

- ACO Partnerships with Community-Based Organizations to Address SDOH

NAACOS Fall Conference

September 8, 2022

ACO Partnerships With Community-Based Organizations



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Addressing Social Drivers of Health and Building a Network of Community Based Organization

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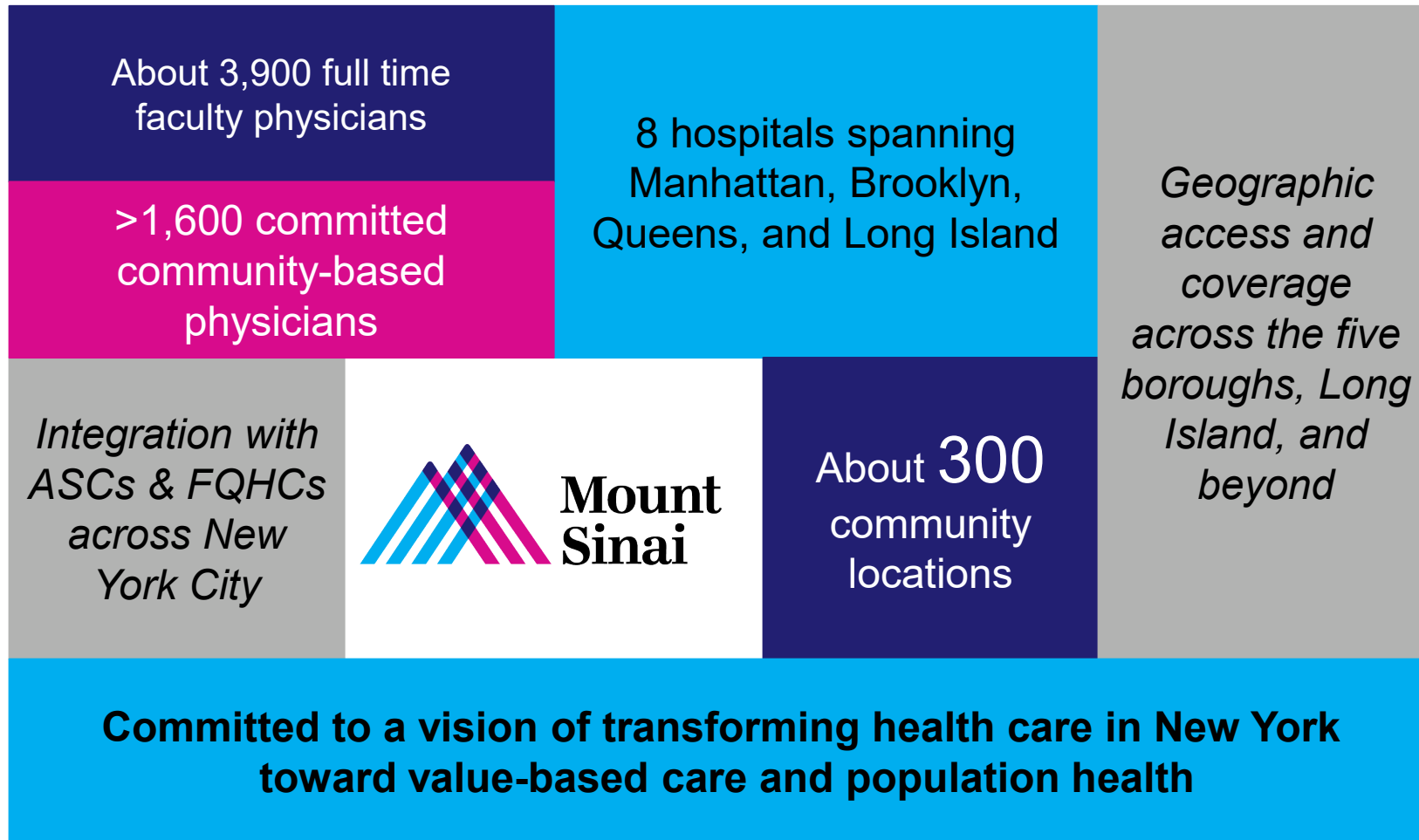
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September 8, 2022

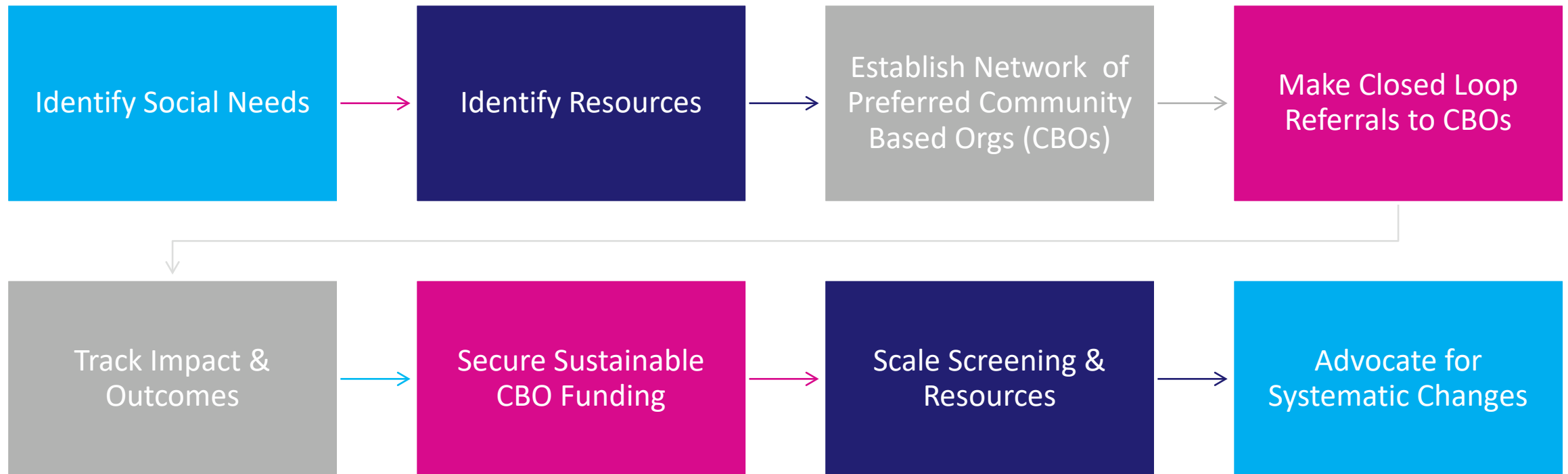


**Mount
Sinai
Health
Partners**

Mount Sinai Health Partners' Clinically Integrated Network (CIN)



Overview of Mount Sinai Social Drivers of Health Strategy



Identifying Social Drivers of Health

Standardized SDoH Assessment

(Launched Q1 2020)

Assessment that evaluates and identifies a patient's social needs across 15 categories

