**NWX-HHS-AOA-1**

**Moderator: Lauren Solkowski**
**May 15, 2015**
**1:00 pm CT**

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode until the question and answer session of today's conference.

At that time, if you'd like to ask a question, please press Star then 1 on your touchtone phone. Be sure to un-mute your phone and record your first and last name clearly when prompted.

Today's conference call is being recorded. If you have any objections, you may disconnect at this time.

And now I would like to turn the meeting over to your host for today, Ms. Lauren Solkowski, sorry Ms. Solkowski. Thank you and you may begin.

Lauren Solkowski: Great. Thank you so much. And good afternoon and thank you, everyone for joining us today, for the Administration's Board community living business document Webinar entitled Tools for Building Housing and Healthcare Partnerships.

As the operator mentioned, I am Lauren Solkowski with the ACL and will be facilitating our Webinar. First on today's Webinar, we have invited colleagues from the LeadingAge Center for Applied Research to present on their housing and healthcare partnership toolkit in addition to a return on investment calculator which is a component of that toolkit.

The toolkit provides the resources and guidance to help providers of affordable senior housing and their healthcare partners to work together to improve health, safety and quality of life for housing residents. The ROI calculator is a tool that organizations can use to estimate the financial value of their housing and health partnership.

So before we learn more about that toolkit, I have a few items that I'd like to run though in terms of housekeeping. Starting with, if you have not done so, if you could please use the link that was included in your calendar appointment to get onto the WebEx so that you can not only follow along with the slides, the PowerPoint slides, as we go through them. But also you can ask your questions when you have them through the Chat function.

If you do not have access to the link that we emailed to you, you can also go onto www.Webex.com. Click on the Attend a Meeting button that is located at the top of the page. And then there enter the meeting number.

The meeting number for today is 662003987. Again that number is 662003987. If you have any other problems getting onto the WebEx, please call the technical support number. And that number is 1-866-229-3239. That's 1-866-229-3239.

Next, as the operator mentioned, all of our participants are currently in a listen-only mode. However, we do welcome your questions throughout the

course of the Webinar. So there's two ways that you can ask your questions. The first of which is using the Chat function.

You can enter your questions there. It’s located on the right-hand side of the screen. And we will sort through them and answer them once we open for the Q&A session.

And the second way to ask your question will be after the speakers have finished their presentations will be through the audio line as the operator mentioned. And when that time comes, she will give instructions as to how to ask you question.

If there are any questions that we cannot answer during the course of the Webinar, we will be sure to follow-up with you to get them answered. If you think of any questions, you can also email them to me. And actually I will, once we start the presentations, I'm going to enter my email address in that Chat box on the right-hand side for everyone's reference.

So, also as the operator had mentioned, we are recording today's Webinar. And we will post the recording, the slides, and a transcript of the Webinar on the ACL Web site as well as for the learning collaborative members that are joining us today, it will also be posted on the N4A Mltss network Web site.

And I will also enter that information in that Chat box so that everyone can see. You won't have to worry about scribbling that down.

Okay so with that, I think I'll go ahead and introduce and welcome our speakers that we have for today. Our first presenter is Robyn Stone. Robyn, is a noted researcher and leading international authority on aging and long-term

care policies and serves as the Executive Director of the LeadingAge Center for Applied Research and is Senior Vice President of Research.

Joining Robyn is Alisha Sanders. Alisha is the Senior Policy Researcher Associate for the Center for Applied Research at LeadingAge and Managing Director for the Center for Housing Plus Services where she works closely with Robyn. She developed the LeadingAge Center-for Urban Housing Infrastructure.

Also joining us today is Guy D'Andrea. Guy is the Managing Partner for Concerned Health. Which is a consulting firm focused on better health system performance especially through innovative measurement and payment systems that reward providers who patients achieve better overall health at a lower cost.

Some of their projects include developing performance measurement models for innovative delivery systems and designing shared savings payment approaches. So thank you all so much for being with us today.

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And with that, Robyn, I will turn it over to you.

Robyn Stone: Great, hi, thanks and welcome everybody. We are really happy to be with you today to share our toolkit which was wonderfully funded by the AARP Foundation. It is really the culmination of about ten years' work that our group has done.

For those of you who don't know LeadingAge, we are an association of about 6000 nonprofit aging services providers. And we run the gamut of very high end continuing care retirement communities to the poorest, low income senior housing properties.

About a third of our membership are actually low-income housing developers and managers. And they came to us because of a tremendous interest in helping low-income elderly residents age successfully in their communities.

So this has been a real joint effort with real, on the ground housing providers who we see as essential, a real essential and perhaps significant part of the community based infrastructure that you all work with.

I'm going to give you a little bit of background if we can go to the next slide please. We just wanted to give you a sense of why we would even want to pay attention to these folks.

They are poor with a median income as you can see of a little over $10,000. And they are also growing older. And many of you I know probably have worked with senior housing residents. And if we remember the origin of affordable, publicly subsidized senior housing, they were typically, young-old moving into these buildings.

Right now we've got a median age of actually in 2006, the latest data that are available, we had a median age of about 74 but almost a third-are over 80. And even the age move-in has gone up. The median is 70 but again, 14% are 80 and over. So this is a significantly elderly population also very diverse.

Only a little more-than a half are white. And you can see, there's quite a distribution depending on the geography and the region of various - very, very diverse populations living in these housing properties.

So if we can go to the next slide. You know, the reason that we got into this -- in addition to the fact that we had a lot of our own housing providers who

were really concerned about aging and community -- was with the tremendous expansion of home and community based services as well as the heavy focus on improving coordination and integration of services both on the healthcare side and the LTSS side, and finally an increased focus on dual eligibles which I know are many of the drivers for all of you out there, this seemed like a real natural fit.

