CBO Contracting Perspectives

Opportunities and Challenges

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CLEAR VIEW STRATEGIES

Comprehensive Care Connections – “C3”

COMPREHENSIVE CARE CONNECTIONS

- Non-profit formed in 2016 by a group of Pennsylvania AAAs
- Initially formed to support AAAs as Service Coordinators during the launch of managed Medicaid long term services and supports (MLTSS), known as “Community HealthChoices” in Pennsylvania
- Single-source contractor for AAA programs across the health care sector
- Informal relationships exist with non-C3 AAAs across the state

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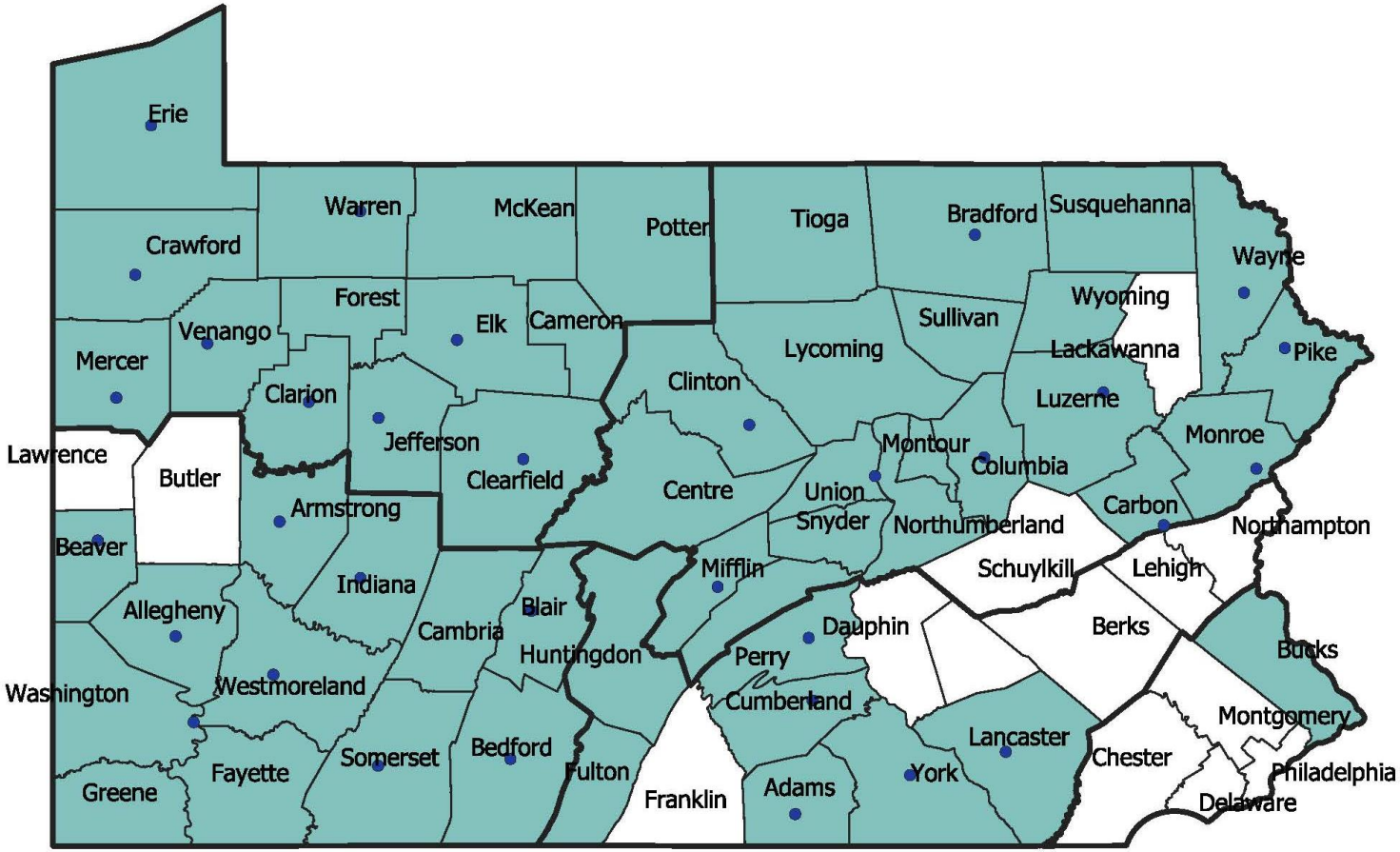
C3 Founding Agencies



