WASHTENAW HEALTH INITIATIVE

# Stakeholder Meeting

## Integrating Health and Social Services

December 10th, 2024

# MISSION:

Improve health, health equity, and healthcare in Washtenaw County with an emphasis on the low income, uninsured and underinsured populations; including advancing work in our community on the structural causes of race-based health inequity.

# In remembrance...

# Catherine McClary

On Monday, December 2, 2024, Washtenaw County was rocked by the passing of a County stalwart, Treasurer Catherine McClary. For over 40 years, Treasurer McClary faithfully served the residents of Washtenaw County with passion, courage, and audacity.

# Collaborative Health Impact Award (CHIA)

- Founded during the WHI's 10th anniversary year.
- Recognizes the power of collaboration to break down silos and enable organizations to achieve more than they ever could alone.

# Collaborations recognized to date

Since 2021, the WHI's Collaborative Impact Award has recognized three Washtenaw County collaborations that have made a significant positive impact on the health of our community.

**IN THE LAST THREE YEARS, VOTERS HAVE RECOGNIZED:**

**2021.** Hoteling those experiencing homelessness during the COVID-19 pandemic.

**2022.** The Recovery Opioid Overdose Team (ROOT).

**2023.** The Behavioral Health Collaborative for Young Black Men and Boys.

# 2024 nominees

**Four collaborations were nominated by our members:**

- Supporting breastfeeding among Latina mothers
- Advocating for more public funds to support seniors
- Collaborating to improve community reentry services
- Reducing unnecessary criminal justice system involvement

# Supporting breastfeeding among Latina mothers.

**AmaMantando**

## A culturally inclusive breastfeeding support group for Latina mothers.

Meeting once a month, virtually, AmaMantando participants learn about the benefits of breastfeeding and common challenges, like not producing enough milk, growth spurts, and the mother's emotional ups and downs while breastfeeding.

# Advocating for more public funds to support seniors.

## Say Yes to Seniors

**Seeking public funds to support the services that older people need to age in place in Washtenaw.** With advocacy from Say Yes to Seniors and support from the Washtenaw County Commission on Aging, the board of commissioners approved over $4 million to the aging network for services to older people, mainly in the areas of food, housing, and transportation as well as case management and other initiatives.

# Collaborating to improve reentry services.

## Reentry Services

### A continuum of care to more fluidly bridge pre- and post-release services.

New services and partnerships created for this initiative include: Medication assisted treatment for opioids, occupational therapy group and individual sessions, an employment skills group, a vocational certificate program, a partnership with MSHDA to provide Housing Choice Vouchers to some of the highest needs individuals experiencing homelessness, a partnership with Michigan Secretary of State to hold Mobile ID clinics inside the jail, and a partnership for field students in the Eastern Michigan University School of Social Work to come in and assist with screenings.

# Reducing unnecessary criminal justice involvement.

## LEADD

### Alternatives to arrest or citation for individuals with unmet basic needs.

LEADD case managers work alongside individuals long-term to provide access to health and safety resources, housing, food, legal advocacy, education and employment resources, ID and licensure, transportation, and other services.

# Our 2024 Collaborative Health Impact Award winner

Collaborating to improve reentry services across Washtenaw County.

- Avalon Housing
- Washtenaw County Community Mental Health
- Dawn Farm
- Eastern Michigan University
- In Season Solutions
- Life After Incarceration Transition & Reentry
- Skill and Ability Education
- Therapeutics LLC
- Washtenaw County Sheriff's Office
- Washtenaw Intermediate School District

# WHI in 2025:
# Health and Social Service Integration


Gerard Queally
President & CEO


Kristi Bohling-DaMetz
Director of Aging and Adult Services


Nikki Kmicinski
CEO

Tane Lewis
Community Support Network Manager


Gerard Queally

President & CEO


WHI Stakeholders Meeting, December 10, 2024


**HL4ME's mission is to coordinate and align community resources to improve the health and wellness of the people of Maine.**

HL4ME, Maine's Community Care Hub (CCH).

**HL4ME's vision is providing Maine people with the skills and resources to take control to build healthier lives.**

HL4ME CCH Video

# HL4ME CCH – Multi-Sector Network

**Health Promotion & Disease Prevention (HP&DP) Programs**

- Varying funding sources supporting…
  - Chronic Disease and Pain Management
  - Diabetes Management and Prevention
  - Intellectual and/or Developmental Disability Support
  - Caregiving
  - Falls Prevention
    - Maine Falls Prevention Coalition (MFPC)

*"We've come to view CCH network staff as an extension of our own care team." –* **FQHC CEO**

**Social Care Coordination (SCC) Services**

- 4 contracts (2 health systems & 2 health plans) to provide services
  - In-home assessments with high utilizers of the Emergency Room (ER)/Emergency Department (ED)
  - Complex Care Management addressing high ER utilization and high-risk clients with no supports
  - Health Risk Assessments and collection of health and Social Determinants of Health (SDOH) needs

**Rural Community Health Improvement Partnership (R-CHIP)/**

- Somerset and Kennebec Counties Community Partnership (SKCCP)

# SKCCP

- 11 community-based organizations, 3 health systems, 1 healthcare advocacy organization, and the Maine CDC Central Public Health District

- Sectors:
  - Public Health
  - Healthcare
  - Housing & Economy
  - Behavioral & Mental Health
  - Social & Familial Services
  - Other

# HL4ME CCH Infrastructure Development

Funder: Center of Excellence, USAging CCH Infrastructure Funding

Timeline: June 2024-May 2026

Primary Infrastructure Activities:

- Strategic Business Development: build capacity to blend funds from public funding resources and healthcare enterprises (systems and plans)
- Network Recruitment, Engagement, and Support: increase contracting strategies and partner support
- Contract Administration, Quality, Compliance, and Continuous Performance Improvement: revise/develop CCH trainings and practices for network partners re: contracting with healthcare enterprises, including improved standards for capturing ongoing feedback (to and from CCH)
- Information Technology (IT) and Security: position HL4ME's IT infrastructure to securely receive healthcare referrals, efficiently record service delivery activities, processes information needed for both claims and outcome reporting, and can securely transfer data

