Lessons Learned from CBO Leaders Engaged with Healthcare Providers

January 31, 2020

HEIDI ARTHUR
Principal, Health Management Associates

STEPHANIE DENNING
Principal, Health Management Associates

GRACE DAMIO
Center Director
Hispanic Health Council

GIOVANNA ROGOW
CEO of Maternal Infant Services Network

AGENDA

- ❑ The Colorado Landscape
- ❑ The CT Prevention Services Initiative
- ❑ The Collective for Community Wellness and the Pathways HUB Model
- ❑ Lessons Learned
- ❑ Q & A

THE HEALTHCARE LANDSCAPE IN COLORADO

- **Lots of attention on big state legislation**
  - Public Option
  - Reinsurance
  - Primary Care Initiative
- **Medicaid still in change mode**
  - **RAEs – not quite two years in, still finding their way**
    Hard to integrate capitated behavioral health and PCCM primary/acute care coordination
  - **Hospital Transformation Program – moving forward, but slowly**
    Department focus on hospital costs creating challenges
- **Multiple initiatives in Colorado that offer opportunities for healthcare payers and providers to**
  - **align operations**
  - **incorporate data sharing**
  - **build infrastructure with CBOs and other social services providers**

SCALE OF HEALTH EQUITY AND SDOH ISSUES IN COLORADO

+ **26 percent of white Coloradans spend more than 30 percent of their income on housing; for African Americans, it's 39 percent**
(https://www.coloradohealthinstitute.org/research/vision-housing-security-health-and-opportunity)

+ **Nearly 7 percent of Coloradans reported that they worried about where they will live in the next two months**
(https://www.coloradohealthinstitute.org/research/CHAS)

+ **Lack of transportation is a barrier to care for 6.3 percent of rural Coloradans, and 5.4 percent of those living in urban areas**
(https://www.coloradohealthinstitute.org/research/transportation-barrier-care-across-Colorado)

+ **One of every 10 Coloradans said they ate less than they thought they should because they couldn't afford food during the past year**
(https://www.coloradohealthinstitute.org/research/CHAS)

CT PREVENTION SERVICES INITIATIVE

PREVENTION SERVICE INITIATIVE (PSI)

Community Based Organization
"CBO", including local health department

New Contract

Refers Patients

Provides services and closes feedback loop

Healthcare Organization
Advanced Network/ Federally Qualified Health Center

Hispanic Health Council

- CBO, 42+ years, statewide
- **Uses four core integrated strategies:**
  - Community-based participatory research,
  - Evidence-based direct services – (decades of HCO partnership and contracts)
  - Policy/system advocacy and advisement,
  - Training of health and human service providers, students and faculty in diversity and inclusion, issues of equity and addressing biases/other attitudes of oppressions

- With 25-year academic partner, has developed, evaluated, disseminated and replicated CHW models – prevention and chronic disease management
- **Deeply involved in development of CHW workforce in CT:**
  - Convened 3 symposia; led development of policy brief, CHW caseload estimator
  - Participated in development of CHW recommendations for CHW certification in CT
  - Trained CHWs to advocate for polices to support CHW workforce

- Used above experience to negotiate CBO-HCO PSI partnerships
- Contributed above experience to inform broader PSI learning process

TECHNICAL ASSISTANCE

Year 1

- Organizational assessments
- Site Visits
- TA plans
- Webinars and tools
- Group Learning Sessions
- Regional calls
- 1:1 TA coaching and support
- Peer to peer relationship building
- TA for Business Planning and Contract Development
- SharePoint

Year 2

- Individual TA
- Partner TA
- Group Learning Sessions
- Sharepoint

PARTNERSHIPS

Community Based Organization (CBO)	Health Care Organization (HCO)	Evidence Based Program (EBP)	Geographical Area
CT Community Care	Community Health Center, Inc.	Live Well with Diabetes Plus	Middletown
Hispanic Health Council	Community Health Center, Inc.	DIALBEST	Stamford
Hispanic Health Council	Value Care Alliance(VCA) /St. Vincent's Medical Center	DIALBEST	Middletown and surrounding towns
Milford Health Department	Fair Haven Community Health Center	Putting on Airs (Asthma)	New Haven
Naugatuck Valley Health District	Prospect Waterbury, Inc.	Diabetes Self-Management Program (DSMP)	New Haven
Southwestern CT Agency on Aging	Optimus Health Care	DSMP	Bridgeport

OVERVIEW:

- **Contract executed 6/2019**
- **Payment based on PMPM for projected service to 40;**
  - expecting 20% attrition rate;
  - 5% withhold paid if A1c level improves at all based on average baseline for the population
- **Leveraged a subcontract (paid by VCA) with Fitscripts App for those enrolled;**
  - **provides managed diabetes through exercise, based on user capability;**
  - **useful to drive engagement from both provider and patient side –**
  - **30% of DIALBEST participants enrolled**

ST. VINCENT'S HEALTH PARTNERS – VALUE CARE ALLIANCE & HISPANIC HEALTH COUNCIL

COMMUNICATION:

- VCA Project Manager is HCO champion
- Monthly touchpoint with CBO, other communication as needed
- Single Point of Contact at Middlesex Hospital (Population Health Nurse)
- Monthly report from CBO

IMPLEMENTATION:

- CHW started in June
- Created a co-branded outreach flyer

Service Volume and (Preliminary) Outcomes and Successes:

- 30 enrolled, 2 dropped out, average 10 visits & educational lessons, 36 calls/client
- Pre-post average change: 69: to 92.3% Blood monitoring increase at least three x/day increase: from 20% to 50%
- Decrease in forgetting to take medication as prescribed: 50% to 10%
- Identified a person who was not taking glucose levels because of needle stick; obtained alternative test
- Increase in reported daily or weekly physical activity at time of assessment: 33% to 50%
- SDOH: helped 2 clients with housing; 4 with inability to pay for high-cost meds; 11 with food insecurity; 2 with employment and 1 with accessing health insurance

1 client (HbA1c decrease11.1-7.8) quote:

"You have taught me a lot. If it wasn't for your support and your guidance I wouldn't have been able to go through the plan. With the help of my doctor and you, I was able to understand my condition more. I am exercising more and I know what to do to live a healthy lifestyle."