And if we can go to the next slide, I can talk a little bit about that even more. A large proportion of the folks living in this housing are dual eligibles. And many of them are elderly, very elderly, and have significant functional as well as chronic condition problems.

So it just seemed natural that this might become a platform for actually helping to think about more formal coordination and care integration. The population trends coming together with the desire to age in community both at the resident level but also the housing level because it's very difficult for your typical (palser) to actually evict someone.

Fair Housing allows residents to stay and of course there are few alternatives for a low-income person. So an eviction is not a simple thing. Not only is it an ugly process but also is particularly problematic when there is no other place for a senior to go. There are not many affordable assisted options and, you know, the one last option, of course, is if functionally eligible, a move to a nursing home.

And then finally the sort of drive for the Feds and the states who are really looking at enhancing community options, improving the health outcomes of people and that includes both health and quality of life. And obviously, a heavy focus on efficiencies and lowering costs particularly for the Medicare and Medicaid programs.

And I would argue also that with the focus on social determinants of health and population health management that housing where you've got tremendous economies of scale and large numbers of folks who are at risk that this is a great place to shine a light. So this all sort of boils down together to the synergies for advancing new models and strategies.

You can move to the next slide. So the value, I talked a little about that. But here, we're really talking about building on existing infrastructure. Where we've already got affordable senior housing, where we have health and supportive networks many of which you provide in the community. And a high concentration of pretty high cost, high risk individuals including many duals.

The economies of scale cannot be underestimated. It is wonderful to have a community living in such close proximity where you can actually get these delivery efficiencies for the providers and make services really more affordable for seniors.

Providers also have access to the residents and the residents have easier access to services which we believe and there's some at least anecdotal evidence that this kind of a platform actually allows for more resident engagement which may encourage greater utilization, appropriate utilization and follow-through and compliance on the provider side.

There's a regular staff presence particularly given the fact that many of these buildings already have a service coordinator on site. So there is staff presence that can really help with knowledge of the resident needs and resources that are available.

Building trust with the residents which is really key, I mean these folks particularly lower income are vulnerable and sometimes suspicious. And the need to really have this trust factor also can't be underestimated and then finally, early recognition of potential issues before they become costly crises. So in essence we're talking about the value of this housing plus services strategy that ultimately helps preserve the seniors' autonomy and independence.

Next slide. The picture of health, you can see this is data that we actually gathered together with the Lewin Group. We have had a federal contract to merge HUD data, HUD administrative data, for the years of 2007 to 2009 with Medicare and Medicaid claims data for low-income subsidized housing properties in 12 jurisdictions around the country.

And these data definitely affirm all of the assumptions and the sort of rationale for why low-income housing may be a really good platform for this type of coordination. You can see that the duals is 70% in HUD assisted housing on average. This is a very high percentage and really shows the potential for states and for integrated care plans and what have you to think about housing as a great place to perhaps partner with.

You can also see that these are very chronically disabled folks. Much more disabled, by the way, and chronically ill then even their counterparts who are duals who are living in the community not in assisted housing. So this again, means that if you want to get the goals, the triple end goals of health, and you want to talk about population health management, this may be a really good place to start. Next slide.

This is just a more detailed overview of some of the data that we have uncovered through our merged database. You can see that the average

Medicare PMPM is also higher than unassisted duals. And if you look at the utilization patterns you can also see that there is a higher utilization rate for many of these services.

So if we move to the next slide, you can also see that the same holds true for the Medicaid PMPM and for use of some of the more long-term services and supports including personal care services and other home and community based services. Next slide please.

I'm going to turn it over to my colleague, Alisha Sanders to talk a little bit now about what actually goes on in these properties. But just to summarize, we have a high risk, elderly population, large proportion of duals, some infrastructure in an environment that provides economies of scale to think very formally about making partnerships with the healthcare world as well as the social services world.

Many of these relationships, by the way, have already been in existence on an ad hoc basis. So the goal of these models is to actually formalize them.

Alisha Sanders: Great. Thank you, Robyn. So I'm happy to jump in here and tell you a little bit about the research that we've been doing in this area and looking at the potential effectiveness of these kinds of strategies.

And Robyn is still sitting here beside me so I'm sure you're all hear from her again. So with that dataset that Robyn just discussed, we originally hoped to be able to look at the effect that service enrichment in a property could have on those residents Medicare-Medicaid utilization costs.

And we weren't able to do that with that dataset because there's no data on the services available in housing. But we were lucky to get a grant from the

MacArthur Foundation that allowed us to build on that study. And so we surveyed those about 2000 properties in 12 jurisdictions, as Robyn said, about the services that were available on the properties in 2008.

So we had to go back to the same year that our data was from, our Medicare-Medicaid data was from. And we asked them about a range of services, a range of service related questions on their property. And I'm just going to highlight a few things for you about the kinds of staff and the types of services that they had available.

So on this slide you can see that a good portion of the properties surveyed had service coordinators available. And just in case there is anybody out there that's not familiar with the service coordinator, this is a role that's based on the property, onsite, that is there to help residents identify, and access, and to connect with services. And they develop very strong and knowledgeable relationships with the residents.

So a little over two-thirds have service coordinators and about a quarter of the properties had activities, and of course a much smaller portion had nurses. And then about 25% of the respondents had no services staff. And you can also see by that pie chart upfront that some properties had multiple staff in different combinations. But still the most common was to have just a service coordinator, a little under half of the properties. Next slide, please.

And then we asked people about the type of services that they had available in their property. You can see from this chart that we asked about them about 13 or so different properties -- excuse me -- services. And the most common was social and recreational activities.

We also saw that it was pretty common to have health education and health screening services available onsite. And sorry, I should have clarified upfront, what we asked about is services that were available onsite purposely to the residents. So not services that residents got referred to out in the community but were available onsite.

