

NWX-HHS-AOA-1

Moderator: Lauren Solkowski
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1:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. During the question and answer session please press star 1 if you'd like to ask a question. Today's conference is being recorded. If you have any objections you may disconnect at this time.

I will now turn the meeting over to Lauren Solkowski. Ma'am you may begin.

Lauren Solkowski: Great. Thank you so much. And good afternoon and welcome everyone. Thank you for joining us today for the Administration for Community Living Business Acumen Webinar on Network Development.

Again this is Lauren Solkowski with ACL and I will be facilitating our Webinar. For today's Webinar we have invited representatives from ACL's 2013, 2014 Business Acumen Learning Collaborative.

They are representatives of the Western New York Integrated Care Collaborative and are here to discuss a report that their collaborative has published entitled Community Based Integrated Care Networks.

So they will be looking at some key pieces from the report and some of the decision making processes that they used to begin defining their network structure.

So before we start with their presentations I have a few housekeeping announcements to run through. First of which if you have not done so please use the link included in your calendar appointment to get on to the WebEx so that you can follow along with the slides but also so that you can ask your questions when you have them through the chat function.

If you don't have access to the link you can also go to www.webex.com. Click on the Attend a Meeting button that's at the top of the page.

And then from there you can enter the meeting number. So today's meeting number is 661512633 again that meeting number is 661512633.

If you have any other problems getting into the WebEx please call the technical support number at 1-866-569-3239 again that number is 1-866-569-3239.

As our operator mentioned all of our participants are in a listen-only mode, however we do welcome your questions throughout the course of our Webinar.

There are two ways that you can ask your questions. The first is which - is using the chat function in WebEx - so you can enter your questions that's located on the right-hand side of your screen in the WebEx.

So once you enter your question we will sort through them through all the questions and answer them after the speakers have presented.

The second way to ask a question is through the audio line. So when that time comes the operator will give us instructions as to how to queue up to ask your question.

If there are any questions that we do not answer or don't get to during the course of this Webinar please feel free to email them to me.

And I will actually during the Webinar I will put my email address up in a post that you all will see on the right-hand side of the screen.

As the operator mentioned we are recording the Webinar. And we will be posting the recording copy of the slides and a transcript on the ACL Web site as well as on the AML TSS Network Web site.

So again I will enter this Web site and the email AML TSS Web site address in that chat box located in the right-hand side of the screen throughout the Webinar and you'll be able to access it there.

Okay so with that I would like to introduce our speaker. First is Ken Genewick. Ken has been the Director for the Niagara County Office for the Aging for the past four years leading his organization mission to promote independence and quality of life through directly and collaboratively provided community based services to older adults and caregivers living in Niagara County.

Ken's diverse private and public sector professional health and long term care experience and education background including a Masters of Business Administration degree with a concentration in health systems administration

from the University of Buffalo allows him to bring a unique perspective on aging and its dual impact on both the system and the individual.

Our next presenter is Diane Oyler. Diane is the Coordinator of Neighborhood Services for the Erie County Department of Senior services.

Her key responsibilities include collaborating with public sector agencies and community based organizations to coordinate, evaluate and improve services for older adults and the disabled including identifying new resources to expand services.

And lastly we have Randy Hoak. Randy serves as the Commissioner of Senior Services for Erie County, New York.

Commissioner Hoak's demonstrated leadership in long term care at home and community based services brings a professional perspective informed by front line experience working with frail, elders, caregivers and people of all ages in need of assistance.

Randy has previously held positions at the Erie County Medical Center Corporation and the town of Hamburg Senior Services department.

So welcome to all of our speakers again and thank you so much for joining us today. Ken I will turn it over to you.

Ken Genewick: Thank you Lauren. And it's a pleasure to be presenting here today with my colleagues and I'd like to welcome all of you that are a part of the Webinar.

Lauren if you can go to the next slide please it would be great. So really the, you know, the discussion that we're going to have today and what's ahead is

we're going to discuss with all of you the aging network in Western New York.

And certainly not only the network but we are looking to accomplish as a collaborative with the backdrop of all the changes that are taking place in New York State.

And we also want to talk about community based integrated care networks, what these networks are, what we've learned about these networks and I think more importantly their value and the utility that we're seeing here in New York State and in Western New York.

We also want to talk about the state of our network, you know, where we are at in the phases that we presented in our report. And then of course at the end we'll have time for questions and answers.

So next please. New York State known as the Empire State and New York State is aging like all other states across the country.

Right now there's almost 20 million people that are 60 or older which is about 20% of the I'm sorry almost 20 million people in the state 20% of which are 60 and older sorry I couldn't read my own slide.

Most live in densely populated downstate area. For those of you who aren't aware of New York State you basically have, you know, New York City, downstate and then what else is- the rest is considered upstate.

We think New York State is aging though as we mentioned there's, you know, approximately 20% are 60 or older.

Also we need to include in there for purpose of our discussion is that there's over 3 million caregivers that live in New York State to provide assistance for their loved ones as well.

Next please. Western New York is obviously on the Western end of New York State. And you can see that there are eight counties that make up Western New York with Erie, Niagara in the top left.

We mention that roughly 20% of New York State is 60 or older. Western New York itself is above the state average. About 22% are 60 and older about 1.6 million people that are served across these eight counties.

