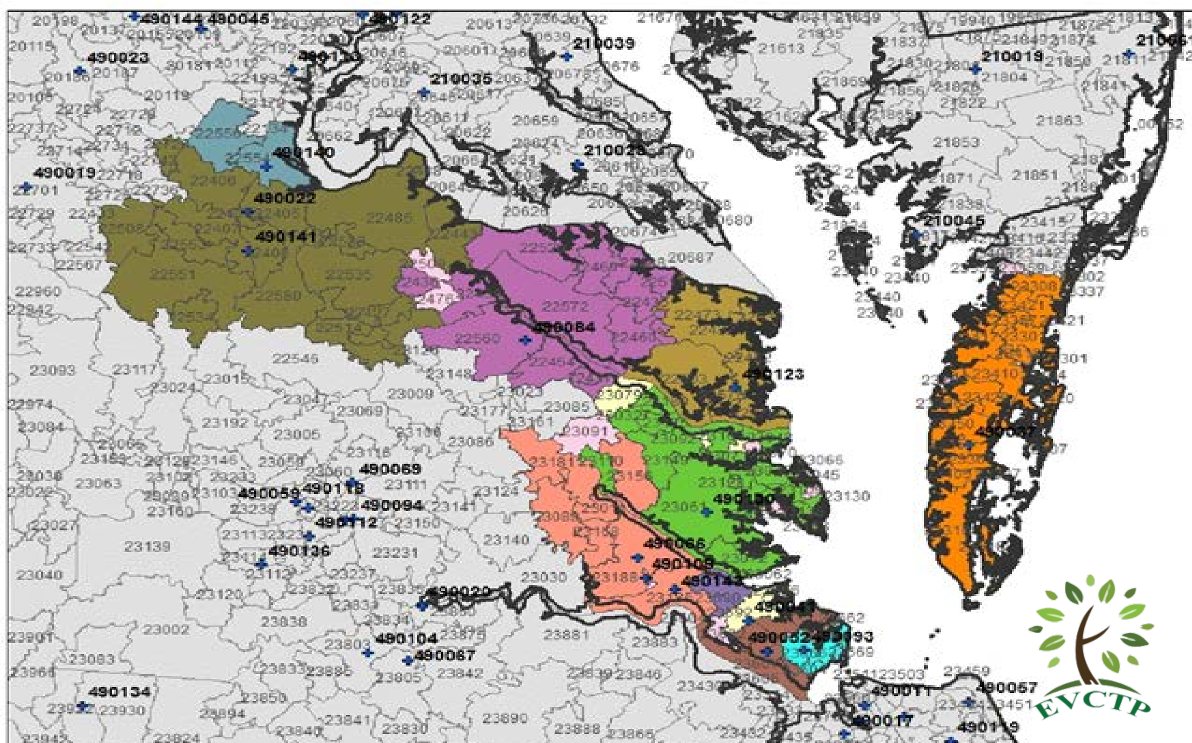
EVCTP Zip Codes – 20% of Virginia



Hospital ZIP Code Region

- 490022
- 490037
- 490041
- 490052
- 490066
- 490084
- 490093
- 490123
- 490130
- 490140
- Restricted
- Unrestricted

140,431 Medicare FFS Beneficiaries

46,188 in Rural Zips

✦ Short-term Hospital

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Miles 0 12.5 25

This material was prepared by Telligen, the Quality Innovation Network National Coordinating Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. [11SOW-QINNCC-00040-11/19]

Synergy!

DAILY PRESS

LOCAL NEWS

HEALTH

Synergy deemed 'unprecedented'

Warner impressed by plan to reduce readmissions of Medicare patients

By Prue Salasky
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JUDITH LOWERY/DAILY PRESS PHOTO

Sen. Mark Warner, D-Va., asks a question about the Eastern Virginia Care Transitions program on Tuesday in Newport News. About two dozen stakeholders attended the event at Riverside Regional Medical Center.