Primarily completed by social workers and Care Management

Embedded in Epic electronic medical record

Aligned with Z-codes for potential reimbursement

Vendor SDoH Data

(Launched Q3 2020)

Detailed RFP developed and posted

Vetting and selection of SDoH vendor

Data leveraged to identify aggregate SDoH trends and target patients for outreach

5,000+ unique metrics, 128+ risk and engagement scores

SDoH Questionnaire on MyChart

(Launched Q2 2021)

Questionnaire sent by Care Management to patients via MyChart to better understand their SDoH-related needs

Patients with SDoH needs are connected to Care Management for follow up support and referrals to Community-based organizations

An additional safe space for patients to share their needs

Community Resource Guides, Referral Platforms & CBO Networks

Online Community Resource Guide

- Comprehensive list of programs
- User-friendly
- Accurate
- Easily accessible
- Potential for EMR integration

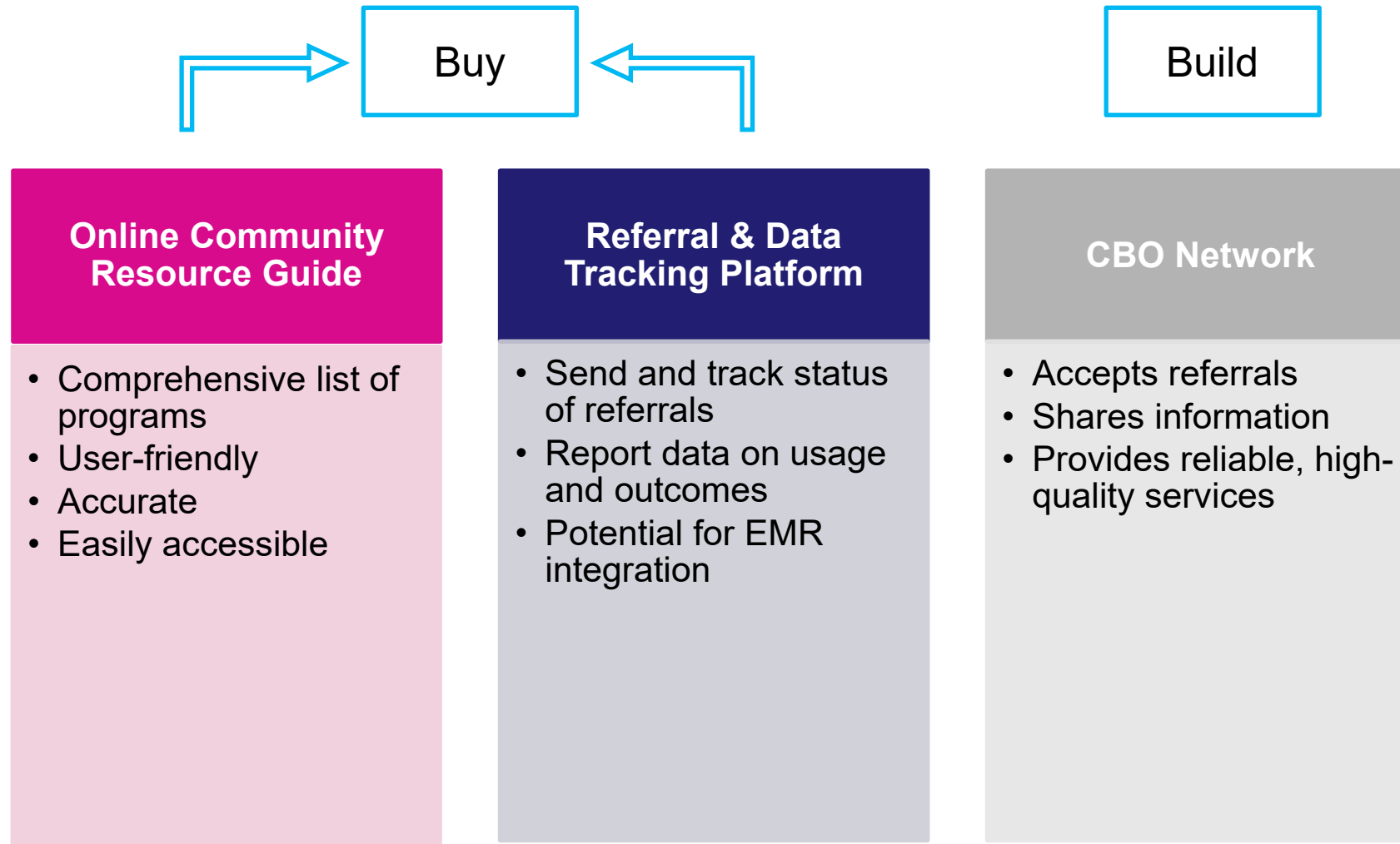
Referral & Data Tracking Platform

- Send and track status of referrals
- Report data on usage and outcomes
- Potential for EMR integration