And really Western York is considered the Buffalo, Niagara metropolitan area. And so as we are, you know, really responsible for our local counties it's important to point out the functionally Western New York is really considered the metropolis.

So when you think of the way consumers, media outlets and companies view this area they really consider Western New York to be really one big region.

There are a few cities most notably Buffalo and Niagara Falls but largely suburban and very rural as well. And as I mentioned is served by eight county governments and really eight different area agencies on aging.

Next please. So the aging network in Western New York, as I mentioned is really county-based area agencies on aging.

Really just to take a step back when you think of New York State unlike a lot of other states we are by far have more AAA than any other state. There are 57 counties. And there are 59 area agencies on aging.

So when you think of your states and how AAAs are set up in New York State we are by far have the most. We have 59 different across New York State.

Also when we think of the aging and disability resource centers ours are also county based. And all of these ADRCs or Aging Disability Resource Centers are housed within the AAAs. So therefore you have 59 AAAs that are also act as dual ADRCs.

We have some regional community based organizations that span, you know, across several counties or across the entire region of Western New York but we have many community based organizations that serve smaller geographic areas.

And next please. So the changing landscape -- and I told Diane I wouldn't sing David Bowie's song Changes -- but you can see that there is obviously changes are happening rapidly in New York State as they really are across the country.

And across the country of course is, you know, really the Center for Medicare Medicaid aim at triple aim driven healthcare which is, you know, better health by addressing the root causes of poor health, providing better quality care and lowering per capita costs.

So that is something that obviously is an aim across the country. New York State is embracing that which we'll talk about as part of their Medicaid redesign team efforts.

Also that is integrating the medical and social models of care where I think it was described in our report that there's thinning lines between the medical models and social models of care.

And of course the payment reform that is part of that. And we certainly see that in our networks, you know, where you're moving from your more traditional grant based type of funding where, you know, people are paid to, you know, perform work and paid the same amount consistently. And even fee for service to your performance based models that emphasize shared risk.

Next please. What that change means for the aging network is that, you know, a lot of these changes and opportunities are really placing increased value on traditional services that our aging networks offers.

And, you know, when you think of the Older Americans Act total three dollars of being, you know, home based services, community based social model wellness, education, prevention services in the home.

There's increased value on those services which are great opportunities for our network as well as emerging services that play to those traditional strengths as well like improving health outcomes, reducing hospital readmissions as well as books on health promotion and wellness activities.

Also as part of all these changes it's bringing new partners to the table to work with the aging network as well as new expectations and rules to govern our work and our reimbursements.

Next please. Opportunities under the health care reform and aging networks that we're seeing nationally of course is improving population health by focusing on things such as chronic disease, self-management, fall prevention,

nutrition and exercise also hospital utilization to drive down those costs of hospitalization re-hospitalization by focusing on care transitions, short term supportive services, and follow-up referrals to preventive services and then long term care driving down costs through care coordination, long term supportive services, and as mentioned earlier caregiver support all with obviously improving health outcomes.

Next please. So what changes look like in New York is as we mentioned earlier with the triple aim New York State has in - since 2011 has engaged in Medicaid redesign through a Medicaid redesign team.

And just looking at why this is being done really is to curtail a significant amount of cost so just research has shown that the US has spent 16% of its GDP on healthcare nearly two times as much as any other nation.

New York State's Medicaid the nation's largest. At one point we're spending \$53 billion to serve 5 million people which is twice the national average. And so, you know, obviously it's an initiative at the state level to reduce those costs significantly.

And so Medicaid redesign, you know, by initiating a global Medicaid spending cap has looked at reforming both, you know, their long term care but also instituting several initiatives.

One being the Balance Incentive Program or what we refer to as BIP which was a state award in New York State from the Center for Medicaid and Medicare Services to expand under your Connects Programs but also try to help provide greater access to non-institutional or long term support and services.

And then of course a huge initiative of the Delivery System Reform Incentive Program which is really the goal of reducing avoidable hospital use by 25% over five years.

This is an up to \$6.42 billion allocated to New York State based upon achieving predefined results. And so obviously there's a lot of change happening in New York State and happening as we speak as it is I'm sure in all of your states as well.

What we've seen though is there are new partners that are emerging to be able to move ahead with which the New York department of - State Department of Health, hospital systems, performing providers systems through DSRIP as well as Medicaid long term care plans.

Next please. So what's needed and expected that we've identified, you know, over our time being part of this collaborative is to really increase our local capacity to deliver services.

Also have the ability to deliver services consistently and inexpensively. And I think when you talk about, you know, local governments particularly county governments that are trying to work as a region the terms, you know, consistently and inexpensively really are the goal.

But, you know, it can be difficult, you know, when you're looking at scaling up if you will as a collaborative entity.

And then of course the ability to serve a large geographic area in a collaborative manner really to better meet the needs of customers and engage and work with partners that are looking to work in a regional capacity.

Next please. And up next is how are we going to do that? And I'm going to pass along to Diane to talk about, you know, our involvement in the Targeted Technical Assistance Initiative beginning in the spring of 2013 (sic) who's going to talk about lessons that we've learned.