NEWPORT NEWS — More than half of hospital readmissions of Medicare patients within 30 days result from socio-economic factors and the physical environment, compared to just 10 percent for medical reasons, Kathy Vesley-Massey, CEO of Bay Aging, said at a forum hosted by the Eastern Virginia Care Transitions program.

Bay Aging is the lead agency in the program, which is a collaboration of five agencies on aging, four health systems, 11 hospitals and multiple other health providers. The group is two years into a five-year Medicare pilot project to bring down patient costs and reduce 30-day readmissions for vulnerable seniors.

NEWPORT NEWS

Its primary methods are encouraging close collaboration between medical providers and community services, and using "coaches" with social work backgrounds (rather than case managers) specially trained to smooth transitions and teach self-reliance to patients leaving the hospital. The coaches make one hospital visit and one in-home visit, then use follow-up phone calls to teach those at risk for readmission how to look after themselves, said Kyle Allen, vice president of clinical integration for Riverside.

Nationwide, the eastern Virginia program is ranked sixth in performance for reducing all-cause readmissions and is one of 44 Medicare pilots out of more than 100 initially that has met its enrollment goals and realized significant savings. The Centers for Medicare and Medicaid Services estimates those at $9,600 per patient, or more than $20 million in savings since its inception, Vesley-Massey said at the roundtable presentation with two dozen stakeholders and U.S. Sen. Mark Warner, D-Va., at Riverside Regional Medical Center.

Warner has launched a bipartisan working group for the Senate Finance Committee with U.S. Sen. Johnny Isakson, R-Ga., to explore how to improve outcomes for Medicare patients with chronic conditions, which he dubbed a major factor in driving the national debt.

Warner expressed particular interest in how the coalition had effected coordination between competing health systems, characterizing it as "unprecedented," and how technology and telehealth could be used to improve care and reduce costs. He asked for hard numbers. "Medicare and Medicaid have a very complicated formula, and it's not very accurate. We need to drill down to see how much does it save the hospital. ... You need more transparency in pricing," he said, suggesting that the savings could then pay for the program.

The project's funding is part of innovation grants provided through the Affordable Care Act, which also provided the impetus by instituting penalties on hospitals for readmissions. Most who qualify for coaching are "dual-eligible" — receiving both Medicare and Medicaid — and have multiple medical conditions.

Several people at Tuesday's forum said these patients are not noncompliant by choice but simply don't have the means or understanding to follow their health care plan.

"It's a unique situation where they took away the carrot and added the stick and it worked," said Jimmie Carter Jr., board chairman for Bay Aging. He characterized the area agencies on aging as the perfect neutral participant, or "Switzerland," with already established connections to community care and the services — Meals on Wheels, transportation, caregiver support, home care — that address those social factors that contribute to readmissions.

The transitions program covers 25 percent of Virginia, and there's a plan in place to extend it statewide, according to Allen, who worked earlier with a similar program in Ohio.

Roundtable participants noted that the eastern Virginia program still leaves gaps, particularly in addressing mental health readmissions. These form a high percentage and are more complex and more difficult to resolve as the patient self-reliance model isn't applicable. "That's an area where this model needs to be built out," Warner said.

Vesley-Massey said that in an inexplicable turnabout, CMS had recently threatened to dismantle the eastern Virginia project a year early, despite lauding its outcomes.

Warner said he was impressed by the use of less expensive community resources and would support the partnership's full implementation. He said it was "more focused" than other efforts he's observed. The senator also supported the suggestion that the program be extended to become proactive rather than reactive, pointing out that it would be more cost-effective to intervene before a hospitalization if those with several chronic conditions could be identified early.

Salasky can be reached by phone at 757-247-4784.