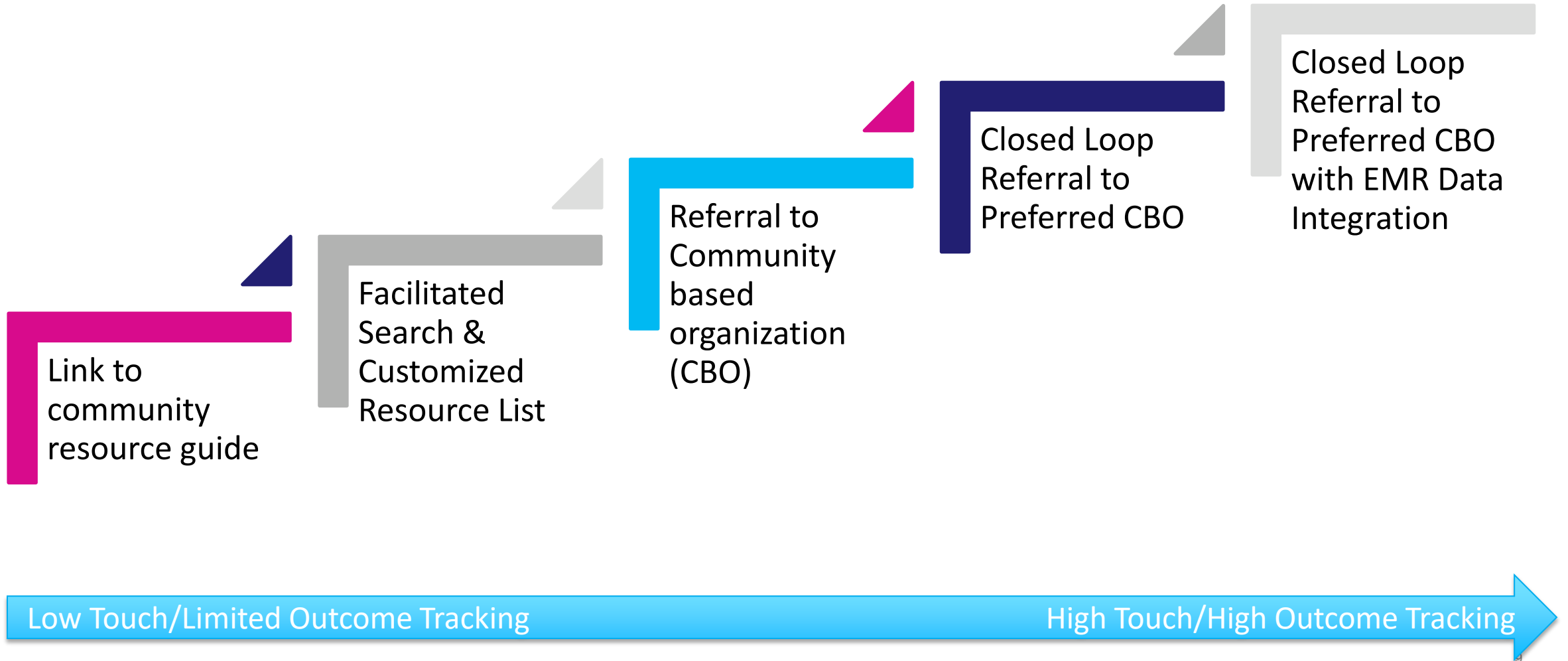
CBO Network

- Provides reliable, high-quality services
- Accepts referrals
- Shares information

Mount Sinai Decision



Levels of Resource Provision *Define an action for any scenario*



Identifying Resources – *Utilizing an Online Community Resource Guide*

FindHelp is an online community resource guide featuring reduced or no-cost services

All MSHS staff can access FindHelp
Directly through Epic

OR

By logging on to an external page using
their Sinai credentials

Patients and community members can
also access FindHelp through a
community facing page

Searches can be done by zip code or type
of service

Information is validated every 6 months

Working on additional Epic integration
and direct data feeds

Defining Platform Users Groups

Mount Sinai Employees

Community Based Organizations

Patients

General Users Group – *Basic Functionality Requirements*

Mount Sinai Employees

- Search for community-based services and resources
- Make closed loop referrals
- Basic data tracking and reporting

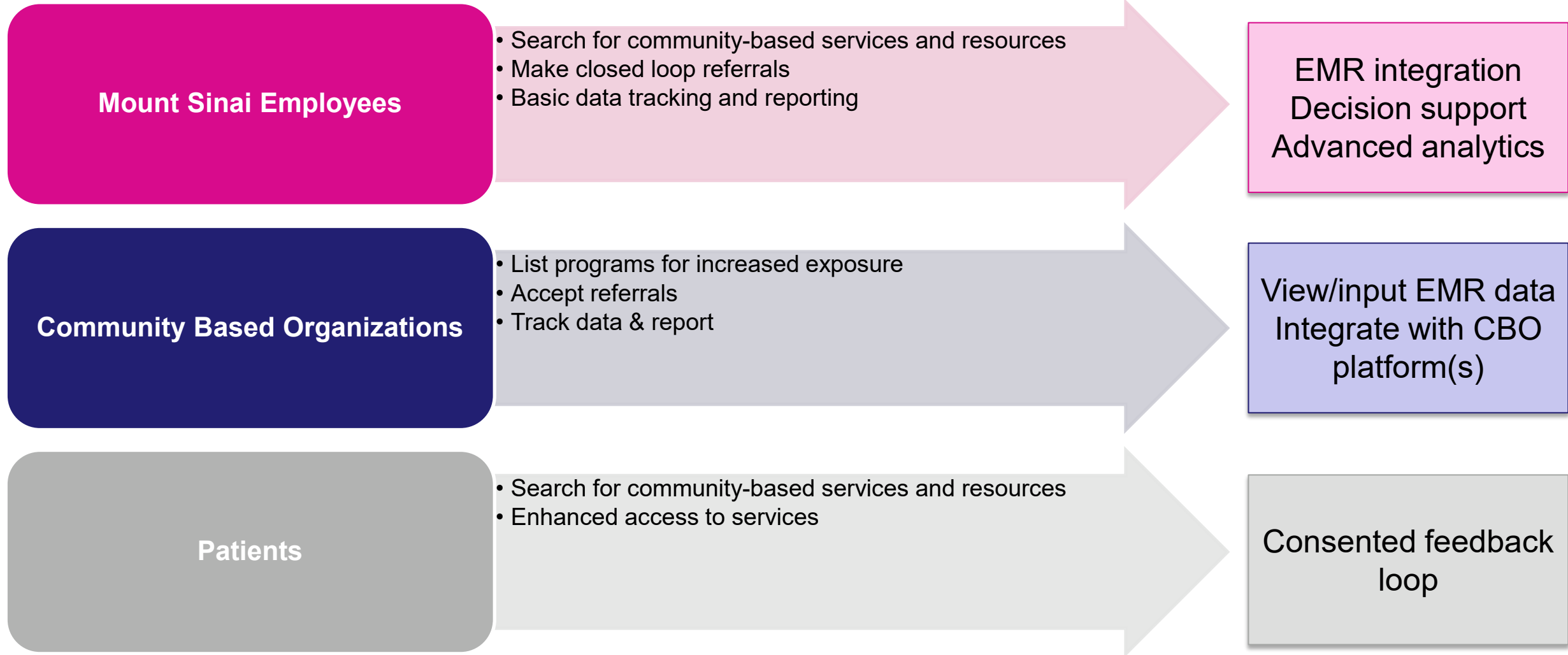
Community Based Organizations

- List programs for increased exposure
- Accept referrals
- Track data and report

Patients

- Search for community-based services and resources
- Enhanced access to services

General Users Group – *Advanced Functionality Desires*



How a Clinically Integrated Network (CIN) Functions

Clinically Integrated Network

Otherwise independent providers coordinate with each other to provide comprehensive patient care with the aim of delivering better care more efficiently

Providers must be dedicated to continuously progressing quality, increasing efficiency and demonstrating improvement