Diane Oyler: Yes, thank you Ken. Absolutely like all of you we were lucky to be a part of the Business Acumen Learning Collaborative. We were part of cohort one.

As Ken just walked through we were facing a lot of change here in New York State that was driven by health care reform on the national level.

So our state unit on aging was calling for us to do a lot of the work that emerging. And we really did know how to do that.

So when this opportunity came out with the National Learning Collaborative it was - we jumped on it. And we were lucky to be invited to participate.

So if you'll go to the next slide please Lauren. So in terms of the early lessons I guess the good news was that we definitely have services that are increasingly valued by the healthcare system.

Now we need to direct our energy to scaling up our local programs and learning the new rules of the road.

So during our time in the learning collaborative we learned a couple of things related to that. The first thing is you really need to build up capacity pretty quickly.

If you normally deliver four DSME classes a year and reach about 40 people that's probably not going to be enough for you to secure partnerships with

physicians to refer to you on a regular basis. So you really need to be able to build up capacity to offer classes regularly and reliably for example.

You also need to be prepared to work under different payment models which will require some infrastructure that you may not already have in place right?

For instance in the collaborative we learned you're probably going to need to get a Medicare billing number to take advantage of some of these new opportunities. To bill for DSME you're going to need to get accreditation for your program.

You're likely to need to build new systems to monitor quality, do reporting, undergo audits all of those sorts of things that go along with that new business.

So we understood that that was a lot for any one organization to do on its own. So one of the biggest takeaways from the learning collaborative was rather than try to do that and go it alone as a standalone organization AAAs and their community based partners should really work together to do these things as a formal network.

Next slide please. So the ACL has been encouraging all of us to look specifically at what they call community based integrated care networks.

As they explained in their original request for application for the first learning collaborative those networks are very similar to Independent Physician Associations or IPAs.

And IPA serves as a vehicle for private practice physicians to get together. It allows the physicians to address issues together without losing their independence.

The signature characteristic of course of an IPA is that it serves as a vehicle for physicians to negotiate and contract with payers.

Next slide please. In the time that we've been looking at community based integrated care networks we found that they're even more similar to rural health networks here in New York State.

And rural health networks are across the country. I don't know how many of you are familiar with them or not. I know a lot of people haven't heard of them before.

But like an IPA they also bring providers together to pursue common goals. Where they're a little different is that they bring different provider types together.

For instance they'll bring together a hospital and ambulance service physicians. And here in New York those can also include county government such as county health departments.

So they're very similar to where we want to go. And they can look very different from one another depending on the needs of the communities they're serving. Their form follows the functions they're going to have to perform.

So as we've been working through our own network building we've definitely been keeping an eye towards those rural health networks and we also have a

partner agency at the table that is part of a rural health network that's been helping us quite a bit.

Next slide please. So in terms of how they can help while in the learning collaborative we learned a lot about the different ways that they can do that.

For us here in New York State where services are very county based they can absolutely increase your geographic reach.

They certainly help to provide economies of scale so that labor intensive activities like going through an accreditation process can benefit more than one organization.

They can provide a single contracting point so it's easier for buyers to do business with providers. And they can perform a lot of the common business functions that are needed such as billing and doing data analytics.

Next slide please. So all of that sounded good to us, when we were in DC and we were learning more about these networks it sounded good to us.

But when we brought these lessons back to New York State and to our partners, our partners wanted to know if these kinds of networks made sense here in New York. And if they do what kind of network should we build? What should that network look like?

If we were going to build something we wanted to make sure it made sense for our community and was a fit for our needs.

Next slide please. So every state's regulatory system is a little different. So we really needed to look at the situation here in our state and map out the best course of action.

To do that we needed a little bit of help. So we secured some help from a local foundation partner. And we certainly would encourage everybody to seek out such partners themselves.

Our partner is the Health Foundation of Western and Central New York. They have been supporting our learning collaborative experience in a number of ways already.

For example they had funded several of our network partners to attend the 2013 n4a conference to kick off our learning collaborative experience.

So when we came back with these questions about network building they were very receptive to sponsoring our work as we took a closer look a systematic look at integrated care networks and building them here.

So with their help we've been working through a three phased process. During the first phase we set up a steering committee and developed a work plan for taking a really deep look at networks during Phase 2.

Phase 2 or the study phase the fact finding phase resulted in the report that the ACL shared with you. It included our recommendations for moving forward with our network building.

And now we're in Phase 3 which is the implementation phase which we're going to describe to you in a moment.

Before we do that though we just want to give you a better sense of what we looked at when we were developing that proposal.

Next slide please. So what we felt we had to look at were four big questions okay? First what does the regulatory landscape look like here in New York State?

That's - as we're going through this Medicaid redesign has been unfolding in New York State. So every time we think we have one thing figured out the state has thrown something new at us. So it really took time for us to get our arms wrapped around all of that regulatory change.

So we had to look at what the landscape looks like in New York State. We had to look at what kind of network structure could help us maneuver in that landscape and position us to be stronger partners.

We - once we identified the type of network that could help us we had to address whether or not that network was achievable in New York State in terms of dealing with personality types, and politics and just the reality on the ground.

And the last question we had to answer when we took stock of all those things is what would we need to make this network happen?

Next slide please. So when we looked at the regulatory landscape just to give you a sense of that we found that the emerging needs of New York State are very similar to what others are reporting across the country.

