Success Stories

Building Collaborative Contracts with Health Care: Western New York Integrated Care Collaborative and Independent Health

Since 2016, The John A. Hartford Foundation and USAging's Aging and Disability Business Institute have honored the achievements of community-based organizations (CBOs) and CBO networks that partner and contract with health care entities. The John A. Hartford Foundation Business Innovation Award recognizes innovative and transformative approaches to addressing health-related social needs.

The winner of the 2023 award is Western New York Integrated Care Collaborative[2] (WNYICC). The award recognizes WNYICC's unique and innovative approach to partnering and contracting with Independent Health[3] (IH) on its coaching programs[4] including Community Health Coaching, Falls Prevention, and Caregiver Support. Unlike traditional partnerships, WNYICC's coaching programs are distinguished by their program-specific assessments, referrals to evidence-based programs, care coordination, quality assurance, and billing and coding to pay for them. WYNICC subcontracts with 16 agencies to deliver these programs. Integrating clinical care with social care is a crucial and distinctive feature of WNYICC's programs, setting them apart from many other programs.

Through their collaborative efforts, the WNYICC Network has made a profound difference in the lives of over 1,500 individuals in the western New York region. They have successfully addressed health-related social needs such as food insecurity, social isolation, and health literacy, showcasing the power of community-based organizations working with health care entities. With over 50 local, trusted community-based organizations in the network providing these vital social services, they are reducing the cost of care and significantly improving the quality of life for western New Yorkers. The WNYICC's Community Care Hub (CCH) is committed to forging more partnerships with health care entities interested in tackling health equity and the social determinants of health for their members through interventions delivered by their community-based network members. This is a testament to the transformative impact of their joint efforts and dedication to future success.

About the Partners

Western New York Integrated Care Collaborative (WNYICC)

WNYICC is a Community Care Hub (CCH) operating across the entire western New York region and offering various services to support people's health and social needs in 15 counties. WNYICC operates a network of 67 CBOs that provide direct services, including post-discharge meals, care coordination, medical nutrition therapy, and evidence-based programs. These programs include Meals Delivery, Community Health Coaching, Falls Prevention, Caregiver Support, Healthy IDEAS, Medical Nutrition Therapy, Chronic Disease Self-Management, and the Diabetes Prevention Program. WNYICC houses a centralized information technology platform allowing all their CBOs to utilize health-related social needs (HRSN) interventions and to document and monitor the outcomes of their HRSN assessments and interventions. WNYICC provides a centralized place for contracting and training and implements a continuous quality improvement process to ensure that all CBOs provide high-value services.

Independent Health

Independent Health is a Medicare Advantage organization with a Medicare contract offering HMO[5], HMO-SNP[6], HMO-POS[7], and PPO[8] plans. IH is the largest provider of Medicare Advantage plans in western New York, serving nearly 380,000 members.

It is the only health plan in the region to achieve five stars on the 2024 Medicare star rating for all Medicare Advantage Plans. Founded in 1980, Independent Health is recognized as an innovative health care plan focused on preventive care.

About the Contract

WNYICC and IH launched their first contract in 2020 with a post-discharge meal delivery program—Meals—for IH's Medicare Advantage (MA) Plans to address food insecurity through the Special Supplemental Benefits for the Chronically Ill (SSBCI)[9]. WNYICC worked with IH to evaluate the SSBCI post-discharge meal benefit and assess its impact on readmissions. The evaluation revealed that people with multiple chronic conditions benefitted most from the post-discharge meal intervention. By 2022, the program had increased 400 percent, delivering over 18,000 meals to 650 clients. Due to the success of the meals program, WNYICC and IH entered into more contracts to address the members' additional health-related social needs.

The Community Health Coaching (CHC) program was delivered by 33 CBOs. WNYICC and IH agreed to a minimum referral volume. This allowed delivery partners to better staff for capacity, and due to the referral guarantees, two agencies hired new staff.

WNYICC and IH also developed a plan to cross-refer the health plan members to other WNYICC programs contracted with IH. The Health Coach makes a simple internal referral to ensure the health plan member receives services quickly. The health plan member's health care provider receives a report from WNYICC describing the services provided. Integrating health plan members' clinical care with their social needs is a priority of the programs. Contracts between WNYICC and IH included the following programs: Meals, Community Health Coaching, Falls Prevention Coaching, Caregiver Support, Healthy IDEAS, Medical Nutrition Therapy, Diabetes Prevention and Diabetes Self-Management. WNYICC has reimbursed $500,000 to their sub-contracted CBOs through these contracts since 2000, reflecting a 102 percent increase in revenue from 2022 to 2023.

