The John A. Hartford Business Innovation Award: 2023 Recipients Speak About Their Innovative Health Care Contracts And Partnerships

September 26, 2023

USAging
Leaders in Aging Well at Home

Aging and Disability BUSINESS INSTITUTE
Connecting Communities and Health Care

Webinar Instructions

Audio Options

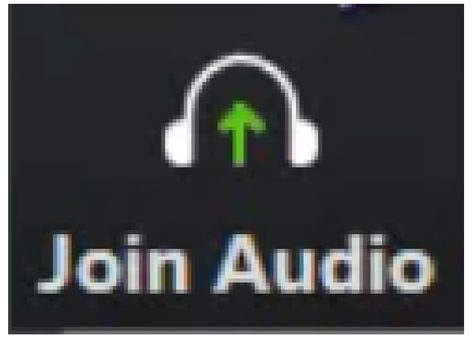
- Use your computer speakers, **OR** dial in using the phone number in your registration email.
- All participants are muted.

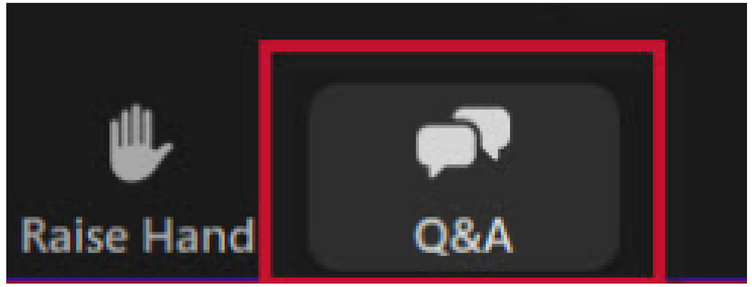
Questions and Answers (Q&A)

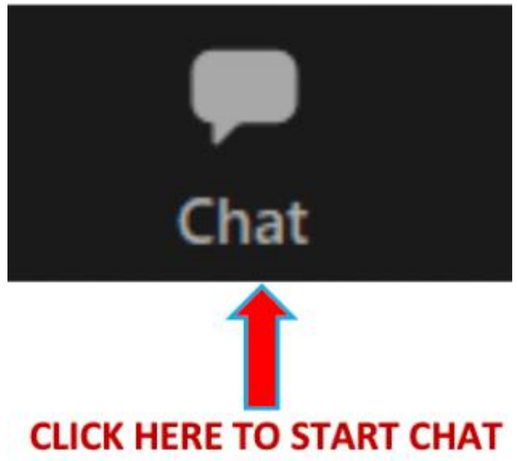
- You can submit questions for the panelists at any time during this presentation. On the Zoom module on the bottom of your screen, click the Q&A icon, type your question in the box and submit.

Chat Feature

- The Chat feature allows webinar attendees, the host, co-hosts and panelists to communicate for the duration of the webinar.







USAging

Accessibility

- **Screen Reader Users: Reduce unwanted chatter**
  - Request speech on demand: Insert, Spacebar, “S”

- **To get our attention if you need tech assistance:**
  - Raise or Lower Hand: Alt + Y

The John A. Hartford Foundation

The John A. Hartford Foundation Business Innovation Award: 2023 Recipients Speak About Their Innovative Health Care Contracts and Partnerships

September 26, 2023

Jane Carmody, DNP, MBA, RN, FAAN

Senior Program Officer
The John A. Hartford Foundation

Congratulations and thank you for creating innovative, age-friendly partnerships!

Runners Up:

Central Ohio Area Agency on Aging

Region IV Area Agency on Aging

Strengthening Aging Services

The John A. Hartford Foundation

Aging and Disability Business Institute
Building business capacity of community-based organizations to adapt to changing health care environment

- Resource library and evidence bank
- Organizational assessment tools
- Spreading success stories
- The John A. Hartford Foundation Business Innovation Award

USAging Leaders in Aging Well at Home

Aging and Disability BUSINESS INSTITUTE
Connecting Communities and Health Care

aginganddisabilitybusinessinstitute.org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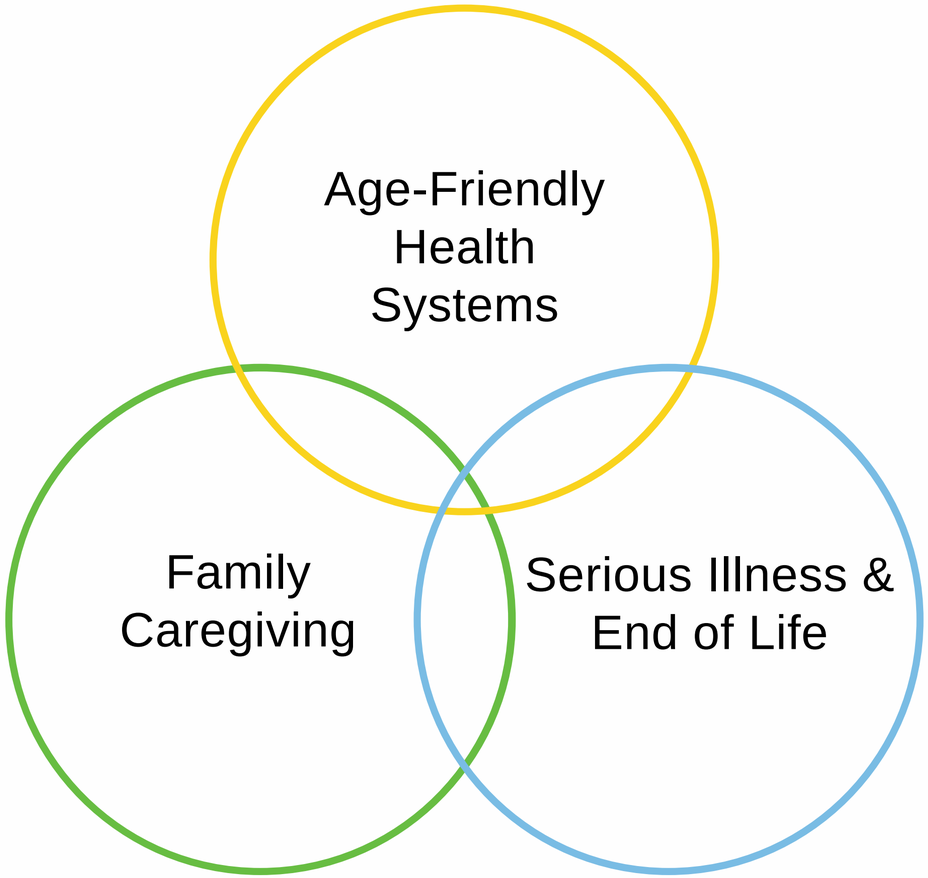
The John A. Hartford Foundation
A private philanthropy based in New York City, established by family owners of the A&P grocery chain in 1929
DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS

Mission

DEDICATED TO IMPROVING THE EQUITABLE CARE OF OLDER ADULTS

PRIORITY AREAS



Planning for the Future: We Need Age-Friendly Solutions

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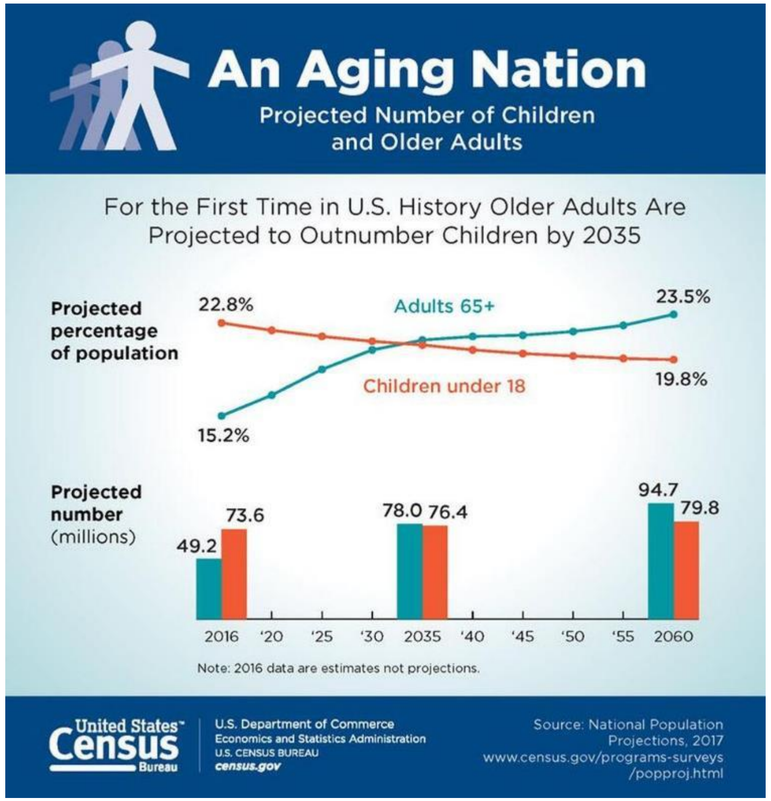
- **Demography**: # of older adults is rapidly growing and becoming more diverse
- **Complexity**: multiple chronic conditions, dementia, disability, social isolation, social determinants of health
- **Disproportionate Harm**: higher rates of health care-related harm, discoordination, poor preparation for disasters