And then you see a good portion of properties also have exercise and fitness activities and transportation related assistance. And a smaller portion have there's more functional and health related services available onsite. So next slide please.

So what we did was we merged those two datasets together to see if we could see an association between having a services available onsite and the resident's Medicare-Medicaid utilization outcomes, certain outcomes, in their Medicare-Medicaid costs. And this is preliminary data. We're just wrapping up this analysis right now.

But I want to clarify that what we are looking at here is just the association with services. We don't actually have utilization data. So this is kind of a higher level look. Which we think is even more significant is that we're seeing association when we don't know who in the property or what portion in the property are using the services.

So we looked at some primary, some high level outcomes areas. We looked at ER visits a couple of different ways, acute care stays, office visits and then Medicare-Medicaid expenditures. And you can see, I won't go through each one of these for you but you can see where the availability of those services onsite increased or decreased those particular outcomes we looked at.

So we saw quite a bit of services that decreased some of the areas that we would be helping to affect. So you can see that the presence of a service coordinator helps decrease the odds of having at least one ER visit during the year. And then several of the services helped to decrease having a hospital stay over the course of the year.

And then of course there are a few that we do see increase either of these. You know, this is just associations and unfortunately we don't necessarily know a lot about why this might increase or decrease. We can speculate some things but some interesting and new data that we haven't had before. Anything to add to that Robyn?

Robyn Stone: No. I would just say, again, reiterate that I think because it's just availability of the service, we don't know. And for example, it may be that on the mental health side, why does it increase the odds of at least one acute stay? Well one could argue that if you add mental health services onsite that you're going to have more appropriate moves to the hospital of people with high needs.

Or that you might have a population with high needs and so you have these services available. I think the most important piece of this is that we are seeing some relationships. And that it underscores the need for us to understand a lot more what happens when people actually use these services.

The other thing is the strength of the exercise variable for us was quite interesting. That in at least three categories, the availability of exercise onsite had a strong relationship with decreasing hospital stays, decreasing the odds of at least one hospital stay, and also decreasing Medicare expenditures PMPM.

So, you know, I think this is a lot of food for thought as well as the role, the potential role, of the service coordinator as a strong association. These are only the significant statistical results that we put on this chart.

Alisha Sanders: Thanks. So Lauren, if we could go to the next slide. So we want to tell you about another evaluation we're currently working on. And this is an exciting evaluation for us because we are looking specifically at utilization. And this is a very rigorous evaluation where we have comparison groups.

This is an evaluation of the supports and services of at home program. Which is a care coordination model anchored in senior housing that was started by a housing organization and a group of their colleagues in Vermont. The basic model is that there is a housing based SASH onsite staff coordinator which is an enhanced service coordinator teamed with a part time wellness nurse.

And they are formally connected with a network of community based service providers that include the home health agencies, the Triple As, mental health providers. So they create this sort of interdisciplinary team.

SASH has been fortunate to link in with Vermont's statewide health reform efforts. And so they are formally functioning as extenders to the medical homes. And it is currently being supported through a larger Medicare demonstration. Next slide please.

So we are doing a three-year evaluation with our partner, RTI International, on this. And as I mentioned, we are comparing SASH participants to two groups. One that is in state and one that is outside of the state and not participating in the Medicare demonstration.

And we have done our first year analysis. And the first year results show that SASH is bending the Medicare cost curve. So we found that the growth in annual total Medicare expenditures was about between $1800 and $2200 lower for the SASH participants than the two comparison groups.

And we have another couple of years of data coming out. And actually we'll continue to look at the evolution and the impact that the program is having. Next slide please.

And then I just want to tell you about one other model quickly that we have some data on. This is a partnership between an affordable housing provider and a health system in Harrisburg, Pennsylvania. What they have established is a weekly onsite clinic.

Where Pinnacle Health, the health system, sends a physician and a nurse navigator, a medical social worker to operate the clinic and then the nurse navigator is really working with the residents all throughout the week. It's really basically a care navigation program.

That they're focusing on those high utilizers to help them identify the barriers to care and help them get through and use the healthcare system appropriately. But they will help any resident in the building. And they identify people through the health system's HIE to allow them to know who to connect with and who to follow up on. So next slide, please.

So I just wanted to show you the drop in the number of ER visits and inpatient visits they have seen through this program. So when they started at the address for the property they had, in the past year, they had 81 ER visits and 57 inpatients stays.

And in their most recent look at the last six months, they dropped down to 11 ER visits and five hospital stays so pretty significant drops in both of those areas. Next slide please; are you doing this part?

Robyn Stone: Oh, I don't know. We hadn't decided who is doing this part. I guess I could say why now.

Well we've already talked about this really which is that this is really about thinking how we link long-term care reform and health reform efforts at the national and state level with affordable housing. And think about looking at the triple aim particularly for vulnerable populations.

And as important as the high risk piece and the super utilizers, we actually believe that the value of affordable senior housing is around the population management perspective which is in senior housing, yes, you have high risk people but you also have mid risk and lower risk people.

And so you can be managing the entire population. Which, you know, if there's large enough volume, is actually very appealing to a local, accountable care organization, managed care plans potentially, other types of integrated models. And we have a fledging group of housers who are working with healthcare in a number of different ways across the country.

So there are quite a few examples. The question for us can the business case be made in different parts of the country? And then what's the replicability process and the sustainability process? And next slide.

So the population health piece is really both the high risk, low risk and we say mid risk, particularly around timely preventive care. Most of these housers that are working with healthcare are also doing a lot of group health

education. A lot of evidence based practices around things like chronic disease self management, exercise, fall prevention, depression screening and intervention.

So again, it's the economies of scale that allow you to get access to a lot more people than you would just having needles in the haystack in the community. And then improved care coordination and finally reduction in the over utilization of expensive services. And I would say appropriate use of other services.

