ILLINOIS COMMUNITY HEALTH AND AGING COLLABORATIVE

Presents

Illinois Pathways to Health

n4a Pre-Conference Intensive Session

July 29, 2017

Mission and Vision

- The Illinois Community Health and Aging Collaborative seeks to improve the health status of older adults and persons with disabilities in Illinois by leveraging the strengths of community-based organizations and elevating their provision of cost-effective, high quality, evidence-based healthy aging programs.

- We envision that evidence-based, healthy aging programs will be accessible to all adults across Illinois, making Illinois a healthier state in which to live.

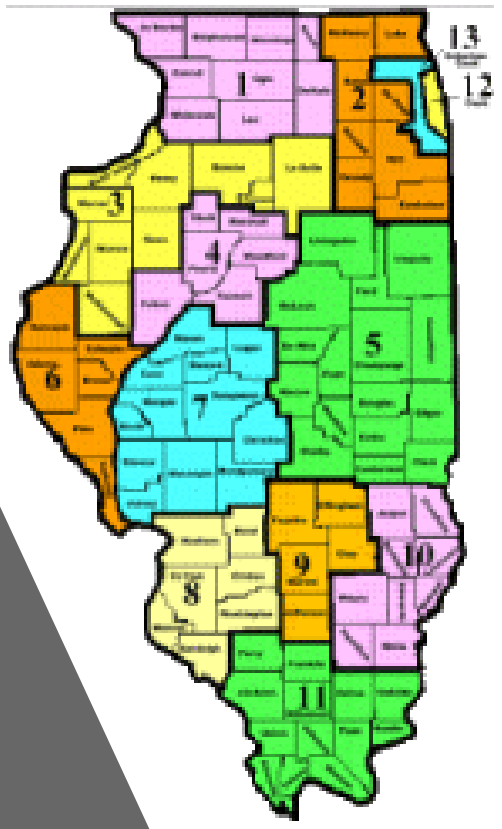
The Collaborative

- The Illinois Community Health and Aging Collaborative:
- Founded in 2013;
- Established in 2015 as a non-profit organization;
- Supported and governed by a Board of Directors comprising experienced, trusted, and progressive leaders in the field of health and aging in Illinois.

Our Founding Partners

- AgeOptions – the Area Agency on Aging for Suburban Cook County
- AgeSmart Community Resources- the AAA for Southwestern Illinois
- CIMPAR – Chicago Medical Practice and Research
- East Central Illinois Area Agency on Aging
- Illinois Aging Services, Inc.
- Northeastern Illinois Area Agency on Aging
- Rush University Medical Center
- Western Illinois Area Agency on Aging
- White Crane Wellness Center

13 Planning and Service Areas in Illinois



Illinois Pathways to Health

The Collaborative and our community-based partners provide…

Illinois Pathways to Health - a statewide integrated delivery system for evidence based programs. All members of the Illinois Community Health and Aging Collaborative are participating in the system.

Since 2006, our partners have enrolled over **15,000** older adults in a variety of evidence-based healthy aging programs.

Our strategic goal is to reach over **21,000** older adults and persons with disabilities by **2021**.

Our Strategic Plan

- ***Our 5-year strategic plan for Illinois Pathways to Health will:***
- Assess and **improve the capacity** of evidence-based health promotion programs in Illinois;
- Establish **reliable sources of payment** for healthy-aging programs;
- **Increase access** to evidence-based programs for older adults and adults with disabilities; and
- Measure and continuously **improve the quality and fidelity** of evidence-based programs.

Illinois Pathways to better health outcomes

- **Achieve the Triple Aim**:
  - Improve the patient experience of care (including quality and satisfaction);
  - Improve the health of older adults and adults with disabilities;
  - Reduce the per capita cost of health care.
- Empower adults to manage chronic diseases and disabilities;
- Empower adults to manage diabetes;
- Empower adults to manage activities of daily living at home;
- Reduce unplanned hospital admissions;
- Reduce emergency department admissions;
- Reduce admissions to long term care facilities;
- Prevent falls, manage falls, and increase self confidence.