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Virginia's Evolution – Timeline *(2013-2015)*

2013-2015

- EVCTP used Evidence-Based Coleman CTI
- Visited 26,000+ Medicare Patients in their Home
- Huge Reductions in Readmission Rate

2014-2015

- Used EVCTP CMS Experience/Data to Contract with MCOs in Virginia's Duals Demonstration
- 2 Major Contracts – CTI & Care Coordination
- Excellent Results

Quarterly 30-Day Readmission Trends
February 2013 – January 2016

Readmission Rate

26.0%
24.0%
22.0%
20.0%
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%

Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q10 Q11 Q12

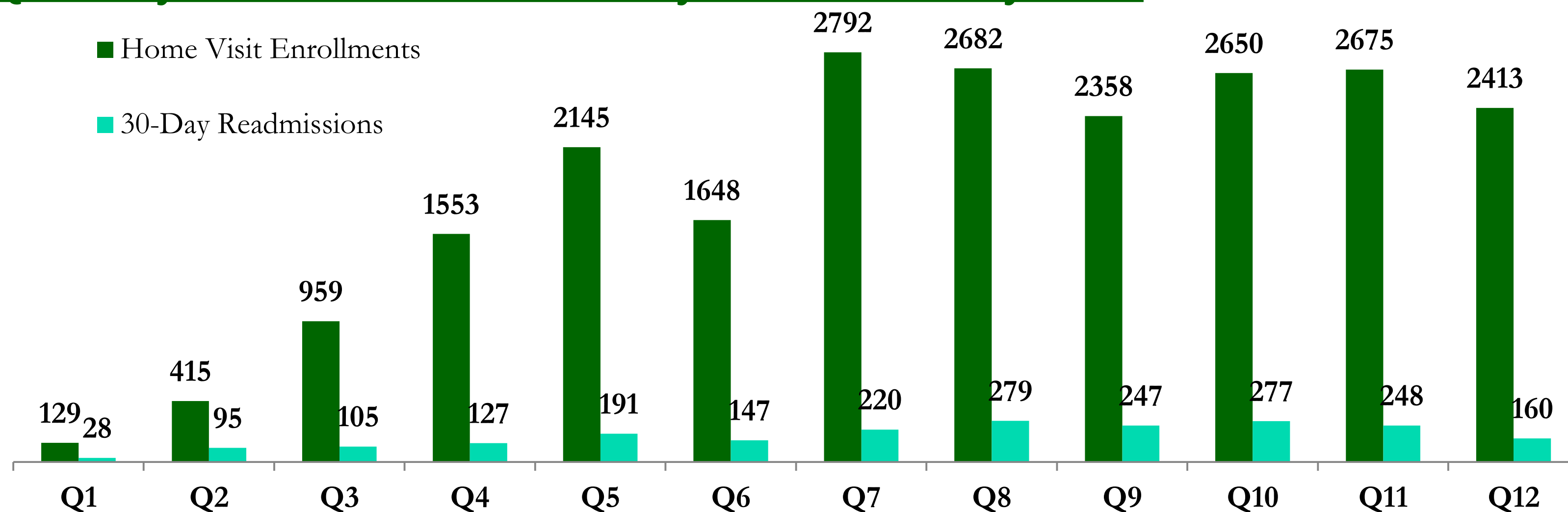
2010 Baseline Target Group FFS Rate
Target Group FFS Rate
Enrollee Rate

EVCTP Achievements: *3rd Party Verifications*

Total Program Savings

	Data Inputs		Hospital & EVCTP Reported Data
A	Target Group Discharges		28,427
B	Target Group 2010 Baseline Readmission Rate		23.4%
C	Final Readmission Rate Among Target Group		16.8%
D	Change in Target Group Readmission Rate	(C - B) ÷ B	-28.3%
E	Number of Clients Enrolled		22,419
F	Final Readmission Rate Among Enrollees		9.5%
G	Number of Readmissions Avoided	(A x B) - (A x C)	1,884
H	Estimated Savings Per Avoided Readmission		$10,226
I	Estimated Avoided Readmission Savings	G x H	$19,265,197

Quarterly Enrollment Data February 2013 – January 2016:



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Virginia's Evolution – Timeline *(2015-2017)*

2015-2016

- Utilized Experience to Market to all MCOs Entering Va
- MLTSS Competition for Statewide Contracts
- 14 -> 7 -> 6 -> 2

2016-2017

- CMS Demonstration Ended
- EVCTP Initiated Medicaid CTI Demo (creative funding)
- New Innovations Added

VAAACares

Evolve Into Healthcare

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formerly EVCTP

Improving Patient Health and Safety in Virginia

Area Agencies on Aging Coalition
Caring for the Commonwealth
Coordinated and Transitional Care for Virginia

INTRODUCTION

VAAACares is the statewide expansion of the Eastern Virginia Care Transitions Partnership. Endorsed by the Virginia Center for Health Innovation, VAAACares is an Area Agency on Aging collaboration to deliver services for insurers, health systems and other providers.