We did see an increase, for example, in the potential for increase in some long-term services and supports for example. And it may be that those are appropriate usage. And I think we're going to need to have policymakers who understand this isn't always just a total reduction in everything. That it's more appropriate use for the right reasons. And next slide.

The benefits, concentrated population, I think we've already gone through this. The other thing that I would add is that the physical and personnel infrastructure is important. Not just that you've already got service coordinators in about 70% of these properties but you have physical space.

You always have some common space. You have the ability of folks living in apartments next to each other to look out for each other. To be peer mentors as well as to have oversight. And, you know, that physical aspect cannot be overestimated.

And then finally, the next slide is the challenges here are managing chronic illness, really looking at the smooth transitions, minimizing the re-hospitalizations. Addressing medication complications, this was a big one for us.

What we have found both in the data as well as our case studies is that there are tremendous poly pharmacology issues in these buildings, particularly because this is a lower income population. There are also behavioral health issues here.

And so the real ability to actually manage medications better is a very positive attribute of housing as a platform. And then again the patient engagement which we think can be increased because of the economies of scale as well as the potential for really addressing the nonmedical social determinates of health and targeting super utilizers while still recognizing that there is room for intervention with lower risk populations.

So in conclusion, this is in the toolkit. So most of what we've gone through is laid out in the toolkit. And what we really are highlighting in this toolkit -- it's a pretty hands-on tool -- is understanding healthcare reform. Why housing and healthcare should work together.

How do they actually collaborate? What are the tools? How do you identify and cultivate a partner? And how do you actually structure the partnership. And so you're going to hear about the ROI calculator. We also have a series of videos that talk about the value of this.

We have some really nice videos of some healthcare providers who are working with housing. And also there's a whole set of resources that can be available to you.

So if you are a houser, this is fabulous. If you're not a houser, we believe this toolkit is just as relevant to your needs. And it may also help you to think

about how you might bring housing as partners into your plans for serving as a CBO in a particular community.

And all of this is on our Web site. So thank you. And now I think we are going to turn it over to Guy.

Guy D'Andrea: Thank you. So hi everybody, this is Guy D'Andrea. And I'm going to pick on the conversation that Robyn and Alisha have started. They've described from the housing provider perspective some of the opportunities and some of the innovative practices that are emerging around how to drive a better population health, better health outcomes, lower total cost.

And what I'm going to do in my presentation is spend a little bit of time addressing similar topics but really from the health system, healthcare provider perspective and some of the things that are going on in terms of overall health system improvement.

And then I'll try to connect the dots between what housing providers can do and what health systems needs. And illustrate how the ROI calculator we've developed with LeadingAge connects the dots and shows how these different entities can work together to drive overall system value and also results that are meaningful to the individual participants.

So next slide, just a brief background about Discern, we are a consulting firm as Lauren mentioned earlier. And we work with healthcare systems, and healthcare providers, and purchasers to try to define how we measure and then reward health system improvement through, you know, payment systems, through quality reporting, and scoring and so on. So next slide.

So I think the next few slides summarize some of the main trends in the healthcare space that we've been now, I guess, engaged in over the last 15 years or so. But that really have begun to accelerate in the last half decade. You know, starting in the late 1990s there was a lot of research that was starting to emerge around the performance of the healthcare system.

And we started to understand that in many ways the healthcare system not only -- the US healthcare system -- was not only very expensive relative to other countries. But also did not produce the health outcomes that we wanted. And that in many cases there were quality lapses where patients with chronic illness either don't receive necessary services or they don't get managed as they navigate through the healthcare system from one provider to another.

There were patient safety issues that were identified in hospitals with infection rates and so on. And so over the last 15 years, there's been a multilevel public and private effort to really to try to define and address some of these challenges in the healthcare system. And really take advantage of the connection between the quality of care and the cost of care.

And the recognition that by focusing on quality and focusing on getting patients the services that they need in the most efficient setting, hopefully before they have an acute exacerbation or other complication, we can improve quality and we can also reduce costs. And so, you know, now we're really starting to see those effects propagate through the healthcare system.

And so for example, we've gone from basically no NCQA recognized medical homes, patient-centered medical homes, to, you know, well into the thousands. And that is a number that continues to grow.

So if you're not familiar with this concept, the medical home is a primary care physician practice that takes a much more proactive role in managing overall patient health and tracking and reaching out to patients who might need more support and management. Especially for patients who are either high risk or who have chronic disease.

We've also now over the last several years largely because of the influence of federal purchasing programs like Medicare, we've seen rapid increase in the number of accountable care organizations. Which are integrated healthcare systems that include primary care, specialty care, and inpatient care that are focused on managing population health. And I'll talk a little bit more about ACOs as we get farther through the presentation. Next slide.

So if you think about this journey that we've been on for the last 15 years or so, there's been quite a lot of evolution and innovation during that time. And in this slide I summarize that in terms of three generations of value based healthcare systems.

So the first generation which really started to gain momentum in the early 2000s was around trying to measure and drive improvements in health delivery processes. To a large degree, these programs were focused on the existing silos or structure of the healthcare system.

So we asked physician practices to report and get rewarded on, you know, measures of what they were doing. We asked hospitals to measure the care that they provided within their four walls.

But in that first generation, the focus is not really on the interconnections of healthcare. It's really focusing on each provider as a stand alone entity and

what they're doing when patients are receiving care, you know, directly from them.

The second generation of value based healthcare systems which, you know, really started to gain momentum about five years ago is one where we're starting to be more focused on healthcare outcomes. You know, are patients healthier? Are they avoiding complications? Are they enjoying better health status rather than only process measures.