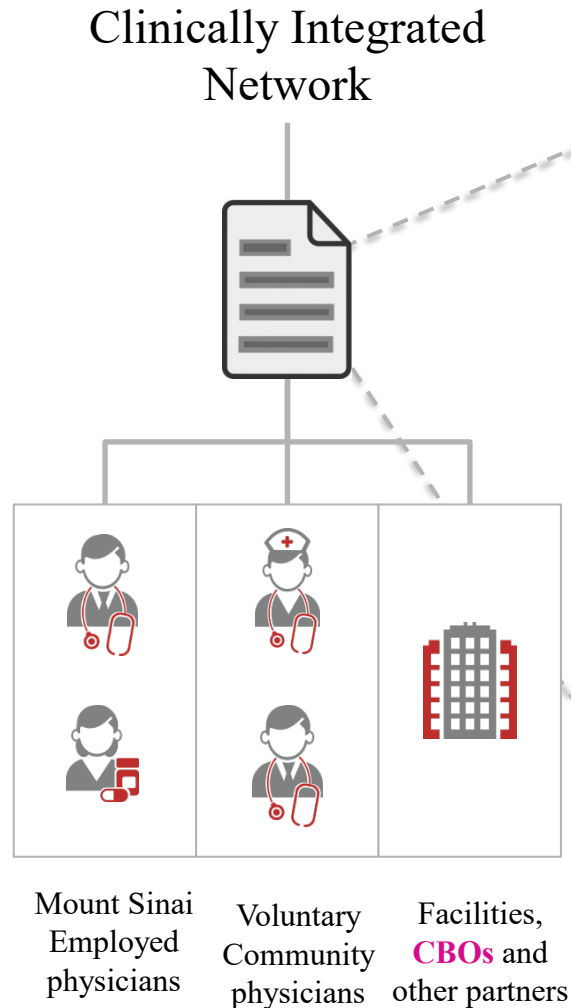
Joint contracting is permitted in CINs provided that the clinical aspects of the network are sufficiently integrated through established standards, requirements, and processes

Physicians joining a CIN accept all insurance contracts negotiated on behalf of the CIN

Goals for Establishing a Preferred Network of Community-Based Organizations

- ▶ The goal of the network is to create a healthier, more equitable community by addressing the social determinants of health through community-clinic partnerships that provide improved access to social services and care coordination.
- ▶ Create sustainable partnerships with community-based organizations by delivering high quality services and identifying new and non-philanthropic funding sources.
- ▶ CBOs joining the Network contract with Mount Sinai, complete additional vetting, agree to pre-determined business requirements (e.g. accept Findhelp referrals, respond to referrals within 48 business hours)
- ▶ Leverage Mount Sinai's data and analytics infrastructure to evaluate programs and demonstrate impact. Provide coordination, measurement, and impact data that can help guide local and regional policies and reimbursement strategies.

Philosophy Behind Mount Sinai's Clinically Integrated Network

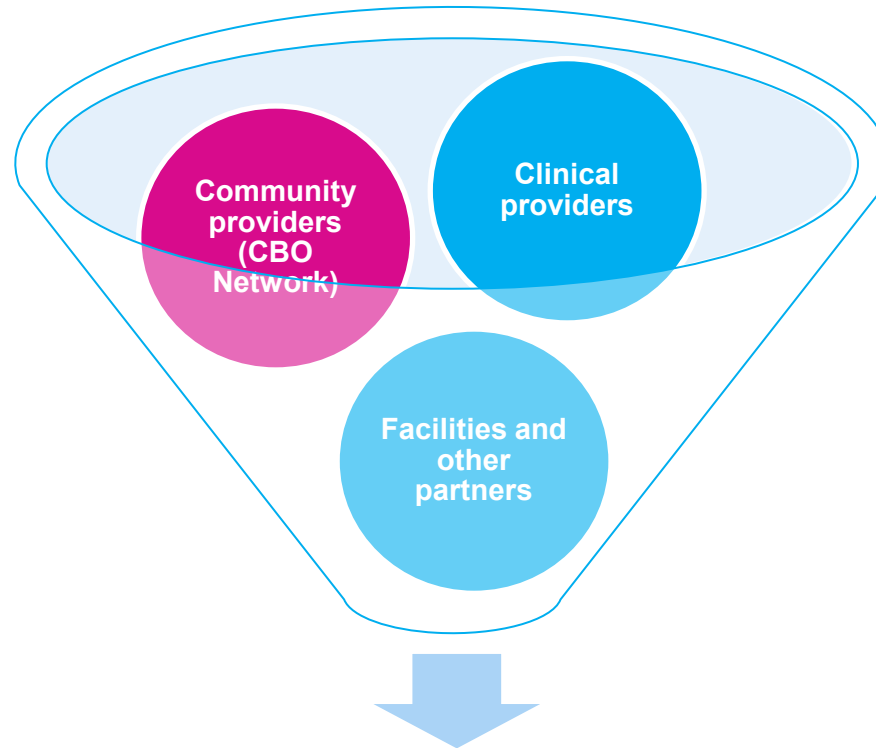


Core Components

- **Selective physician partnership:** Network of physicians opting to collaborate to deliver evidence-based care and improve quality, efficiency, and coordination of care
- **Selective Community Based Organization (CBO) partnership:** Network of CBOs opting to collaborate in a standardized way to address Social Determinants of Health (SDoH) via a data driven community-based approach
- **Comprehensive improvement initiatives:** Identified and evolving metrics and targets designed to meaningfully impact the clinical practice of all physicians in the network to improve value across the full continuum of care
- **Performance improvement architecture:** Data-driven mechanisms and processes to monitor and manage utilization of health care services, designed to control costs and ensure quality of care

Philosophy Behind Inclusion of CBOs in CIN

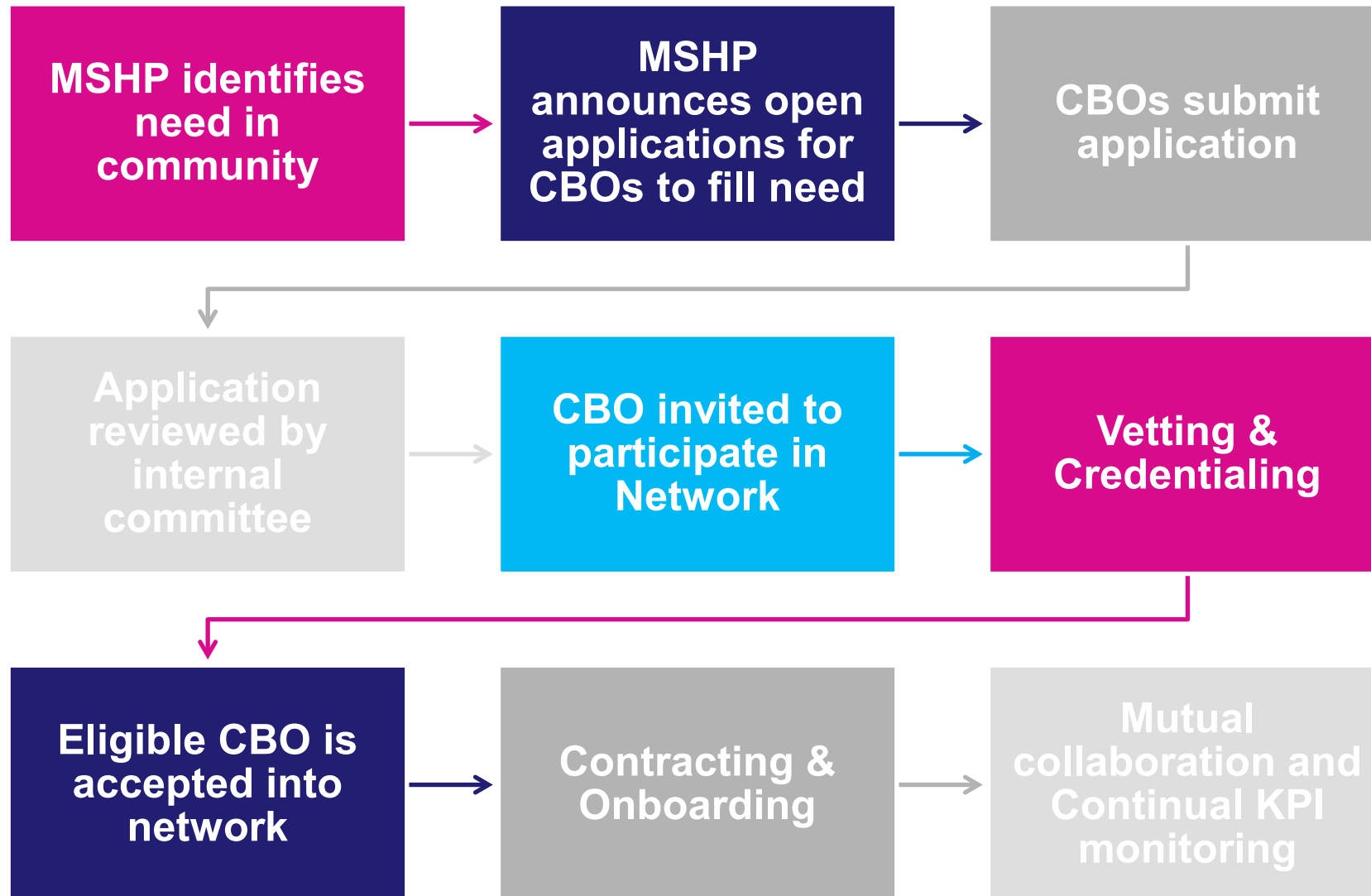
- ▶ Broaden the existing Clinically Integrated Network from just clinical providers to also include **community-based organizations and providers**
- ▶ CBOs joining the Network contract with Mount Sinai, complete additional vetting, agree to pre-discussed business requirements (e.g. accept referrals, share data & feedback)