The VAAACares program serves as a one-stop shop for comprehensive care coordination, care transitions, and a host of other home and community based services that support the health and safety outcomes for Virginians with chronic health conditions and disabilities.

VAAACares services provide techniques that promote patient and caregiver engagement to take an active role in their health care. VAAACares facilitate new behaviors and self management strategies that result in successful responses to common health problems that occur after transitions between health care settings. One major key to success is getting into the home! The places where people live, learn, work, and play, the choices made, and the opportunities they have all play a role in their physical, mental and social well-being. Only by going into the homes and learning more about the patients can we begin to execute meaningful plans of care that lead to successful recovery, reduced readmissions, lower healthcare costs, and improved communication between patients and their PCP's.

IMPLEMENTATION STRATEGY

Three Root Cause Analysis (RCA) tools were utilized – Hospital Readmissions Review, Physician and Staff Expert Panel Review, and Consumer Focus Group Surveys.

The key findings of what contributed to readmissions included end stage disease/co-morbidity, lack of patient compliance with discharge plans, medication mismanagement, lack of follow up with the patient's primary care provider, and acuity of the patient. These findings dovetailed with the Four Pillars of the Coleman Care Transitions Intervention® model leading EVCTP to select this as the preferred model – supplemented with enhanced services.

Partner hospitals submit daily census to EVCTP for screening. Eligible participants are referred to Area Agencies on Aging for coaching – including a hospital visit, home visit, follow-up phone calls, and coordination of any enhanced services that improve the after hospital care of the patient.

IMPACT

EVCTP Care Transitions Intervention Performance for Chronically Ill Target Group

High-Risk Chronic Illnesses:

AMI, CHF, COPD, PNEU, Septicemia, Stroke, AFIB, Diabetes, Renal Failure

Demonstration Period: September 2013 – December 2015

High Risk Target Group
22,397 Patients
23.4% Baseline Readmission Rate
Before Care Transitions Intervention

Care Transitions Intervention Reduced Overall Target Group to a 14.7% Readmission Rate in the final quarter

Care Transitions Intervention Enrollees with a Home Visit
21,857 Enrollees
8.7% Readmission Rate of Enrollees in the final quarter

*Readmission rate refers to Q11 only.

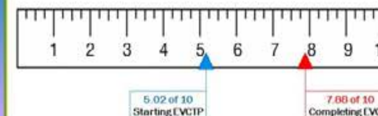
TRANSPORTATION
Chronic Disease Self-Management
Tele-Education and Telehealth
Behavioral Health Screening and Enrollment
In-Depth Options Counseling and No Wrong Door
Advance Care Planning
In-Home Services
Meals on Wheels
Adult Day Care
Housing

TOP 10 PATIENT SERVICE NEEDS MET IN-HOME

Not ONLY Social Determinants of Health, Social Determinants of LIFE!

PATIENT EMPOWERMENT

When given the opportunity to gain insight and skills, engaged patients are better equipped to manage their conditions, remain at home longer, and are more likely to use fewer healthcare services, thereby reducing healthcare costs.



Confidence Question: On a scale of 1 to 10, with 1 being not at all confident and 10 being completely confident, consider the following:

I am confident that I can manage and control most of my health problems.

CONCLUSIONS

Since 2013 EVCTP successfully collaborated with acute care medical facilities and insurers to improve patient post discharge outcomes. Success led to the development of VAAACares, a statewide expansion to improve patient care and decrease acute care hospitalizations.