The Need for Age-Friendly Health Care

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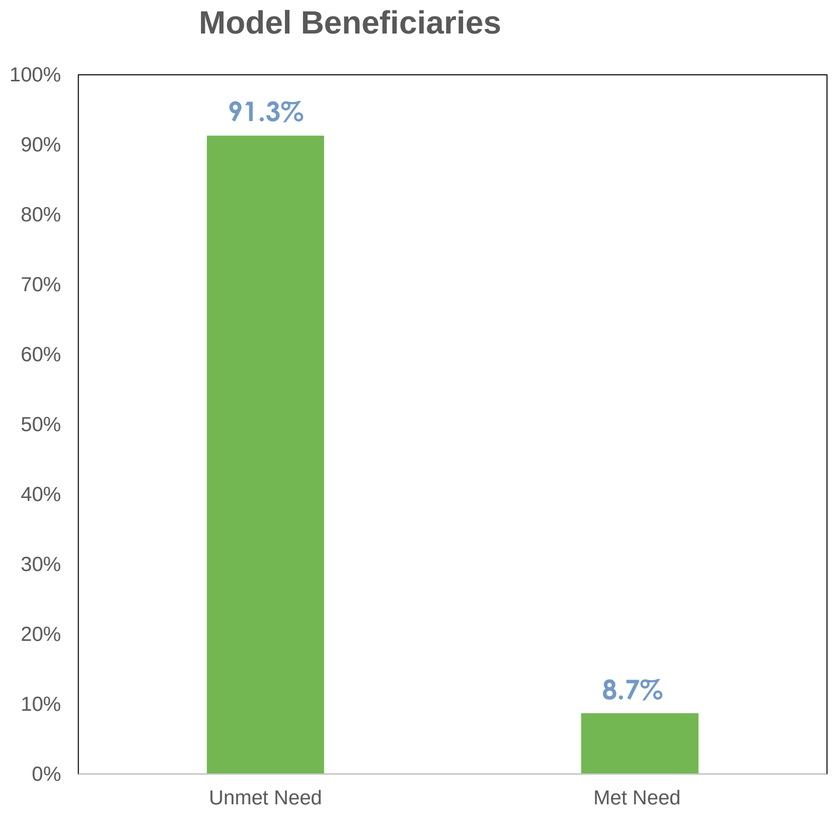
Evidence-Based Care Not Reliably Applied

- We have many evidence-based geriatric-care models that have proven very effective
- Yet, most reach only a portion of those who could benefit
  - Difficult to disseminate and scale
  - Difficult to reproduce in settings with less resources
  - May not translate across care settings

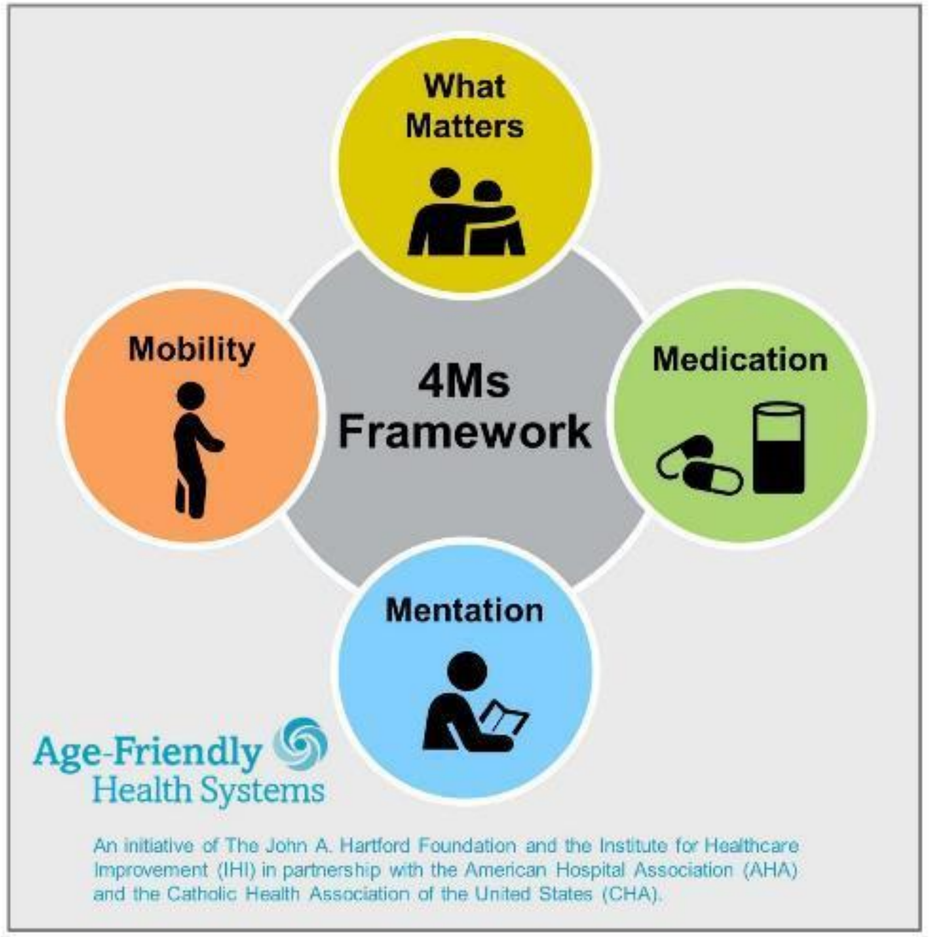


IHI Analysis of Model Beneficiaries 2016
Met Need – 8.7%
Unmet Need – 91.3%

Age-Friendly Health Systems

The aim: Build a movement so ***all care*** with older adults is **equitable age-friendly care**:

- Guided by an essential set of evidence-based practices (**4Ms**)
- Causes no harms
- Is consistent with **What Matters** to the older adult and their family



Fulmer, T., Mate, K. S., & Berman, A. (2018). The age-friendly health system imperative. *Journal of the American Geriatrics Society*, *66*(1), 22-24.

Age-Friendly Health Systems

The John A. Hartford Foundation

Age-Friendly Health Systems

an initiative of
The John A. Hartford Foundation
and the
Institute for Healthcare Improvement
in partnership with the
American Hospital Association and the **Catholic Health Association of the United States**

IHI.org/agefriendly

A Growing Number of Stakeholders

The John A. Hartford Foundation

Institute for Healthcare Improvement

American Hospital Association

CHA Catholic Health Association of the United States

VA U.S. Department of Veterans Affairs

NEW YORK STATE Department of Health

HANYS Always There for Healthcare

CVS minute clinic

AGS Geriatrics Healthcare Professionals

HRSA Health Workforce

AARP Real Possibilities

Frances Payne Bolton School of Nursing Case Western Reserve University

GAPNA Gerontological Advanced Practice Nurses Association

RUSH

USAging

Michigan Health Endowment Fund

Massachusetts Healthy Aging Collaborative

Center for Consumer Engagement in health innovation A better way to better health. For everyone.