Clinically Integrated Network

Together we can more effectively serve our communities and address SDoH

Sample Process for Joining the CBO Network



Proposed CI Program for CBOs - *Participation Requirements*

- ▶ **CBO Communication:** (A) Provide and maintain accurate organizational information in the MSHP designated platform; and (B) Report adverse events consistent with incident reporting protocols as defined by MSHP.
- ▶ **Program Engagement:** (A) Proactively prepare and participate in monthly CBO network program implementation and quality improvement meetings; and (B) Attend quarterly CBO network leadership meetings.
- ▶ **Compliance Training:** (A) Complete the Mount Sinai Health System online Annual Health Insurance Portability and Accountability Act (HIPAA) privacy training module on the Mount Sinai Clinical Integration Learning Center or through a Mount Sinai approved attestation process; and (B) Complete additional relevant Mount Sinai Health System compliance training on topics including but not limited to fraud and abuse prevention.

Proposed CI Program for CBOs - *Quality Performance Measures*

Performance Measures

Measure	Description	Target
Referral response time	% of referrals confirmed received and status updated in platform or through other process as specified by MSHP within 48 business hours	TBD
Referral follow-up time	% of referrals in which CBO followed up with patient and updated status in platform or through other process as specified by MSHP within 72 business hours of receipt	TBD
Closed referral rate	% of referrals addressed by CBO as "Got Help" or "Could Not Help" in platform or other process as specified by MSHP	TBD
Referral acceptance rate	% of referrals successfully completed by the CBO	TBD

Additional measures will be tracked and reported for **informational purposes**, such as:

- ▶ Total number of referrals accepted
- ▶ Time-bound closed referral rate

Sample Contracting & Onboarding Process*

1. Master Services Agreement

- MSHS CBO network contract will legally bring CBOs into MSHP IPA and allow us to negotiate on your behalf with payors

2. Business Associate Addendum

- Allows us to securely share data and information; auto-renews annually

3. *Optional*: Scope of Work

- Can be used for specific projects or initiatives as needed (may include fee schedule or payment info)

4. CBO Network Handbook

- Contains business and incident reporting requirements, platform details

Feedback from CBOS on Platform & Network Value

Provision of Services

- Referral volume
- Allocation management
- Access to data & reporting

Joint Fundraising

- Pursue grants together
- Letters of support

Health System Benefits

- Access to academic & institutional staff
- Access to real-time clinical information from a trusted source

Support Connection to Payers

- Payer discussions and contract negotiations (to achieve more sustainable funding sources)
- Identify patients best served by initiatives

Network Collaborative

- Planning and facilitation of meetings
- Best practice sharing across sectors

Thank you!

Ashley Fitch

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Opportunities for ACO Partnerships with Community Based Organizations

NAACO Conference

September 8, 2022

Kathy E. Vesley

President & CEO

Bay Aging

VAAACares®



Why Partner with a CBO? – ACOs, Physician Groups, Health Plans

- Trusted entity
- Already engaged in the community & in homes
- SDoH and Health Related Social Needs (HRSN) expertise
- Expertise in blending & braiding opportunities – Gravity Project – Moving to more reimbursements from CMS
- Patient satisfaction
- Cost effective

Overview for Today

- Information Sharing and Reporting
- Shared Governance
- Funding Model
- Community and Patient Engagement
- Evaluation and Outcomes

“You need to find an individual on the health system side, otherwise the CBO struggles. You have to find that key person inside who wants to make this happen. Someone has to ‘boundary span’ to bring the CBO into the health care system”