Data results illustrate the blend of Care Transitions, Care Coordination and Evidence-Based Prevention Education and Patient Empowerment is very effective for patients at-risk for re-hospitalization by improving health and safety outcomes for Virginians with chronic health conditions and disabilities.

VAAACares utilizes the "blend of services" coupled with the expertise of Area Agencies on Aging. VAAACares has proven to be a highly successful model of patient-centered care.

Similar results experienced with Medicaid population.

VAAACares

Challenges → New Door Pried Open

Call it a day or continue the quest to help people with multiple chronic conditions by supporting the MLTSS delivery system to achieve better health care outcomes with lower costs!

- **Solicited Support**
  - Virginia's State Unit and Medicaid
  - Health Innovations Center – SIMS
  - General Assembly / Governor's Office – Medicaid Pilot
  - AAAs Cohesive Collaboration
  - Community Action – Fund Pilots
- **Also Supported By**
  - AAAs Across the Nation / T.A.
  - MCOs – Mentors
  - Health System Partners – Contracts
- Used Demo to Develop Statewide Collaboration of AAAs to Provide MLTSS Coverage for 100% of Virginia
- **VAAACares – Virginia Area Agencies on Aging Caring for the Commonwealth**

VAAACares

Building to VAAACares – *Taking Risks*

- Business Acumen Investments
  - Staffing
  - IT
  - Structures
  - Legal Guidance
  - Training Partnership
  - Marketing
  - Culture Change

- Enormous investment of time, resources, energy and commitment to excellence in all areas of performance

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Building to VAAACares – *Innovation*

- Care Transitions Intervention
- Evidence Based Services: Tailor Products to Payers' Needs
  - *Chronic Disease Self-Management, Diabetes Self-Management, Healthy IDEAS, Fall Prevention, Advance Care Planning, Motivational Interviewing, Patient Activation Measure, Tele-Education, Tele-Health, Patient Confidence Score and more …*
- Referrals to Other Home and Community Services
  - *Meals on Wheels, Transportation, Personal Care, Housing and Supports, No Wrong Door*
- Complex Care Coordination
  - *POC, Authorizations, Level of Care, ICTs, Repatriation*
- Improved STARS and HEDIS Scores for Partners!

VAAACares

Virginia's Evolution – Timeline *(2017-2018)*

2017-
2018
NOW!

THE
FUTURE !

- Initiated Statewide Contracts for MLTSS
- Currently have 4 Contracts
    - 2 Contracts are Statewide
    - Each Tailored to MCO Preferences

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VAAACares Business Model

- 100% Virginia AAA Support
- Offers Major Insurers and Other Health Care One-Stop Shop
    - *One Contract, One Referral Site, One Billing and One Reimbursement, One Source Accountability*
  - Tailored to Each Health System and Health Plan
  - Health Plans = Better Market
- Supports Positive Health Outcomes and Demonstrates Lower Cost
- Leverages Important Role of AAAs
  - Decades of experience and success of being in people's homes

VAAACares

VAAACares – *Advice for Next Steps*

- **EDUCATE** Yourself, Your Staff, Board and Partners
  - N4a Business Institute, AAA Colleagues, Webinars
- **DETERMINE** Model for Partnerships (AAAs) & Potential Markets
  - VAAACares = Collaboration, not LLC (Cost Nimble)
- **COMMIT** to Developing AAA Expertise
  - Not, "If you've seen 1 AAA…" rather Uniform Standards!
  - Readiness Assessments On-Going
  - Continuous Quality Improvement (CQI)
- **INVEST in Staffing, Software, Legal Advice, Etc.**
  - Clinical adds Credibility to Social Determinants
- **DO AS I SAY, NOT AS I HAVE DONE … SO FAR!**
  - NCQA Certification
  - Software with ROI / Simulation Ability
  - Expand to Medicare Advantage