Our Menu of Programs

- ***Illinois Pathways to Health*** offers older adults and persons with disabilities a menu of evidence-based programs to help them achieve their personal goals for health and wellness, including:
- ***Take Charge of Your Health*** (Chronic Disease Self-Management Program)
- ***Take Charge of Your Diabetes*** (Diabetes Self-Management Program)
- ***Tomando Control de su Salud*** (Spanish CDSMP)
- ***Tomando Control de su Diabetes*** (Spanish DSMP)
- ***Take Charge of Your Diabetes Plus*** *(8-week clinical wrap-around workshop for Medicare beneficiaries, with Medical Nutrition Therapy, accredited by AADE)*
- ***A Matter of Balance*** (Falls Prevention Program)

Program Partners in Illinois

- 13 Area Agencies on Aging
- Public Health Departments
- Community-Based Organizations
- Care Coordination Units
- Hospital Systems and Community Hospitals
- Centers for Independent Living
- Adult Day Services Centers
- Senior Centers and Nutrition Sites
- Independent Living and Assisted Living Facilities
- Fire Departments

Take Charge of Your Health

Progress Report: *Take Charge of Your Health*

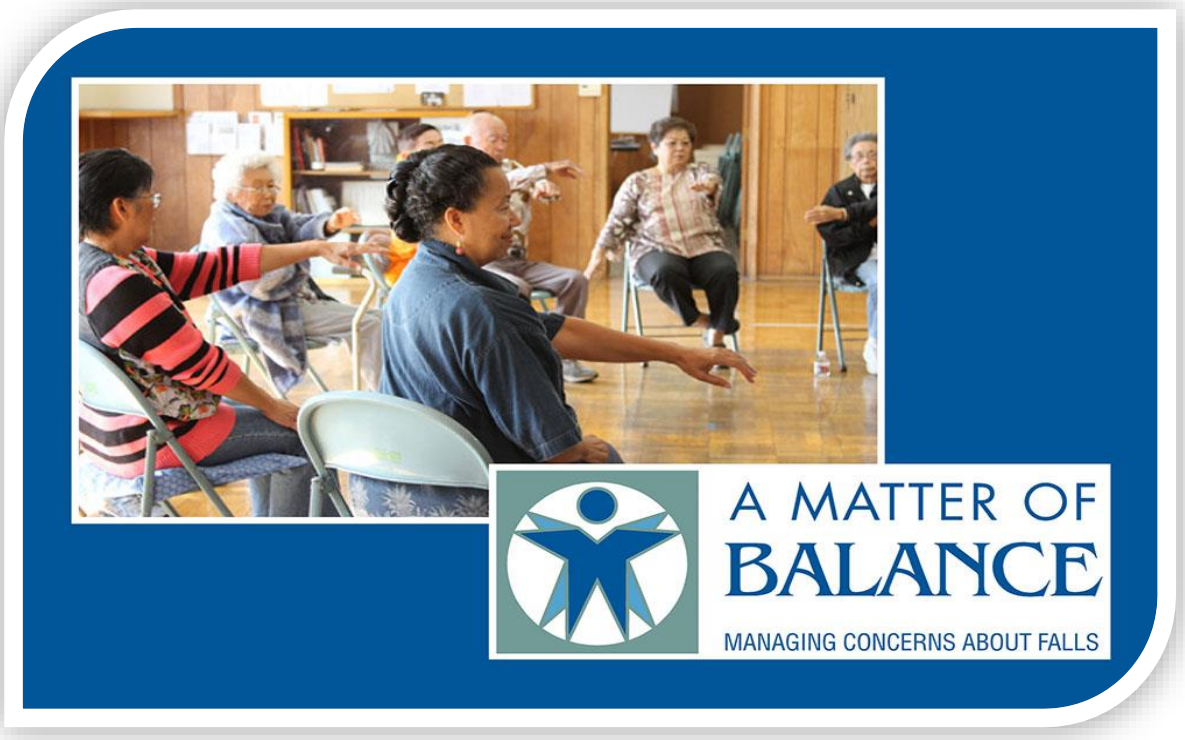
- ***Take Charge of Your Health*** workshops are available in all 13 PSAs in Illinois
- AgeOptions and partners report the following data for Take Charge of Your Health under a two-year grant with ACL as of 6-30-17:
- CDSMP: 92 workshops, 1079 registrants, 1055 participants, 742 completers
- DSMP: 43 workshops, 665 registrants, 637 participants, 524 completers
- Spanish CDSMP: 7 workshops, 112 registrants, 108 participants, 65 completers
- Spanish DSMP: 7 workshops, 86 registrants, 81 participants, 49 completers