Age-Friendly Health Systems

The scan Foundation

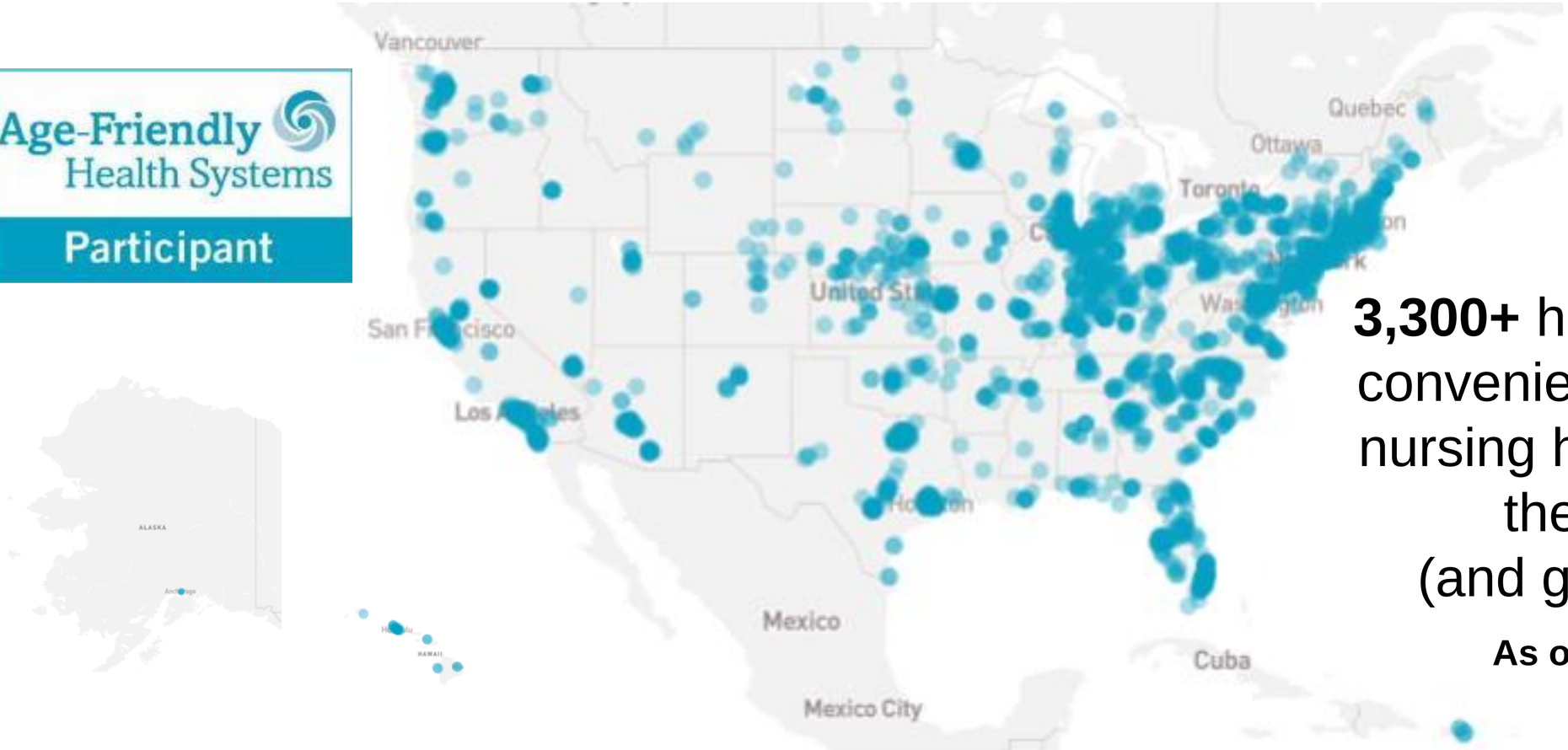
UCLA Anderson School of Management

CHAP

A Growing Movement!

The John A. Hartford Foundation

Age-Friendly Health Systems
Participant



3,300+ hospitals, practices, convenient care clinics and nursing homes have joined the movement!
(and growing globally)

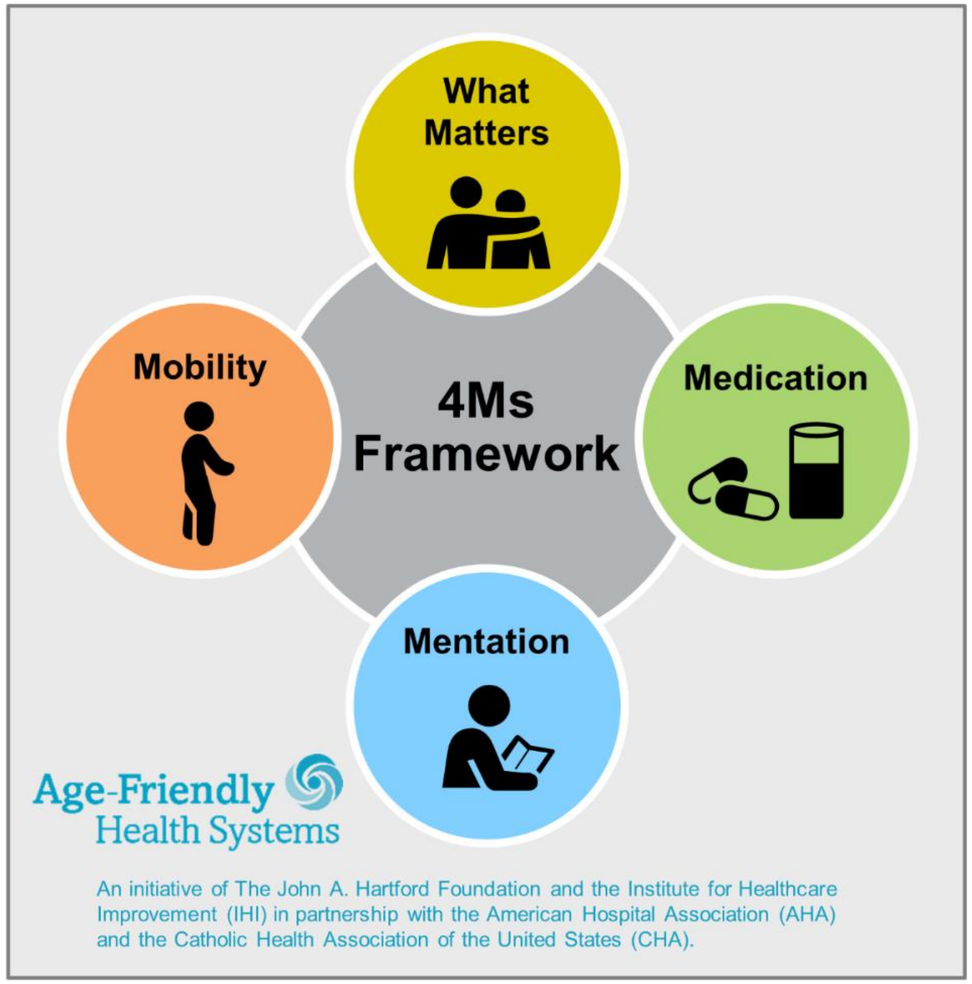
As of September 2023

http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/Background.aspx

The 4Ms of Age-Friendly Care

The John A. Hartford Foundation

IHI.org/agefriendly



What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

Age-Friendly Health Systems

2.7 + Million Older Adults received Age-Friendly Care

Other Age-Friendly Clinical Programs and Resources – In the ED and OR

- **Geriatric ED Collaborative** – training and educational resources, join as a member gedcollaborative.com
- **Geriatric ED Accreditation** – meet standards and receive recognition from American College of Emergency Physicians in 3 levels acep.org/geda
- **Geriatric Surgery Verification** – meet standards and be verified by American College of Surgeons facs.org/quality-programs/geriatric-surgery

Age-Friendly Health Care in the Home

- **Hospital at Home** – join Users Group to help you adopt model hahusersgroup.org

- **Home-Based Primary Care** – get training from Home Centered Care Institute (hccinstitute.org), improve QI in National Learning Network (improvehousecalls.org), join American Academy of Home Care Medicine provider directory (aahcm.org)

Age-Friendly Care for People Living with Dementia, Serious Illness, Multiple Chronic Conditions

The John A. Hartford Foundation

- **Alzheimer's and Dementia Care Program** – nurse practitioner led model started at UCLA, EDC helping to spread to systems adcprogram.org
- **Center to Advance Palliative Care** – clinical training and resources capc.org
- **Patient Priorities Care** – helps coach older adults and health care providers on asking and acting on What Matters patientprioritiescare.org

Age-Friendly Public Health Systems

The John A. Hartford Foundation

Trust for America's Health & JAHF partnered to create **Age-Friendly Public Health Systems**:

- Working with state and local health departments – *in partnerships with aging services and health care*
- 6Cs Framework for healthy aging
- Recognition Program
- Free monthly trainings

afphs.org

Countering Ageism

The John A. Hartford Foundation

- Longevity is one of our greatest success stories
- Yet, **ageism** gets in the way of realizing benefits:
  - Is unjust, and has **negative impact on health**
- Need to redefine aging by emphasizing:
  - “We” are all aging (not “they” and “them”)
  - Aging is accumulation of experience and knowledge, a natural progression (not something to be fixed)
  - Ageism contributes to inequity, and intersects with other forms of discrimination