ST. VINCENT'S HEALTH PARTNERS – VALUE CARE ALLIANCE & HISPANIC HEALTH COUNCIL

ACCOMPLISHMENTS

+ VCA identified one participating hospital to partner with HHC from its network of 5 hospitals
+ Adapted the DIALBEST intervention—17 to 10 sessions and to shortened timeframe and over a large geography
+ Addressed need for a program to provide home-based support for the folks who need intensive, tailored service tailored in their own context
+ PSI: standing HCO agenda item, core element of population health strategy
+ CHW and Population Health nurse coordinate details about the patient needs, channel information to and from large # of PCPs
+ CBO used PSI opportunity to update its database
+ Established payment for patient engagement; withhold based on aggregate improvement in A1c across participants

ST. VINCENT'S HEALTH PARTNERS – VALUE CARE ALLIANCE & HISPANIC HEALTH COUNCIL

ACCOMPLISHMENTS

- **Enhanced HCO and CBO capacity for chronic disease management**
  - HCO access to expanded populations for chronic disease management
  - Provider awareness of CHW EBP targeting patients with intensive need
  - CBO adds capacity added to address SDOH
- **Community extenders**
  - New workflows for referral and care coordination between HCOs and CBOs
  - CHW integration into care teams
- **Enhanced Infrastructure**
  - New data collection and management tools and processes for CBO
  - Array of data sharing arrangements for CBOs and HCOs
- **EBP adapted to address patient time constraints due to contracting delays**
  - Opportunity to determine if reduced service intensity produces results
- **Experience with payment for performance**
- **Retrospective and concurrent evaluation**
- **Collaborative learning model; network development**


THE COLLECTIVE
FOR COMMUNITY
WELLNESS

CCW SERVICE TYPES

- stakeholder engagement
- outreach, and home visiting
- health access, insurance navigation and enrollment
- chronic disease management, health education, and health literacy support
- mental health, substance abuse support, harm reduction, and peer services
- housing
- case management
- family services
- services for children and youth
- assistance for DV survivors and crime victims
- re-entry support
- workforce development, economic stability and financial literacy
- community research
- perinatal services
- food security and nutrition
- environmental improvement, and more.

REGIONAL BEHAVIORAL HEALTH IPA HAS RELATIONSHIPS THE COLLECTIVE CAN SUPPORT….

CBHCare

Montefiore

- Montefiore Hudson Valley Collaborative (PPS)
- Hudson Valley IPA
- Next Generation ACO

Westchester Medical Center Health

- Center for Regional Health Innovation (PPS)
- Transitions of Care – CBHS' work with WMCHealth on Care Transitions has been identified by UHF as a PPS Promising Practice.

Home and Community Based Services ("HCBS")

- CBHS has HCBS Infrastructure grants with four MCOs

Direct to Payor contracting

CBO VALUE

OPPORTUNITIES

+ **Health care systems cannot do what CBOs can do**

+ **CBOs represent diverse groups, address intersectional issues in health planning, health funding, and service organization, engage underserved populations, address SDOH, provide accessible community-based interventions to promote health and wellness, promote cultural competence, and much more!**

CHALLENGES

+ **Required functions to engage in care delivery system**
+ **CBOs landscape complicated:** CBOs are diverse in size, operate independently
+ **No shared set of goal**
+ **Multiple streams of funding**