Participants value *Take Chare of Your Health*

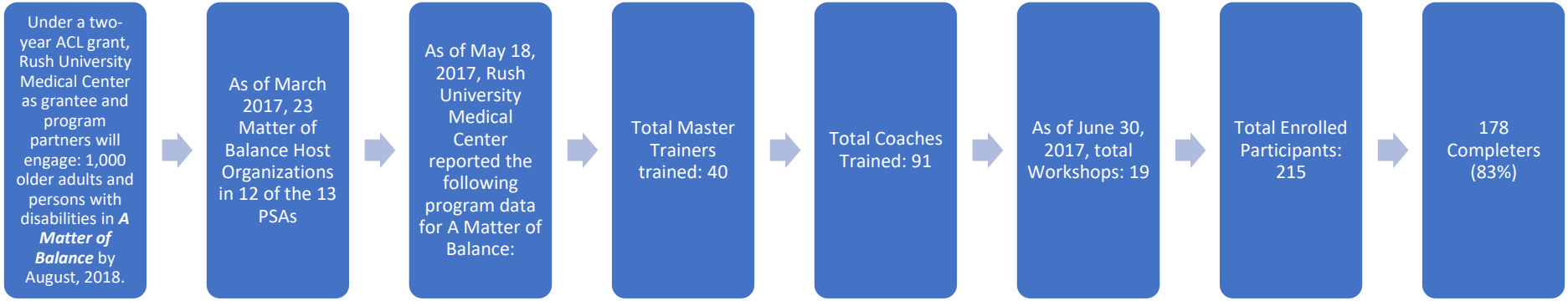
- “What I learned is that I know best how to help myself and it’s important to take action now. The things that have helped me the most to manage my chronic conditions are support from this workshop and from the other folks participating. I am not alone on this journey!” – Sharon from Suburban Cook County attended a workshop in the Spring of 2016.

- “I learned that I need to pay more attention to my diet and exercise. I didn’t know that my chronic condition was affected by not managing more carefully. I’m working on watching my carb intake. Portion control is more than a saying.” - Dan from Suburban Cook County attended a workshop in Fall of 2015.

A Matter of Balance – Falls Prevention



Progress Report: *A Matter of Balance*



Participants value *A Matter of Balance*

- "The exercises did more for me than going to the chiropractor has ever done…This class has changed my life…I have really noticed a difference all over my body, I can tell that I'm not as stiff in my back". - Gentleman, age 91, from Casey, IL, completed MOB Class in 2016

- "I am very glad I invested the time to take this class. I have told 2 friends in St. Louis and 3 friends locally – urging them to take it." - Rosemary, retired dental hygienist, from Millstadt, IL, completed MOB class in 2016

- "Interesting and educational. Introduced light exercises. Better balance when walking, and more confidence going up and down stairs. We met new friends and learned tips from one another. We go to the gym three times a week." Our advice to people at risk of falling: "You own it. It doesn't own you. Take care of it. Complete all the classes. You'll enjoy it." – Ed (age 95) and Karen (age 75) completed MOB class together in LaGrange Park, IL in 2016.

Return on Investment

- Research suggests that ***Take Charge of Your Health*** leads to a $714 per person savings in emergency department (ED) visits and hospitalization, which yields $364 per person net savings after considering national average program costs of $350 per participant

- Research has shown that ***A Matter of Balance*** participation was associated with a-$938 decrease in total medical costs per year. This finding was driven by a $517 reduction in unplanned hospitalization costs, a $234 reduction in skilled nursing facility costs, and an $81 reduction in home health costs.

Collaborative Partners in Illinois

- Health Care Providers
- Health Care Systems
- Health Insurance Companies
- Managed Care Organizations serving adults only eligible for Medicaid
- Managed Care Organizations serving adults dually eligible for Medicare and Medicaid
- Pharmacies
- College of Pharmacy, University of Illinois Chicago
- Fall Clinic at University of Illinois at Urbana-Champaign
- Illinois Fall Prevention Coalition
- Illinois Department on Aging
- Illinois Department of Public Health
- Retirement Research Foundation

Developing ICHAC as a *Network Hub*

- ICHAC participates in NCOA's Network Development Learning Collaborative.
- Team Illinois includes ICHAC as lead partner with AgeOptions and Rush University Medical Center as key partners
- Team Illinois identified the following areas for growth as a Network Hub:
- Align the needs of sustainability partners, such as health insurers, health care providers, etc., with evidence-based programs offered by our program partners through ***Illinois Pathways to Health;***
- Know our competitors;
- Create and implement non-disclosure agreements;
- Know which administrative functions of a network hub should be carried out directly by the Collaborative versus by sub-contractors, e.g., accounting, billing;
- Develop mutually agreed upon metrics to measure success of our partnerships.