- Kyle Allen, DO, AGSF
Riverside Health System

VAAACares® - One-Stop-Shop Model

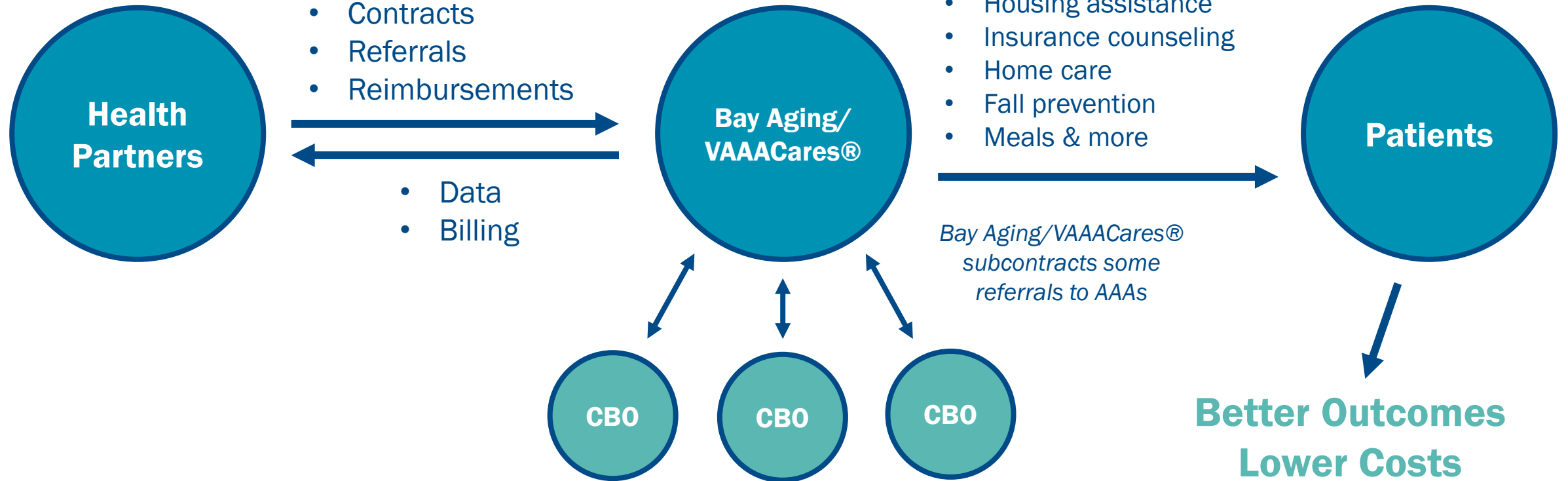
- 100% Virginia AAA Support
- Offers major insurers and other healthcare providers a one-stop-shop for contracts
 - one contract, one referral site, one billing, one reimbursement and one source accountability
- Supports positive health outcomes and demonstrates lower costs
- Leverages AAAs' 45-years of trust and experience delivering quality services in people's homes
 - knowledge of community assets - close gaps in SDoH and HRSN



Community Integrated Health Network

Services addressing Social Determinants of Health:

- Care transition support
- Care coordination
- Chronic disease self-management programs
- Health screenings and assessments
- Healthy Ideas/behavioral health
- Caregiver supports
- Veteran Directed Care
- Medication counseling
- Transportation assistance
- Housing assistance
- Insurance counseling
- Home care
- Fall prevention
- Meals & more



The Evolution of VAAACares®

Small, rural non-profit to statewide broker

CMS CCTP pilot partnership with Bay Aging and Riverside Health System.

Bay Aging initiated VAAACares® statewide for contract opportunities in Duals Demonstration.

Used “Duals” data to land statewide MCO LTSS contracts.

2012

2013

2015

2016

2017

2021

CCTP full launch with 5 health systems, 69 skilled nursing facilities, and 5 Area Agencies on Aging – covering 20% of the state.

Based on Medicare savings and health outcomes, the VA General Assembly awarded funding to Bay Aging/ VAAACares® to demonstrate impact in Medicaid.

Used CMS/General Assembly outcomes data to land Statewide MCO “Duals” contracts.

Community Care Hub selected by ACL to develop statewide Community Integrated Health Network to include all CBOs and health entities.

Overview of Evidence-Based Coordinated and Transition Care: Patient Activation for Self-Management

Example: Blend and Braid

Core Components

- Assessment
- Medication Assistance, Access, and Adherence
- PCP Appointment Adherence
- Red Flags
- Patient Centered Record

Incorporate Evidence Based Models

- Chronic Disease Self-Management Education
- Fall Prevention
- Diabetes Self-Management Education
- Healthy Ideas (Depression)
- Advance Care Planning
- Telehealth / Tele-education

Coordination of Other Services

- Transportation
- Nutrition / Meals on Wheels
- Personal and Companion Care
- Housing Assistance
- Emergency Services i.e. fuel assistance
- Friendly Caller/Visits
- Adult Day Services

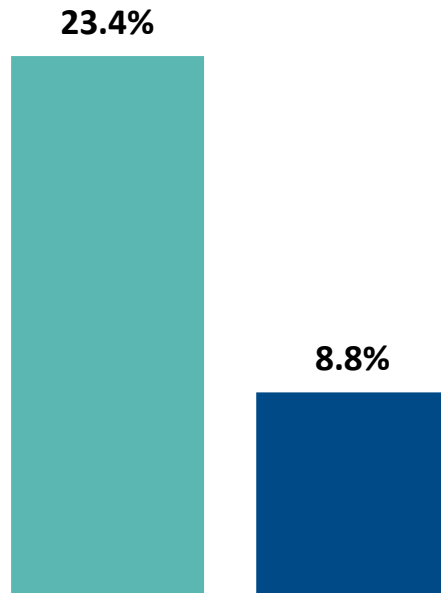
Sample: Care Transitions Outcomes

Readmission Reduction Rates for High Utilizers = Savings

Medicare Contracts

*CMS Data –
Mathematica/QMR*

26,752 participants

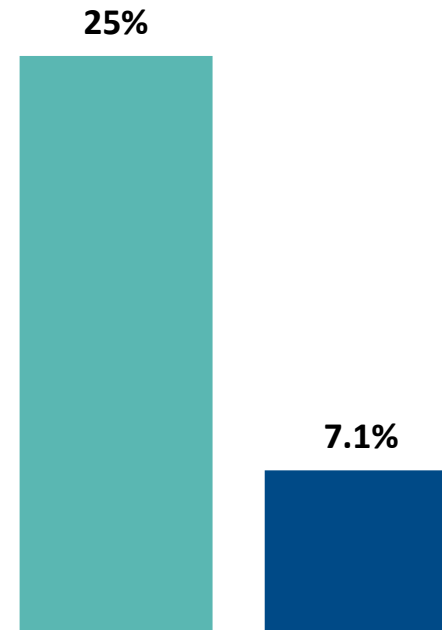


**Readmissions
Avoided:
3,894**

Medicaid Contracts

Hospital/Health Plan Data

12,757 participants



**Readmissions
Avoided:
2,287**

LEGEND



Expected Readmissions



Actual Readmissions

Care Transitions Reduction Pilot – Highest Utilizers

*Outcomes for 89 Enrollees (Medicaid, Medicare, and Self-pay)
The ACO referred highest utilizers – highest cost*

43 of the 89 Enrollees had 100% Decrease Utilization

Prior to Enrollment		Post Enrollment
63 ED Visits	➡	0 ED Visits
35 Hospital Admissions	➡	0 Hospital Admissions

**35 Enrollees Reduced Utilization by 56.1%
With no 30-Day Readmissions**

11 Enrollees Readmitted Within 30-Days of Discharge

How to Partner with a CBO

- Identify needs and potential partners
 - **ALERT:** CBOs = Health Related Social Needs: transportation, mental health, nutrition, housing, etc.
 - **ALERT:** Referral platforms do NOT provide SDoH or HRSN
- Build relationships = CONVERSATIONS
 - **ALERT:** CBO partner is NOT “just another vendor”
- Discuss service needs and reimbursements
 - **ALERT:** Invest in services, NOT referrals
 - **ALERT:** CBOs do NOT have endless funding: expect to pay for services and performance outcome
 - ? Invest in referral platforms: who is accountable?