Phase I Implementation | Phase III Implementation | Phase II Implementation

50 0 50 100 150 200 km

Legend

- C3 Agency Locations
- C3 Counties

Map Data Sourced from Pennsylvania Spatial Data Access http://pasda.psu.edu

COMPREHENSIVE CARE CONNECTIONS

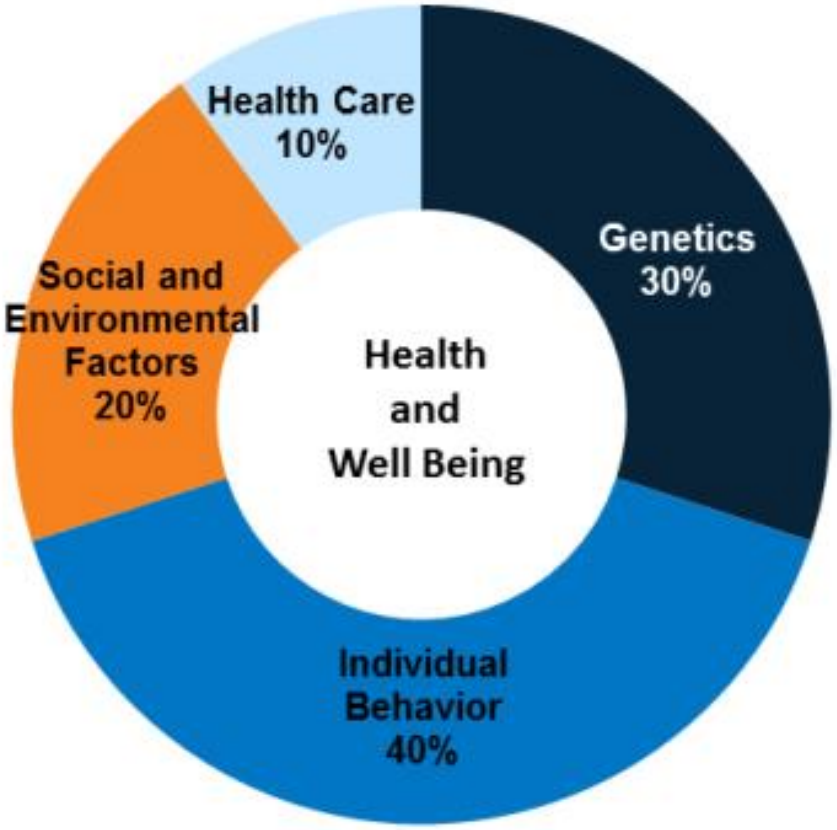
Why Address SDOH?

Figure 2

Impact of Different Factors on Risk of Premature Death

Why Addressing SDOH should be a Priority

60%



SOURCE: Schroeder, SA. (2007). We Can Do Better — Improving the Health of the American People. *NEJM*. 357:1221-8.

KFF

https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Why Addressing SDOH should be a Priority

- Health care is a relatively weak health determinant when compared to social factors[1]
- 68% of patients suffer from at least one SDOH challenge with 57% having moderate-to-high risk[2]

1 – https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/
2 – https://www.healthcaredive.com/news/1-in-5-patients-at-high-risk-of-socioeconomic-health-problem-survey-finds/544233/

Why do CBOs matter in this conversation?

- Only 15-21% patients indicate wanting a health care clinician's help addressing their socioeconomically-induced health condition

- CBOs represent a ready-made, experienced, nationwide solution to address Social Determinants of Health (SDOH)

What Experience do CBOs have?