We have suspected that New York State was different. Some of you may be suspecting the same thing about your own home state.

We're - it's not that different. It may look different on the surface but once you dig in deeply the dynamics are unfolding are nationally driven so what we're seeing is very consistent.

There's definitely a need for our services whether that be health promotion, or care transitions, or care diverse services that's definitely there.

There is definitely a need for a local capacity. You've probably been hearing a lot about our value for having feet on the street right?

So they definitely need our local capacity. Services need to be delivered consistently and reliably wherever people in need of services are.

But there are some new expectations as well. The most important one that we have to address here in New York State again is that need for regional reach which may seem easy for you guys because a lot of you are organized regionally already.

But New York State has traditionally had a very strong county based delivery system for many services and that's changing now.

New opportunities are opening up. But to take advantage of them organizations are expected to have reach beyond one county.

There's also very - this is very different from our traditional system which really has emphasized neighborhood based services within one county.

And then looking on the horizon payment reform is also going to be impacting us. Right now we're still finding that grant dollars are still slowing just for program development.

But things are starting to change. Grant funders are increasingly asking us about our sustainability plan. They are increasingly encouraging us to talk to the performing provider systems that were set up by DSRIP or accountable care organizations.

So they want - there is definitely an emphasis for switching from grant based business to negotiated contract based business.

Next slide please. So given what's happening in New York State we definitely felt that an integrated care network could definitely be helpful.

Our appreciation for that grows every day. I think Randy will tell you little bit more about that soon. But the question is if we're going to set that network up what did we need it to look like?

We identified a couple of big things. Number one the opportunities are coming up all the time. We were telling Lauren before we got started sometimes our network development work has been slowed because while we're developing the network we're also responding to program development opportunities.

So because opportunities are coming up all the time we need to be able to establish this network easily and quickly.

The second thing is we need the number of funders and buyers in the system are increasing. We're not just working with the state unit on aging anymore. We're seeing a lot of different types of buyers and funders.

So we need something that can help us to build and manage relationships with those funders, and buyers and the people that will refer business to us.

We need something that can perform key business functions. The most important ones include going after the new business in the first place but then also taking care of all of the administrative work that comes along with that from managing the contract, to reporting and so on and so forth.

And the last one which really comes primarily from our CBO partners whatever we build has to help insulate the collaboration from political dynamics.

AAAs here are county based. So they want to make sure that whatever we build if the cast of characters changes this work can still continue.

Next slide please. So with that menu of things in front of us we turn to looking at several of the network models that we were introduced to while in the learning collaborative.

Some of you may have already been introduced to some of these things like the super messenger model, clinical integration model, provider primary provider model which we learned more about on Webinars like this.

So all of those models can kind of blend together when you're first learning about them so we wanted to really take stock with what each one entails and then compare those to what we (need).

Next slide please. So if you take time to read the report in this section this table basically summarizes how we went about doing that model by model comparison.

We looked at five different models and about a dozen different network functions that we identified that we would need going forward.

For each of those functions we identified if it was something that a particular network type could perform.

We also identified whether there were local examples of that function already being performed by an organization.

So if we had it locally it's a large X. If it's something the model could do but it's not available right now it's a small X.

This helped us to take stock of what we already had here in place in Western New York and what we would need to move forward.

So for example you can see we have a large X indicating that we have MOU based coalitions that are helping partners to get to the table and are providing regional reach beyond one county. They don't provide much more than that though. That's the model in the first column.

At the other end of the table you see that we do have local examples of primary providers performing network functions on behalf of the CBO partners.

All of the AAAs in New York State for example are primary providers that perform key network functions for their local aging network already providing IT services for example but they don't have regional reach because they're limited to the county.

So in all cases with the models that we looked at we were missing something that we needed moving forward okay?

So on that note I'm going to hand it over to Randy and he's going to tell you a little bit more about what we've been doing here locally, what's working and then where we're heading with filling in this network model.

Randy Hoak: Thanks Diane. Good afternoon everyone. Yes as Diane said I'm going to talk about what was currently working what's been working for a little bit - a little while here what we need, and what we are doing about it and what we plan on doing about it.

So Diane mentioned this MOU based coalition. And that's working here. That has been working here. And we have an example of success where we've been able to partner with - I'm sorry next slide. I'm going to forget to do that. So you're going to hear Diane and Ken saying next slide.

So these MOU base coalitions we've been successful. And we have a definite example recently where we were able to secure some funds from the New York State Department of Health to deliver caregiver services.

And this has been great. We've been - it's been a very positive experience. We've engaged some of the partners that have been on board with this collaborative all long as well as some new partners.

What's been nice about it is it's really highlighted and reinforced some of the needs that we've identified in the earlier part of this presentation.

And it helps us to do something right now. And that was one thing that we identified we need to do something. Our partners were looking for some tangible results.

However it's a little clunky to work under this arrangement especially if you're going after funding for a program that's going to be delivered in eight counties.

So were talking a lot of MOUs, a lot of time that could be saved if there was a different type of network available to execute some of this work.

The other thing that works - next slide thank you. The other thing that has been working here is the primary provider model.

And this is a model that's very familiar to AAAs in Western New York and I'm sure across the country. A lot of this work we do already.