How to Partner with a CBO Cont.

- Share responsibility for financial models and agree on contract terms
 - ✓ Medicare
 - ✓ Medicaid
 - ✓ Blend & Braid
 - ✓ Grants
 - ✓ CAPGI – Collaborative Funding Pools
 - ✓ Strategic Approaches with ACOs and Value Partnerships
 - **ALERT:** Ensure capacity, need for volume in contracts, how to demonstrate value
 - **ALERT:** CBOs (VAAACares®) charge for service. We do NOT charge our partners to “join.”

How to Partner with a CBO Cont.

- Identify referral process, data and security issues, etc. Establish standards before software.
 - **ALERT:** Sophisticated CBOs may not join SHARPS – We operate a business!
 - Need patient data to perform quality services and determine outcomes
 - Need to access EHR to input data – for your benefit & to prove the ROI
 - Need one-stop billing & accountability
- Establish regular conversations and reviews
 - **ALERT:** Hubris is not your friend!

VAAACares® provides the coalition the means to move from hospital-centric to a larger, cross continuum team to support patients transitioning from the postacute care setting to home with the community based supports that hospitals need but cannot realistically provide.

THANK YOU!

Questions? Comments?



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Deputy Administrator, Administration for Community Living

September 2022

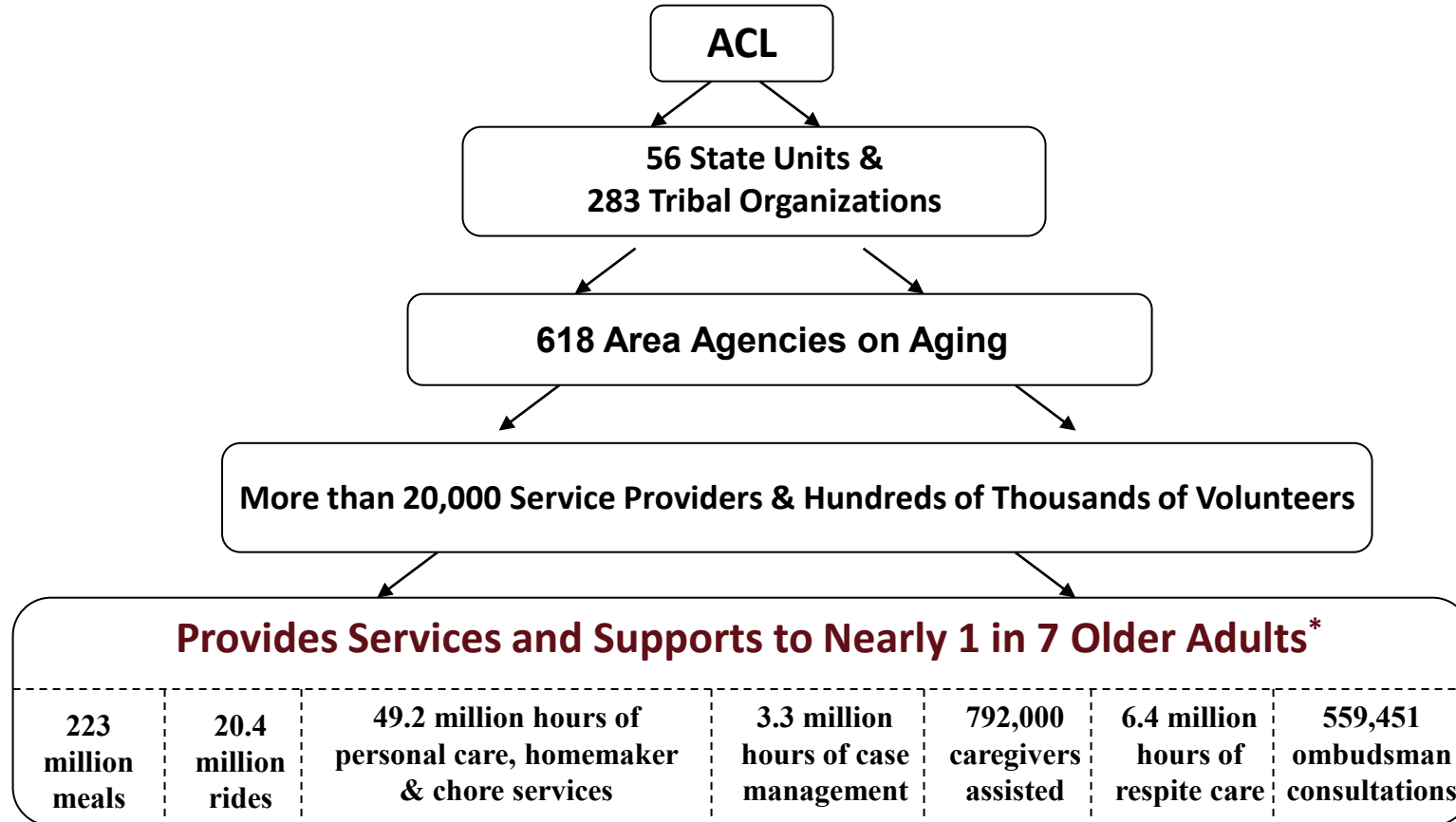
ACL's Primary Roles

- Implement critical disability and aging programs
- Advise the HHS Secretary on disability and aging policy
- Work with other HHS Agencies, Departments, and the White House on disability and aging policies, including:
 - HHS Office for Civil Rights, Centers for Medicare & Medicaid Services, Substance Abuse and Mental Health Services Administration, and the Centers for Disease Control and Prevention
 - Departments of Housing and Urban Development, Education, Labor, Justice, Veterans Affairs, and Transportation
- Engage a range of disability and aging stakeholders to inform policy development and implementation

Core Competencies and Services Offered by Aging and Disability Networks

- ACL funds over 20,000 community-based organizations in every state and in communities across the country
- Acute focus on high cost, high need populations
- Robust planning and assessment, expert knowledge/navigation of complex social services system
- Core services include:
 - Assessment for SDOH needs
 - Benefits eligibility and financial resource coordination
 - Care transitions
 - Case management
 - Housing assistance (eviction prevention, supportive services, home mods)
 - Information and referral
 - Nutrition assistance (home-delivered and congregate meals, access to SNAP benefits, food banks, etc.)
 - Social isolation support
 - Transportation assistance

Reach of the Aging Network via the Older Americans Act Programs – Helps Over 10 Million Older Adults (1 in 7) Remain at Home through Low-Cost Community-Based Services



*Data Source: FY 2019 SPR and Title VI PPR

Achieving Health and Social Care Alignment through CBO Networks

- When CBO networks partner with health care providers, the resulting alignment can lead to better outcomes and lower costs ([Brewster et al. Health Affairs](#))
- Networks have the capacity to:
 - Deliver a broad scope of services
 - Expand and evolve populations served
 - Build stronger administrative infrastructures
 - Capitalize on economies of scale
 - Provide expanded geographic coverage
 - Offer “one-stop” contracting for variety of services/payers
 - Expand quality improvement initiatives

Community Care Hub

- A community-focused entity that organizes and supports a network of community-based organizations providing services to address health-related social needs.
- A Community Care Hub centralizes administrative functions and operational infrastructure, including but not limited to:
 - Contracting with health care organizations
 - Payment operations
 - Management of referrals
 - Service delivery fidelity and compliance
 - Technology, information security, data collection, and reporting
- A Community Care Hub has trusted relationships with and understands the capacities of local community-based and healthcare organizations and fosters cross-sector collaborations that practice community governance with authentic local voices.