Contact Us

- Visit our website: https://www.ilpathwaystohealth.org/
- Please contact:

ILLINOIS COMMUNITY HEALTH AND AGING COLLABORATIVE

Michael O'Donnell, Executive Director
Phone: (309) 531-2816
Email: mjodonnell66@gmail.com

Living well
Take Charge of your Health

MAC
MAINTAINING ACTIVE CITIZENS
Your area agency on aging

MAC, Inc. Living Well Center of Excellence Network Development Across Maryland

Leigh Ann Eagle, Executive Director
Sue Lachenmayr, State Program Coordinator

Discussion Topics

* Establishing Contracts with Hospitals to Drive EBP Expansion
* Challenges and Successes in Working with the Multiple AAAs
* Lessons Learned

Statewide Services for AAA and Health Care Partners

Statewide EBP Licenses	Statewide Calendar for Workshops	EBP Leader Trainings	Workforce Certification
Tracking of Referrals and Participant Engagement	Fidelity/Quality Assurance Monitoring	Data Entry and Reporting of Chronic Conditions and Disability Status	Reporting of Participant Self-Efficacy and Clinical Pre-/Post Measures
Ability to Add Additional Measures and Questions	On Site Technical Assistance	Annual Evidence-Based Training Academy	Quarterly Newsletters and Coordinator Webinars

Benefits to AAA Partners

- Partnerships with Hospital Systems
- Potential Funding Support for Workshop Implementation
- Reimbursement for QIO/QIN Additional Surveys
- Funding Support from State, National and Foundation Grants
- Regional Experts to Assist with Contracting
- Expertise and Resources to Attain DSMT Accreditation
- Expertise In Pricing Services and Contracts
- Training on Programs Reimbursable by Medicare
- Medicare Billing
- Diverse Health Care Partnership Models

Hospital Partners

* Peninsula Regional Medical Center (ACL CDSME, Falls, Pearls, H2H, Malnutrition Pilot)
* Johns Hopkins (CDSME, Falls, HRSA)
* Meritus Health (CDSME, Falls)
* University of Maryland Medical System (9 hospitals – CDSME, Falls)
* Medstar (10 hospitals - CDSME)
* Atlantic General (CDSME and Falls)
* Frederick Memorial Hospital (CDSME)
* Anne Arundel Medical Center (DSMP)

Contract Model: Regional Local Hospital

* Provide an array of cancer survivorship services (garden, cooking classes, gym and exercise boot camp, and an array of holistic programs), annual cancer retreat
* Cover cost of site/space for program and meeting implementation
* Provide an array of services to individuals in weight loss program (garden, cooking classes, gym, depression screening and programs)
* Provide targeted outreach to engage at risk minorities

Contract Model: Regional Local Hospital

* Train hospital-based CHWs and staff in evidence-based programs
* Provide depression screening and PEARLS to at risk individuals
* Host PRMC partner meetings and participate in hospital initiatives
* Pilot hospital to home services for Medicare/Medicaid individuals
* Pilot referral to nutritional services for individuals with diagnosis of malnutrition upon hospital discharge

Contract Model: Multiple Hospitals Across 2 States

* Empower individuals with chronic conditions to manage their health through Stanford Chronic Disease, Diabetes and Cancer Self-Management and a Hypertension Session O
* Identify high risk zip codes, identify partnering sites/organizations in those zip codes
* Recruit community individuals residing in high risk zip codes to be trained as workshop leaders
* Provide hospital-based liaisons to connect sites and leaders, set up workshops, and conduct pre-/post- BP, BMI, Body Fat and weight