***Further develop HL4ME CCH's capabilities, capacities, and support infrastructure to better align and coordinate health and social care service deliveries that positively affect Health Related Social Needs (HRSNs) in underserved populations in Maine.***

# Contact Information

Gerard Queally
President & CEO, Spectrum Generations
Managing Partner, HL4ME
gqueally@healthylivingforme.org


Kristi Bohling-DaMetz
Director of Aging and Adult Services

Tane Lewis
Community Support Network Manager

MARC

MID-AMERICA REGIONAL COUNCIL

# Mid-America Community Support Network

# Mid-America Regional Council (MARC)

- A nonprofit association of city and county governments
- The federally designated metropolitan planning organization for the Greater Kansas City region
- The designated Area Agency on Aging (AAA) for the Kansas City, Missouri, region
- A forum for the region to work together to advance social, economic and environmental progress
- **MARC operates as the Community Care Hub (CCH) for the regional Community Support Network (CSN) and the statewide ma4 Network**

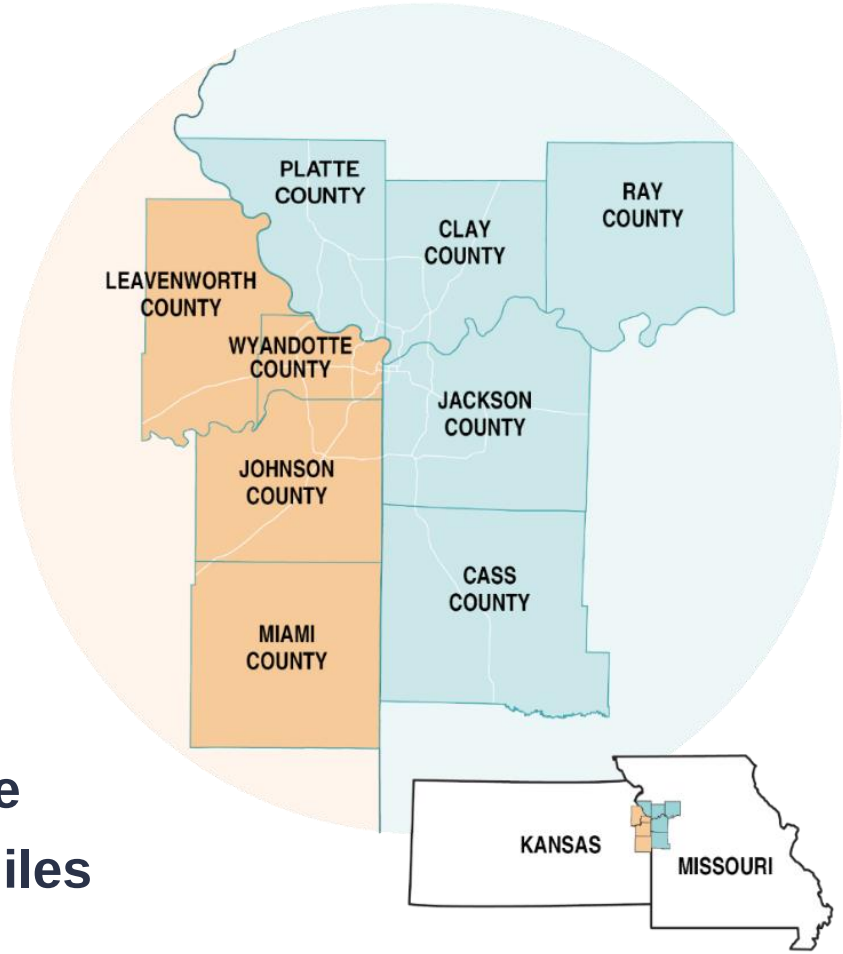
Mid-America Community Support Network

Mid-America
Community Support
Network

# Community Support Network (CSN)

## *A Community Integrated Health Network*

The Community Support Network (CSN) offers community support services to health care entities and their participants across the Kansas and Missouri bi-state metropolitan region.




**Two states**

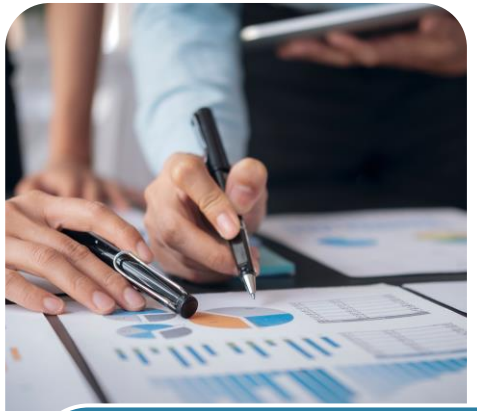
**Nine counties**

**119 cities**

**2 million people**

**4,400 square miles**

# CSN Development



## Research

2016-2017

- Gathered information from AAAs across the country
- Return on Investment studies
- Healthcare statistics
- CMS Guidance on SDOH

## Stakeholder Meetings

2017-2018

- Convened broad stakeholder group
  - Identification of community HRSN
  - Identification of CIHN approach
  - Recognition that MARC had the best existing infrastructure to manage CCH

## Consultants

2018 → ongoing

- CIHN Leaders
  - AgeSpan, formerly Elder Services of the Merrimack Valley
  - Partnership to Align Social Care
  - Partners In Care Foundation
- National consultants

# CSN Development

## Steering Committee

2018

- Regional CBO Administrators and additional collaboration partners
- Developed standard service array
- Provides ongoing feedback

## Contractual Network

- Development of Standard Network Partner Agreement
- Development of Standard Network Subcontractor Agreement
- Development of Standard Business Associate Agreement
- Development of standard Data Sharing Agreement


## Initial Funding

2018

- Philanthropic grants to fund administrative start-up
- Identification of braided funding options
- 2018 ACL CDSME grant
- Began engaging HCEs

# CSN Development

Initiatives that informed the CSN's initial service array, pricing, contracts, workflows and policies:

- Veteran Directed Care Program
- The ma4 Network
  - ACL CDSME grant
  - Development of a statewide network of evidence-based program providers including AAAs, University of Missouri Extension faculty instructors and regional subcontracted CBOs
- Participation in national learning collaboratives