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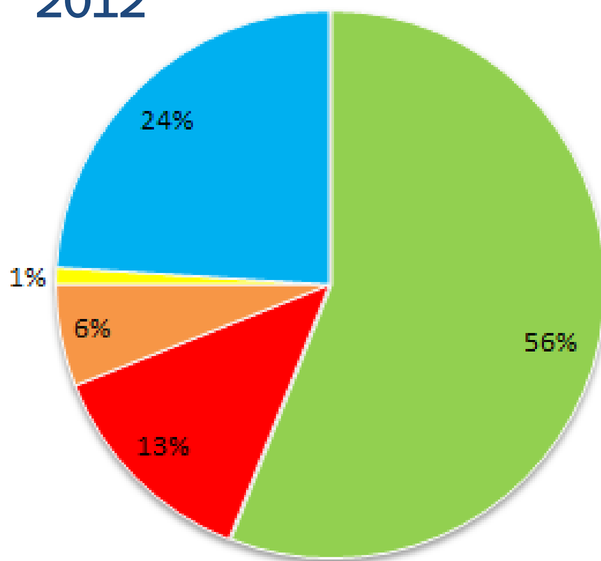
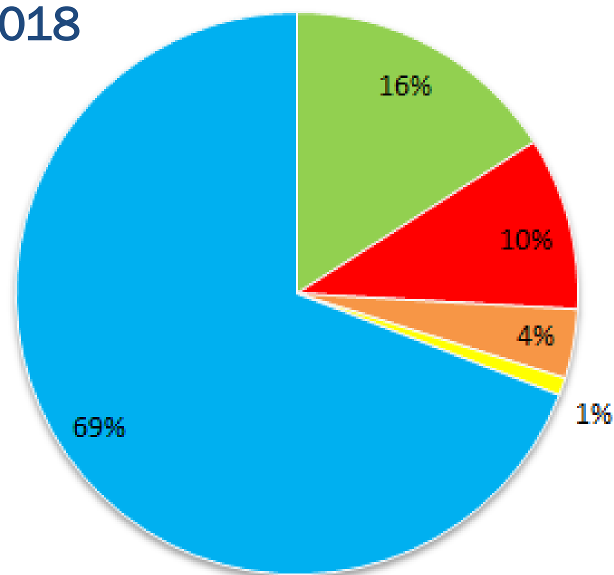
VAAACares – *Results*

Better Health for AAAs and the Members, Clients and Citizens Served!