National Center to Reframe Aging

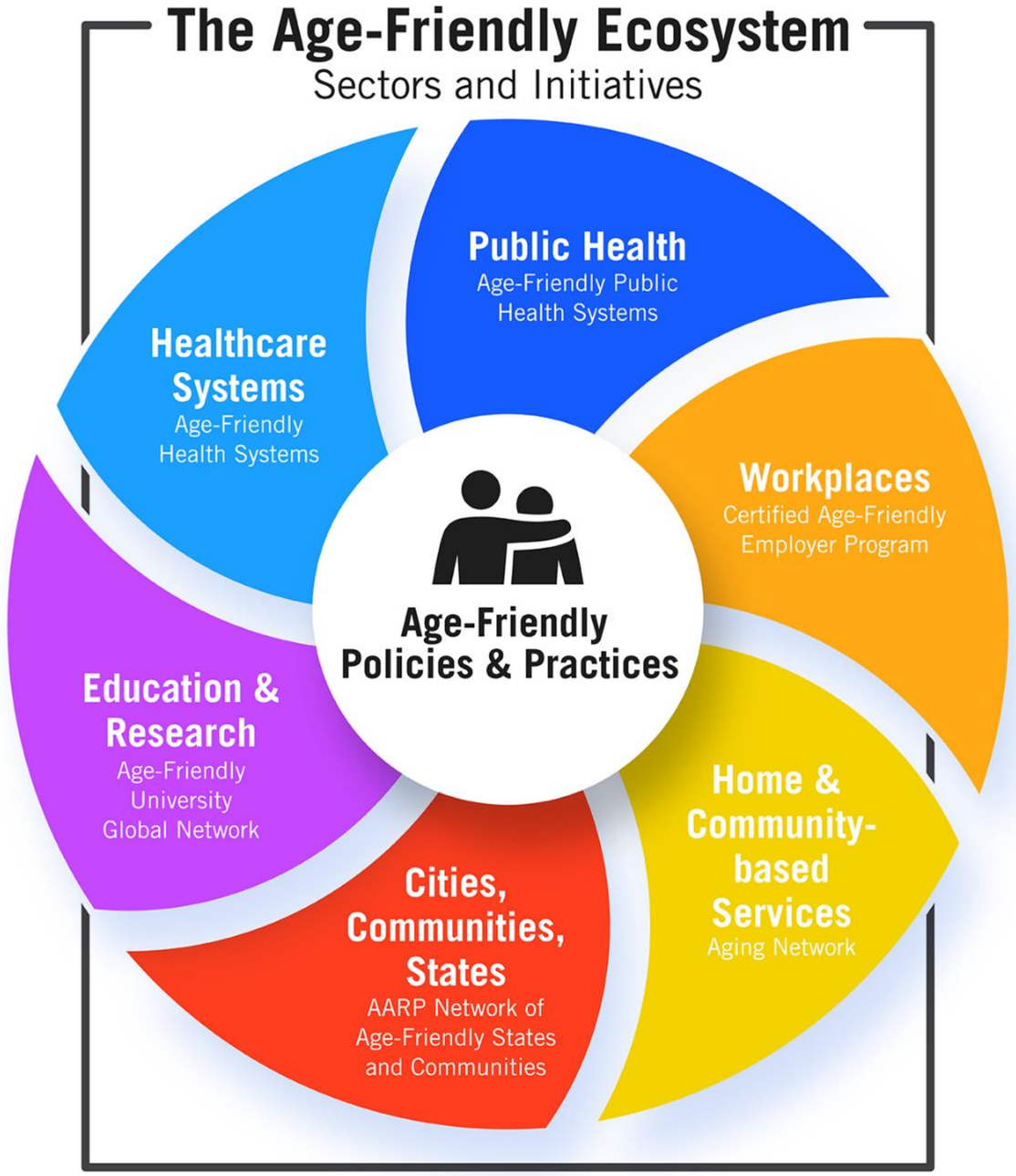
LED BY THE GERONTOLOGICAL SOCIETY OF AMERICA

ReframingAging.org

ReframingAging.org

We All Need an Age-Friendly Society

- Longevity is greatest success story of last century
- As we age, we can make vital contributions and power up communities – with support
- A just society requires us to make all sectors **age-friendly**



Age-Friendly Solutions for All

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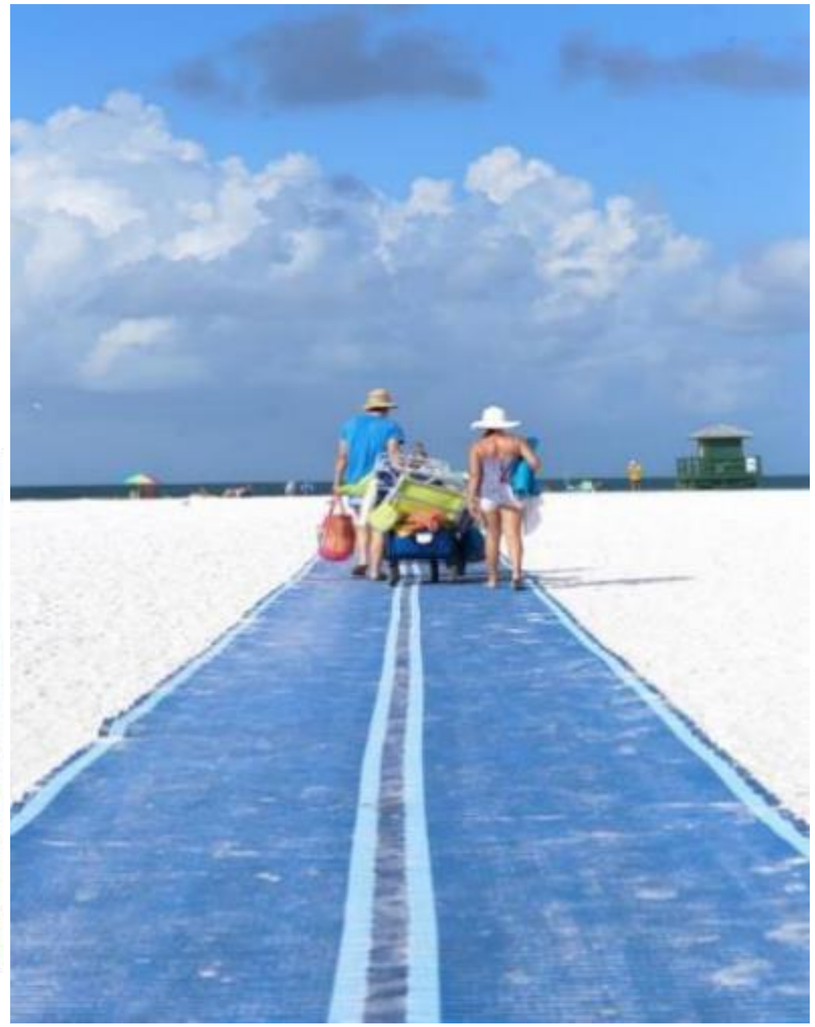


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Thank You!
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DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS

SOCIAL DETERMINANTS OF HEALTH ACCELERATOR PROGRAM

COAAA
CENTRAL OHIO
AREA AGENCY
ON AGING

“WITH EXCEPTIONAL, INCLUSIVE CARE AS OUR FOUNDATION, WE WILL PAVE THE WAY FOR THE FUTURE OF MEETING HEALTH EQUITY THROUGH SOCIAL CARE AND INNOVATION”

THE PARTNERS (*CURRENT TO 9.2023)