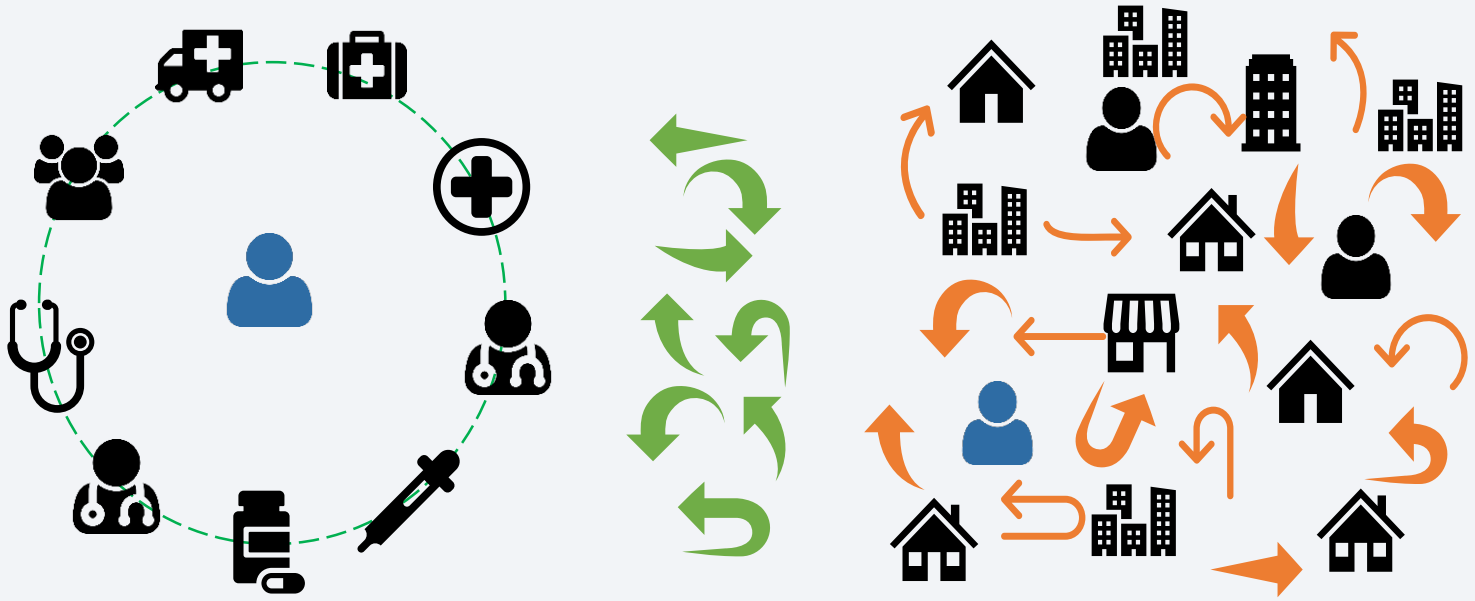
HEALTHCARE ENGAGEMENT: OPTIONS FOR CBOs

+ **Individual CBO-HCO partnerships**
+ **Multi-sector or single-sector coalitions**
+ **Focused constituency models**
+ **Network hubs**

CURRENT STATE – TRADITIONAL HEALTHCARE AND COMMUNITY BASED ORGANIZATIONS (CBOS) OPERATE IN SILOS

Healthcare Services and Health Homes

Community-Based Organizations Addressing SDOH



Valuable resources and workforce that address the Social Determinants of Health (SDOH) exist in CBOs that can be leveraged to impact traditional healthcare outcomes

OUR LOCAL BEHAVIORAL HEALTH NETWORK GAVE CCW A "DESIGN CHALLENGE"

ESTABLISH A SINGLE POINT OF ACCESS FOR SDOH, PLUS:

System of Services	Data	Key Features
Coordinated and consistent system of services: + Food & Nutrition + Housing + Employment + Education + Social Activities + Leisure + Spirituality	**Provide accurate and meaningful data including:** + Services provided + Populations served + Impact of services + Real time feedback	+ Accessible + Collaborative + Consistent + Data driven + Outcomes oriented + Person-centered + Quality focused + Responsive

PATHWAY HUB MODEL: “CARE TRAFFIC CONTROL” & SINGLE CONTRACTING ENTITY

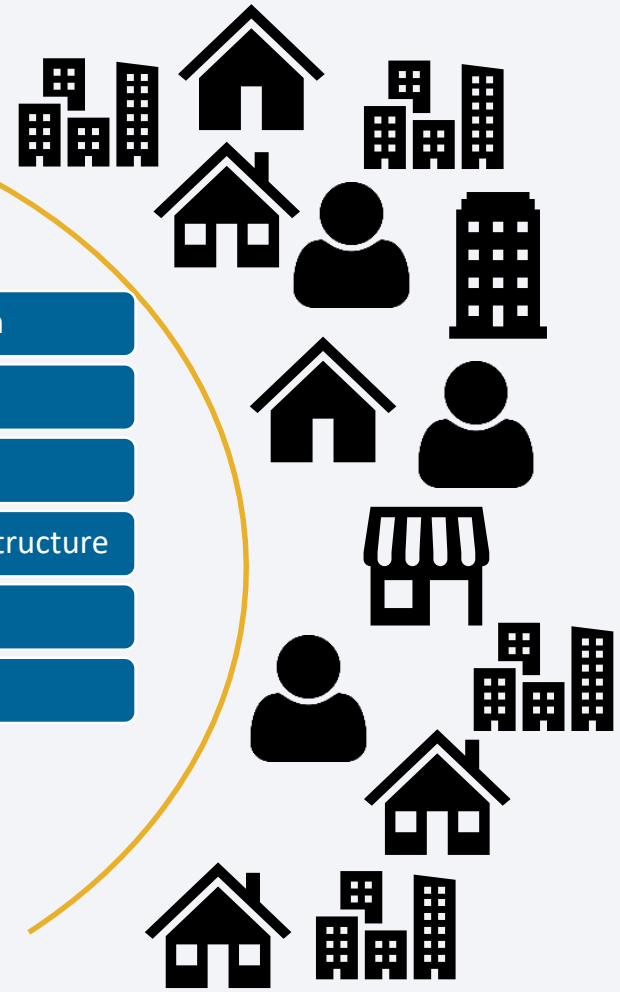
- **The CCW HUB will contract with payers and other funders, on behalf of its member CBOs**
  Contracts for Pathways will be for targeted populations (e.g. Maternal and Infant population)
  - **Pay for Performance contracting to mitigate health risks and make connections to care and services**
    - Extender for MCO care management
    - Outreach and connections to Health Home care management
  - **Targeted interventions may be indicated where unmet local needs are identified by the standardized data collection about care needs**

- **HUB reduces CBO and Payer contracting burden and streamlines administration**