The coaching programs are innovative in their program design and funding mechanism, using the new 2023 health coaching billing codes. WNYICC approached IH with the latest billing codes and explained how they can support programming and the CBOs who can implement these programs. IH agreed to adopt these billing codes to help deliver and expand programs to their members. The following chart is an example of the ways WNYICC bills IH for their programs:

WNYICC Programs Funding Mechanism

Program	Funding Mechanism for IH	Billing Codes Used
Post-Discharge Meal Delivery Program	Supplemental Benefit	S5170
Community Health Coaching	Program, extension of IH case management	0591T, 0592T with modifiers
Healthy IDEAS	Program, extension of IH BH case management	0591T, 0592T with modifiers, z-code
Falls Prevention	Supplemental Benefit	0591T, 0592T with modifiers, z-code
Caregiver Support	Program, extension of IH case management	0591T, 0592T with modifiers, z-code
Diabetes Prevention Program (DPP)	Medicare Part B Benefit	Medicare/Medicaid codes
Diabetes Self-Mngmnt Training (DSMT)	Medicare Part B Benefit	Medicare/Medicaid codes
Medical Nutrition Therapy	Medicare Part B Benefit (i.e. DM/CKD) & **added Supplemental Benefit** for any other diagnosis	Medicare/Medicaid codes

The program design is a significant innovation of WNYICC programming. WNYICC's Community Health Coaching program empowers individuals with chronic conditions to manage their care better and improve their quality of life through the assistance of a Health Coach. The program also assists health plan members by coordinating resources and providing tools to address factors prohibiting them from managing health conditions.

IH and WNYICC meet weekly to co-design and evaluate ongoing programs. The Community Health Coaching program team member, the Health Coach, is one of WNYICC's trained health coaches in the programs offered. The Health Coach meets with the health plan member and their caregiver, as a part of the Caregiver Support program, to conduct a thorough social determinants of health (SDOH) assessment and a program-specific assessment. These assessments aim to discover the social needs of health plan members and their caregivers. After reviewing the assessment outcomes, the health plan member and caregiver receive six months of health coaching and training on care coordination related to their specific needs. Next, the Health Coach enrolls the health plan member and caregiver in evidence-based workshops based on their needs. These workshops include Chronic Disease Self-Management Program, Tai Chi, Matter of Balance, and Powerful Tools for Caregivers.

The goals of the Community Health Coaching program are to:

- Coordinate and connect members to help address social risk factors such as food insecurity, inadequate health education, poor access to resources, and needed coordination with transportation services.
- Provide health and wellness coaching that offers greater confidence in making informed decisions, enhanced problem-solving and goal-setting skills, and better motivation to manage health.
- Coordinate with clinical health care, including assisting with scheduling appointments, arranging transportation, preparing for clinical visits, and ensuring providers receive regular progress updates.

Impact and Outcomes

The participants in the coaching program were all age 65 or older, with 21 percent age 80 or older. This program reached 11 percent of people living in rural areas, 32 percent in urban areas, and 58 percent in suburban areas, with 68 percent being female and 32 percent male. The CHC impacted the members' health-related social needs (HRSN) by addressing 26 interventions in 2023. The HRSN's most needed were:

- Health and wellness coaching focused on health education and literacy with the most attention on physical activity, mental health, falls, and pain.
- Coordinate with clinical care by scheduling doctor or specialist appointments, exams, or vaccinations.

Outcomes

The following outcomes demonstrate each program's impact.

Healthy IDEAS

- 85% of participants improved the PHQ9[10] (Patient Health Questionnaire) or UCLA Loneliness score by 15%.
- 76% of participants increased their physical and social activity.
- 57 referrals were made to clinical providers, including primary care physicians, mental health providers and registered dietitians.

Post-Discharge Meals Program

- 1795 participants received meals.
- 46,094 meals were delivered.
- 73% report that receiving the meals helped prevent readmission.

Medical Nutrition Therapy

- 107 participants were in this program.
- 86% of plan members who completed the program showed increased vegetable intake.
- 90% made changes in their eating habits.
- 69% increased their physical activity time.
- 70% of those "at-risk for malnutrition" improved to a "normal nutrition status."

Community Health Coaching

- Each plan member averaged eight goals and interventions.
- 75% with high or medium-priority HRSN concerns created goals to resolve the areas of concern.
- 92% of the HRSN concerns were resolved or are progressing toward resolution.

Falls Prevention

- 51 plan members participated in the program.
- There was an average 40% reduction in fall risks.
- 33% were assisted in selecting and using a Personal Emergency Response System (PERS), a wearable device designed to detect falls.
- 55% developed *MyMobility Plan*[11], a mobility plan created by the Centers for Disease Control and Prevention (CDC) to help older adults protect their mobility and independence.