Contract Model: Multiple Hospitals Across 2 States

* Referral criteria embedded in Electronic Medical Record
* Started in late April to generate referrals for OUTPATIENT – Primary Care and Urgent Care facilities; inpatient referrals to follow
* Physician clicks on Community Health Programs tab in EMR
* E-mail to the Call Center Screening for unmet social needs at point of intake/enrollment and linkage to social services
* Call Center has patient information, uses motivational interviewing to enroll them in a class.
* Patient attends CDSME (30, 60, and 90-day post f/up)

Contract Model: Multiple Sites Across 2 States

* CDSMP/DSMP/CTS/Hypertension Leader Trainings February-March 2017 – 65 leaders; 3 Leader Trainings scheduled for September 2017 (45-60 new leaders)
* Training and technical assistance for hospital liaisons, regional coordinators on data collection and recruitment
* Onsite assistance at all workshop session 1, fidelity/quality assurance monitoring of workshop delivery/data collection
* Expansion of database to include clinical pre-/post-measures (BMI, Body Fat, Weight)

Challenges in working with our AAA Partners

* Transition from State 'Pay for Completer' Model
* 21 AAAs, 19 are local government
  * Limited flexibility, unable to partner with hospitals/health care providers
* Limited staff, due to fixed/reduced budgets

Despite these challenges, the number of AAAs offering EBPs now includes all counties and most AAAs have increased the number of workshops/participants in EBPs.

Opportunities to Engage AAA Partners

* Maryland State Office of Aging provided funding 10 AAAs to develop a referral path for home and community-based services for at least older adults upon hospital discharge.
* This was an initial interaction with a hospital, but it may open the door to further partnering/contracting with hospitals.
* Veterans are a new priority population for EBPs – we believe expanding reach across the aging network will increase the potential for funding via VA Choice.
* PEARLS expansion provides opportunities for Medicare reimbursement.

Lessons Learned in Engaging Health Care Partners

* Risk assessments to refer individuals to appropriate EBP
* Centralized referral, convenient community-based locations, HIPAA compliant and continuous quality assurance processes
* Tracking referrals and reporting of participant engagement and long-term goals
* Pre-/post clinical measures (BP, BMI, Body Fat, Weight, Handgrip strength)
* Matching of participant self-efficacy to required ACO/NCQA measures (ability to self-manage, set action plans, understand steps to take to improve condition)

Assessing Patient Risk and Referral to Evidence-Based Programs

Chronic Disease Assessment

* Do you have 2 or more chronic medical conditions?
* Are you taking more than 5 medications?
* Do you have difficulty managing your condition(s)?

Falls Risk Assessment for patients over 65

* Have you fallen in the past year?
* Do you feel unsteady when standing or walking?
* Do you worry about falling?

Depression Screen: Over the past two weeks, how often have you been bothered by any of the following problems?

* Little interest or pleasure in doing things
* Feeling down, depressed or hopeless

Malnutrition/Food Insecurity Screen: During the last 12 months

* Have you worried whether the food would run out before you got money to buy more
* Have you found that the food that you bought didn't last, and you didn't have money to get more.

Unique Services of Value to Health Care Partners

* Population health approach - EBPs are a key component within the continuum of care
* Targeted outreach to engage hard-to-reach individuals (minorities, non-English-speaking)
* Flexibility in program delivery venues (community sites, in-home)
* Opportunity to add tailored clinical measures and/or data elements
* Bundling of multiple EBPs (CDSME, PEARLS, EnhanceFitness)
* Linking of high risk individuals to wrap-around services

the healthy living Center of Excellence

Building a Collaborative Community Network: The Massachusetts Experience

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

The Power to Redefine Aging.
Hebrew SeniorLife
HARVARD MEDICAL SCHOOL AFFILIATE

Overview of the HLCE

Vision: Transform the healthcare delivery system. Medical systems, community-based social services, and older adult will collaborate to achieve better health outcomes and better healthcare, both at sustainable costs.