But we're especially starting to see programs that are trying to focus on the interaction of different parts of the healthcare system. So that's asking primary care providers, for example, to be more externally focused and not just worrying about what a patient is experiencing when they're in the primary care physician's office.

But what happens to that patient when they are in getting treatment or getting advice from a specialist physician or as they navigate through the healthcare system? How can we reach out to those patients and engage them more fully in their healthcare?

And so there are a few different kinds of organizations that meet that description. The most important ones right now are accountable care organizations of which there are many varieties. And I describe them briefly. And then I already touched on patient-centered medical homes.

And then the third generation is where we move from medical care to really thinking about population health. And how do we integrate medical care delivery with all the other factors that influence the outcomes the patients achieve, the overall population healthcare costs and results.

There was a study or a report that just came out from the Institute of Medicine in the last couple of weeks that described our objectives for measuring health system performance. And it was very focused on broad aspects of the social outcomes of the healthcare process not just whether a patient in a physician office gets the right care in that moment.

But really, how do we measure whether the healthcare system is actually supporting better overall results in a broad, broad sense. So, we're just now starting to see organizations start to align themselves with this. And that's why I have those question marks in that example.

We hear terms like community integrated medical home. We're starting to see programs like the ones that Robyn and Alisha mentioned where medical care providers are aligning themselves with housing providers and other community resources to try to really manage overall population health.

So the way I would summarize these different generations of value based care, the first generation is really just asking providers, healthcare providers, to do what they do better. In the second generation, we're asking healthcare providers to transform how they deliver medical services to patients.

And then in the third generation that I think is starting to emerge and will start to gain momentum in the next several years, we're really asking providers to work with all of the other resources that affect patient health to transform population health management.

You can see in the slide that the dates that I've given for these generations, you know, different people would give you different dates, but you can certainly note that they overlap. And that's certainly true today. There are a lot

of medical care and a lot of healthcare that's still managed in a not even in a value based setting, right.

It's still in a traditional fee for service care delivery setting. We still have a number of organizations that are in that, you know, first generation description. And then a smaller number that are moving ahead to the second.

And then a very small number but hopefully a growing number that are looking at the third generation, population health management approach. And of course that's where housing providers do have an opportunity to really make a contribution. Next slide.

So as we think about value based care, we have to think about how to define value and how to establish expectations of the healthcare system. One of the reasons that this concept is starting to gain so much momentum is that large purchasers, private health plans, state Medicaid programs, but most especially the Federal government, have begun to move a larger portion of their payment to health systems to value based systems.

These are systems that tie payment to quality performance. They put providers at risk through various mechanisms for the results that they achieve. And the Department of Health and Human Resources have stated a goal to move most healthcare payment to alternative arrangements just in the next few years.

So, you know, all this change I've been describing that has taken place over the last 15 years is only going to accelerate in the next five to ten years. And again that creates an opportunity to create and form new partnerships between entities in the healthcare system.

Most of the alternative payment arrangements define value by creating some set of benchmarks, some set of quality measures that they expect healthcare entities to meet. Those might be adherence to evidence based guidelines for care.

They might measure patient satisfaction with care processes. They might look at reducing complication rates and reducing ER use, unwanted utilization. Typically the newer programs would combine a number of different measures across these different domains.

And then they would link that to the total cost of care for patients. And provide some incentives for a healthcare provider to reduce that total cost of care relative to a benchmark. And the specifics of how those benchmarks are set and how those financial mechanisms work, do vary from one arrangement to another. But these are the common themes.

And health systems that meet these goals can earn these payment incentives. So the overall goal here is to create a market mechanism that rewards improvement. That rewards quality and thereby will drive improvement, and quality and better outcomes in the system. Next slide.

So what we've done for LeadingAge is to develop a calculator that helps to quantify this definition of value. And connect that to what housing providers can offer specifically around the Medicare accountable care organization program. And I'll talk a little bit more about that momentarily.

But this calculator, as I'll demonstrate in a few minutes, is a tool that you can use first of all for ACO quality measures, right. So what are ACOs being held accountable for? To understand the potential cost impact of interventions that

might be based in a housing setting, to understand the implications of those on the overall cost of care.

And then how housing can impact both the cost of care and the results on those quality measures. Which we hope provides a foundation to engage with ACOs in a conversation about working together, helping to manage patient health, helping to improve results.

The calculator as I'll demonstrate it today is focused on Medicare ACOs. Because that's one of the more well defined and more common structures that we see in the marketplace right now. But the concepts that we'll discuss really could apply to a range of other accountable or value based healthcare arrangements. Next slide.

So just a brief summary, when we talk about Medicare ACOs, what we're talking about is typically an integrated network of hospitals, doctors, and providers that are in their delivery systems that have come together and agreed to share risks around delivery of care to Medicare patients.

These networks enter into a contract with Medicare to serve a defined population that has to include at least 5000 Medicare beneficiaries. The minimum is there because below that number, it's hard to manage risks because there's a lot of volatility with smaller numbers.

The population is defined through an attribution model where the patients that receive most of their healthcare that are in the ACOs would be attributed to that ACO. The ACO is then evaluated on a range of quality measures. And we'll get into the details on those momentarily. But they include domains around patient satisfaction, preventative care, care coordination, and so on.

ACOs in the Medicare program continue to get paid to submit claims and receive reimbursement from Medicare in exactly the same method as they have previously. But then, at the end of each year, they're eligible to earn a shared savings payment if their total population costs have gone up at a lower rate than the benchmark which Medicare sets looking at national trends in healthcare expenditures.

So if an ACO is able to take the population that it serves and over time, reduce, relative to trend, reduce the costs of that population, they can earn a shared savings payment. The shared saving eligibility though is also tied to their quality performance.

They have to achieve certain minimum quality results in order to be eligible to receive any shared savings. And then the actual shared savings is adjusted above that level based on how they do so the higher their quality scores, the higher their shared savings eligibility. So next slide.