Financial support + Inclusive codesign= innovation

MOLINA® HEALTHCARE

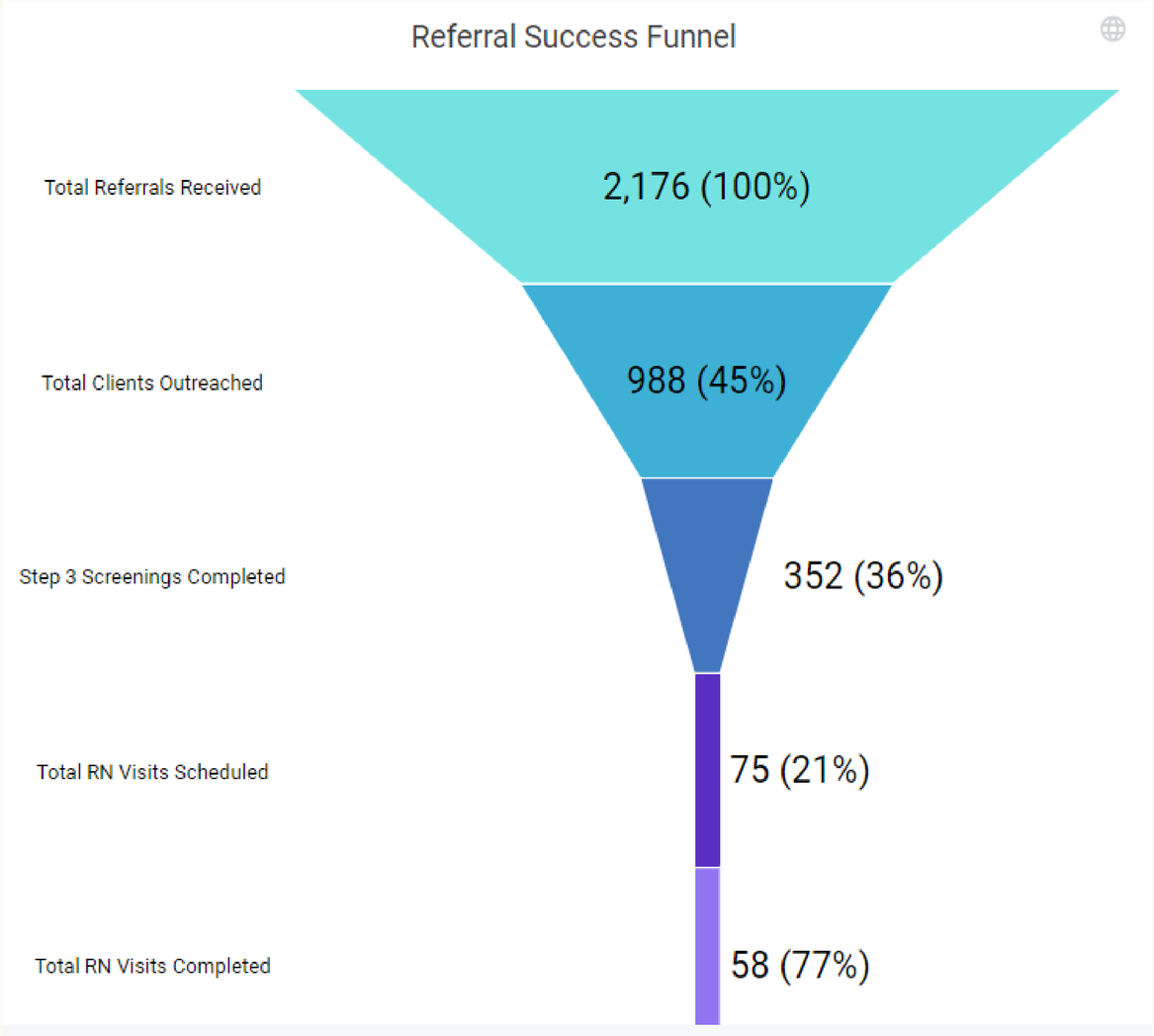
aetna®
Aetna Better Health®

MonAmi

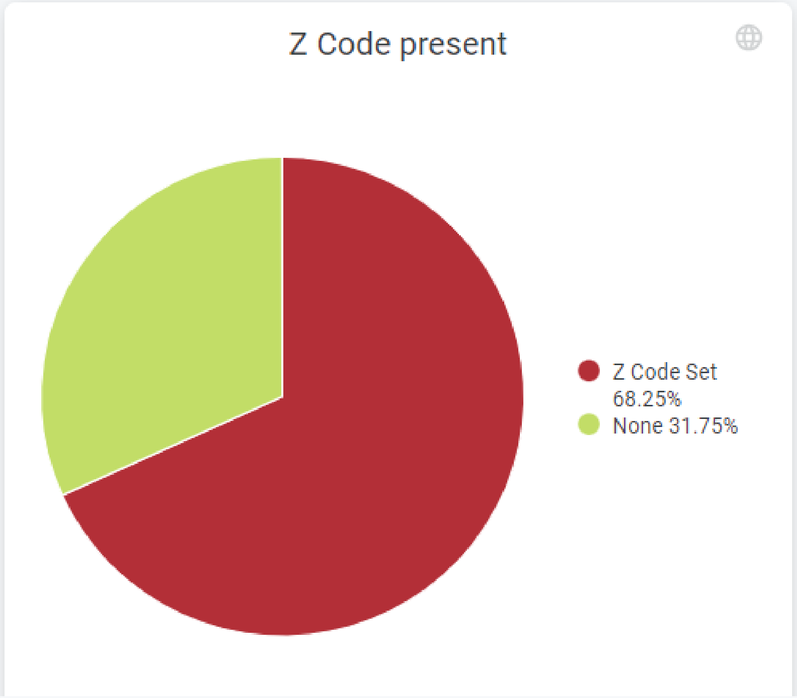
PRODUCT LAUNCH TIMELINE

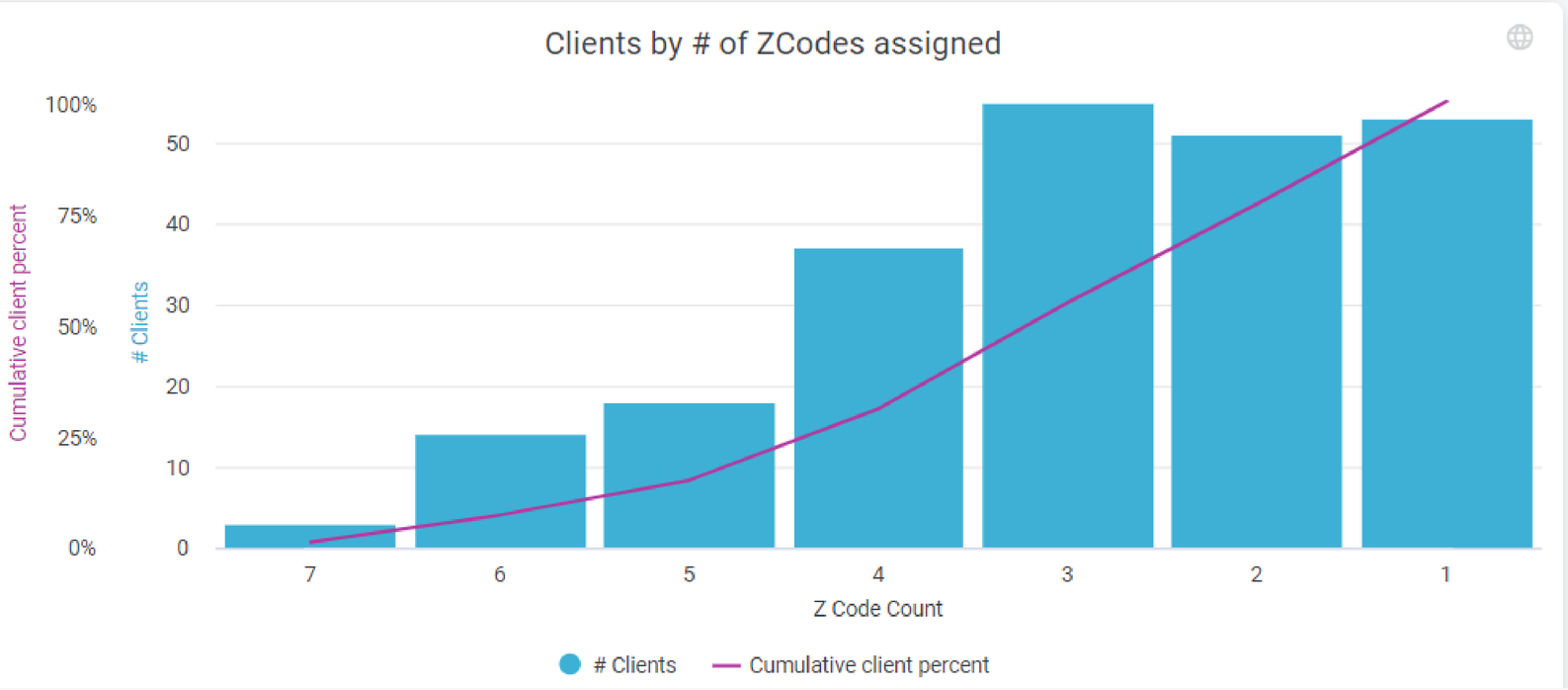
JULY 2022	SEPT 2022	OCT-DEC 2022	MARCH 2023	SEPT 2023
Idea generation Planning	Concept pitch Strategy	Co-design Product Iterative process	Program launch	Product and process operationalized

KEY METRICS


Referral Success Funnel
Total Referrals Received
2,176 (100%)
Total Clients Outreached
988 (45%)
Step 3 Screenings Completed
352 (36%)
Total RN Visits Scheduled
75 (21%)
Total RN Visits Completed
58 (77%)

KEY METRICS





Powered by

“TALKING ABOUT SOMETHING THAT MIGHT NOT FIT WITH WHAT WE ACTUALLY “DO” BUT COULD SIGNIFICANTLY BENEFIT OUR CONSUMERS.”

Social Care: The Future of Health Equity

COAAA SDoH Accelerator Program

COAAA CENTRAL OHIO AREA AGENCY ON AGING

SOCIAL CARE CLINICIANS

Skilled in engaging and connecting with members of our community.

OUTREACH

Meeting members where they are, building trust and impacting change

SDOH SCREENING

One of a kind screening tool using trauma informed care and motivational interviewing

INNOVATION

Developing unique interventions to meet the needs of the Central Ohio community

OUTCOMES

Closing the loop with reporting to CMs, PCPs and stakeholders, pre and post screenings of interventions

THANK YOU

Katie M. White
Director
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Melissa Gualtieri
Director of Clinical Innovations
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www.coaaa.org

HEALTH CARE CONTRACTING

Community of Care:

Addressing health related social needs (HRSN) through the integration of social care and medical care in a Primary Care First practice & Rural Health Clinic.