And they're really network functions. We perhaps didn't think of them as network functions before we had the opportunity to join the Tiger Technical Assistance but we've been able to identify these as resources that can be helpful.

So these - this model will help us to leverage existing infrastructure and maximize our existing relationships.

So it gives us the opportunity to be cost effective partners. And as Diane had mentioned it insulates or one of the concerns that we have is the political dynamics of a government based environment.

So that is very prevalent in the primary provider models. There's political turnover. There's turnover in staff. There's changes in policy and direction of the governmental entities.

So what -- next slide please -- so we have been able to identify some needs that we've looked to address incrementally over time.

Certainly the geographic reach is a need that we've been able to convey. But also a short term need for quality improvement and relationship management. That was certainly lacking in the two models that we had experience with locally.

And also this continues to be a learning experience for us the need to take on financial risk as we move forward with these partners.

So working under the -- next slide please -- working under the constraints that we've kind of set forth with a better idea of what the needs are locally we started to identify what we can do next. What do we need to do immediately and what are the things some of the low hanging fruit that we can address?

So those priorities are regional reach certainly, low cost and the ability to grow and change over time because as we were able to stress early in the presentation we are in an environment that is under a great deal of change and pressure to change.

Next slide. What was very a valuable experience for us probably about half way through this process was to sit down with some folks that worked in a clinical setting but had gone through a similar process and similar evaluation years previous to us.

And this was a group of the Safety Net Association of Primary Care Affiliated Providers of Western New York, they called themselves SNAPCAP.

But they were not a very formal entity at the outset. This was a group of primary care providers, leaders within those providers that really met on a very informal basis and would describe themselves as more of a coffee club.

They then transition into a Limited Liability Corporation when the needs that were impacting their sector became apparent to them.

And then eventually they went on to a 501(c)(3). And they are a central part of one of the DSRIP performing provider systems in Western New York. So they were able to point us in several directions of work that we needed to do right away.

Next slide. Probably first and foremost was seeking legal advice. And this was - this is where we really were able to get the ball rolling.

And I think it's very important that if you find yourself at this stage in network development to make sure that you have the appropriate legal advice.

And our partners at SNAPCAP were able to refer us to an attorney who really is considered an expert by many on not for profit law, governance and the like.

So he was able to put a lot of these terms answer a lot of these questions for us for our partners, for our county leadership in relatively easy to understand terms that we could bring back to our leadership and we can - our partners could bring back to their not for profit board members.

Next slide please. This was not as easy as we thought it would be. We - when we participated in our TTA cohort we heard a lot about LLCs.

And there was a number of regions within the country that were looking to go in that direction or had been successful in developing networks through the - an LLC model.

And after a couple meetings with the attorney that we're now working with we decided that wasn't going to work well in New York State.

So he - and we decided against it because of the very difficult transition in New York City - New York State to go from an LLC to a 501(c)(3).

Unless you structure that LLC in the state of Delaware which was a loophole that the attorney provided for us to - if we wanted to do an LLC we could. It would be relatively easy and quick. But it would have to be in the state of Delaware and then we could down the road convert it to a 501(c)(3).

As we stress in this presentation we are local government entities. And we thought that, that would be a little awkward to propose to our county based and state leaders to establish an LLC in the state of Delaware.

So I just stress this point because this is an example of the political concerns that often need to be considered in this work.

It certainly was an interesting conversation. And eventually we were able to identify the vehicle that we needed a taxable not for profit corporation.

And that's where we are focusing our efforts on right now. So New York State law allows this entity to begin, to become incorporated, and to begin to function while the bylaws and other governance issues are being hammered out.

Next slide. So where we are right now, we're continuing to build this as we go. The Health Foundation of Western and Central New York is continuing to be a great partner and they're covering costs of incorporation while we work with this attorney and our partners.

We are looking at identifying the three members that are going to start off this process. We're really looking at leadership and discussing with the leadership from our counties what our role is going to be, what that's going to look like, what the implications are within county government. And we're also engaging our steering committee in that conversation as well.

We are really making sure that we allow this - the form to follow the function as programming develops.

So we're giving you a few examples of what we're looking at programming wise some of the health promotion activities, the diabetes self-management, care transitions this caregivers grant that's been a regional application.

So as those needs arise we are looking to make sure that the function of this network is going to address those as they come up.

Next slide please. What's been very important for us to remember is that as we get moving we will find the answers to - we found the answers too many of these questions as we worked through some of the issues.

We learned from some of our - the other organizations the other participants of our cohort that it can be very easy to get stuck on answering a question before you move along. And what we have found is a lot of this work needs to be done in parallel tracks.

So some of the work that remains that we are looking to address in this next phase is what's the ownership and governance structure?

As we mentioned we have some ideas as far as the direction that we're headed there but there's a great deal to be hammered out yet.

What does membership mean? How does an organization become a member? What's the value to that organization? What limitations may they have as a result of their membership? What circumstances can a membership be revoked? And how can we cover startup and ongoing administrative costs?

So there's been several opportunities that we've worked on under this philosophy without putting a lot of the covering some of the legal questions but looking forward the partners that we've had at the table and the newer partners due to some of the other initiatives that we're working on they have been able to see the value in the concept and the model that we've discussed and that we're moving towards.