So as you start to think about as a housing provider, how you can create value in a partnership with an ACO, and these are themes that Robyn and Alisha spoke to earlier, you need to ask yourself two interconnected questions.

First of all, how can you impact the ACO's results on its quality measures? Can you help them to engage with patients or get patients engaged with their care process in managing their health? Can you help to facilitate access to care by helping to schedule appointments or providing transportation? Or making sure that patients have a designated primary care physician?

Can you help to screen for health risks by, you know, observing patient health status by hosting screening events and, you know, other mechanisms? And

certainly in addition to these strategies, there might be other strategies that you could employ to impact quality measures.

And then you would also want to ask how can you impact costs by, you know, improving overall health status? Can you generate better health outcomes and therefore fewer complications of chronic illness, fewer hospitalizations, fewer unneeded ER visits?

Can you help to manage the social determinates of health? Again these are all themes that Robyn and Alisha spoke to earlier. And cited some research that's already out there that suggests in fact housing providers can have an impact on these kinds of results.

So at this point, if I could ask Lauren to turn the controls over to me, I'll pull up the ROI calculator and share a demonstration of that.

Lauren Solkowski: Okay I'm going to pull up the spreadsheet here; one second. And then I will email a link to try to turn the controller over to you. Okay, one second again.

Guy D'Andrea: While we're working on transferring the control, Lauren, could you click on the tab in the spreadsheet that says ACO measures and benefits?

Lauren Solkowski: Yes, one second. Okay.

Guy D'Andrea: So as we work on the controls, basically where I would really start in using the ROI calculator is on this tab that lists all of the various measures that a Medicare ACO has to report and has to be accountable for which then affects their performance under the Medicare Shared Savings program.

Okay and I think I've got...

Lauren Solkowski: And Guy before you start, just really quickly, for the participants, if the Excel you are seeing is, you know, small, there is that toolbar that's on the right-hand side of your screen that you may be seeing that says Participants, Recorder, there's a couple of other options there.

If you click on Participants, it will minimize that toolbar screen. And you should be able to see the three Excel spreadsheets in a larger view. Okay, thanks Guy.

Guy D'Andrea: Thanks Lauren. So this tab and this spreadsheet lists the different measures that Medicare has included in the ACO program. And you can see that for each measure there is the domain that that measure is in. There's some information about how the measure is collected, the type of measure. And then a description about what that measure is focused on.

And really what I think you will want to do to begin is to ask this question of yourself, what can your housing do to provide better results on this measure? As Alisha was describing earlier, there's a lot of variation in the various services that housing providers have available onsite.

So each housing provider has to do an assessment of what they provide onsite, what they could provide. And ask this question, can we help an ACO do a better job of, for example, helping their patients get timely care? And if the answer to that is yes, what specifically could you do to help them achieve that?

Because as you go through the questions and, of course, some of them are more focused, as we mentioned care coordination, on preventative health. So,

you know, getting flu vaccinations for your residents is a way that you can help them be healthier but also help the ACO meet its quality expectations.

You know, going through this list and really think about qualitatively what can you do to help the ACO be successful, I think is the starting point for that conversation and for building a partnership with them. So that's really where I would begin your own self-assessment.

Then in terms of using the calculator, what you could do is look at the measure scoring tab. And so here, what you're basically going to quantify on this tab and I'll shrink it down here for a minute is what the ACO's performance would be without you, without your support. And then what it could be with your support.

So it's really taking that qualitative analysis which I just described earlier where you're looking at the list of measures and you're thinking about which of those measures you can impact and how you would impact them. And then in this spreadsheet or this worksheet, you're starting to take that information and try to put it in a quantifiable framework so that you could start to calculate the impact of your collaboration with an ACO.

So in terms of the steps for this sheet, you would first of all want to look at which performance year the ACO is being measured for. And this is something you'll have to get from the ACO. So ACOs for Medicare enter into a three-year agreement with the program.

Depending on the performance year, the actual requirements and the quality benchmarks do change. So depending on which you select, which performance year they're in, that will influence the scoring and therefore the outputs of the calculator.

You'd also want to find out from the ACO which shared savings tract that were on. There's basically a one-sided model in which the ACO can only get savings but can't have losses. And then a two-sided model which is less common where they're at risk, they have more upside but then take on some downside risk. Most of the current ACOs are in the one-sided model.

So then in terms of the quality measure results, that's the summary. But the next step to use the spreadsheet is to basically input the ACO's actual or expected performance on each of the quality measures.

For Medicare ACOs this is actually publicly available information. Medicare does post the results of the various quality measures for ACOs. Here, we've put in placeholder data. And it's important to observe for some measures, a higher score is better. And then for some measures, like readmissions, a lower score is better.

But you would put in the ACO's current performance. And then perhaps most importantly, you would estimate your projected impact of housing provider interventions on those scores. So, you know, for those measures where you don’t actually think you could have an impact because of the kinds of services you provide, you might, you know, you could zero out the impact.

But in other areas where you think you can have a substantial impact, you could quantify that. You can also test different values and see, okay well if we are able to have a large impact, the results would be X. If we have a smaller impact the results would be some fraction of X. So this is a way to test different scenarios as well.

So if you have the ACO's current performance and then estimate your impact on that performance then the calculator looks at that result. And then summarizes that on the performance with and without housing.

Now in the performance, Year One, you can see that without housing the score is actually higher because in Performance Year One, it's all about reporting.

But in Performance Year Two, with these values that we entered into the calculator as default values, you can see what the quality score would be without housing and then with housing and how it goes up and most importantly in this example, that it would actually make a difference in terms of the eligibility of the ACO to receive shared savings payments.