Christine Vanlandingham
CEO
Region IV Area Agency on Aging
cvanlandingham@areaagencyonaging.org

REGION IV
Area Agency on Aging, Inc.
SPECIALISTS IN AGING
Offering Choices for Independent Lives

Corewell Health™

The John A. Hartford Foundation
BUSINESS INNOVATION AWARD
2023 RUNNER UP
The John A. Hartford Foundation | USAging Leaders in Aging Well at Home | Aging and Disability BUSINESS INSTITUTE Connecting Communities and Health Care

WHO WE ARE:

Contract/Partnership:

- Embeds AAA social care clinicians in medical care teams to address complex care needs of older adults
- Targets patients age 60+ with complexity score of 14+; high utilizers of ED and inpatient services
- Two contracts
  - Rural Health Clinic – FFS contractual relationship
  - Primary Care First practice – FFS shared vision to move to value-based up-side/down-side risk-based contract

REGION IV
Area Agency on Aging, Inc.
SPECIALISTS IN AGING
Offering Choices for Independent Lives

At our core, we are here to ensure that older adults and people with disabilities can live life as independently as possible in the setting of their choice.

What guides us.

Mission: Offering Choices for Independent Lives

Vision: Through choice and range of service, every aging adult lives a quality life.

Core Values:

- *Dignity*
- *Empowerment*
- *Equity*
- *Independence*
- *Interdependence*
- *Person-centeredness*
- *Wisdom of age*

Corewell Health™

At our core, we are here to help people be well so they can live their healthiest life possible.

What guides us.

Mission: Improve health, instill humanity and inspire hope.

Vision: A future where health is simple, affordable, equitable and exceptional.

Values:

- *Compassion*
- *Collaboration*
- *Clarity*
- *Curiosity*
- *Courage*

Common purpose:

Identified Issue (the need)

Seniors who have multiple chronic conditions experience some of the worst health outcomes in the region often resulting in increased disability and avoidable death.

(HBC, Aging Subcommittee)

CoC Value Expectations (goals)

Stabilized Health for Seniors who have Multiple Chronic Conditions

Right Care, Right Setting, Right Time

Reduced cost of care overall: Reduced Hospitalization & ED visits, Increased Primary Care

Increased Caregiver and Social Support

Sustainability through Establishment of Payment Model (Contracts executed)

SHARED VISION:

Integrate social care into the delivery of health care and unify the efforts of both medical and home & community-based organizations to improve health & reduce health care cost for older adults with complex care needs.

ALIGNED OBJECTIVES:

Better health (reduced ED/inpatient utilization)

Driving care to the right setting (increased primary care utilization)

Improved patient experience

Connectivity to community-based services/resources

Maintenance of independence

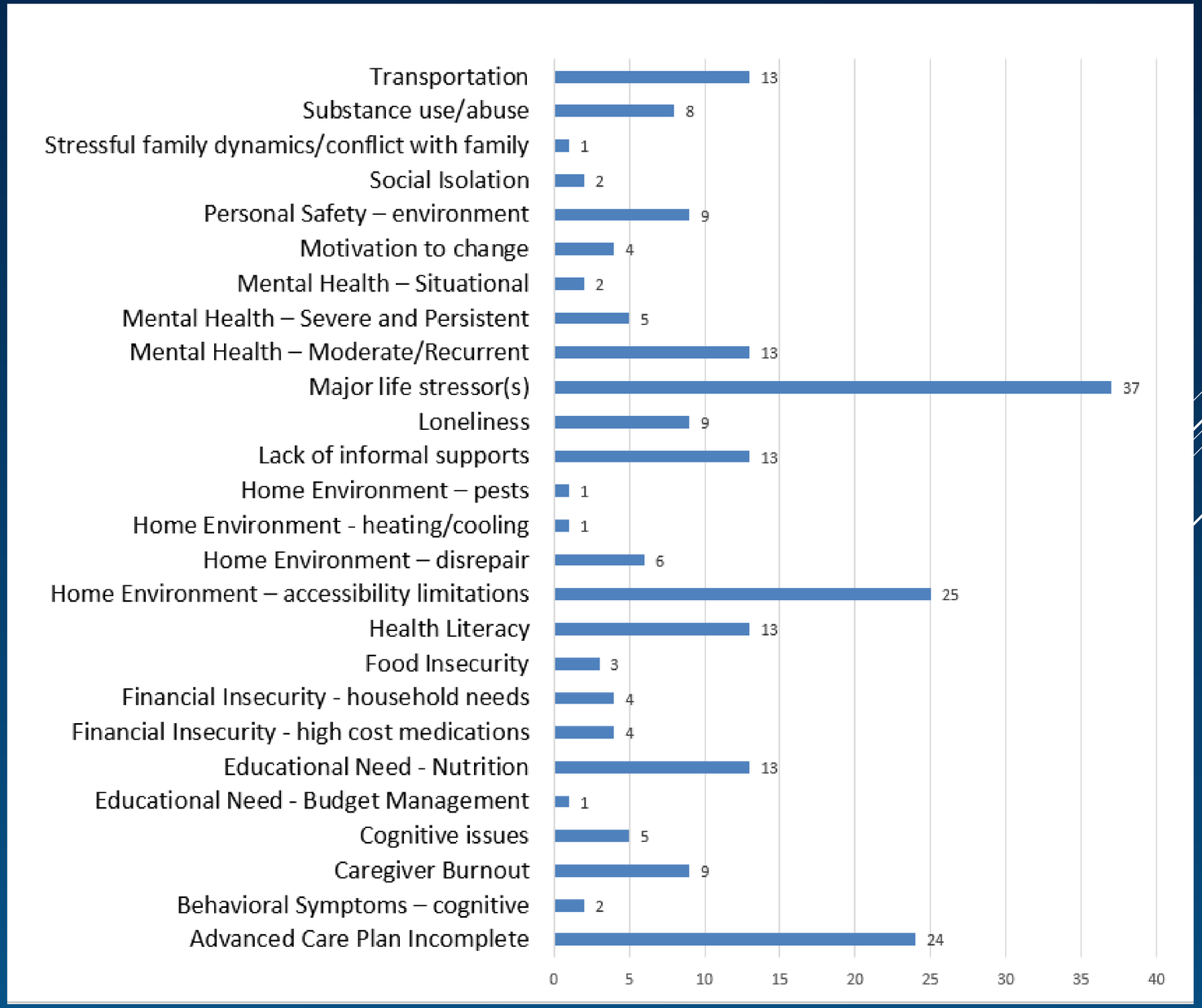
Support for caregivers

Tapping a network of Community-Based Organizations to resolve barriers

Top Three Categories of SDoH Barriers for CoC patients:

Mental Health = 57
Home Environment = 33
Food/Nutrition Education = 16

[ACP incomplete = 24]



Results:

Improved Health – Lower Costs

CoC patients enrolled at least 6 months:

- 86% reduction in unplanned inpatient hospital stays
- 63% reduction in ED to inpatient
- 80% reduction in Length of Stay
- 100% reduction in ED to nursing home

Engaged & Supported Caregivers

- 83% of CoC patients have a Caregiver.
- 93% of Caregivers indicate they now feel supported in their caregiving role

Area Agency on Aging / HouseCalls Partnership –

Why it works

"Utilizing a care model that integrates social and medical care clinicians as one patient-centered team has generated significant value to our patients, caregivers, and care teams.

With this model, each team member has a better understanding of the patient/caregiver's goals and challenges. The care plans are enhanced with needed perspectives that improve outcomes and reduces costs."