So that's all I have for right now. And we would - are really eager to hear what your questions may be.

Lauren Solkowski: Great, thank you. Ken, Randy and Diane thank you so much. So we will start the Q&A portion now. So operator if you could please provide instructions for asking a question through the phone that would be great.

Coordinator: Thank you. If you'd like to ask a question please press Star 1. Please unmute your phone and record your name when prompted, it is required to introduce your question. Once again that's Star 1 if you have a question.

Lauren Solkowski: Thank you. So while we wait for questions to come in I actually had a question for you - for you guys.

So - and I know this is something that we've heard from our current cohort in terms of, you know, getting your foot off the ground and, you know, making that initial step.

Diane you had mentioned you made a connection to your - the foundation the Health Foundation of Western and Central New York. So my question is how did you make that initial connection with them?

Diane Oyler: Well in the case of the Health Foundation of Western New York I think we are lucky in that they fund projects in two areas exclusively.

One is for children, you know, zero to five. The other is frail elders. So they had been - they've only been around I think for what about 15 years now. But since the beginning they've really been very good partners to the aging network in their territory.

So we happen to be involved in another capacity building grant effort that the foundation had underway at the time called Ready or Not.

And so a lot of the work that we are planning on doing with our Ready or Not grant when this application - when this opportunity came forward with the learning collaborative it offered us a way to do a lot of that work and get the resources from the ACL for free.

So that was - that kind of gave us an automatic opening to talk to the foundation about this. They were excited from the beginning because it did complement their existing efforts so well.

But really I think that a lot of times people make the mistake of viewing grants in isolation. So when they, you know, they may a lot of your cohorts may have existing grants and regional partners already that are helping them to do work at point A.

And they need to make sure they're connecting the dots. And that's what we did with this. When we received this we automatically communicated that success to the Health Foundation of Western and Central New York.

One of the first things you guys did was encourage us to get our partners to the n4a preconference intensive in 2013.

We automatically said okay let's ask the foundation to do that for us because we knew that this was consistent and in alignment with their own goals, and mission and vision.

And it starts with a phone call to your program officer your local program officer to see if there's interest.

And then once that's in place writing a pretty short proposal a two-page proposal outlining what it is that you want to do.

And keeping them posted of your successes as you go. Don't be shy about your successes. You've got to build up that excitement in your local foundation partners and always connect back your success to the things that they're interested in so that's all we've been able to leverage that relationship with the foundation.

And they've gone on to build new relationships themselves with you guys, with the Hartford Foundation, with SCAN.

So it's been a win-win. So I think wherever you have a win-win you can certainly make the case with your local foundation.

Lauren Solkowski: Great. Thank you so much. Operator I'm checking back to see if we have questions come in on the phone.

Coordinator: Currently there are no questions. Once again that's Star 1 if you'd like to ask a question.

Lauren Solkowski: Thank you. Checking we don't have other questions on the chat but I did get a note from - it's the California Association of Adult Day Services.

And sort of they - she mentioned that they're just starting to build a network and would like to bring all of their adult day health care and adult day services together as one unit. So they're just starting this work.

And so are just - she indicated an interest in connecting with you all maybe via through their executive director to talk, you know, more after this Webinar, you know, to learn more...

Ken Genewick: Sure. We'd be happy to do that.

Randy Hoak: Yes.

Lauren Solkowski: ...that you talked about today. That would be great. So I'll make that connection following the Webinar.

Okay I'm just checking my box here. Let's see

Randy Hoak: I do think if I could just add Lauren I mean that's a great - I'm glad to hear that there's a group of adult day providers that are looking to organize in that way.

I believe that - and it was our experience in our work in our cohort the state associations or associations of specific agencies can be helpful in these.

I know that there's a state association I believe in Pennsylvania that was a participant of our cohort. And if the willingness is there and if the capacity within the association that's another place to look because they may be structured in such a way to have the regional reach and also, you know, the contracting, the QI there's a great deal of potential there.

And what we found as we've had more conversations with medical providers that there's associations that function in that way on the medical side that have been able to really model what we're looking at in New York as well.

Lauren Solkowski: Oh great. A question that came in via chat is what was your timeline for the - for this network implementation?

Diane Oyler: Well we've got overtime. I'll tell you that much. I think that originally we were hoping to get something going before our cohort ended at the end of 2014.

It's been really difficult to maintain a timeline for several reasons. Number one during our fact-finding phase we secured consultants to help us unravel the regulatory picture here in New York - working with some consultants the, you know, it alters the timeline.

And new questions keep popping up. It was while we were in the early stages of building or looking at building this network that all of a sudden DSRIP hit in New York State. And a lot of attention got diverted to that.

And so maintaining a timeline has been difficult. We originally had these conversations with the attorney early last fall I would say.

So at that point we were right in the in Erie County we were at a point where we were going through a county executive election. So we had to kind of wait for the - had to wait for the election calendar to catch up with us.

But in terms of once all that's settles getting it done is very quick. The incorporation itself can take a matter of weeks according to the attorney.

And now we're at the point where it will go as quickly as we are ready for to go. The incorporation papers are pretty much ready to go we just have to identify our three directors.