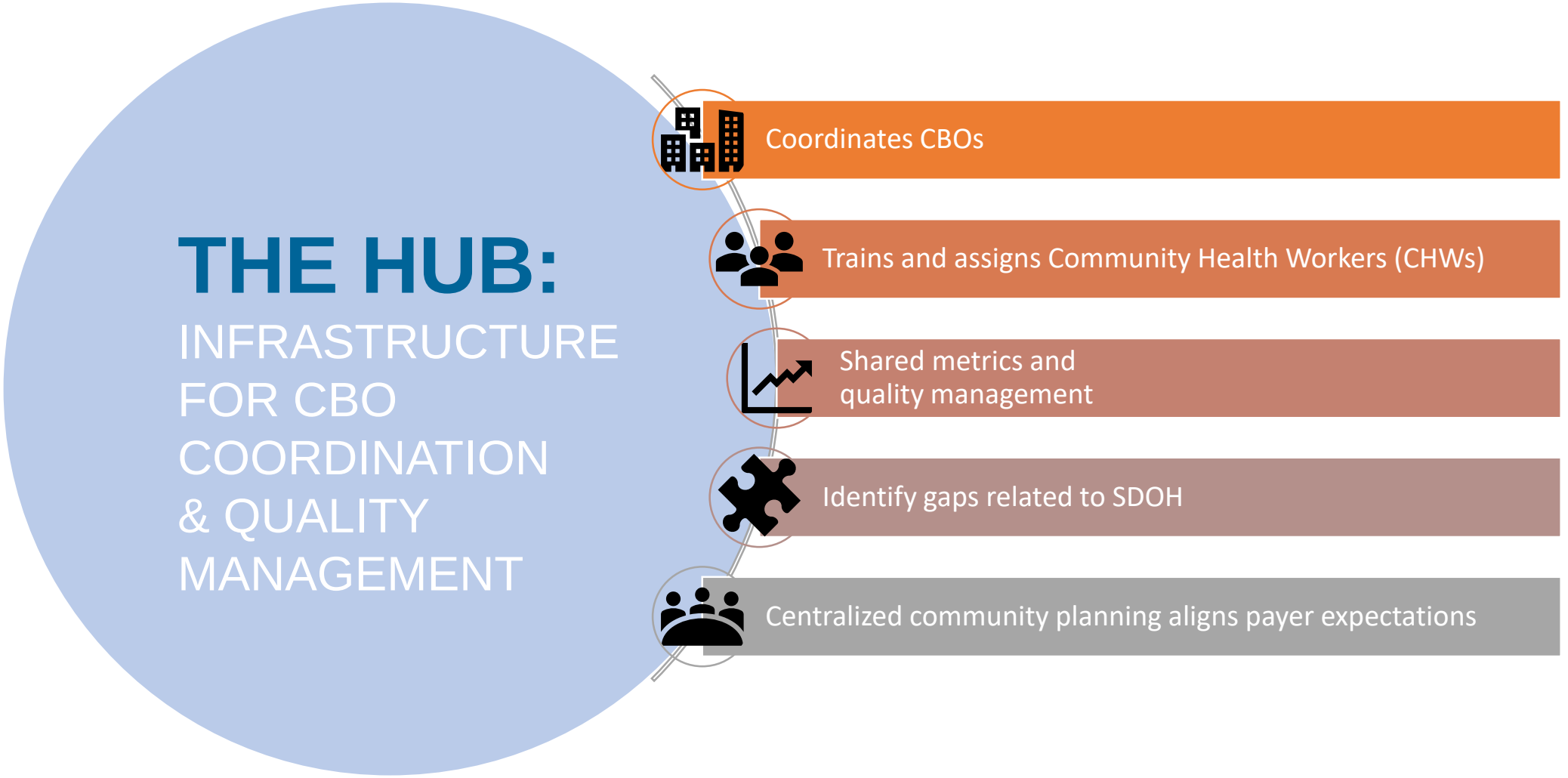
- **Pathways HUB model leverages and activates existing community-based workforce**

PATHWAYS HUB APPROACH ALIGNS RESOURCES

- Standardized Risk Assessment approach
- Standardized documentation
- Standardized performance metrics
- Centralized contracting & administration infrastructure
- Coordinated CBO engagement
- Standardized P4P approach