~ Melinda Gruber, VP Continuing Care Services, Corewell Health

- Allows providers and patients to prioritize care goals and create a plan around chronic diseases that require more attention
- Utilizes subject matter experts on Health-Related Social Needs in order to achieve disease related goals – Longitudinal care plan
- Provides for a more pro-active and tailored (personalized) approach to complex needs
- Improves patient / care giver satisfaction
- Reduces TPCC by efficient use of community-based services, and reducing inpatient and emergency department utilization, SNF admission and outpatient services
- Increases touch points with patients
- Expands the team for team-based care
- Reimburses team for non-face to face work
- Improves quality outcomes

Current State

Fee For Service Billable Codes

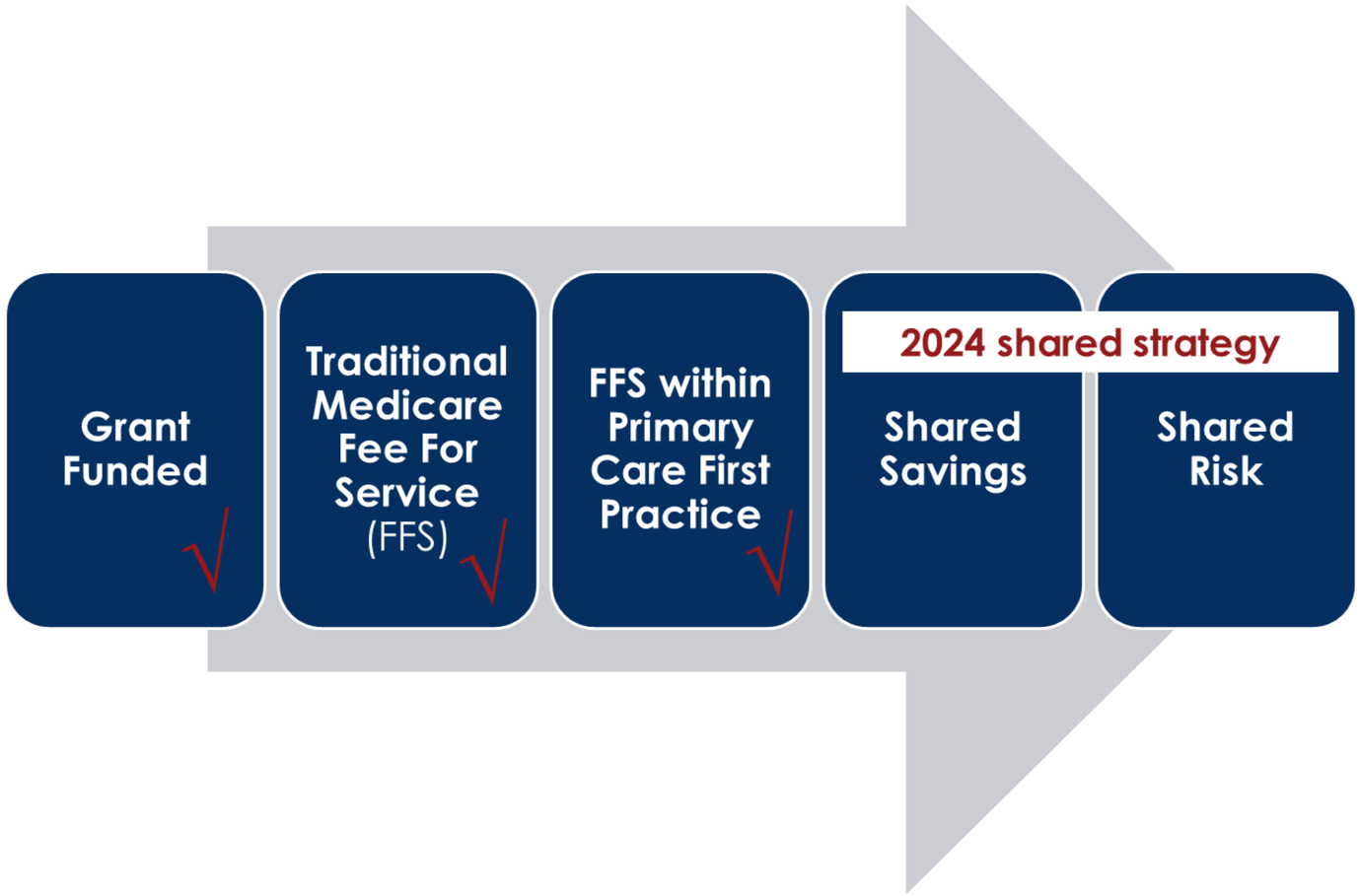
Billing Code	Code Description	Summary Requirements
HCPCS G0506	Comprehensive Assessment & Care Planning	▪ Patient enrolled in person ▪ Systematic assessment & care planning personally performed by the billing provider ▪ Add-on code to the standard E&M code (99212-99215), AWV or IPPE initiating visit
CPT 99490	Standard CCM	▪ 20+ minutes of care management outside of office visits performed by clinical staff ▪ Care plan established and regularly reviewed
CPT 99439 (New in 2021)	Non-complex Add-on	▪ Additional 20 minutes of "non-complex" CCM ▪ Reportable up to 2x per month (after 99490)
CPT 99487	Complex CCM	▪ 60+ minutes of care management outside office visits ▪ Care plan created and/or significantly revised
CPT 99489	Complex Add-on	▪ Billed incrementally for each additional 30 minutes spent beyond the first 60 minutes for Complex CCM case

Corewell Health™

Area Agency on Aging, Inc.
SPECIALISTS IN AGING
Offering Choices for Independent Lives

Where we're going:

From Fee-For-Service to Value-Based Payment



Corewell Health™

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Offering Choices for Independent Lives

Western New York
Integrated Care Collaborative

Community Integrated Health Network: since 2016

WNYICC is the **Community Care Hub** of the Network

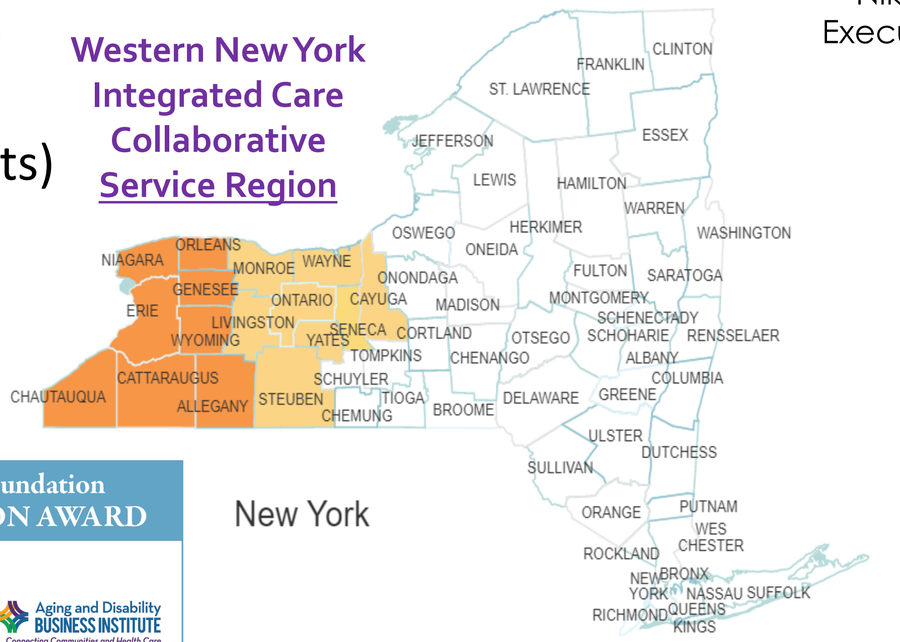
Nikki Kmicinski
Executive Director

55 Network Members

2 County Departments of Health
1 Independent Living Agency (ILCs)
8 Area Agencies on Aging (AAAs)
44 Social Care Agencies (non-profits)

More information: **wnyicc.org**

Western New York Integrated Care Collaborative Service Region



New York

The John A. Hartford Foundation
BUSINESS INNOVATION AWARD
2023 WINNER

WNYICC Contracts with Health Care Payers

Contract Types	No. of Contracts	No. of Lives in plans
Medicare Advantage	15+	96,373+
Medicare FFS in NY	Provider & Supplier	180,000+
Managed Medicaid (MCOs) WNY	5+	320,000+
Medicaid FFS in WNY	Supplier	300,000+
Commercial Plans	5	200,000
Total	25+	1,096,373+

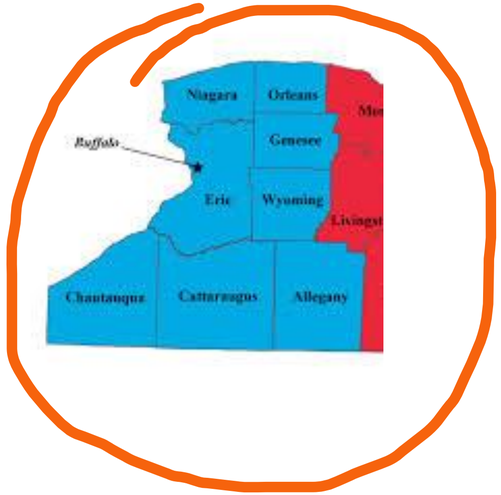
Western New York Integrated Care Collaborative

Program Need

Independent Health needed to address the health-related social needs of their members.

Any benefits they offer must be available to all beneficiaries.