# MARC as Community Care Hub (CCH)


## Benefits to HCE and CBO partners:

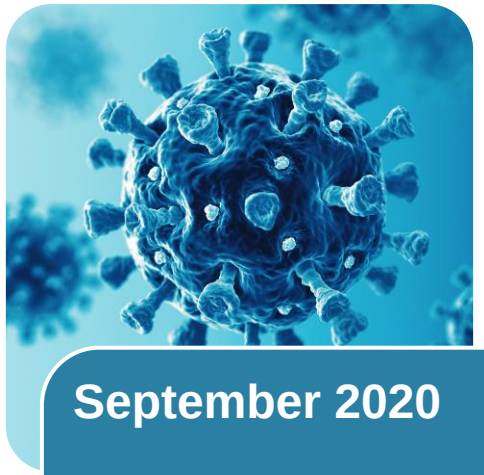
- One-stop shop for contracting, financial administration, IT and cybersecurity oversight
- Centralized intake & referral, service coordination, training, and QA and CQI management
- Data aggregation and reporting

# CSN Launch: COVID Pilot

**January 2020**

Pilot design

- SDOH support services established
- Clinics refer directly to CSN for SDOH needs



**September 2020**

Redesigned

- Community Support for those testing positive for COVID 19
- Referrals managed through data uploads

**Nov. 25, 2020**

Launch

- Outreach
- SDOH Screens
- Community Support
- Home-delivered Meals
- Transportation
- Referrals for ancillary services

# CSN Collaboration

## Administration for Community Living

- Community Care Hub National Learning Community

## Partnership to Align Social Care (PASC)

- Community Care Hub workgroup
- Health Equity Learning Collaborative

## ToRCH

- Medicaid pilot: Transformation of Rural Community Health
- Rural county hospital with the support of a closed-loop referral platform, as a network hub under the guidance of a community leadership board

## HealthTeamWorks

- Performance improvement non-profit
- Vision for health, equity, and resilience
- Focused on value-based and person-centered care

## The Kansas City Health Collaborative

- Vision for a healthier Kansas City with equitable access
- Membership including health systems, insurance companies, public health, and community-based organizations
- Piloting community network approaches in defined urban geographies

# Final Thoughts

**Collaboration**

- Identify community-based organizations (CBOs) delivering health-related social needs (HRSN) services
- Assist CBOs with the partnership process
- MARC trains CBO facilitators free of charge as needed

**Contracts**

- Centralized contracts provide consistency across the network
- Commitment builds trust between organizations
- Contracts provide accountability for all partners
- Centralized contracts increase the marketability of the network to third-party funders

**Quality Standards**

- Ensure fidelity of programs
- Provide uniform policies and procedures, streamlined workflows and oversite
- Allow for accurate reporting of impact and outcomes to Federal, State and Third-Party funders

# Lessons learned

- **Standard contracts are critical to quality assurance**
- **Formal contracts can be intimidating - TA required**
- **Start slow and build over time**
- **Network with experienced partners is critical**
- **Expand community support services within the network**
- **Privacy and security standards embedded in network**

**It is hard work but impactful and rewarding!**

# Perfect Timing...

## COE Grant

*20 Awardees  18 States  2-Year Funding*

- Age Well (VT)
- Atlanta Regional Community Care Hub Development (GA)
- Better Health Together CCH (WA)
- Community Assistance and Transition Care of Houston (TX)
- Direction Home Aging & Disabilities (OH)
- DRCOG Community Care Hub (CO)
- Health Coalition of Passaic County, Inc. (NJ)
- Health Promotion Council Community Care Hub (PA)
- Healthy Living for ME® (ME)
- Illinois Pathways to Health (IL)
- Inclusive Alliance (NY)
- Iowa Community HUB (IA)
- Mass Home Care (MA)
- **Mid-America Community Support Network (MO, KS)**
- Oregon Wellness Network (OR)
- Partners in Care Foundation, Inc. (CA)
- Southern Nevada Pathways Community Hub (NV)
- Southwest Community Care Partners (AZ)
- Texas Healthy at Home (TX)
- Western New York Integrated Care Collaborative (NY)

*Additionally, MARC was selected and awarded a Care Transitions Evaluation grant, as one of seven (7) out of these 20 awardees.*

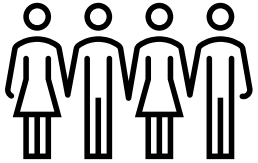
# Work Plan Objectives and Milestones

1. Convene stakeholders, funders, and partners as an advisory committee to identify shared goals and objectives, coordinate ongoing initiatives, bolster cross-network information exchange, and build a strong, collaborative community services network.
    - Community asset mapping (social health, policy, and healthcare)
    - CSN Advisory
    - Shared vision for health equity in the greater KC region
2. Identify priority populations, HCBS gaps, and barriers to access to care within the Mid-America Community Support Network (CSN) catchment area to inform equity-focused service expansion.
    - Market analysis with input from the CSN Advisory (service type and capacity)
3. Build capacity for data collection, analysis, and evaluation to measure and continuously improve the CSN's impact on regional health equity.
    - Measures of success
    - Data sources, data collection, data partners
    - Client Management System *(not part of this funding but will facilitate the work)*
4. Expand the CSN to meet the geographic and home and community-based services (HCBS) needs, goals, and objectives identified in the strategic plan.
    - CBO Coalition
    - Financial modeling
    - Contracting
5. Implement a continuous quality improvement (CQI) committee to regularly review data and reports and make recommendations for ongoing program enhancements. identified in the strategic plan.
    - CSN CQI Workgroup
    - Models for Improvement (e.g., PDSA)
    - Culture of CQI