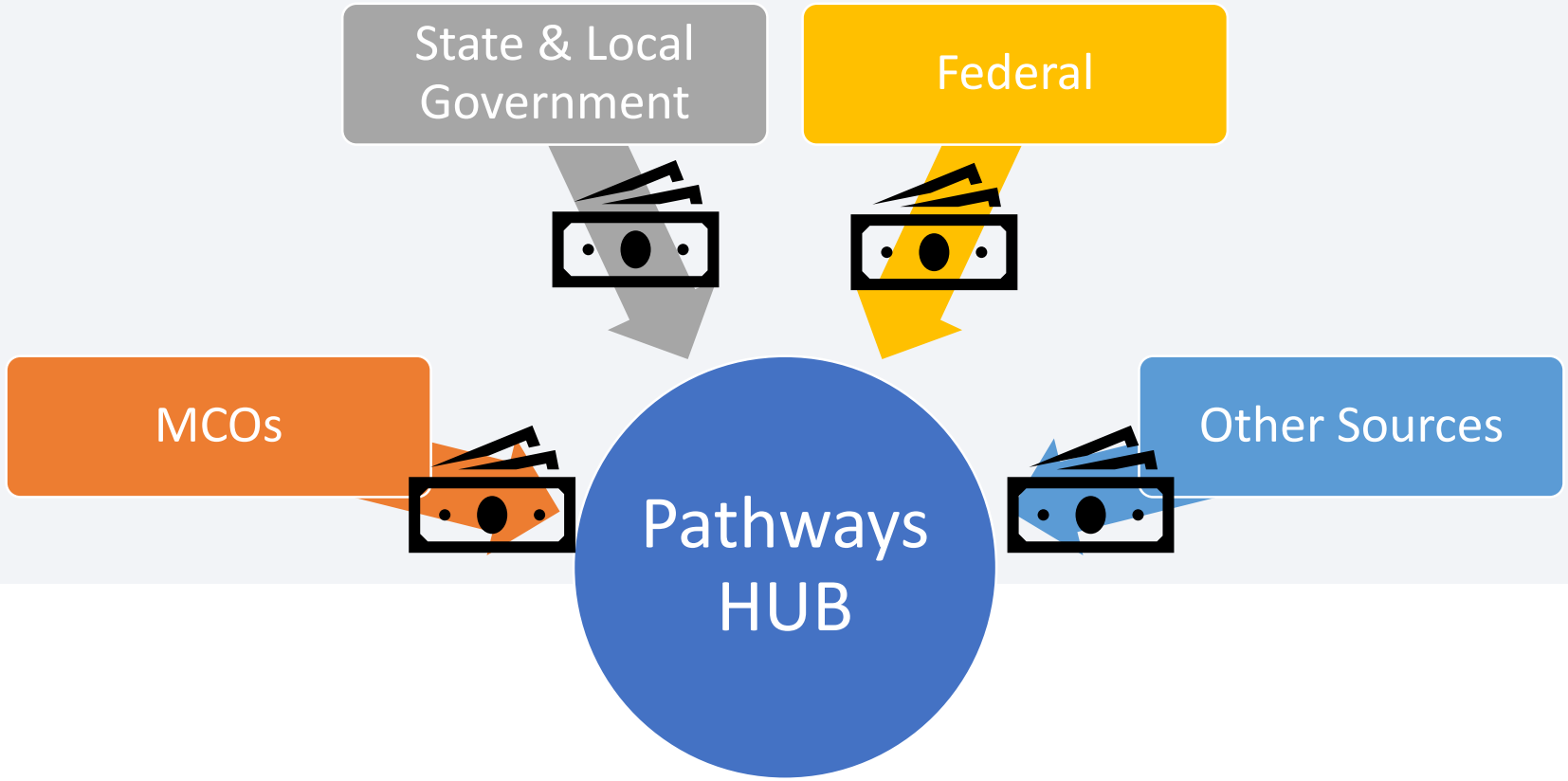


THE HUB: INFRASTRUCTURE FOR CBO COORDINATION & QUALITY MANAGEMENT

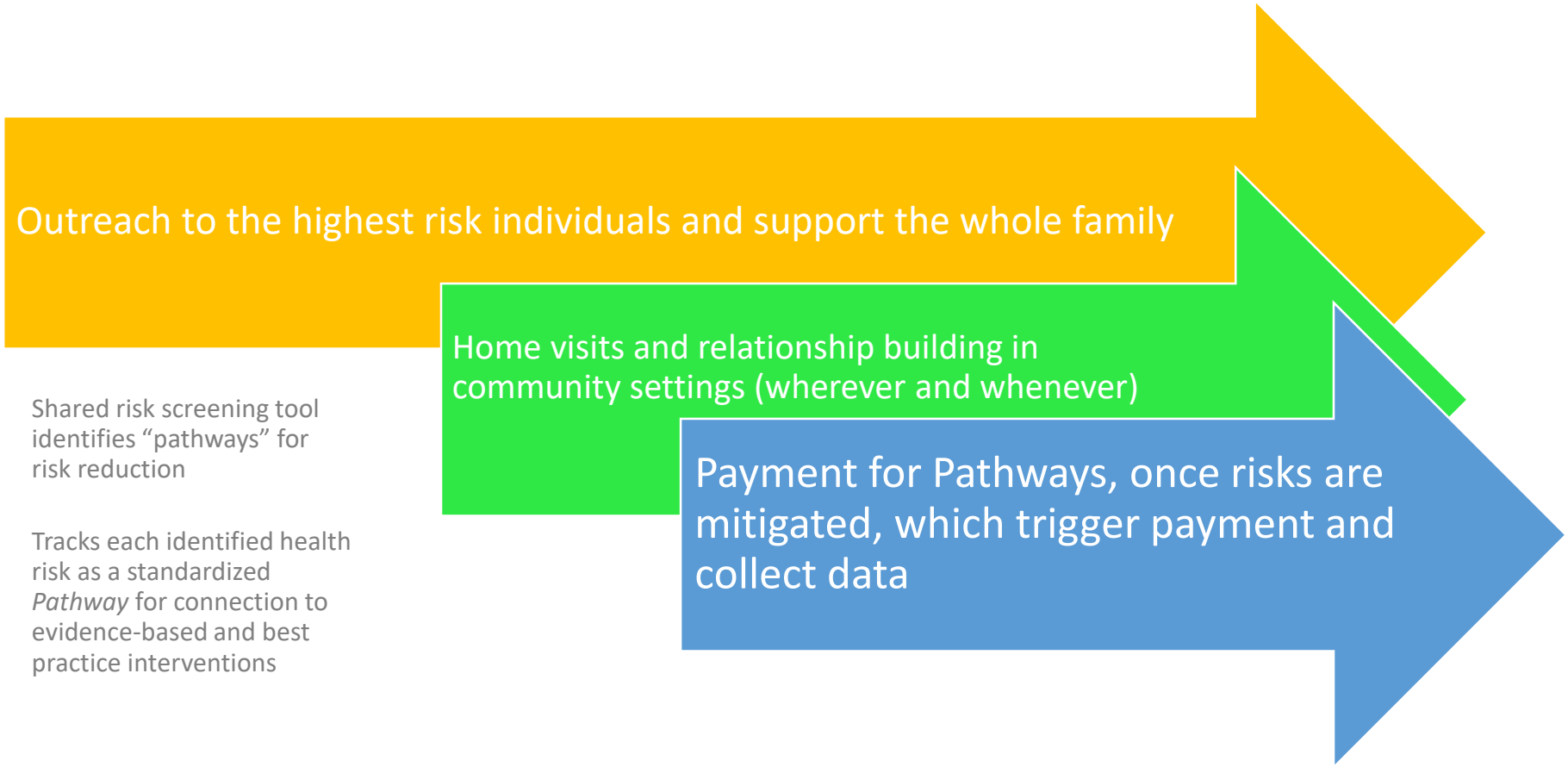


PATHWAYS HUB INFRASTRUCTURE FOR CBO CONTRACTING

HUB facilitates contracting with multiple payers; braids and blends funds from an array of sources.



