Empowering People to Live and Age Well Through Integrated Systems of Care

The SASH™ Example

National Well Home Network, Stefani Hartsfield
Our Vision

There is a great urgency to reach people experiencing systemic health disparities. A better coordinated, more participatory system that links health care to where people live is essential.
A Replicable System

Partnerships

Value Based Funding

Integrated Care Team

Proven Practices

Shared Data
Partnership Is Key

• A partnership among community organizations and agencies in housing and health care.

• Based in nonprofit affordable housing.

• Part of Vermont’s All-Payer Model (APM) quality and value based payment initiative, currently managed by the state ACO.

• Able to target high-cost and high-risk populations.

• Focused on evidence-based wellness and prevention to serve whole population.
Imagine that it’s April, 2020 and Betty is your member (client)...What could you do to see how she is doing?

Chat in your thoughts?

An estimated 41% of U.S. adults had delayed or avoided medical care by June 30, 2020, because of concerns about COVID-19.

(CDC, Sept. 2020)
SASH™ - A System That Works

problem, is so efficient and makes you know you have an advocate to rely on. This has been proven again with a friend in trouble who called me for a decision about whether to call the ambulance to go to the ER or not. I immediately called her, and she has handled it from there.

We have a wonderful nurse, Jodi, who comes right over to solve a health issue. You can tell she is concerned and cares about you. She also taught Tai Chi free of charge. So... kudos to our SASH team.
Proven Practices

Core Elements

• Shared Consent
• Standardized Assessment
• Person-Centered Care Plan
• Transitions/Navigation Support
• Data Driven, Population Health and Wellness Planned Programming
• Centralized Database - Outcomes
• Prevention-Focused, Evidence Based Practices
Integrated Care Team

- Hospital
- Nursing Home
- Community Mental Health Agency
- Nonprofit Housing
- Home Health
- Area Agency on Aging
- Primary Care Provider
- Public Health

Participant
Core of the SASH Team

SASH Care Coordinator

SASH Wellness Nurse

SASH Community
- 100 Participants

Housing Organization as Host
Median # of chronic conditions: 6
People with 3 or more diagnoses: 75%

Shared Data

HEALTH SCREENS
Risk of Falls .......... 58%
Social Isolation ...... 37%
Suicide Ideation ... 10%
Medications...A Value Add Example

Home based medication reconciliation with an RN is vital to integrated care.
Darryl had been happily living in affordable housing since he moved out of his parents home at 35. Recently his diabetes led to dangerously high glucose levels. He experienced bacterial infections, nerve damage and severe swelling in his legs. His typically happy demeanor declined at the prospect of live-in help.
Darryl chose to take diabetes classes at the hospital.
• His Direct Support Worker accompanied him to events at the local high school, his point of passion.
• He started tracking his insulin levels.
• Eventually he felt comfortable enough to call his doctor independently.
Demonstrated Cost Savings

$1450 per year

Reduction in rate of growth Medicare expenditures for every urban-area SASH™ participant

$400/person per year

Reduction in rate of growth of Medicaid expenditures for institutional long-term care
**Improved Health Outcomes**

- **40%** Decline in Emergency Department use among high utilizers
- **70%** With hypertension decreased their blood pressure within 3-6 months
- **48%** In a diabetes self-management pilot reduced A1C levels in 6 months
- **67%** Entered into advance directives, well above the national average of 46%
SASH Operating Infrastructure

Funding
- APM / ACO
  State Medicaid

Administrative Entity
- SASH Statewide Administrator

Regional Housing Hosts
- Northwest Counties
- Northeast Counties
- Western Lake Region
- Southwest County
- Southeast Counties
- Central Counties

Housing Organizations
- 6 Orgs, 43 Sites
- 1 Org, 31 Sites
- 1 Org, 18 Sites
- 2 Orgs, 7 Sites
- 5 Orgs, 14 Sites
- 6 Orgs, 27 Sites

Partner Organizations
- Primary Care
- Public Health
- Home Health
- Local Universities
- Hospitals / Health Systems
- Area Agencies on Aging
- Behavioral & Developmental Health

Partnerships

Map of various regions and locations related to housing and health organizations.
Volume Matters
Questions
Align Your Systems With Your Values
A Framework For Building Vibrant & Inclusive Communities.

June 23, 2021

Hannah, an Inclusa Member
We are Inclusa

1,100 Colleagues
Employs 1,100 colleagues.

6,000 Providers
Contracts with over 6,000 provider partners.