And for the ACO, of course, that is a very important result. Because if they're not eligible for shared savings payments then it doesn't matter what financial result they achieve, they wouldn't receive that payment.

So in the first tab, we look at the measures and we started to think qualitatively where can housing have an impact. And again, for each individual housing provider, that will be an answer that depends on the services that they offer.

Then we try to quantify that impact by looking at the scores on measures and the potential impact on the score impacts due to the housing provider collaboration and intervention with the ACO. And then finally that all rolls up to the ROI calculator.

And this ROI calculator is focused on the perspective of the ACO. So what's the ROI to the ACO of working with a housing provider to achieve these

results? So one of the things you need to think about is for the significant drivers of cost, hospitalizations, readmissions, and ER visits, what are the current rates that the ACO is experiencing, and what impact can you have for your population on those rates; right?

So if you can, you know, generate a 2% reduction in hospitalization for example. And think back to the slide that Alisha shared earlier about the results from the Presbyterian health program in Harrisburg where they were able to achieve very significant decreases in both hospitalizations and in ER visits.

So here you're looking at those possible reductions and then quantifying the costs before and after those interventions. So that then can then propagate through the calculator.

The calculator also looks at the impact on the shared savings eligibility for the ACO based on the change in the improvement in the quality scores that you can help to generate. So in this case, in this example, given the data that are entered into the calculator, as we saw earlier, the shared savings eligibility without housing was 0%. And then with housing was almost 2 1/2%.

So then clearly that then flows through to the shared savings payment that the ACO could receive. That's money that they wouldn't have gotten otherwise. And then that flows through to the ROI calculation.

So the overall results look at the costs that you're asking the ACO to invest in the intervention, right. So this program investment is essentially your costs that you're asking the ACO to support. And then by looking at your population, the ACO's total population, the average cost of care, the possible

impact on utilization through the care improvements that you would help the ACO to implement, we can estimate an ROI for the ACO.

Now in this case, the direct savings are actually because the ACO is not eligible for shared savings without improving their quality scores, there would be no shared savings directly. But then when you factor in the impact of the improvement in their quality score and their shared savings ability, there is a positive ROI.

And, of course, where the programs are already eligible for direct savings that number increases and I can show an example there. So where the shared savings eligibility was already there without housing then the ROI with housing actually increases pretty substantially because there's that much more payment available to the ACO.

So just to summarize, the way that we use this calculator, it's to think about which measures you can impact to try to quantify the potential impact on those measures. And then to connect that impact to the financial outcomes for the ACO both in terms of their direct savings through reduced utilization as well as their increased shared savings eligibility through improved quality performance.

And while again, this is built around the Medicare shared savings program that basic concept could apply to any accountable care arrangement or any other health system that is subject to value based purchasing incentives that you might be seeking to form a partnership with.

If we go could go back to the slides. There's one more slide which I think just summarizes what I described. Thanks.

So in terms of using the calculator, I think the first use is really about just developing a framework so you can help understand from the ACO's perspective what is going to drive their results in a shared savings program. And so that you can frame the value proposition to them and think about the services that you might want to offer to them in the context of the incentives that apply to them.

If you have the necessary data or if you can make some assumptions about those data or test different assumptions, you can use the calculator as a way to look at possible quantitative results. And then going forward, you could use the results of the calculator and the framework as an evaluation model.

So if you said to the ACO you think you can impact a certain set of measures, then that is a set of measures you might work with the ACO to track over time to connect to the interventions that you've implemented to continue to refine and improve your model.

So at this point, that's the demonstration and sort of the overview of the calculator. I'll turn it back over to Lauren to facilitate the Q&A.

Lauren Solkowski: Excellent. Thank you so much Guy and thank you to Robyn and Alisha for excellent presentations.

So yes, now we would like to open up the lines for Q&A. Operator, if you could please provide instructions again for asking a question through the audio lines?

Coordinator: Absolutely. At this time, if you would like to ask a question from the phone line, please press Star then 1 on your touchtone phone. Be sure to un-mute your phone and record your first and last name clearly when prompted.

If at any time you decide that you would like to withdraw your question, you may do so by pressing Star 2. Again if you would like to ask a question, please press Star 1.

Lauren Solkowski: Thank you. So while we're waiting for some questions to come in through the phone, I will ask a question that came through the Chat. And Robyn and Alisha I think this is directed towards you.

So the question is that the Oasis Institute works with many affordable senior housing organizations to deliver their evidence based programs. One of the large challenges is getting enough participants to come to the group workshops or to have the group workshops.

Are there any thoughts in terms of motivating and/or recruiting participants for those deprived from working with the service coordinators?

Robyn Stone: You know, I don't think there is any magic in engagement. You know, I think we have a couple of providers that are trying to work through -- and this is actually more not empirically based at this point -- but have been looking at the PAM, the patient activation measure, and both that tool as well as its coaching mechanism.

And I think what it adds to some of the folks that are doing evidence based practice is it starts with a screen around level of engagement. So that, again, you have to get people engaged to even do the PAM. But I think, you know, if you can get enough people to get engaged with a process. And we have found in many of our housing properties where folks are actually doing standardized assessments that elders really like that.

So it may be starting to engage people around an assessment process where you use the PAM as part of that to then identify sort of the levels of engagement that you're starting with. And maybe that's where you begin to, you know, sort of target.

You know, I don't think there is any real answer to this. But we do think that one of the problems that housing properties have and in their partnerships with evidence based practice is that they don't really know their residents. They may think they know their residents because their service coordinators see a few of them.

But the models of housing with services that we are working with have standardized assessments and so they are getting their residents engaged as part of developing healthy aging plans, working on their specific needs and goals. And, you know, this begins to build more of a trust and an engagement then you would if you just came into a property that really didn't have any clue about their residents.

