Together4Health ~ A Care Coordination Entity

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HEARTLAND ALLIANCE HEALTH

What is a Care Coordination Entity?

- A collaboration of providers that develop and implement a Care Coordination model – an integrated delivery system; risk-based payment based on health outcomes
- Must include participation from hospitals, primary care providers, and behavioral health providers
- To become a CCE, a group of providers may create a new corporate entity and contract with the state through a “lead provider”
- A CCE may subcontract with an existing health plan for back office functions

Together4Health Partners

Togeth4Health, LLC – 34 owners

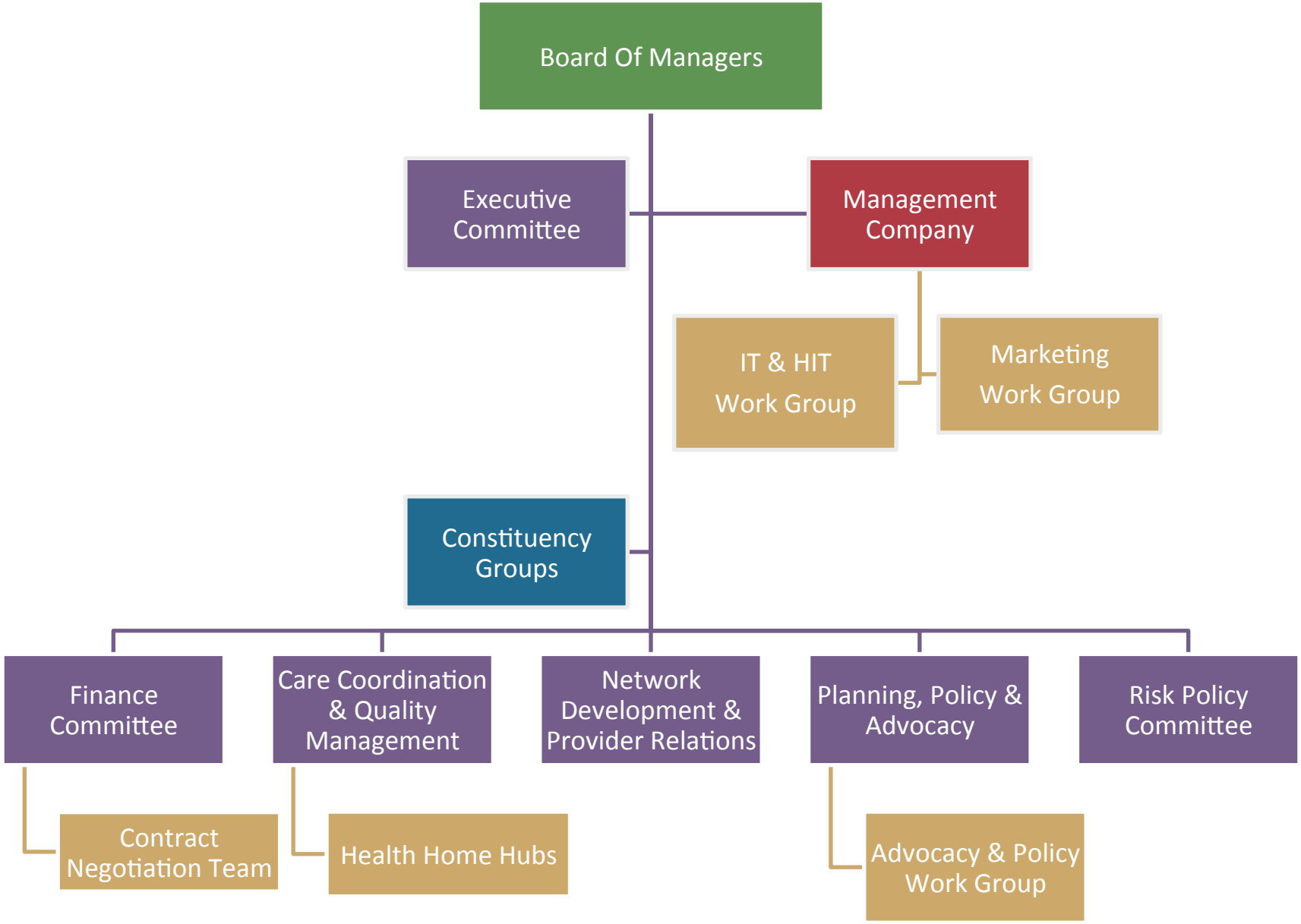
- 5 Hospitals (safety net → academic medical center)
- 8 Federally Qualified Health Centers
- 11 Behavioral Health Organizations
- Social Service Organizations (housing; grocery & nutrition; supported employment; financial literacy; senior day centers)
- Organization members (CSH, AFC, TASC)
- Health Information Network (Alliance of Community Health Services)

Why did we do this?