Needed an efficient option to partnering with multiple community-based organizations for multiple programs



Programs Contracted / MA Funding Mechanism

Program	Funding Mechanism for IH
Post-Discharge Meal Delivery Program	Supplemental Benefit
Community Health Coaching	Program, extension of IH case management
Healthy IDEAS	Program, extension of IH BH case management
Falls Prevention	Supplemental Benefit
Caregiver Support	Program, extension of IH case management
Diabetes Prevention Program	Medicare Part B Benefit
Diabetes Self-Management Training	Medicare Part B Benefit
Medical Nutrition Therapy	Medicare Part B Benefit (i.e. DM/CKD) & added Supplemental Benefit for any other diagnosis

Key Metrics

Healthy IDEAS Outcomes: 2022

- **85%** of participants - PHQ9 or UCLA Loneliness improve score by 15%
- **76%** of participants increased their physical and/or social activity through the program.
- **57** referrals made to clinical providers: PCP, Mental Health providers or Registered Dietitians.

Post-Discharge Meals Program - 2022

- **695** Participants received meals
- **18,094** meals delivered
- **73%** report that receiving the meals helped prevent a re-admission.

Medical Nutrition Therapy

- **79** Participants: Oct 22 - April 2023
- **86%** of completers increased vegetable intake.
- **90%** made changes in eating habits
- **69%** increased amount of physical activity
- **70%** of those "At risk for malnutrition" improved to "Normal nutrition status".

Key Metrics

Community Health Coaching

- Average **8** Goals/Interventions per participant
- **128** High or Medium Priority HRSN Concerns with Goals to resolve Areas of Concern
- **92%** Resolved or In-Progress
- **8%** Incomplete

Falls Prevention Program

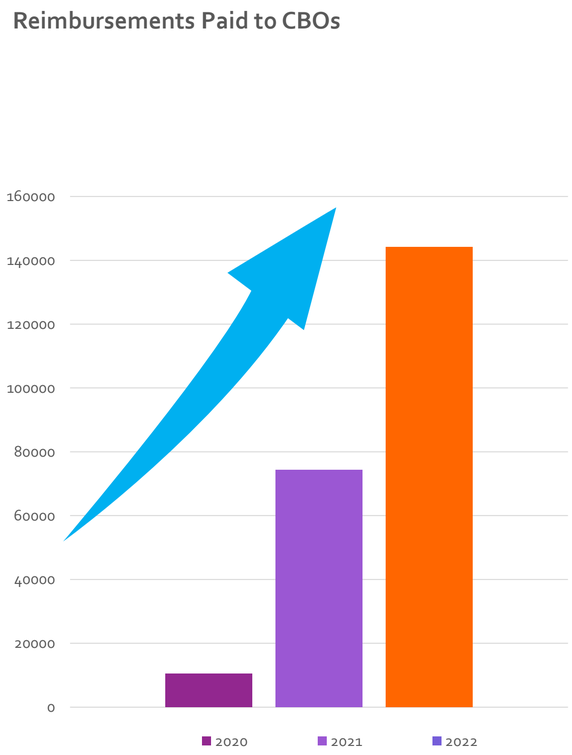
- **27** participants Jan- Jun 2023
- **12** developed MYMobility Plan
- **9** registered for free PERS from plan
- **20** goals set to address HRSN
- **18** goals to address falls hazards in home
- **42** goals to address scenarios which increase falls risk (ie stress, medication, physical activity)

Program Delivery

- **97%** of Program Delivery completed by **32** community-based organizations
- <u>As of Jan 1 2023</u>:

$229,052 paid out in reimbursements to CBOs

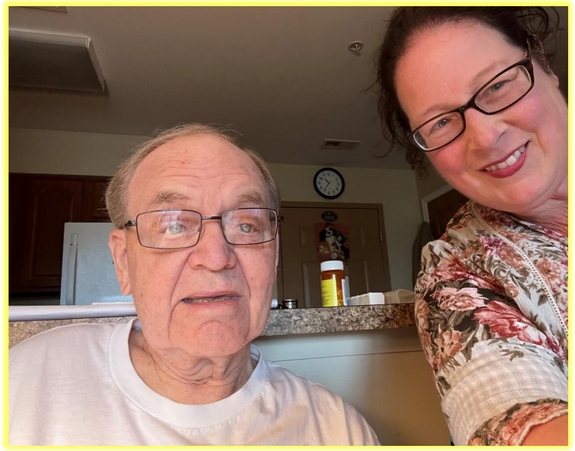
93.9% increase in 2022



Case Studies

"Joe"

- Received **Meals** and **Medical Nutrition Therapy** after an admission to the hospital.
- RD helped Joe make a plan for obtaining and preparing nutritious food for himself.
- During assessment, Joe revealed that he has had recent falls.
- RD referred him to **Falls Prevention Program** where he worked with a Falls Prevention Coach and addressed several areas of falls risk.



"Anita"

Western New York Integrated Care Collaborative

SATISFACTION SURVEY
Healthy IDEAS Program

Healthy IDEAS

Greetings from your Healthy IDEAS Health Coach! Please complete this survey to allow Western New York Integrated Care Collaborative to hear from you on your experiences with the Healthy IDEAS Program. Your responses to this survey are very important in helping us identify opportunities for improvement. Your answers are confidential and will only be used for quality assurance and future programming purposes. **Please return the Completed Survey** in the enclosed postage-paid envelope provided as soon as you are able.

1. How long did you/have you participate(d) in the Healthy IDEAS Program?
☐ 0-1 month ☐ 1-2 months ☒ 3-6 months ☐ Not sure

2. Has participation in the Healthy IDEAS Program helped improve your quality of life?
☒ Yes ☐ No ☐ Not sure

3. On a scale of 1 to 5, How would you rate the professionalism of your Health Coach?
☐ 1 Not At All ☐ 2 Occasionally ☐ 3 Sometimes ☐ 4 Mostly ☒ 5 Extremely Professional

4. Did your Health Coach assist you in making goals to address concerns or hardships you were experiencing?
☒ Yes ☐ No ☐ Not sure Comments: Finding affordable housing

5. Did your Health Coach connect you to any new resources or services? If Yes, please describe
☒ Yes ☐ No ☐ Not sure Comments: physical activity Exercise personal trainer I've lost 58 pounds I was 303 pounds now I weigh 230 pounds I'm Still losing

6. Please mark below if you increased any of the following as a result of participating in the Healthy IDEAS Program?
☒ Increased engagement with healthcare providers ☒ Increased amount of physical activity
☐ Increased amount of social activity ☐ Increased my ability to improve my mood

7. Which areas were you able to learn more about through your participation in the Healthy IDEAS Program? Please mark all that apply.
Right now I'm Depress due to I've less my Big Sister in Angels I have a Counselor I Speak w/ every two months or three I have a psychiatrist.
☒ Causes of Depression ☒ Good Mental Health
☐ Community and Health Resources Available ☐ Other Education -**Please Describe:**
☒ Common Signs of Depression

8. Please indicate if you were you able to set goals in any of the topics below through your participation in the Healthy IDEAS Program? Please mark all that apply.
☐ Excursions/ Community ☐ Spiritual, Religious, and Kind Acts
☒ Physical Activity ☐ Recreational and Other Leisure Activities
☐ Social Activities/ Interaction with Others ☒ Other Goal Types -Please Describe:
☒ Health & Wellness Help me to get Legal Aid to get back my Security deposit from my old apartment.

9. Would you recommend this Healthy IDEAS Program to others?
☒ Yes ☐ No ☐ Not sure Comments:

10. Do you have any recommendations for improvement to the Healthy IDEAS Program?
☐ Yes ☒ No ☐ Not sure Comments:

11. How did you most benefit from participating in the Healthy IDEAS program?
Comments: I'm more open with expressing my feelings I had a problem with the city a park ny ticket help me to get out of that situation, I was found innocent.

Thank You for Completing this Important Survey! We value your feedback.

WNYICC# 1_1_19

What Makes this Partnership Unique?

IH Values Partnering with a Community Care Hub like WNYICC

- **LOCAL:** 50+ local, trusted Community-Based Organizations
  - Independent Health values local partnership
  - Local CBOs know our community and community needs
  - Community knows and trusts the local CBOs

- **SINGLE POINT OF CONTACT:** contracts, data, billing, referrals, program development, escalation
- **REGIONAL:** able to reach all IH members/ beneficiaries
- **TRUST:** In-Person Safety Check -Meals program / In-Home interventions -trusted, recognized CBOs
- **FLEXIBILITY:** to co-develop programs

Joint Operating Committee/ Workgroup

Meets Weekly to discusses the following for each program:

- Referrals / referral process
- Marketing/ Communication
- WNYICC/CBO Capacity
- Escalation of incidents
- Provider outreach
- Billing
- Outcomes/ Reporting

Co-Branded Handouts/Materials →

Western New York Integrated Care Collaborative | Independent Health

Panel Discussion

Moderated by Jane Carmody, DNP, MBA, RN, FAAN
Senior Program Officer
The John A. Hartford Foundation

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