# The Ecosystem – Stronger Together

*Shared measures of success.*

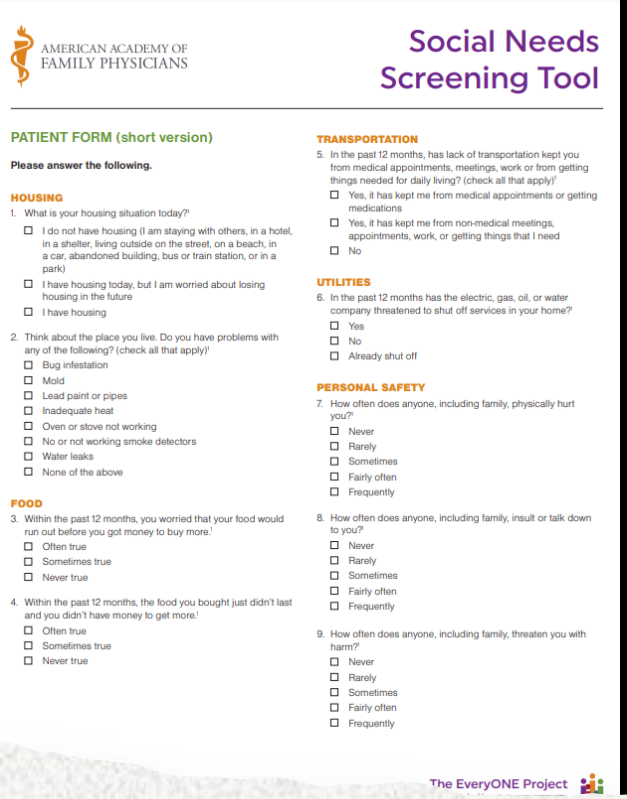
*Person-Centered Care – meeting people where they are.*



*Flow of financial resources, meeting people where they are.*


*Efficiency of centralized support in a backbone hub.*

*Solid and reliable foundation of community-based organizations (CBOs).*



AMERICAN ACADEMY OF FAMILY PHYSICIANS

## Social Needs Screening Tool

**PATIENT FORM (short version)**

**Please answer the following.**

**HOUSING**

1. What is your housing situation today?[1]
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future
   - ☐ I have housing
2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[1]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

**FOOD**

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true
4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

**TRANSPORTATION**

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)[1]
   - ☐ Yes, it has kept me from medical appointments or getting medications
   - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - ☐ No

**UTILITIES**

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[2]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

**PERSONAL SAFETY**

7. How often does anyone, including family, physically hurt you?[2]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently
8. How often does anyone, including family, insult or talk down to you?[2]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently
9. How often does anyone, including family, threaten you with harm?[2]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

The EveryONE Project

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

## The Accountable Health Communities Health-Related Social Needs Screening Tool

### What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model.[1] We're testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

### Why is the AHC HRSN Screening Tool important?

Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patients' treatment plans and make referrals to community services.

### What does the AHC HRSN Screening Tool mean for me?

Screening for HRSNs isn't standard clinical practice yet. We're making the AHC HRSN Screening Tool a standard screening across all the communities in the AHC Model. We're sharing the AHC HRSN Screening Tool for awareness.

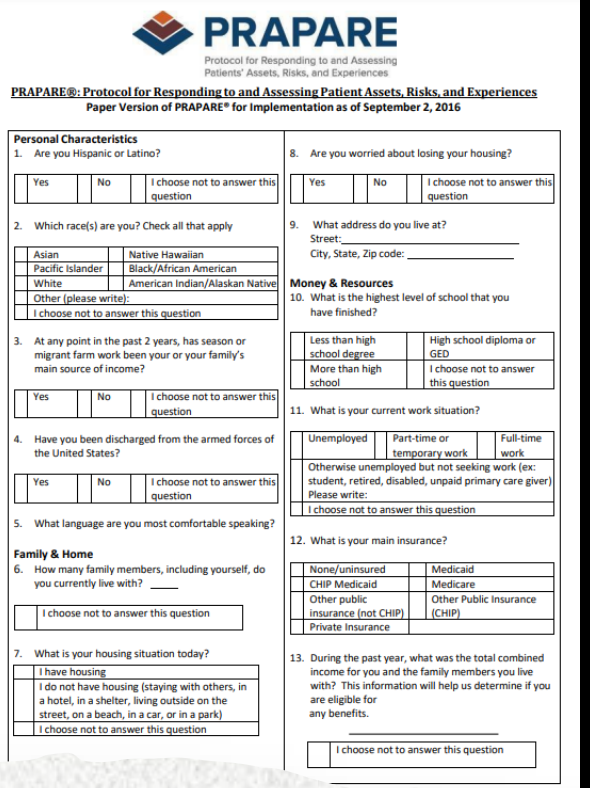
### What's in the AHC HRSN Screening Tool?

In a National Academy of Medicine discussion paper,[2] we shared the 10-item HRSN Screening Tool. The Tool can help providers find out patients' needs in these 5 core domains that community services can help with:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs

[1] United States, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2017, September 05). Accountable Health Communities Model. https://innovation.cms.gov/initiatives/ahcm.

[2] Billioux, A., MD, DPhil, Verlander, K., MPH, Anthony, S., DrPH, & Alley, D., PhD. (2017). Standardized Screening for Health-Related Clinical Settings: The Accountable Health Communities Screening



PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

**PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences**
**Paper Version of PRAPARE® for Implementation as of September 2, 2016**

**Personal Characteristics**

1. Are you Hispanic or Latino?

| Yes | No | I choose not to answer this question |
|---|---|---|

2. Which race(s) are you? Check all that apply

| | |
|---|---|
| Asian | Native Hawaiian |
| Pacific Islander | Black/African American |
| White | American Indian/Alaskan Native |
| Other (please write): | |
| I choose not to answer this question | |

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

| Yes | No | I choose not to answer this question |
|---|---|---|

4. Have you been discharged from the armed forces of the United States?

| Yes | No | I choose not to answer this question |
|---|---|---|

5. What language are you most comfortable speaking?

**Family & Home**

6. How many family members, including yourself, do you currently live with? ____

| I choose not to answer this question |
|---|

7. What is your housing situation today?

| |
|---|
| I have housing |
| I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park) |
| I choose not to answer this question |

8. Are you worried about losing your housing?

| Yes | No | I choose not to answer this question |
|---|---|---|

9. What address do you live at?
Street:_____
City, State, Zip code: _____

**Money & Resources**

10. What is the highest level of school that you have finished?

| | |
|---|---|
| Less than high school degree | High school diploma or GED |
| More than high school | I choose not to answer this question |