Key Features:

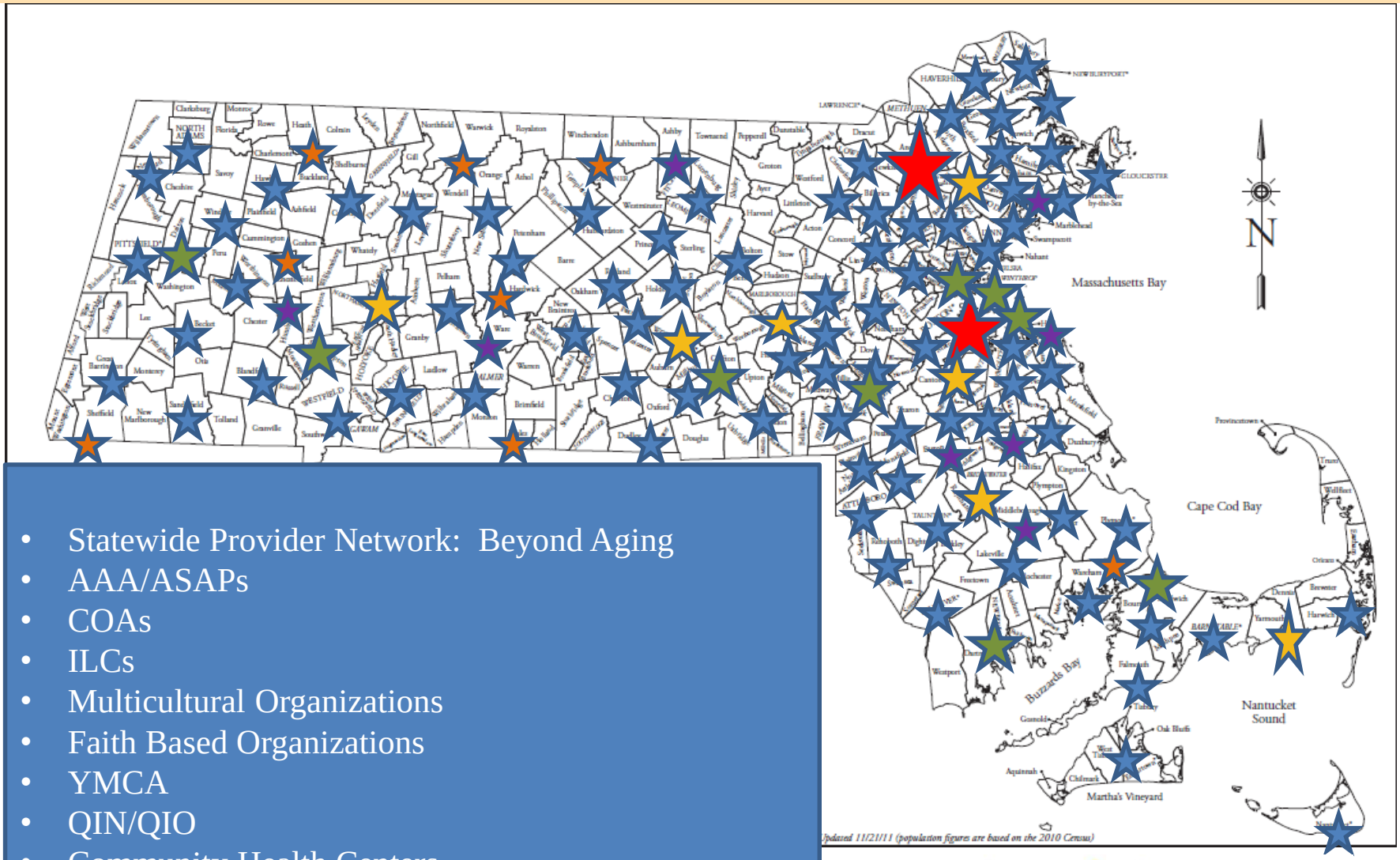
* Statewide Provider network of diverse community based organizations
* Seven (7) regional collaboratives
* Centralized referral, technical assistance, fidelity, & quality assurance
* Multi-program, multi-venue, multicultural across the lifespan approach
* Centralized entity for contracting with statewide payors
* Diversification of funding for sustainability
* EBP integration in medical home, ACO and other shared settings