National Learning Community

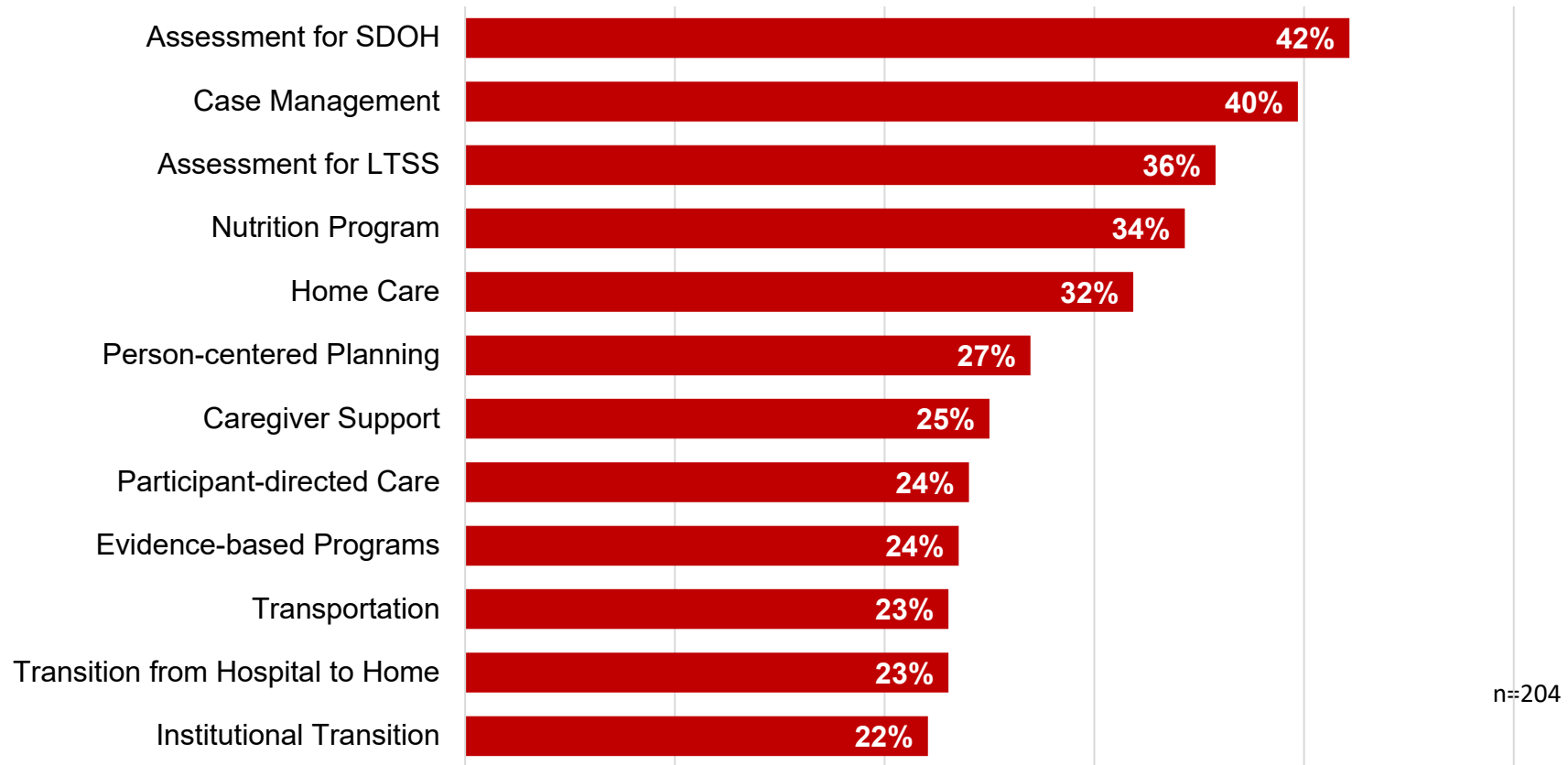
- Bring together organizations serving as Community Care Hubs (Hubs) to take part in shared learning, information and resource sharing, and coordinated TA with the goal of building the strength and preparedness of the Hub to address SDOH and public health needs through contracts with health care entities.
- Two tracks, approximately 40 participants:
 - Network Development
 - Network Expansion
- Timeline: November 2022 – September 2023

Community Care Hub

Forecasted NOFO

- Funding will support:
 - Development and enhancement of Community Care Hubs (~10 awards)
 - Regional Centers for Excellence to provide technical assistance and mentoring, as well as facilitate partnerships across health payers and CCHs (~5 awards)
- ~\$4 million for 2-year cooperative agreement
- Project period: Sept 2023 – Sept 2025

Out of 1000 contracts between CBOs and Health Care Organizations - Most Common Services Provided



Real Life Example of SDOH Integration

- ACO in North Carolina completed a population health data analysis that revealed increased ED admissions for malnutrition
- ED implemented a food insecurity screen
- Positive screens referred to CBO network covering multiple counties in NC
- Network lead sends the referral to the appropriate CBO partner
- CBO conducts a full SDOH screen
- CBO develops a person-centered plan
- Interventions deployed
- Provided reports to the Medicare ACO on the impact

NC Example – Patient Experience

- Medicare bene with repeat ED visits for falls and positive malnutrition screen
- Full SDOH assessment by CBO revealed:
 - In-home assessment found no working stove or microwave in the house
 - Significant fall risk throughout the house
 - Patient reports inability to meet insulin copayments for several months
 - Dual Eligible (Medicare + Medicaid)
 - Self-reports of social isolation and loneliness

NC Example – Patient SDOH Interventions Deployed

- SDOH Person-Centered Plan leveraged a braided funding approach to address identified needs:
 - Home-delivered meal voucher
 - Enrollment in SNAP
 - Community Development Block Grant for energy assistance
 - Local church donation of microwave and stove repair
 - Enrollment in Low-Income Subsidy for Medicare Part D to help pay insulin copayments
 - Enrollment in a LTSS Medicaid Waiver
 - Linkage to a local senior center depression intervention

Get connected to a
Community Care Hub
HubNLC@acl.hhs.gov