Just get the final okay from our county executives. We're meeting our partners again tomorrow. We're hoping to have this in place within the next what would you say guys a month or two?

Randy Hoak: Yes hopefully.

Diane Oyler: Yes.

Ken Genewick: Yes. I think it's important maybe just to talk about what Diane had mentioned as well is that, you know, we obviously came in with plans, and goals and timelines.

But, you know, so much happens and it's no - not like anyone else is experiencing in their work as you maybe your day to day operations that you run and the landscape changes.

But, you know, I think what's been great about what we've done is that, you know, we've run into roadblocks here and there but we've kept the conversations going. And, you know, it gets discouraging at times if you aren't meeting your self-imposed deadlines.

But just the fact that, you know, you keep it going and you don't stop at a roadblock or a dead end, you know, Randy mentioned earlier this caregiver's initiative that we were able to work with.

And frankly I mean we've got seven counties to collaborate with the regional not for profit to be able to apply for a grant that's, you know, a 5 year grant to help provide caregiver relief for those caring for individuals with Alzheimer's disease.

It's an initiative that had we not started this targeted technical assistance in 2013 we never would have been able to come together as quickly as we did.

And even though we certainly - it's been helpful to learn what, you know, what one of these not for profit corporations can do for us to make that quicker that effort would have never been put together had it not been for this initiative.

And so we found success in other arenas that would not have been built had we not have this relationship.

Diane Oyler: Right. And I think the only other thing I would add Lauren is that as our CBO partners have been - the more seasoned ones who had experience in the rural health network sometimes when you're doing the network building when you're trying to justify go in from a coalition of partners to doing something more formal you really need to have a reason.

And I think that comes - so all of a sudden an opportunity will come your way that really requires you to make the change.

So to go back to the SNAPCAP example our primary care friends they were a coffee club until, you know, they had a - until Health Homes came along. And all of a sudden it made sense for them to become an LLC.

Then the transition from LLC to 501(3)(c) that only happened because they needed to be - have nonprofit status to make another move that they wanted to make with DSRIP.

So you've got to have a trigger to justify going from one step to the next with the network formation is what we've found here locally at least. People don't want to just build something for the sake of building something.

That's why we chose this particular type of model where you can go - we can get the paperwork in place. We can be incorporated. We're actually a thing, you know, it's real and tangible.

And then as opportunities present themselves you can become more and more structured and flip from one from a taxable nonprofit to a 501(3)(c) as the need arises. So that's what we mean from following function.

Lauren Solkowski: Right.

Diane Oyler: So yes so with this Alzheimer's grant we've really found that yes we can get partners together with MOUs but as Randy said getting the contract in place we're going - doing the work plan and has been a bear.

And I think every time one of these opportunities comes our way and we're not prepared people realize the need for that network. And I think that's you need to have that trigger.

Randy Hoak: Yes. The other thing when it comes to that specific issue is we are at the mercy of the regional partner that may or may not be available at the time.

So the mission could change, the leadership could change, we could have an established partner for years that we may look to in an opportunity that comes our way but things change. And folks that have worked in and among the not for profit world they know that well.

I'd also just like to echo the reason that is critical it - there's a temptation. And this came up several times throughout the course of our interaction with some of our partners is a temptation to identify who this is going to be.

Diane Oyler: Yes.

Randy Hoak: Who's going to be running this? How are we going to pay them? Where are they going to work? Where is their office going to be or where is a building going to be?

And we have successfully dodged any of those commitments to this point because we want to protect that reason. I'm sure that many other communities can relate to, you know, seeing not for profits merge more and more a call for not for profits to merge.

So when you're presenting your community with another not for profit that reason becomes all the more important.

Lauren Solkowski: That's great. So I guess another question just - well actually let me check back with the operator before I go back to the chat. Are there any questions on the phone?

Coordinator: Yes. We do have a question from Kristin Jeffries. Your line is open.

Kristin Jeffries: Am I on?

Lauren Solkowski: Yes, hi Kristin.

Kristin Jeffries: Okay, hi. This is Kristin Jeffries with the Wisconsin Institute for Healthy Aging in Madison area.

And I had sent a question over the chat as well. And you may have answered this but could you comment on the proposed financial arrangements, the startup funding for the network, how will the network be funded to perform

the administrative functions listed in the table? And Randy you were getting at this a little bit but if you could comment on where the startup funding is coming for this?

Randy Hoak: Sure.

Kristin Jeffries: Please.

Randy Hoak: The startup funding to date has been provided for by the foundation the Health Foundation of Western and Central New York.

So moving forward we are looking at several possibilities. I would say the primary possibility is through reimbursement for delivery of services as well as, you know, grant revenue through perhaps indirect costs that may be associated with different grant programs.

Kristin Jeffries: Okay. So taking a certain percent of the either the reimbursement revenue or the grant revenue and assigning that to the administrative and support functions of the network of corporation then okay.

Randy Hoak: Yes. That's something that we're looking at.

Diane Oyler: And I think...

Kristin Jeffries: And is it also possible that the network member organizations and grant it most of them are county organizations or county governments perhaps private nonprofit CBOs.

Would they be also asked to contribute a certain amount to the - as a member to the network as an ongoing annual fee or anything like that?

Randy Hoak: Yes. That's something that we've discussed. And it's something that other organization SNAPCAP that I had mentioned that they had instituted at one point.