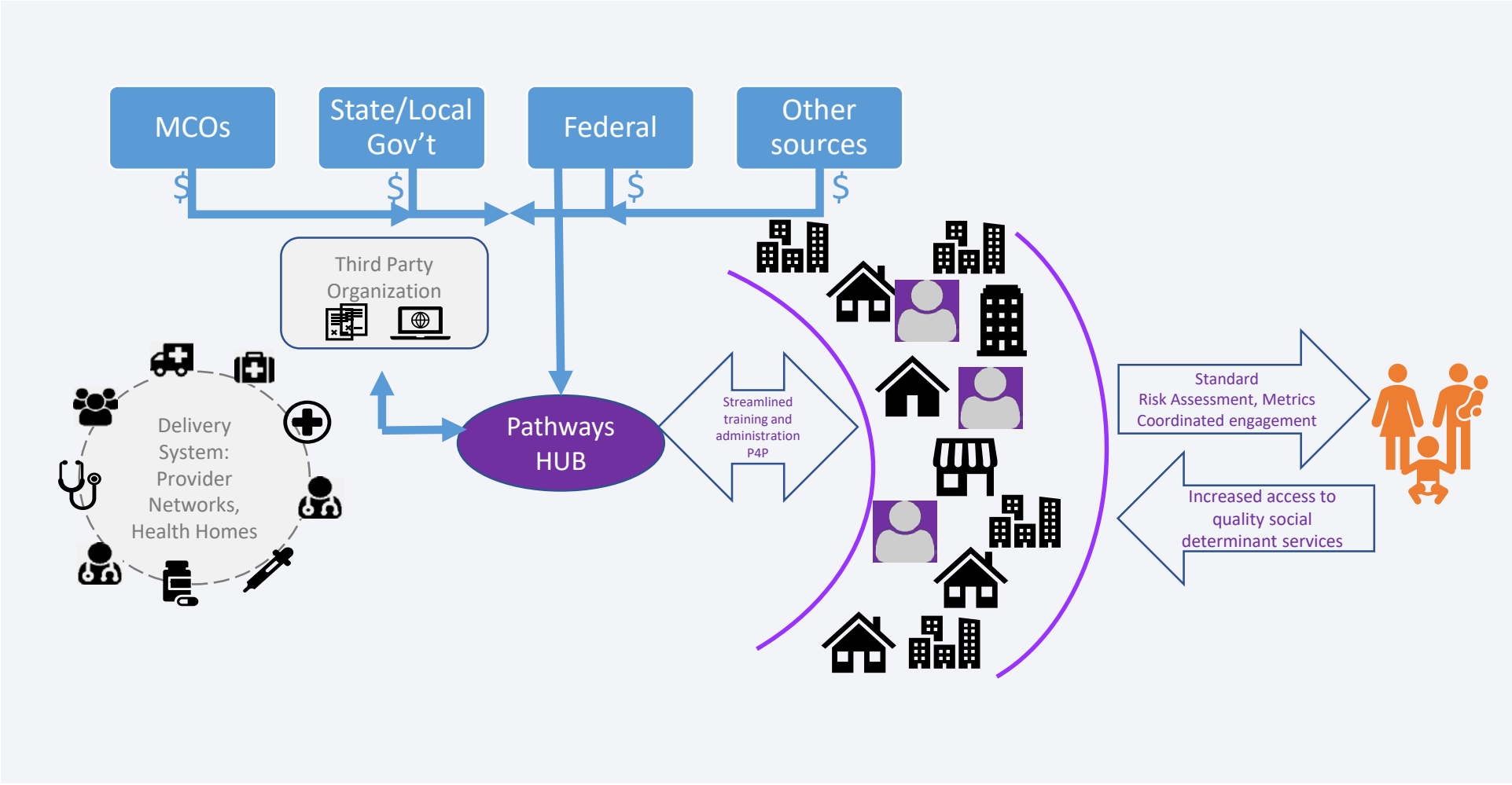
PATHWAYS:
P4P METHODOLOGY BASED ON RISK REDUCTION