What types of services do AAAs offer?

- **Care Transition** Services *(EX: hospital, nursing home, or rehab facilities to home)*
- Needs **Assessments** and **Care Coordination** *(required for SSBCI)*
- **Chronic disease self-care management programs**
- Home-delivered (and congregate) **meals**, **nutrition counseling** and education
- Non-medical **transportation**
- **Caregiver** supports
- Senior Centers/**Adult Day** programs
- In-home personal care services
- **Social Isolation**/depression screenings
- Housing assistance and coordination (**home mods**, repairs, etc.)
- Information, referral and enrollment assistance to eligible services and programs

Can they deliver results (positive outcomes)?

PA Care Transitions Experience: by the #s

AAAs participated in the CMS Community Care Transitions Program (CCTP)

- 16,847 – consumers transitioned to their communities from 11 regional hospitals
- 94% – received a comprehensive medication review and reconciliation
- 19-33% – decrease in hospital readmission rates
- 17.4% – increase in compliance with PCP visit within seven days of discharge

Timeframe: 2012-2015

C3 and Humana at Home

Humana at Home

- A **care management** program that helps eligible Humana patients remain independent at home
- Focus is on patients who—
  - ➢ Are frequently hospitalized (or at risk of being hospitalized)
  - ➢Have limited family support
  - ➢Have chronic conditions such as:
    - —congestive heart failure (CHF)
    - —chronic obstructive pulmonary disease (COPD)
    - —coronary artery disease (CAD) or
    - —diabetes

Humana at Home – Service Offerings

Long-Term Care Management:

- Regular contacts for assessment/care planning, assistance with benefits and other eligible resources, and self-care coaching
- Support is provided by phone and through home visits (typically weekly)
- As the member's needs change, services are modified to meet an appropriate level of care
- Goal: Engagement with the member

30-Day Transitions Service:

- Care management services are provided for 30 days after a hospital or sub-acute discharge
- Care Manager visits the member in the facility or home, coordinates care with the member's primary care physician, and provides telephonic support.
- Goal: reduce unnecessary hospitalizations and emergency room visits

Source: Humana website

What is C3's role?

- C3 developed a services process with Humana that allows us to coordinate the partnership using a standardized model across multiple area agencies on aging
- Leverages the benefit of a single administrator, coordinated response metrics, quality improvement, and sharing of best practices
- Piloted in Pennsylvania, C3 is working with Humana to expand the partnership into other states

Humana at Home – Where are we now

11 AAAs

42 Care Managers

"C3's statewide reach makes them a perfect partner for national health plans."
-Humana at Home presenter

"I am tickled by the dedication and commitment C3 has to Humana's Success"
- Dana Tomson, Humana Clinical Care Lead

Challenges and Lessons Learned

- Manage **Medicare compliance** as a downstream provider *(not designed for CBOs)*
- Focus on **outcomes** and **customer satisfaction**
- Manage complexity caused by working in multiple **IT systems**
- Know the **health plan benefits**
- “Sell” the program **enrollment**
- **Volume** is critical

National Interest from MCOs

Frequent Programs of Interest

- Comprehensive Needs **Assessment** (for SSBCI)
- **Care Coordination**
- Coordination of home delivered **meals** and nutrition education
- Home Environmental and Barriers Assessments—
  - ***Falls risk*** *hazards*
  - ***Self-care barriers****: electricity is turned off, lack of HVAC, no refrigeration or cooking ability, pest issues, etc.*
  - ***Medication review***

Other Potential Programs… *(continued)*

- **Evidence-based self-care management** programs:
  - *diabetes, chronic disease, etc.*
- **Screenings**—
  - *Annual Health Risk Assessments and Hard-to-Reach engagement*
  - *Social isolation, behavioral/depression*
  - *Breast cancer*
  - *Homelessness*
  - *Falls Risk*
- **Home Mods**/repairs

CLEAR VIEW
STRATEGIES

COMPREHENSIVE
CARE CONNECTIONS