Health is impacted by factors outside of the health care delivery system, including housing, education, poverty, employment, food availability, transportation, and safety. Recognizing that addressing these socioeconomic determinants of health is needed to meaningfully impact health inequities, a national policy shift is taking place.

Government agencies, payers, and providers are all adopting a social determinants perspective. To effectively address these nonclinical needs, partners must work across sectors. Now, the question is how — what are the best practices for effectively aligning systems?

Aligning Systems for Health: Health Care + Public Health + Social Services, sponsored by the Robert Wood Johnson Foundation (RWJF) and managed by the Georgia Health Policy Center (GHPC), is focused on learning from stakeholders across the nation about effective ways to align these three sectors to better meet people’s goals and needs.

Given variance in the local context, there is no single model or formula to align systems. However, Aligning Systems for Health seeks to understand commonalities that drive successful efforts to align sectors. This series examines how communities that describe their work as aligning systems are doing it around four core components of a Framework for Aligning Sector that RWJF and GHPC are testing: purpose, governance, data, and sustainable financing mechanisms.

VAAACares® is a statewide Area Agency on Aging collaboration delivering comprehensive care coordination services for insurers and health systems. It relies on dedicated certified health coaches to effectively transition patients out of the hospital and facilitate with the skills and confidence to manage and control their health problems. Health Coaches support in-home assessments and links to social services and community resources for post-discharge hospital patients with complex needs.

**Local Context**

In 2012, Bay Aging became a founding member of the Eastern Virginia Care Transitions Partnership in response to a funding opportunity from the Centers for Medicare & Medicaid Services (CMS) Innovation Center’s Community-Based Care Transitions Program. Community-based organizations were funded to use evidence-based practices, like the Coleman Care Transitions Program, to reduce 30-day all-cause readmissions to hospitals by 20%. The Eastern Virginia Care Transitions Partnership, consisting of Bay Aging plus four other Area Agencies on Aging and five health systems, covered 20% of the state — a large rural area in eastern Virginia — and targeted nine diagnoses with high risk for readmissions for eligibility purposes. The model relied on coaches (e.g., certified nursing assistants and teachers) to support in-home assessments and linkages to social services to ensure that all the patients’ needs (social and medical) were met.
While the initial CMS funding opportunity is over, the success of the Eastern Virginia Care Transitions Partnership lives on, with the principles and learnings applied to VAAACares, a statewide coalition of Virginia’s Area Agencies on Aging that serve dually eligible Medicare and Medicaid individuals enrolled in Commonwealth Coordinated Care Plus, Virginia’s managed long-term services and supports program.

**PURPOSE**

The Eastern Virginia Care Transitions Partnership conducted root-cause analysis, with input from hospitals, physicians, staff, and patients to understand key contributors to readmissions in the region and to design a model that addressed those concerns. The Coleman Care Transitions Intervention model, which focuses on patient engagement in their care, was supplemented with enhanced services that included direct referral assistance, case management, benefits counseling, family caregiver support, and nonclinical services such as Meals on Wheels, housing or home repair, and transportation.

Partner hospitals identified inpatients meeting the high-risk program criteria, and those who consented to participate received a bedside visit from an assigned Area Agency on Aging health coach 24 hours prior to discharge to ensure successful transition from the hospital. Within 72 hours of discharge, the coach conducted an in-home assessment and then worked to connect the patient to any needed services.

“We had really good partnerships, and everyone was invested in the project,” recalls Cathy Eades, director of care transitions at Bay Aging. “We were all on the same team because of the structure that CMS set up for us, and that was awesome. It helped bring us all together.”

Ongoing training, support, and reporting built quality and consistency among health coaches and referring hospitals. Today, VAAACares and other similar contractual arrangements Bay Aging maintains with other independent providers differ slightly in their shared goals, namely less emphasis on readmissions and more focus on whole-person care by addressing the social determinants.

**DATA**

The Eastern Virginia Care Transitions Partnership established data-sharing agreements with partner hospitals and built out integration with electronic health records for health information and referral exchanges, as well as centralized billing and tracking of readmissions.

Between 2013 and 2016, the partnership completed over 26,000 home visits for Medicare patients discharged from partner hospitals and reduced the 30-day readmission rate from 18.2% to 8.9%, resulting in estimated savings of more than $17 million through 1,804 avoided readmissions.

Bay Aging shared monthly trend reports with partner Area Agencies on Aging and health systems. Each report included aggregated, group-level data, as well as hospital-specific readmission information or individual care coordinator performance, but this identifiable information was not shared with all partners.

Bay Aging also maintains an independent database for reporting performance measures, tracking episodes of care and patient outcomes, and other quality assurance measures. The agency acts as a “one-stop shop” for referrals, billing, reporting, and data analytics — simplifying the administrative process for partners.

Eades admits that given the system is going on 10 years old and partners and partners’ data systems have changed, the current data system is not as robust as desired. Bay Aging, as the coordinating entity for VAAACares, manages the case management system that houses all referrals received each day. Assignments are emailed out and all partners and participating Area Agencies on Aging have access to the system for documentation purposes. However, double documenting and entry are often required when partners, like managed care organizations, use non-interoperable systems. Even among state and federal government agencies, systems are not interoperable, and each often requires separate documentation. Eades says affordability and creating closed-loop systems are ongoing challenges for Area Agencies on Aging, given the multiple siloed data systems.