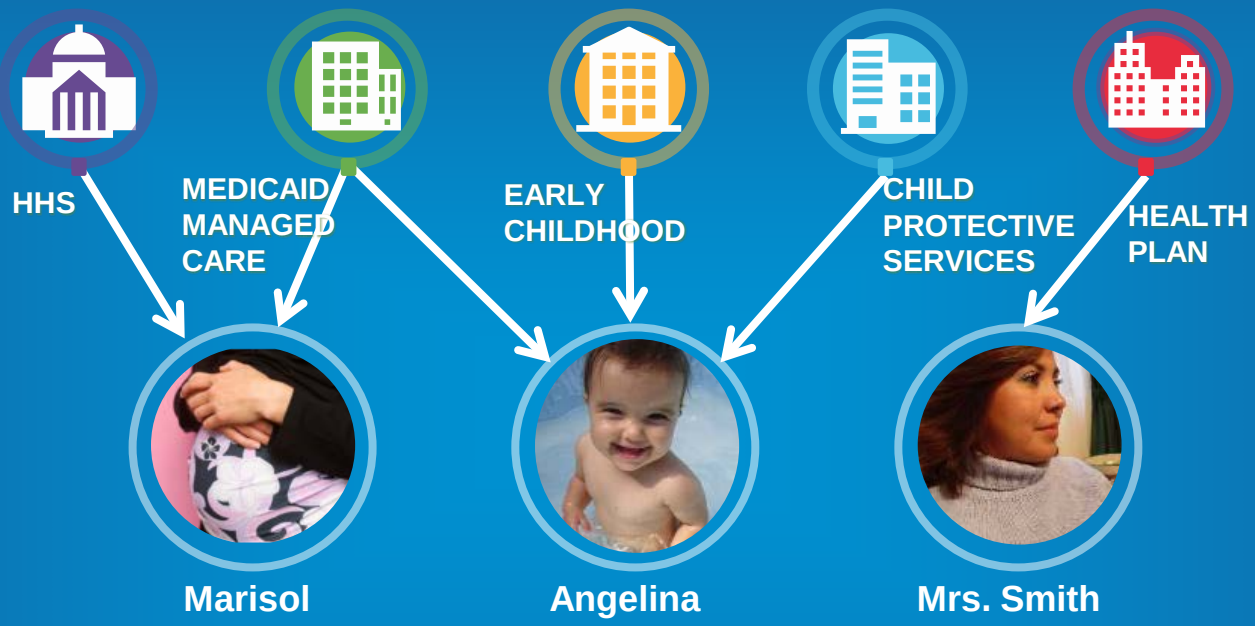
Shared risk screening tool identifies “pathways” for risk reduction

Tracks each identified health risk as a standardized *Pathway* for connection to evidence-based and best practice interventions

PATHWAYS HUB IN ACTION

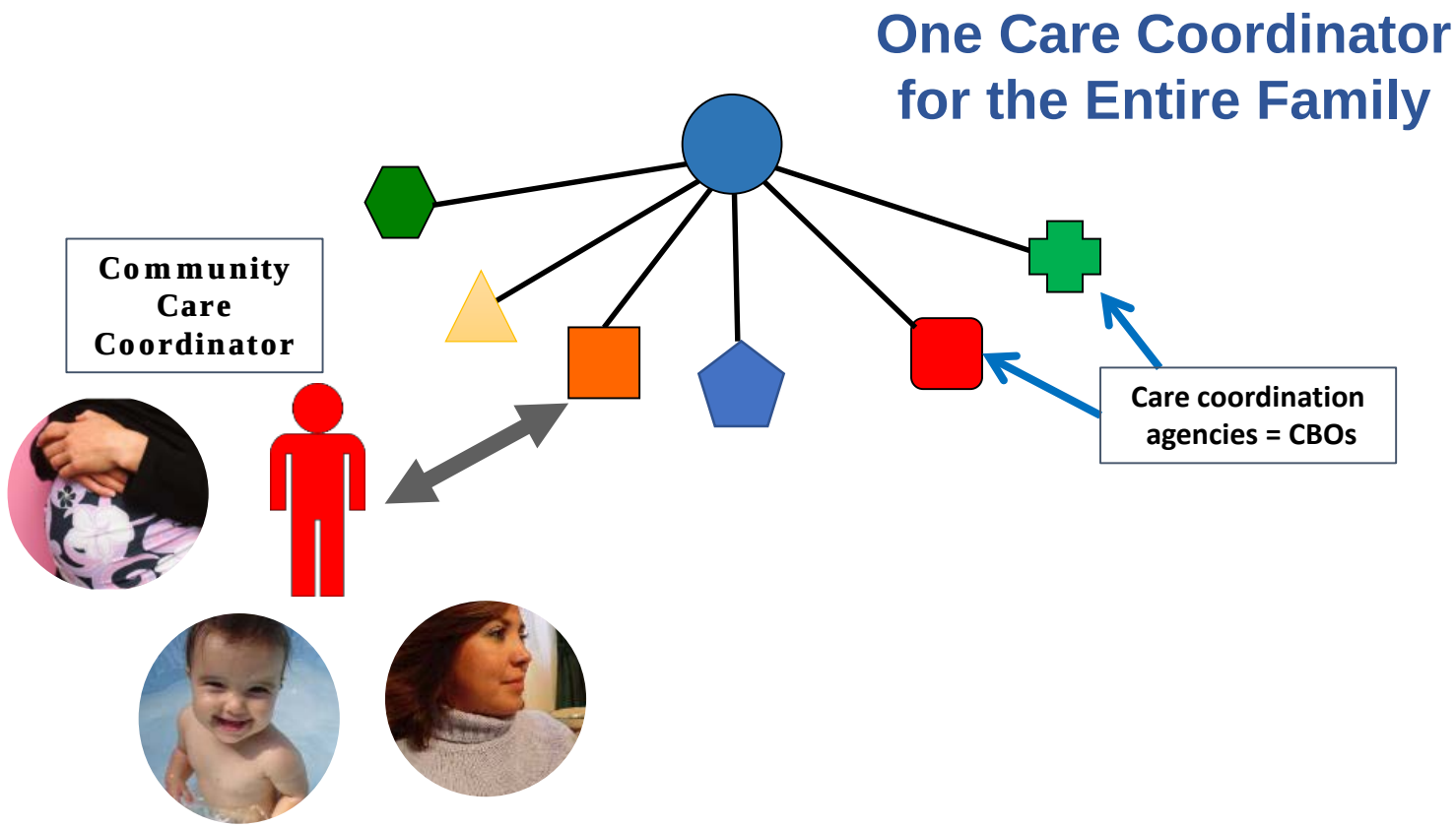


CARE COORDINATION AND SERVICE APPROACH



Multiple agencies involved – limited communication – No effective tracking of identified and addressed risk factors

