# LTQA Annual Member Meeting

**June 23, 2021, 2:00 – 4:00 pm ET**

**Event Summary**

## LTQA Annual Member Meeting 2021

LTQA hosted its annual meeting on June 23, 2021. The event featured opening remarks from Carol Raphael, the chair of the LTQA board, followed by a vote on the re-election of two board members, introductions and sharing of priorities by attendees, and presentations on an integrated housing and healthcare model as well as the work of Inclusa, Inc.

## Opening Remarks and Board Vote

Carol Raphael, the chair of the LTQA Board, shared brief remarks to begin the meeting. She noted how the past year has highlighted the importance of a well-functioning LTSS system as well as the need to create opportunities for social connection. LTQA is in a unique position to leverage the experiences of health plans, payers, states, , providers, and advocacy and consumer groups to drive consensus on how to create a delivery system that will meet current and future needs. Ms. Raphael asked attendees to keep three questions in mind during the meeting: How do we know what's working? How do we identify effective strategies to scale successful models without losing what makes them work? Where are the greatest opportunities to come together to strengthen capacity and integration of the (?) LTSS system?

Ms. Raphael then led a vote regarding the re-election of Camille Dobson and Terry O'Malley to second terms on the LTQA board; both were re-elected.

## Introductions and Priority Sharing

Attendees introduced themselves and shared their organizations' current top priorities. Key themes of these priorities included:

- Potential uses of the enhanced FMAP funding, including workforce development and integrated care
- Ensuring the inclusion of LTSS in the upcoming federal infrastructure bill

- Biden administration's proposals around paid family medical leave
- Supporting and developing the direct care workforce
- Advancing integrating care and coordination for individuals who are

- dually eligible for Medicare and Medicaid
- Equity in LTSS and ending institutional biases
- Expansion of HCBS options for LTSS recipients
- Maintaining access in rural communities
- Extending services to individuals who are not yet eligible for Medicaid
- Increasing the options for receiving non-medical benefits within Medicare
- Measuring the quality of HCBS
- Protecting the rights of individuals living in nursing homes
- Long-term care financing reform
- Developing business acumen related to long-term care
- Creating innovative care models

## Support Services at Home (SASH™) Presentation

Pat Polansky of the Center of Champion Nursing in America, an AARP and Robert Wood Johnson Foundation initiative, introduced Stefani Hartsfield, a consultant to the National Well Home Network to discuss the Support and Services at Home (SASH) model.

*About the National Well Home Network*
The National Well Home Network is committed to support and promote proven housing-based health and service models to build long term services that facilitate high quality, efficient and effective healthy aging at home with partnerships between health care providers, payers, public health, housing and home and community-based services to make the best use of all resources, regardless of individual income or setting. Their work is founded in the SASH™ model, the core elements of which are shared consent, standardized assessment, a person-centered care plan, transitions and navigation support, data-driven population health and wellness programming, a centralized outcomes database, and prevention-focused, evidence-based practices.

*About the SASH Model*
SASH is a system which has replication and dissemination potential while remaining flexible where needed. The model involves embedding interdisciplinary staff (CHW and RN) to work within existing affordable housing with naturally created patient panels. Panels consist of approximately 100 participants who live in one or more affordable housing sites and are part of an integrated care team with their primary care physicians and local hospitals. The model can also expand out into individual homes and the community. The housing-based care team, consisting of a SASH care coordinator (similar to a Community Health Worker) and part-time wellness nurse, is integrated with other teams such as the community mental health agencies, home health providers, local Area Agencies on Aging (AAA), Independent Living Service Providers, as well as local hospitals and nursing homes, allowing information to be shared and leading to better communication, reduced duplication, increased efficiency, and reduced high-cost utilization. SASH participants often have complex needs and multiple chronic conditions. Bringing care to them can address social determinants of health and eliminate some common access barriers such as transportation.

*The Core Elements of the SASH Model*
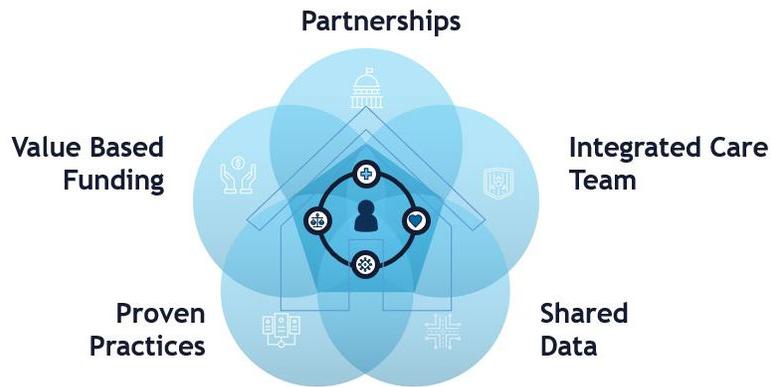


The SASH process starts with a meeting with each participant to learn and listen about what matters to the participant – what are their goals?  Every participant completes a health and wellness assessment at least annually, which is used for the collaborative care planning process as well as panel management. SASH uses individual as well as population health approaches to data. The staff can determine the best and most relevant outreach and programming for the 100 people in the building based on data on their risks and conditions. Being place-based when nurses perform medication reconciliation is another key advantage, as they can see the actual medications and how they are stored and organized, allowing them to come up with a realistic plan with the primary care clinician.