Eades is hopeful that national initiatives like the Gravity project, which aims to create reimbursement codes for community-based organizations’ activities addressing social determinants, will ultimately foster better data-sharing and tracking practices for payers, clinical care providers, and social services organizations.
FINANCING

The Eastern Virginia Care Transitions Partnership was initially reliant upon CMS for funding. During the pilot, CMS funds did not cover administrative, overhead, or infrastructure costs. Area Agencies on Aging were paid only once per eligible discharge in a 180-day period for any given beneficiary.

However, in 2016 CMS abruptly curtailed the program to redirect funds to accountable care organizations. The partner hospitals initially renewed their contracts, but one by one decided to bring case management in-house.

“The thought was, if we have got to pay for it, we want to control it,” Eades recalls. “When it was a gift, it was different. But now, with all of the talk around social determinants, some hospitals are again rethinking their strategy and are turning again to VAAACares because they realize that the Area Agencies on Aging are a major player in that area.”

When CMS funding ended, the Virginia General Assembly provided one-time bridge funding for a Medicaid pilot, given the success achieved by the Eastern Virginia Care Transitions Partnership for the Medicare population. The majority of funding for VAAACares now comes from three health plans to cover care transitions, care coordination, and in-home assessment support for Medicaid and dual-eligible members through a fee-for-service reimbursement model. Eades describes Bay Aging as a one-stop shop where they receive the referral, send the referral out, bill, receive the reimbursement, and then pay the agency providing the services.

“The big vision is that we will have a seat at the table with insurers, health systems, and managed care organizations as part of the ongoing conversation about taking care of this population of people,” says Eades.

GOVERNANCE

Bay Aging manages administrative functions, including acting as the hub for electronic referrals across partner Area Agencies on Aging and coordinating standardized staff training and reporting across all partners. Participating Area Agencies on Aging have business associate agreements with Bay Aging, but Bay Aging is the sole organization entering into indemnification arrangements with the health plans.

At the time of the Eastern Virginia Care Transitions Partnership, there was an independent board of directors, led by Bay Aging. The board consisted of three executive designees from each of the original partners and served to facilitate dialogue across partners and formalize existing relationships. As contracts with the original hospital partners fell, so too did the board.

Bay Aging just received an Administration for Community Living two-year Community Integrated Health Network grant, which includes two years of planning to re-establish a statewide VAAACares governance structure and data-sharing plan. Bay Aging will serve as the national lead entity, and the first convening, occurring in fall 2021, will be cohosted by the Virginia Hospital and Healthcare Association and the Virginia Health Innovation Center.

INSIGHTS FROM THE COLLABORATIVE

Eades credits the success of the Eastern Virginia Care Transitions Partnership and VAAACares to the fact that community-based organizations have a history of working in the community and really knowing the community — knowing the resources and the people.

“Before COVID-19, we hung our hat on the fact that we had boots on the ground in everyone’s home. Our partners in health systems see the value of us being in people’s homes, and only a community-based organization can really do that,” explains Eades. “Every community is different and if you have people that literally live in those communities, patients trust them. If you have a national care case manager in Nebraska calling the patient in Virginia, how can they possibly know the community? It really does need to be local.”

While being in-person “is everything,” Eades predicts that post-COVID-19, some rebalancing will be required. “Even though in my heart, I think that going into someone’s home is the only real way to know what that person really needs or that family really needs, I don’t know that we’ll ever not be at least somewhat telephonic again, because we can serve more people if we incorporate some of it telephonically.”
Aligning in Action

Eades recounts one of her favorite stories of impact:

“We had a patient whose wife had recently died. He had multiple chronic conditions, chronic obstructive pulmonary disease, diabetes, and other issues. He was not eating properly and was not taking good care of himself, so he was constantly being admitted to the hospital. His daughter lived several hours away. And when he was finally referred and he agreed to participate in our program, our health coach was able to wrap a whole host of services around him. She was able to get diabetic meals delivered, build a handicap ramp on the back of his house, and secured a medication management machine. He was able see the pills and knew he had to take those. He did not have heat in his home and we were able to reach out to a church group and get his propane tank filled. Finally, we worked with his daughter who agreed that she would come at least once a month to visit her dad and put the medications in his pill machine. And the list goes on. We completely wrapped services around him and we were able to keep him out of the hospital.”

Aligning During COVID-19

Every aspect of VAAACares was impacted by COVID-19. Initial coach contact occurs when the patient is still in the hospital, and during the pandemic, coaches were not allowed in hospitals. This impacted case managers’ ability to get patients’ full stories and uncover all their needs.

Area Agencies on Aging continued with functions like personal care and companion care aids, but there were a lot of personal protective equipment requirements. Other functions like, Meals on Wheels, stayed open but had to make adjustments. For instance, the usual volunteers (an older population) were afraid to come in, so office staff ended up driving routes. Bay Aging was able to use some of the meal money and contracted with local restaurants that were impacted by the pandemic to make the meals for them, instead of purchasing frozen ones.

“This gave our restaurants and local economy a way to continue making money, and our clients were getting two home-cooked instead of a frozen meal,” recounts Eades.

Area Agencies on Aging and partner organizations did not have the resources for all of the needed Zoom licenses to continue group counseling sessions, so the Bay Rivers Telehealth Alliance secured 40 Zoom licenses for the agency.

“We were able to start doing Zooms, shared resources with others, and we muddled through,” says Eades.