COMMUNITY HUB



RISK FACTORS

Health Care

Health Insurance
Primary Care
Specialty Care
Screenings
Child development

Behavioral Health

Drug and ETOH
Depression
Anxiety
Domestic Violence

Education Employment

Job Readiness
Self Esteem
Clothing
Application Assist

Social

Food
Clothing
Housing
Heat
Electricity etc.

Safety

20 CORE PATHWAYS – NATIONAL CERTIFICATION

- + Adult Education
- + Employment
- + Health Insurance
- + Housing
- + Medical Home
- + Medical Referral
- + Medication Assessment
- + Medication Management
- + Smoking Cessation
- + Social Service Referral
- + Behavioral Referral
- + Developmental Screening
- + Developmental Referral
- + Education
- + Family Planning
- + Immunization Screening
- + Immunization Referral
- + Lead Screening
- + Pregnancy
- + Postpartum

Desired Organizational Characteristics

- + Promote connection between CBO's and Payors
- + Maximize collaborative efforts, particularly with respect to data management and accessing funds
- + Build and manage relationships with Payors/Funders
- + Facilitate important business functions, such as data collection, data sharing, negotiation and payment
- + Marketing
- + Quality control and improvement
- + Regulatory collaboration/compliance
- + Minimize impact of political dynamics, personal relationships

Manage Costs Through:

- + Investment in Shared Infrastructure
- + Unified Electronic Platform
- + Centralized Services/Management Services Arrangement (Economies of Scale/Expertise)
- + Contracting
- + Compliance
- + Credentialing
- + Data Analytics
- + IT
- + Office Management
- + Billing

PCHUB PRINCIPLES & MODEL SHOWCASE

WHY?

- HEALTH EQUITY
- SYSTEM NAVIGATION
- EXPANDING PATHWAYS

PAYING FOR PATHWAYS

HEALTH & HUMAN SERVICES

MEDICAID MANAGED CARE

EARLY CHILDHOOD

SKETCH FOR STRATEGIC PLAN

EMPOWERING LEADERSHIP

LOCAL HUB DESIGN

The ADMINISTRATIVE ENGINE

SEE ALL MOVING PARTS

USING SHARED DATA TO BUILD SUSTAINED CONNECTIVITY in the Community

EDUCATION

EMPLOYMENT

MULTIPLE FUNDING STREAMS FOR –

1. INTERVENTION
2. CARE CONNECTION

IDENTIFYING & ADDRESSING RISK

HOUSING

SUBSTANCE ABUSE

HEALTH CARE

FOOD

FAMILY

ADDRESS ALL RISK FACTORS

DUPLICATION ADRESSED

CARE CONNECTION PROGRAMS

EVIDENCE BASED

FINANCIAL CONTRACT

SOCIAL PATHWAYS

meeting national STANDARDS

WHAT ARE the METRICS?

REASEARCH EVALUATION PARTNERS

CLIENT CHOOSES CHW

COMMUNITY HUB

CHW

CONNECTING CLIENT WITH ALL AVAILABLE PATHWAY SERVICES

FINAL BACK-UP FUNDER

IDENTIFYING GAPS

WHOLE PERSON APPROACH

HEALTH HOME

FINANCED BY PAYER

EVIDENCE that WE ARE BETTER

OPPORTUNITY FOR RELATIONSHIP BUILDING

- KNOWLEDGE
- RELATIONSHIPS
- DATA

IN THIS TOGETHER

BETTER INFORMATION = BETTER CARE

FIND → TREAT → MEASURE

- FIND: ENGAGE CLIENT; ASSESS RISK
- TREAT: ASSIGN PATHWAYS
- MEASURE

ACTIVATING HUMAN DELIVERY SYSTEM

- PREPAREDNESS
- READINESS

ImageThink

LESSONS LEARNED

LESSONS LEARNED

- Assure time for contracting, establishment of BAA, agreement on information sharing and other partnership protocols before service period is due to begin
- Assure that agreements/contract allows for model to be fully executed – including multi-faceted outreach that would need approval of HCO legal/privacy depts.
- Know the outcomes of the intervention
- Know the value of the model – if ROI hasn't been specifically measured, it may be available by linking outcome to ROI documented in literature
- Defend the model - don't negotiate cost to the point that the HCO is supplementing/losing $ or model is compromised
- Build in to cost time spent on engagement and on travel if geography between clients is an issue
- Assure that HCO has adequate number of patients to refer/ learn patient population as it might influence model (e.g. disengaged from clinical services for extended period)
- Assure CBO/CHW and HCO competence in diversity/inclusiveness/equity issues

LESSONS LEARNED (CONTINUED)

- CBOs need to be speaking the same language and have a related vision
- A shared health equity lens is important to build CBO trust
- Healthcare providers must partner with CBOs to plan projects
- The CBO value proposition needs to make a clear case for improved health and cost savings, even if the data requires a pilot project to prove it
- Everyone needs to understand what's in it for them, so they can commit throughout the process
- Everyone has a different way of determining value, but the ROI needs to be clear

CONTACT US

Heidi Arthur
HMA, Principal, NYC
harthur@healthmanagement.com

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