Our Partnership Path

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

the healthy living Center of Excellence

HLCE Provider Network



- Statewide Provider Network: Beyond Aging
- AAA/ASAPs
- COAs
- ILCs
- Multicultural Organizations
- Faith Based Organizations
- YMCA
- QIN/QIO
- Community Health Centers

the healthy living Center of Excellence

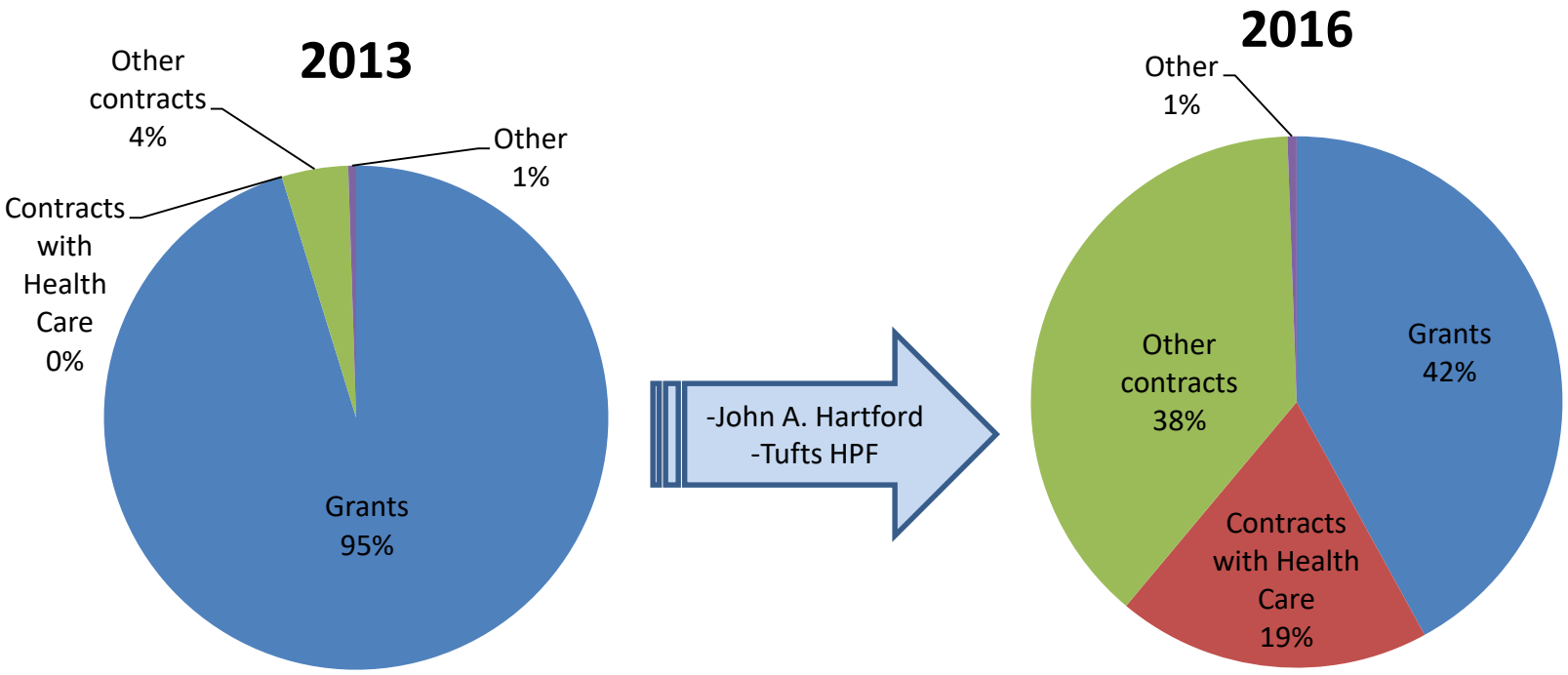
Value to Community Partner

- Multi-site license for CDSME (no cost, but …)
- Discounted or no-cost trainings in diverse programs
- Bi-monthly Fidelity / Best Practice Webinars
- Fidelity Committee
- Connections with Health Care
- Program reimbursement
- No membership fee
- Website with calendar and leader portal
- Annual Sharpening Your Skills Conference

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

the healthy living Center of Excellence

Outcomes: Towards a More Sustainable Model



Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

the healthy living Center of Excellence

Key Learnings

- Start TODAY (or someone else will)
- Develop a shared mission and vision
- Look beyond usual suspects / aging network
- Consider including your competitors
- Provide Value to partners beyond $$$
- Be collaborative… until you can't
- If you know 1 network ….
- Communicate, Communicate, Communicate
- Celebrate Successes

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

the healthy living Center of Excellence

Celebrate Your Successes

Elder

Choices for a life-long journey

the healthy living Center of Excellence