Long-term Care
Supports the provision of long-term care services and supports in almost 40 service categories.

15,000+ Members
7557 people with intellectual/developmental disabilities, 5222 elders, and 2523 people with physical disabilities.

20+ Years
Wisconsin-based 501(c)(3) delivering the Family Care Program for over 20 years.

68/72 Counties
Serves 68 of Wisconsin’s 72 counties.
It’s not what we do; it’s how we do it.
Transformation is not a new thing for us.

LOCAL RELATIONSHIPS
Focus on Building/Sustaining Local Relationships
• Clear shared vision and commitment to the outcomes
• Coalition of the willing

ALIGNMENT OF VALUES
Build and Align Internal Values Associated with:
• Partnership - A Power-With approach
• Community-Centric and Strength-Based approach
• VALUES DRIVEN

INNOVATION
Allocate Resources where Systems Change is needed
• Stay the course
Provider Network Development
Building a network of Partners.

- Stabilization First and Innovate Next
- Focus on Partnerships – Power-With Approach
- Balance Network Development With Strong Focus on Self-Directed Support Options
- Build the Network Local-Out
Co-Create With, Invest In & Support Provider Partnerships

Key Steps:
Focus on Provider Engagement
  • Collaborative Solution Development

Invest in Technical Assistance
  • Provider Grants
  • Bring in external TA

Risk Sharing
  • Infrastructure Growth
  • Upfront Investment
Value-Based Reimbursement Model

Reforming the service delivery system payment model; strengthening the network. Tying payment to outcomes produced by services delivered; rewarding quality over quantity.

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.
The Impact
Competitive Integrated Employment Case Study Results

31.6% Growth
in number of people employed in competitive integrated employment.

105% Growth
in hours worked by members working in competitive integrated employment.

56% Increase
in average hours worked per month for members in competitive integrated employment.

*results occurred after two years of implementation.

PROVIDER SUCCESS IS GROWING!

2012
7 Providers

2015
16 Providers

2019
27 Providers
The Impact
Competitive Integrated Employment Case Study Results

<table>
<thead>
<tr>
<th></th>
<th>PROVIDER A</th>
<th>PROVIDER B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NUMBER OF MEMBERS</strong></td>
<td>50</td>
<td>47</td>
</tr>
<tr>
<td><strong>TOTAL HOURS WORKED</strong></td>
<td>1385.75</td>
<td>2030.45</td>
</tr>
<tr>
<td><strong>AVERAGE HOURS WORKED</strong></td>
<td>27.72</td>
<td>43.20</td>
</tr>
<tr>
<td><strong>PAYMENT METHOD</strong></td>
<td>Fee-for-Service (FFS)</td>
<td>Supported Employment Outcome Based (SEOB)</td>
</tr>
<tr>
<td><strong># HOURS JOB COACHED</strong></td>
<td>1264.50</td>
<td>220.75</td>
</tr>
<tr>
<td><strong>TOTAL PAID</strong></td>
<td>$35,760.06</td>
<td>$18,855.85</td>
</tr>
<tr>
<td><strong>IF IN OTHER PAYMENT MODEL, WOULD HAVE BEEN PAID</strong></td>
<td>$14,864.32 (SEOB)</td>
<td>$7,174.38 (FFS)</td>
</tr>
</tbody>
</table>

**DIFFERENCES OF PAYMENT MODELS**

- **Fee-for-Service (FFS)**: Focuses on paying for services of Job Coach and eliminates incentive to increase hours worked.
- **Supported Employment Outcome Based (SEOB)**: Focuses on paying for member hours worked and incentivizes increasing hours worked, fading of support needed, and quality employment.
The Power-With Approach

With stakeholders and funders.
Community Supported Living

Expansion into New Region

Co-Created with Provider

Alignment Built Internally

Shared Risk

Focused Community Engagement

Celebrated Wins
The Impact
GSR 7 & 14 Expansion Case Study Results

100% Growth

GSR 7

100% Growth

GSR 14
Let’s Review!

Building more vibrant and inclusive communities is possible, with:

**Relationships**
Build strong local relationships; be part of the community.

**Aligned Values**
Align vision and values internally and externally.

**Innovation**
Be steadfast and vested in allocating resources where change is needed/desired.
Questions?
Kris Kubnick  
Chief Member Experience Officer  
Kris.Kubnick@inclusa.org  
715-301-1889

Tim Garrity  
Chief Innovation Officer  
Tim.Garrity@inclusa.org  
608-785-6062

inclusa.org