2012



2018



Federal
Local
Private Payers
State
Contributions

Federal
Local
Private Payers
State
Contributions

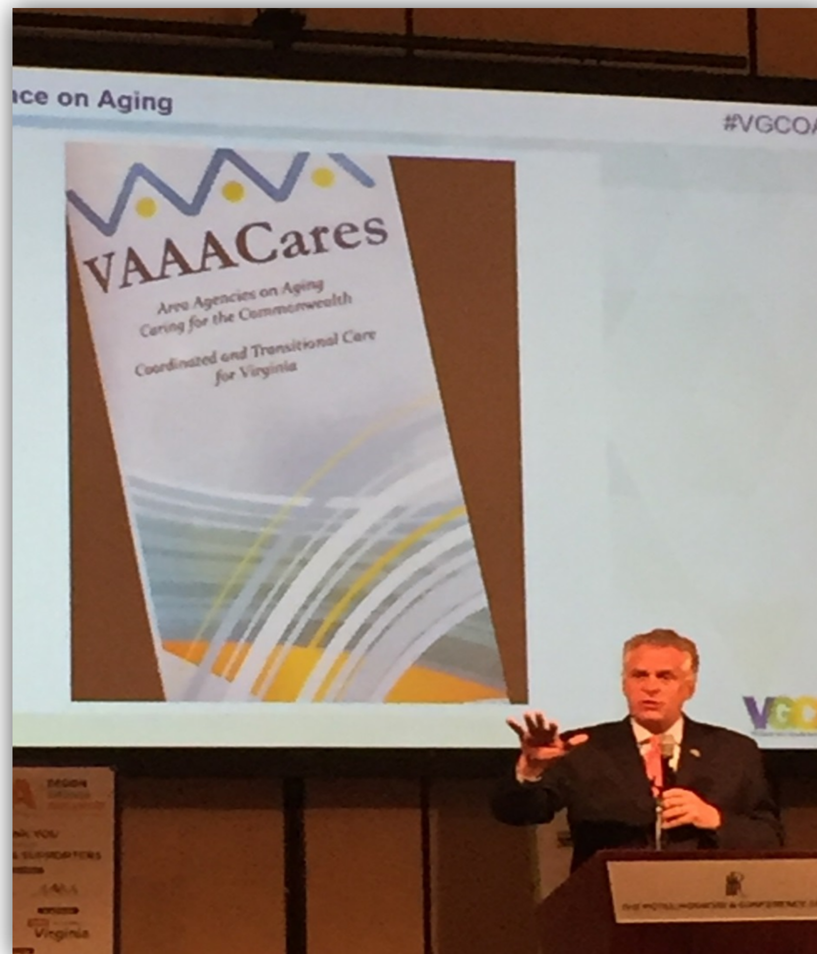
VAAACares

VAAACares – *Results*

Better Health for Virginians

Governor Terry McAuliffe Getting the Word Out!

2017 Virginia Governor's Conference on Aging



Thank You! Questions?

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Integrated Care and Payor Partnerships

Joan Hatem-Roy, LICSW
Chief Executive Officer
Elder Services of the Merrimack Valley, Inc.

Environmental Scan of Massachusetts

- **98% Insured**
- **Multiple Dual Eligible Plans**
- **Two Medicare Advantage Programs**
- **Medicaid ACO through Medicaid Waiver**

Evolution of our Health Care Partnerships

2004:
First contracts with Senior Care Options Plans (duals)

2007:
Pilots and partnerships with hospitals for care transitions

2014:
CCTP award and partnerships

2016:
CCTP transitions to contracts with ACOs for care transitions

2016:
First Contract for community self-management programs

2017 and beyond:
- NCQA
- Improve Data Analytics
- Expanded contract capacity
- Bid For CP-LTSS for Managed Medicaid

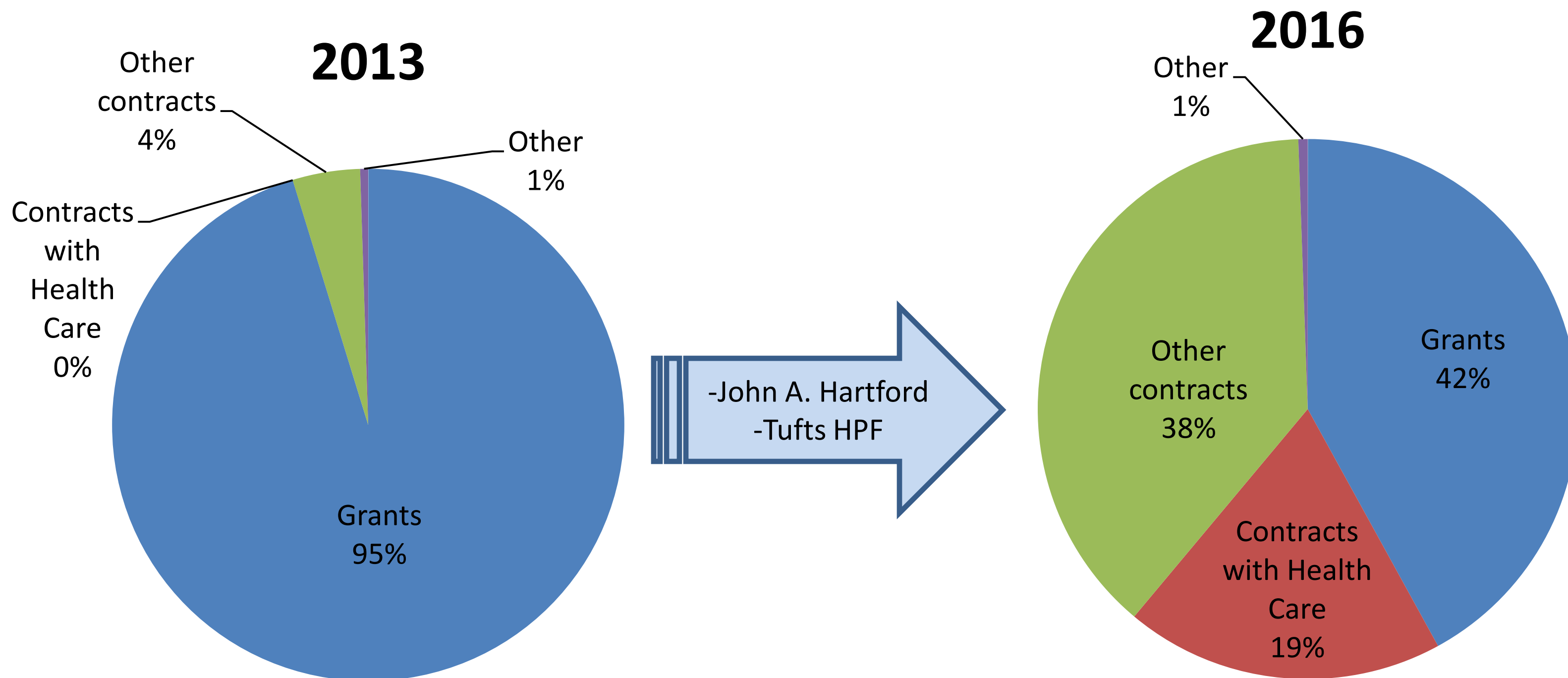
Supports Provided by CBOS Under Contracts