Partnership Building and Sustaining

The partnership began because IH needed to address its members' health-related social needs, a way to offer these benefits to all its members, and a way to partner with multiple CBOs on multiple programs efficiently. IH values partnering with a WNYICC as a CCH that reaches all IH members in the region and works with more than 65 local CBOs who are trusted by their community and understand their community and its needs. WNYICC is attractive as a single point of contact who can manage contracts, centralize data, billing, referrals, and escalation, and develop programs to meet the needs of IH members. WNYICC is proficient in data sharing and provides quality assurance by attending to the Health Insurance Portability and Accountability Act[12] (HIPAA) while monitoring compliance. WNYICC is seeking HI-TRUST[13] certification (cybersecurity assurance) to continue strengthening its contracting work.

The partnership grew more robust by creating a joint operating committee that met weekly to discuss issues related to the current, ongoing programs. These discussion items included referrals and the referral process, program marketing and communication, the capacity of WNYICC and the CBO to deliver programs, incident escalation, outreach to health care and service providers, billing, program outcomes, and reporting methods. The success of this partnership was demonstrated by creating a co-brand logo used on program materials. WNYICC and IH have also entered into additional contracts with IH commercial plans and Medicaid Managed Care.

Lessons Learned

WNYICC learned to be flexible and express the CBO's needs to Independent Health as they negotiated contracts and developed programs. New coaching Current Procedural Terminology[14] (CPT) codes allow billing for programs and services without needing a clinical rendering provider. Establishing a collaborative partnership with the plan is essential. Holding weekly meetings to review processes, escalate issues, and review referral volume helped move the programs forward. As a Community Care Hub, providing centralized contracting, compliance, referral management, and revenue cycle management for the CBOs helps to strengthen a partnership. It allows CBOs of all sizes to participate in programs. The health plan benefits from this centralization and realizes that members receive programs addressing social care from trusted local sources.

The Future

WNYICC and Independent Health plan to increase the referral volume for all current programs and continue to add more programs for their members, which are contracts funded through Medicare Advantage SSBCI and other funding options through the health plan. WNYICC and IH view the partnership as a long-term relationship. IH has generously increased reimbursement rates annually based on increased delivery costs. IH is also contracting with WNYICC in their other lines of business, such as commercial plans and Medicaid Managed Care plans. WNYICC is moving forward in many ways. They applied as a Regional Social Care Network through the New York State Health Equity Medicaid 1115 Waiver. They are beginning to pilot their data integration methods with a Regional Health Information Exchange. WNYICC has begun conducting pilot studies with local clinical provider groups to provide Community Health Interventions (CHI), Principal Illness Navigation (PIN), and Care Transitions (CT) to local hospitals.

WNYICC's Coaching Programs have positively impacted IH members, proving a successful initiative for the western New York region. The confidence in WNYICC and the trusted relationship that has been built has led to additional contracting and strategic partnerships with Independent Health. The future for Western New York Integrated Care Collaborative continues to contain transformative opportunities to partner with additional health care entities as they grow stronger and expand their reach.

Endnotes

1. The John A. Hartford Foundation Business Innovation Award- Aging and Disability Business Institute
2. Western New York Integrated Care Collaborative > Home (wnyicc.org)
3. https://www.independenthealth.com/about
4. Western New York Integrated Care Collaborative > Programs > Community Health Coaching (CHC) Program (wnyicc.org)
5. HMO basics- Medicare Interactive (Health Maintenance Organization)
6. Special Needs Plans (SNP) | Medicare (HMO-SNP)
7. What is a Medicare Advantage HMO-POS plan? | 65 Incorporated (Point of Service)
8. Preferred Provider Organization (PPO): Definition and Benefits (investopedia.com) (Preferred Provider Organization)
9. Implementing Supplemental Benefits for Chronically Ill Enrollees | Guidance Portal (hhs.gov)
10. PHQ-9 depression scale.pdf (nih.gov) (Patient Health Questionnaire)
11. Plan to Stay Safe, Mobile, and Independent | Features | Injury Center | CDC
12. Summary of the HIPAA Privacy Rule | HHS.gov
13. The Global Standard of Information Protection Assurance | HITRUST (hitrustalliance.net)
14. List of CPT/HCPCS Codes | CMS

About the Aging and Disability Business Institute

The mission of the Aging and Disability Business Institute (Business Institute) is to build and strengthen partnerships between aging and disability community-based organizations (CBOs), CBO networks and the health care system. Led by USAging in partnership with the most experienced and respected organizations in the aging and disability networks, the Business Institute provides CBOs with the tools and resources to adapt to a changing health care environment, enhance their organizational capacity and capitalize on emerging opportunities to diversify funding. Funded by the U.S. Administration for Community Living, the Business Institute is the home of the Center of Excellence to Align Health and Social Care, which funds and supports community care hubs and the CBO networks that they lead. Learn more at aginganddisabilitybusinessinstitute.org.

USAging Leaders in Aging Well at Home | Aging and Disability Business Institute Connecting Communities and Health Care | Western New York Integrated Care Collaborative | Independent Health

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