*Evidence of Impact*
SASH has demonstrated cost savings amounting to over $1450 per year per urban SASH participant for Medicare well was a $400 per year per SASH participant for Medicaid. There have also been many improved health outcomes, including a 40% reduction in emergency department utilization among high-utilizers and projects in which 70% of individuals with hypertension decreased their blood pressure and 48% of individuals with diabetes reduced their A1C levels within 6 months. SASH's embedded care teams make it easy to overlay existing care management processes with chronic condition management.

Implementing SASH required a great deal of work in terms of determining the necessary infrastructure and funding and coordinating with housing organizations which are not usually connected. HUD-funded housing exists everywhere; it's just a matter of putting a system in place to get it there.

*Discussion*
Attendees were interested to know how SASH differs from other integrated care programs such as PACE. Many individuals who participate in PACE or have AAA case managers also live in SASH housing sites and can receive complementary support from the SASH staff. SASH provides a longitudinal check-in that other programs don't. In addition, there is no eligibility criteria for SASH. PACE requires state certification that people are at a frailty level requiring nursing home-level of care. SASH is a true prevention-based population health model able to serve all risk

stratification levels of vulnerable adults to address needs as they occur and curb high-cost utilization before it starts.

Attendees also asked about the feasibility of implementing the SASH models in areas where MLTSS is provided by several different managed care plans. Cases such as these may necessitate payers coming together in a partnership to take on a shared risk pool; attendees agreed that plans which see the value in the SASH model may be willing to take part in such an initiative. This is consistent with how SASH has been funded, initially by a multi-payer demonstration and currently through an All-Payer Model.

## Inclusa Presentation

*About Inclusa*
Inclusa is a nonprofit Managed Care Organization which has delivered Wisconsin's Family Care Program for more than 20 years. Inclusa supports the provision of long-term care services and supports to more than 15,000 members in 68 of Wisconsin's 72 counties, where it contracts with 6,000 providers and employs 1,100 individuals, mainly social workers and nurses. Inclusa has evolved over time into a value-based organization devoted to building vibrant, inclusive communities. The organization employs a trademarked approach called "Commonunity," in which the concepts of belonging, accessibility, contribution, home, and choice are aligned around the individual.

*About Commonunity*
Kris Kubnick of Inclusa, Inc. shared some of Inclusa's methods and achievements in supporting its members through "Commonunity". Inclusa has succeeded in advancing its mission and moving its local LTSS landscape towards value-based payment by identifying and utilizing three key levers. The first and primary one is building and sustaining local relationships with a clear commitment to the outcomes of inclusion. The second is building and aligning the internal values associated with partnerships in a power-with approach which is based on strengths and focused on the community. The third level is innovation, being bold and allocating resources where systems change is needed and staying the course.

*Inclusa's Value-Based Reimbursement Model*

Supports Members to Achieve and Maximize their Autonomy, Independence, Natural Supports and Inclusion.

Win for People Supported

Win for Service Providers

Win for Payer of Services

Better net income when costs compared to revenue;

Use limited staff more effectively;

Desirable outcomes and use of best practices results in increased net income per unit of service.

Effective, Cost-Effective and Sustainable.

Provider partners are a key to collective success and increasing community integration for individuals. Inclusa has approached building their network by focusing on current provider infrastructures embedded in communities, identifying gaps and working with providers to expand lines of support and change how they look at delivering support. Relationships are a key component of getting providers to be passionate about outcomes. Inclusa is transparent with providers about its vision as an organization and invests in technical assistance to help providers build capacity. Provider grants allow providers to try something new without taking on too much risk. While this represents a significant up-front cost for Inclusa, the organization is invested in the long-term gains that result.

*Evidence of Impact*
Value-based reimbursement for LTSS transforms and advances Inclusa's goals in meaningful ways. The organization's competitive integrated employment efforts have resulted in a 31.6% increase in people employed, 105% growth in hours worked by members, and 56% growth in average hours worked per month for members in competitive integrated employment. Greater success has been seen among those served by providers participating in a supported employment outcome-based (SEOB) payment model, which focused on paying for member hours worked compared with hours of job coaching provided.

Inclusa has also successfully increased the percentage of its members living in the community using innovative community-supported living models. 58% of Inclusa's members are currently living in the community, and that number has continued to grow by between 1.5 and 3 percent every year. Community-supported living is a holistic approach to supporting individuals in their home that is centered around individuals' preferences and outcomes and provides fluid levels of support. Community engagement has been key to the success of this initiative.

*Discussion*
Attendees asked how Inclusa was able to move the needle on value-based payment. The key component was to build collectively with providers, meaning that when it was time to move forward and expand there was not resistance from payers or funders. The Department of

Health Services also saw the value in it as the evidence accrued. Attendees also asked if Wisconsin has moved away from sub-minimum wage pre-vocational programs. Although some are still in place, there is now a strong focus on only leveraging vocational services and supports for competitive integrated employment.

## Conclusion

As we think about how the LTQA community can continue to advance community integration and interconnectedness as demonstrated by the SASH model and Inclusa's work, we hope to keep in mind the questions raised at the beginning of the meeting regarding knowing what works, identifying effective strategies for scale, and capitalizing on opportunities to come together to strengthen capacity and integration. With the ultimate aim of improving outcomes and quality of life for individuals managing functional limitations, the LTQA community will continue to explore effective models and opportunities for collaboration in this space