It is a much more intentional process. I wish I could tell you that we've done evaluations of this so that we know it's working. We don't. But I think anecdotally and Alisha can speak to this as well, in the case studies that we've done, the more that there is standardized assessment, and buy-in, and working with residents to think about their healthy - their plans for a healthy aging, the opportunities may be there to engage.

Lauren Solkowski: Great. Thank you, Robyn. Okay. So I'll switch back with the operator. Have we had questions come in through requests?

Coordinator: At this time, I'm showing no questions on the phone line.

Lauren Solkowski: Okay thank you. We haven't had other questions comes in the Chat. In the meantime, we'll give it a few more minutes

I wanted to let the participants that are with us in the learning collaborative know that in terms of the next, our next upcoming Webinars that based on some of the information that we're learning from email as well as the information that, you know, is shared during the recent April in-person meeting, we are working on scheduling the topical Webinars on some of those things that we've heard for the summer, for June, July and August.

And we'll have more information on that very soon. So I know I'm switching around the topics. But in a little while we will be sharing, you know, more specifically what those topics are. I just wanted to mention that your thoughts to be (unintelligible).

And also again, just as a reminder that, earlier, Guy did an excellent presentation on the calculator and it was a lot of information. But then again this presentation is being recorded. So we will have the transcript as well as the audio companion of that available as well as these slides, again on our Web site and on the N4A Web site, if you have rights. Any of those materials (unintelligible) just send me an email and I am happy to share them with you.

Can we check back, I don't think we have...

Coordinator: Excuse me, we do have a question on the phone line.

Lauren Solkowski: Okay. Go ahead.

Coordinator: That question comes from (Mike Collier), your line is now open.

(Mike Collier): Hi this question is directed to Guy. And here in Vermont, a lot of the discussions and the meetings that I've been attending have already started to shift attention towards the next gen ACO application process that CMS has announced.

So even though we haven't finished Year Three of the current ACO, two things are going on. Both the state and the ACOs are really looking ahead to what the design of the next version would look like if they were to be selected. And for some of the same reasons I think, the biggest of the three ACOs that we have in this state, is not actively courting network participants or partners.

At least partly I think because they are trying to figure out sort of strategically what partnership relationships they want to have in sort of ACO 2.0. You know, on the one hand, I think the ROI calculator is just a really excellent presentation and something that even as I was watching Guy go through it, we probably want to do some follow-up and ask some more questions.

On the other hand, I'm wondering whether some of the assumptions are likely to change as CMS moves in the direction of next gen?

Lauren Solkowski: Guy, I don't know if you're responding. You might be on mute.

Guy D'Andrea: I think I was on mute.

Lauren Solkowski: Okay. I was on too, it looks like.

Guy D'Andrea: Well what I was saying is that you're right that as the different programs get implemented and updated over time including the next gen program, that the underlying calculations that are illustrated in the calculator, as I demonstrated it will change.

But I think that the basic framework for thinking about value will still pertain. And well as an exercise in trying to define value, I think the calculator is still useful. Looking at that list of measures, Thinking about how as a housing provider, you can impact those results. I mean all of that will be relevant under any accountable care arrangement.

Thinking about how those innovations that you can implement would flow through the utilization and cost results for an ACO all that still is going to be very relevant.

And if you're in a mode that you described where the ACOs are waiting until the next set of rules come out, I think you can still engage in some of the evidence collection and assessment that you would need to do around these broader themes of value based care and population health that would position you to have those conversations when they're ready.

(Mike Collier): Thank you. Those points are well taken.

Robyn Stone: Can I just say one other thing; this is Robyn. And this may be for other folks on the phone who don't have an ACO in their area. And that is that this framework, you can think about those indicators as ways to have a discussion with your healthcare potential partners in terms of what they may be looking for.

So you may be talking to a health plan that is managing duals for example. Where, you know, they have a set of indicators. Some of them may be similar. Some of them may be different. But I think we thought about this and Guy can add on or whatever. But not just as an actual numbers cruncher.

But as a way of framing your thought processes around value and also then having discussions with survey partners. Who may have, you know, may have some of the same indicators but there may be different goals. And those goals could be plugged in.

And then, you know, you need to figure out either empirically or through what evidence base there may be in the literature. We have worked with Guy around making the case for example for housers from some of the literature that is already out there. That is demonstrated outcomes for certain kinds of practices. And so really this is a tool. It's a tool to use regardless of whether you're working with an ACO.

Lauren Solkowski: Okay thank you. Oh, go ahead.

Coordinator: I'm sorry; at this time there are no additional questions on the phone line.

Lauren Solkowski: Okay thank you. And I just wanted to - someone had let me know that it was difficult to hear what I was saying earlier. So hopefully this will come more clearly.

I essentially was just saying that if, you know, I know that we have had a lot of excellent information shared today. But, you know, that just a reminder that the Webinar is being recorded. And that we will have a transcript as well as the audio recording available online at the ACL Web site and the N4A Web site that I posted links to those in the Chat box on the WebEx.

But if you would like access to those as well as the PowerPoint slides before they are posted live, just send me a quick email and I'm happy to share those with you in advance before they're posted.

So I'm checking one more time to see if we have other questions in the Chat. I'm not showing any other questions. I'll check one more time with the operator for audio questions.

Coordinator: There are currently no questions from the phone line.

Lauren Solkowski: Okay thank you. Well with that, I just wanted to thank our speakers again for presenting and joining us today. And thank you, our participants, for your questions.

Again, if you think of any other additional questions after we hang-up, please feel free to email them to me. And I think with that we will conclude today's Webinar. Thank you so much again for joining us today on a Friday afternoon.

And I hope everyone has a nice rest of the afternoon and also enjoy the rest of your weekend.

Coordinator: Thank you very much for your participation in today's conference call. Participant lines may disconnect at this time.

END