11. What is your current work situation?

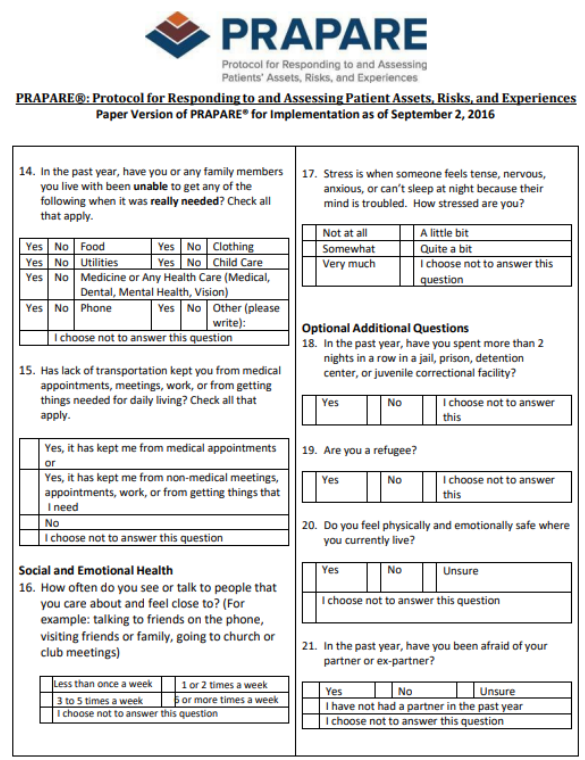
| | | |
|---|---|---|
| Unemployed | Part-time or temporary work | Full-time work |
| Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write: | | |
| I choose not to answer this question | | |

12. What is your main insurance?

| | |
|---|---|
| None/uninsured | Medicaid |
| CHIP Medicaid | Medicare |
| Other public insurance (not CHIP) | Other Public Insurance (CHIP) |
| Private Insurance | |

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

| I choose not to answer this question |
|---|



PRAPARE
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14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

| | | | | | |
|---|---|---|---|---|---|
| Yes | No | Food | Yes | No | Clothing |
| Yes | No | Utilities | Yes | No | Child Care |
| Yes | No | Medicine or Any Health Care (Medical, Dental, Mental Health, Vision) | | | |
| Yes | No | Phone | Yes | No | Other (please write): |
| I choose not to answer this question | | | | | |

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

| |
|---|
| Yes, it has kept me from medical appointments or |
| Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need |
| No |
| I choose not to answer this question |

**Social and Emotional Health**

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

| | |
|---|---|
| Less than once a week | 1 or 2 times a week |
| 3 to 5 times a week | 5 or more times a week |
| I choose not to answer this question | |

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

| | |
|---|---|
| Not at all | A little bit |
| Somewhat | Quite a bit |
| Very much | I choose not to answer this question |

**Optional Additional Questions**

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

| Yes | No | I choose not to answer this |
|---|---|---|

19. Are you a refugee?

| Yes | No | I choose not to answer this |
|---|---|---|

20. Do you feel physically and emotionally safe where you currently live?

| Yes | No | Unsure |
|---|---|---|
| I choose not to answer this question | | |

21. In the past year, have you been afraid of your partner or ex-partner?

| Yes | No | Unsure |
|---|---|---|
| I have not had a partner in the past year | | |
| I choose not to answer this question | | |

# Assessment Tools

*AAFP EveryONE Projcect*
*CMS HRSN Screening Tool (Accountable Health Communities)*
*PRAPARE*

**HCE**
**Concern**
*Reliable*
*Capacity*

**CBO**
**Concern**
*Reliable*
*Funding*

CSN

# Community Cohesion

*"It is critical that the approach to address health-related social needs reflects **communitywide governance and planning**. By incorporating **input from community leaders** and reflecting the demographic and lived experience of those served, the hub can ensure inclusion of local priorities, goals, and culture. Communitywide governance and planning to address health-related social needs should incorporate input from community leaders and **reflect the demographic diversity and lived experience of the those served by the hub**. HHS agencies, including ACL and the Centers for Disease Control and Prevention (CDC), are accelerating efforts to develop communitywide approaches to address SDOH and inequities through hubs."*

Health Affairs Blog, 11/29/22: Improving Health and Well-Being Through Community Care Hubs, https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs

# Questions?

Mid-America Community Support Network

**Kristi Bohling-DaMetz,** kbohling@marc.org
**Tane Lewis,** tlewis@marc.org


Nikki Kmicinski

CEO

# WNY **Integrated Care**
# COLLABORATIVE

Nikki Kmicinski, CEO

December 10, 2024

Better Health with Integrated Care.