- **Managing Chronic Conditions**
  - Chronic disease self-management, diabetes self-management, nutrition programs (counseling, education & meal provision), education about Medicare preventive benefits, peer supports, telehealth/telemedicine
- **Activating Beneficiaries**
  - Chronic disease self-management, community/beneficiary/caregiver engagement, community training, employment related supports, evidence-based care transitions, financial management services, independent living skills, information, referral & assistance/system navigation, nutrition education, person-centered planning, peer supports, self-direction/self-advocacy tools and training, benefits outreach and enrollment, supported decision-making, assistive technology, behavioral health services
- **Diversion/Avoiding Long-Term Residential Stays**
  - Transitions from nursing facility to home/community, person-centered planning, self-direction/self-advocacy, assessment/pre-admission review, information, referral & assistance/system navigation, environmental modifications, caregiver support, LTSS innovations, transportation, housing assistance, personal assistance
- **Preventing Hospital Admissions**
  - Evidence-based care transitions, care coordination, information, referral & assistance/system navigation, medical transportation, evidence-based medication reconciliation programs, evidence-based fall prevention programs/home risk assessments, nutrition programs (counseling & meal provision), caregiver support, environmental modifications, housing assistance, personal assistance

Building Partnerships with Health Care

- Competitive and Consolidating Marketplace
- What populations are they serving?
- What are their challenges?
- What is their marketing strategy?
- Measures of Effectiveness and Evaluation
  - Star Ratings for Health Plans
  - HEDIS (Healthcare Effectiveness Data and Information Set)
  - PQRS (Physician Quality Reporting System
  - HCAHPS(Hospital Consumer Assessment of Healthcare Providers and Systems)

Success with one Service Line: Evidence-Based Programs



the healthy living Center of Excellence

Diverse Value Propositions

Health Plans

- Quality Ratings
- Member Satisfaction
- Member Activation
- Decreased unnecessary utilization
- Connection with community resources (SDOH)

Hospital / ACO

- Reduces length of stay
- Reduced ER visits
- Reduced readmission
- Improved patient mix (tertiary rather than chronic)
- Safe transition
- Connection with community resources (SDOH)

Medical Groups

- Improved satisfaction
- Increased referrals
- Decreased no-show
- Time savings for providers
- Improved safe transitions
- Improved quality, value, accountability (Pay for Performance: MACRA, MIPS)

Key Learnings

- Start TODAY (or someone else will)
- Develop a “Partnership” not, vendor relationship
- Expand your value proposition
- Diversify your pitch
- Communicate, Communicate, Communicate
- Celebrate Successes

Contact Information

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