I'm not sure if they still have that membership organization structure but it's certainly something that we'd be willing to consider.

But it's really not I wouldn't say that it's really the primary method of financing. We're not looking at that becoming really the sustainable income for the network.

Diane Oyler: I think one of the most important things we've grappled with is this question. And, you know, there is a real hesitancy to build something that's really large in the beginning that's going to take a lot of capital to support because the idea of building this network is to be - help be a revenue generator for the member organization not a revenue consumer.

So we really are looking at low cost ways and really building it out as the need arises and the revenue for doing those services is coming in.

So we're really trying to keep that in mind. And I think one of - an important indicator for us is that when we did sit down here in Erie County and talk to our county executives one of his first questions was is this going to be another nonprofit that we're going to have to invest a lot of money in?

So locally, you know, we can - we have been invited to create another proposal write another proposal to cover, you know, more extensively these startup costs.

But there's not a lot of appetite locally for building a really expensive high end organization. They're going to have to earn their revenue as they go.

Randy Hoak: Which I think is why as we're looking at this, you know, what models make most sense is the not for profit corporation is easy to set up which would allow you to develop the 501(c)(3).

But to Diane's point, you know, to build, you know, a grand not for profit, you know, without having the revenue to go along with it would not be the right approach we want to take because the not for profit corporation can be small enough as your building and frankly not necessarily even realizing any profits, you know, that it will be easier to build small.

Diane Oylar: Right. And leverage the strengths of your partner organization. That's the one - that's what we have to do.

Right now I mean we have in terms of supporting our network efforts we're using a part time consultant. So until resources are in place we're keeping our - the cost for this as low as possible.

Kristin Jeffries: All right. Thank you very much.

Lauren Solkowski: Okay. Operator is there any other question on the phone?

Coordinator: Not at this time.

Lauren Solkowski: Thank you. We do have another question. So this one is asking about can you talk a little bit more about the type of healthcare partnerships that you have now and are you getting paid for the services as you more formally form your network?

Diane Oyler: I think the most important one that we're - partnership that we're looking at right now is with our local performing provider system and our hospital systems.

The way we're doing a lot of our program development work one of our first lessons we learned and it was from the folks in Merrimack Valley was you've got to demonstrate your value.

So we've had a pilot program in place with our local hospital called (Risa Home) that basically works on care transitions from hospital to home.

The grant funding for that is winding down. So those - and interestingly now they're looking at us because they have experience with us. And looking at as being part of what their billing as rapid response teams to deal with hospital to home transitions.

We haven't started talking about compensation yet but that would be an example of an emerging partnership.

Apart from that we're aggressively working on building on building up our capacity to deliver reimbursable DSME.

And put that in place to get the Medicare reimbursement for that apart from any specific partnership.

Lauren Solkowski: Okay. Another question that just came in, are you still doing credentialing when organizations join?

Diane Oyler: We haven't filled out what the credentials would be. I mean as AAAs there's provider credentials that we must have if it's going to be for a social adult day or for a home care agency those sorts of things.

So to the extent that you're dealing with existing services we fall back on our existing AAA credentialing.

But as we're moving forward with accreditation whatever the accrediting body requires in terms of those credentials is something we would have to just as you do know with you in your AAA capacity you're just going to have to make sure your partners - if you're doing medical nutrition therapy they have to be a registered dietitian. If...

Lauren Solkowski: Right.

Diane Oyler: ...they're going to be supervising DSME classes they have to be one of the acceptable clinical types. So that's all part and parcel depending on what program you're developing or pushing out.

Lauren Solkowski: Right. Okay just checking quickly. Okay operator any other questions on the phone?

Coordinator: No. There are no questions at this time.

Lauren Solkowski: Thank you. I will give it another minute or so just to see if we have any last minute thoughts from anyone. Sorry about that. So yes let's just wait another minute and then.

Randy Hoak: And while we're spending that minute I just want to say that our email addresses are up there. And we found that to be a very valuable interaction throughout our cohort as the Tiger Technical assistant.

And there was plenty of phone calls between folks in different parts of the country to just kind of clarify, you know, throw out the clarifying questions and seek their counsel as well.

So please we'd be more than happy to talk to you off line if you have questions that occur to you later on after digesting this, or after having a conversation with a colleague, or there's something that comes up that you think we may be helpful with don't hesitate to call or drop us an email.

Lauren Solkowski: Excellent. Thank you so much for that Randy. So I'm showing no other questions at this time. So I think we'll get ready to conclude.

I just wanted to thank Ken, and Diane, and Randy again for joining us today and for such a wonderful comprehensive presentation.

Thank you so much. Thank you for all of our participants and for your questions for them. They were great.

Again if you think of any other questions once we hang up please feel free to email them to me. My email address is listed there in the chat box on the right-hand side of the screen. So just thank you again to everyone and enjoy the rest of your day.

Ken Genewick: Thank you.

Diane Oyler: Thank you Lauren.

Lauren Solkowski: Thank you guys so much.

Randy Hoak: Bye-bye.

Lauren Solkowski: Bye-bye.

Coordinator: Thank you. That concludes today's conference you may disconnect at this time.

Lauren Solkowski: Thank you.

END