# Community Care Hub

## Award-Winning Business Model

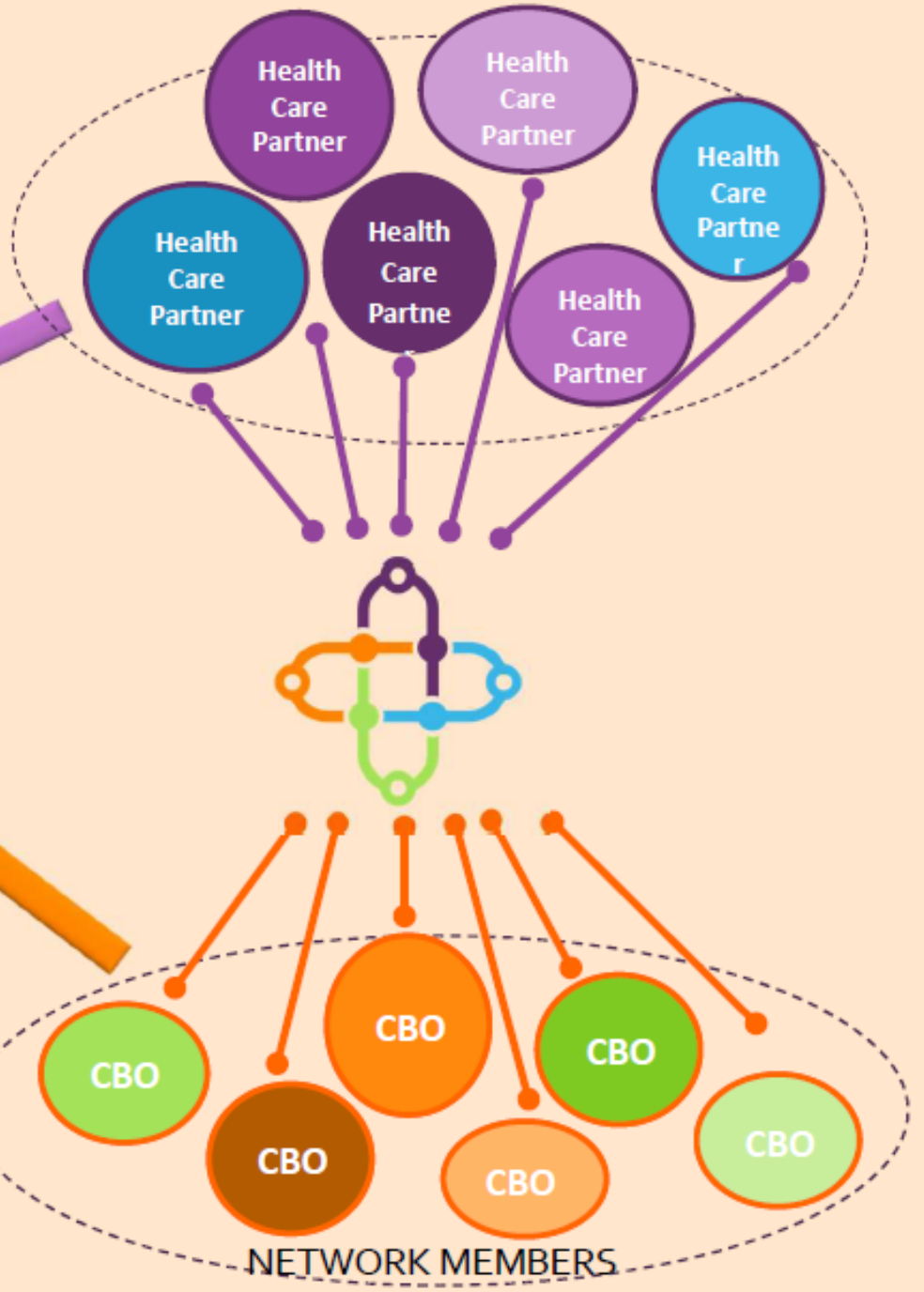
https//:wnyicc.org

**Patients / Community Members**

- Better Quality of Life
- Improved Outcomes
- Reduced Healthcare Costs

Clinical Care Delivery

Delivery of Services Addressing Health-Related Social Needs




- Food /Meals
- Case Management
- Community Health Coaching
- Falls Prevention
- Chronic Disease Self-Management Programs
- Caregiver Support, Training, & Respite
- Health / SDoH Screening
- Diabetes Prevention Program (DPP)
- Transportation
- Housing Supports
- Nutrition Counseling
- Care Transitions
- Social Isolation Supports
- Care Coordination
- Community Health Integration services
- Child and Family services
- Legal services
- Benefit Navigation and more

## 120+ Network Members

- County-Based AAAs
- Independent Living Centers
- County-Based Health Departments
- 100+ non-profit Community Based organizations (CBOs)


WNY Integrated Care COLLABORATIVE

www.wnyicc.org

# Integrated Care – Mission and Vision

**Mission:** Better Health with Integrated Care.

Our service-provider network produces **better health** outcomes and quality of life by providing comprehensive, cost-effective, community-based **integrated care**.

**Vision:** To represent community-based organizations in providing sustainable, high-quality integrated business models for community-based programs and services proven to address social determinants of health.

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# Integrated Care's Evolution

**1**

**2014-2015**

-2 AAAs and 7 CBOs participated in ACL Business Acumen Learning Collaborative;

**2**

**2016**

- Incorporated as 501c3 non-profit corporation with 9 Voting Members

**3**

**2017-2018**

- Grant from Health Foundation of Western Central NY
- Hired 1st staff (N. Kmicinski)
- Became Medicare provider
- Executed contract for DPP/DSMES

**4**

**2019-2020**

- Contracts for Healthy IDEAS, Community Health Coaching, Meals

**5**

**2021-2022**

- 52 Network Members; 75% contracted to provide services.
- Contracts for Falls prevention and Caregiver Support

**6**

**2023-2024**

- Awarded John A Hartford Business Innovation Award
- Featured in White House Playbook to Address SDOH
- Awarded 1 of 9 Social Care Networks in NYS 1115 Waiver

**7**

**2025**

- Launching Social Care Network in Western NY.
- 120+ Network members and growing

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# **Integrated Care's** Role in the Network

| | | | |
|---|---|---|---|
| **Advocacy** | **Administrative Role and Network Strategy** | **Billing and Invoicing** | **Contracting and negotiations with health plans and payers** |
| **Compliance** | **Credentialing / Licensing** | **Reporting and data analysis** | **Medicare Supplier / Provider**<br>**Medicaid Supplier** |
| **Network Collaborations and Engagement** | **Outreach and Referral Processing** | **Technical Support and Health IT portal** | **Training Academy** |

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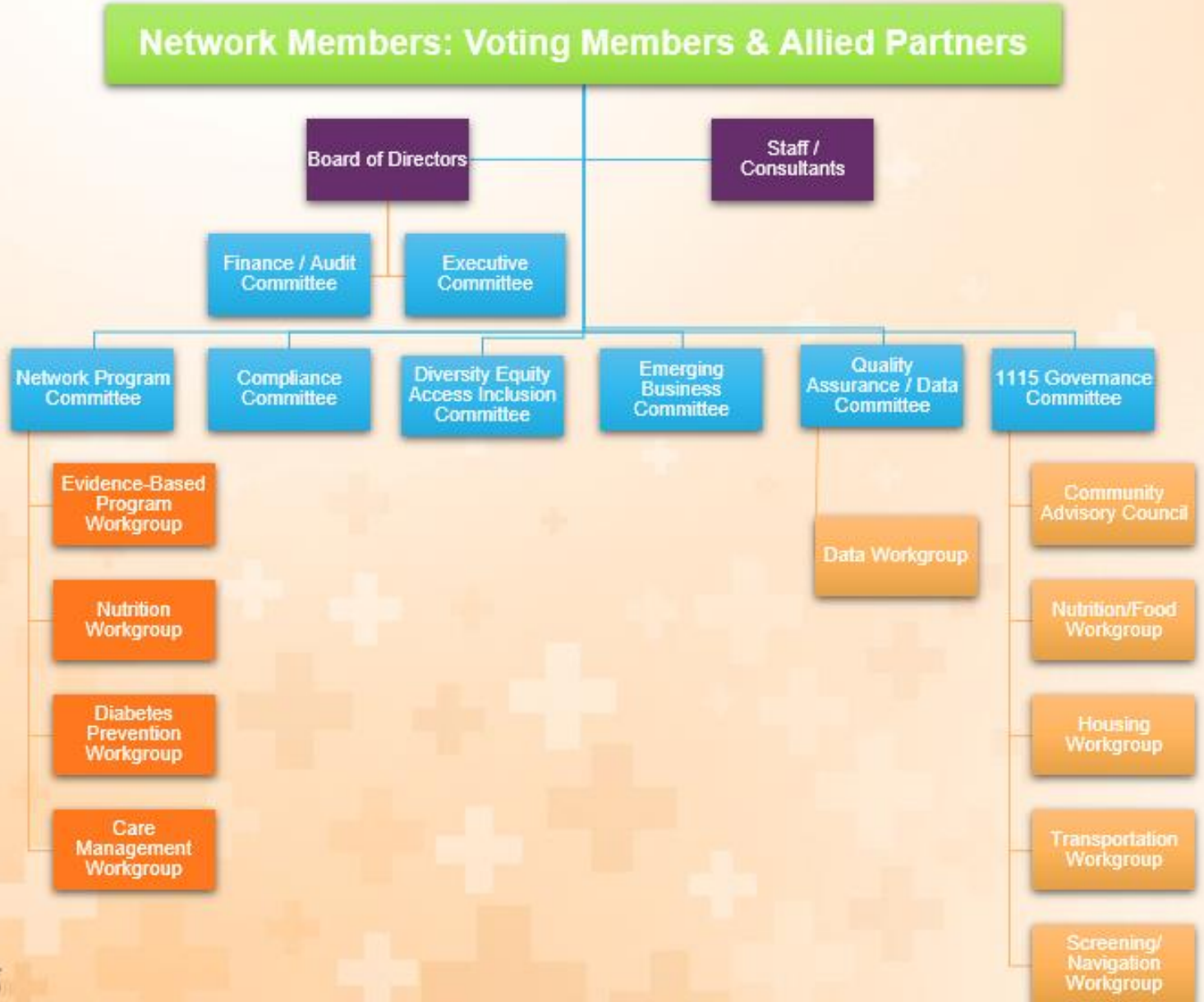
# **Integrated Care** Governance



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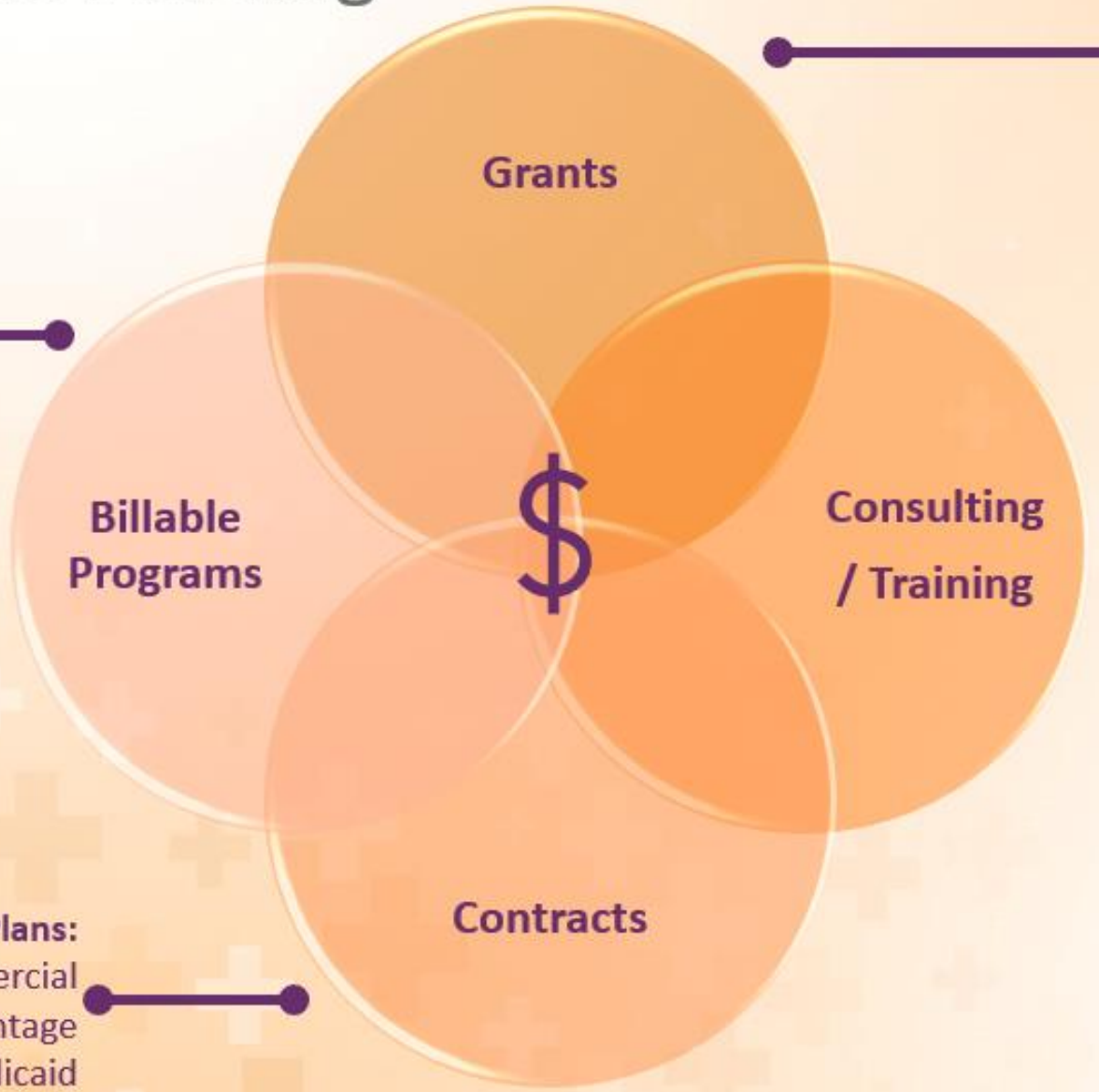
# **Integrated Care** Funding




**Local:** Foundations
**State:** NYS Office of Aging; NYS Dept. of Health
**Federal:** Administration for Community Living; Center of Excellence

**Medicare Provider**
**Medicaid Provider**
Diabetes Prevention Program
Diabetes Self-Management
Medical Nutrition Therapy

**Other CCH's**
**Master Trainers:** for Evidence-Based Programs

**Health Plans:**
Commercial
Medicare Advantage
Medicaid



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# Integrated Care's Health Plan Contracts

| Program | Funding Mechanism |
|---|---|
| Post-Discharge Meal Delivery Program | MA Plan Supplemental Benefit |
| Community Health Coaching | MA Plan Program, extension of case management |
| Healthy IDEAS | MA Plan Program, extension of BH case management |
| Falls Prevention | MA Plan Supplemental Benefit |
| Caregiver Support | MA Plan Program, extension of 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 MA Plan Supplemental Benefit for any other diagnosis |
| Housing Supports and Navigation | NY Medicaid 1115 Waiver program |
| Nutrition & Food Supports | NY Medicaid 1115 Waiver program |
| Transportation to HRSN Services | NY Medicaid 1115 Waiver program |
| Navigation and Enhanced Social Care Management | NY Medicaid 1115 Waiver program |

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# Integrated Care – Benefits of Network Membership

**Advocacy for CBOs and Network Members;**
**Pulse on national, state, local trends & policies**

**Strategy development to support Network**

**Health IT Portal and data reporting**

**Referrals to Programs**

**Compliance and Quality Assurance**

**Regional Coordination & Network Engagement**

Free To Join

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# **Integrated Care** – Benefits of Network Membership

**Free trainings through Integrated Care Training Academy**

**Earned revenue / Sustainability**


**Billing and Claims Submission**

**Ability to enter contracts with health care entities**

**Contracting / Negotiations** on behalf of Network

**Shared Services**

**Technical Assistance**



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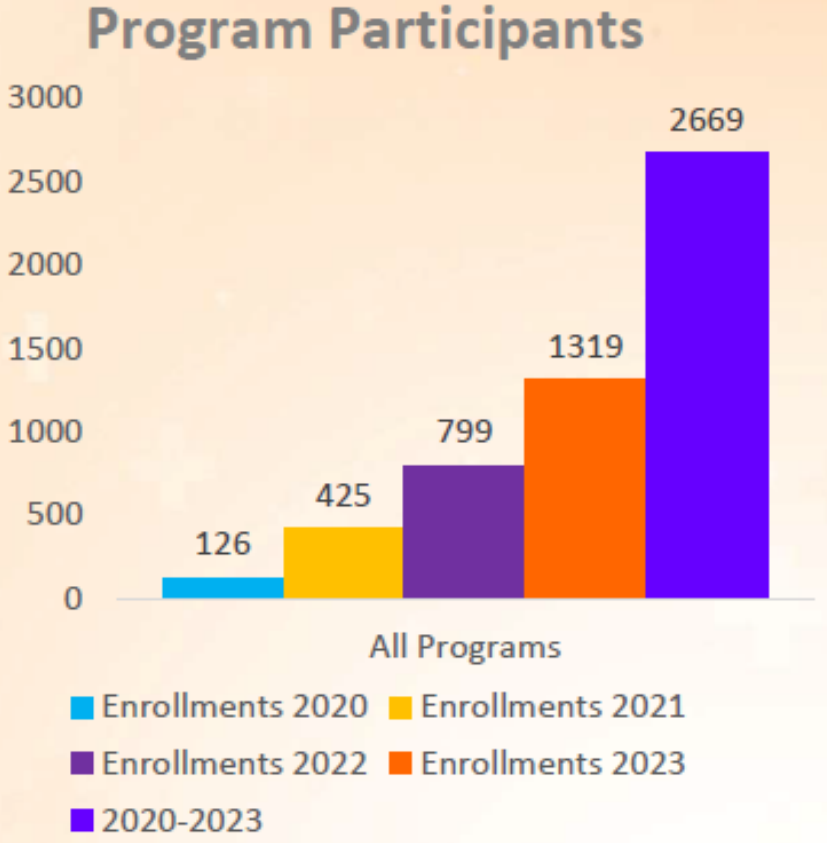
# Integrated Care – Reimbursements to Delivery Partners

- **97%** of Program Delivery completed by **33** community-based organizations
- <u>As of Dec 31, 2023</u>
  - **$520,661** paid out in reimbursements to CBOs
  - **102%** increase in 2023

# Integrated Care – Program Outcomes

- **Post-Discharge Meals Program**
  - **1795** Participants received meals 2022+2023
  - **46,094** meals delivered
  - **73%** report that receiving the meals helped prevent a re-admission.
- **Medical Nutrition Therapy**
  - **86%** of completers increased vegetable intake.
  - **90%** made changes in eating habits
- **Healthy IDEAS Outcomes**
  - **85%** of participants:PHQ9 or UCLA Loneliness improve score by 15%
  - **76%** of participants increased their physical and/or social activity through the program.
  - **8** referrals per client made to clinical providers: PCP, Mental Health providers or Registered Dietitians.
- **Community Health Coaching**
  - Average **8** Goals/Interventions per participant
  - **75%** High or Medium Priority Needs with goals to resolve
  - **92%** Resolved or In-Progress
- **Falls Prevention Program**
  - Average **40%** reduction in falls risks
  - **33%** assisted with PERS; **55%** developed MyMobility Plan

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# **Integrated Care** – Upcoming Opportunities

**NY State Health Equity Medicaid 1115 Waiver – WNY Social Care Network launching January 2025**

**Data Integration-** With Regional Health Information Exchange

Pilots with local clinical provider agencies to provide **Community Health Interventions (CHI), Principal Illness Navigation (PIN) & Care Transitions**

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# Panel Discussion