- The needs of the people we serve
  - Economic realities
  - Policy shifts
  - Emerging health demands
  - Need for holistic services (housing, employment. food security, social supports) that impact health
- Opportunity to become a provider led network
  - Proactive response to changes in how health care is provided and paid for

Together4Health governance structure

- Representative Board of Managers
  - Constituency groups
- Due Diligence Committees
- Working Groups
- Chicago Health & Social Innovation Research Center
- Management Company – Heartland Health Outreach


Board Of Managers
Executive Committee
Management Company
IT & HIT Work Group
Marketing Work Group
Constituency Groups
Finance Committee
Care Coordination & Quality Management
Network Development & Provider Relations
Planning, Policy & Advocacy
Risk Policy Committee
Contract Negotiation Team
Health Home Hubs
Advocacy & Policy Work Group

Together4Health – Our mission

To be a regional *community health home safety network* that supports vulnerable people

- living with chronic and multiple medical and mental health conditions
- living in poverty
- experiencing homelessness
- unemployed and underemployed
- with limited access to services due to cultural or language barriers

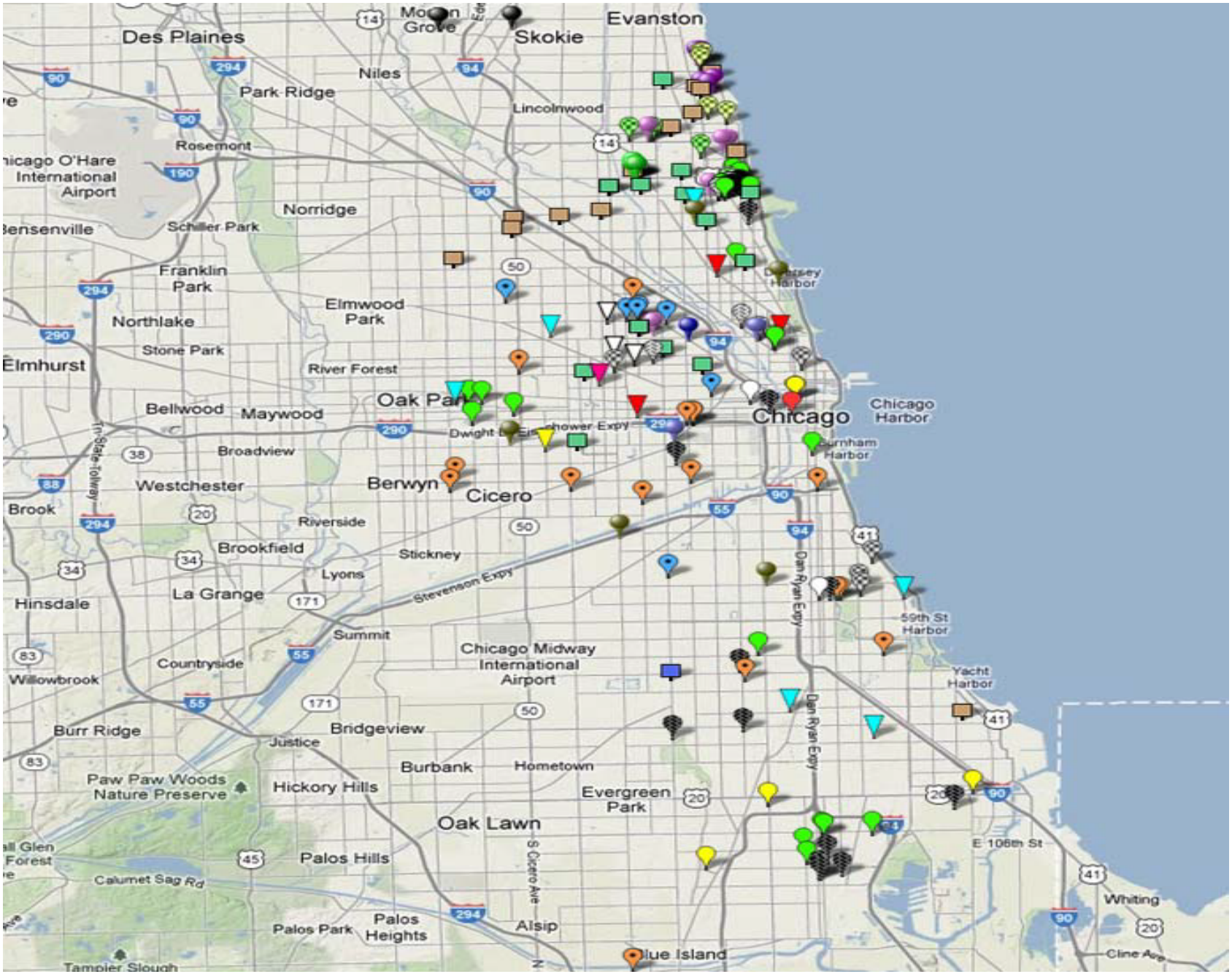
Together4Health providers go outside our own walls, linking the people we serve to a full range of services that improve and support the health of our community.

Together4Health – Our values guide care

- Person- and family-centered services address both individual and community needs
- Incorporate housing and social services that strengthen participants' ability to engage in, and benefit from, health care
- Evidence-based, evidence-informed, innovative, and promising practices evaluated and vetted by consumers of care
- Create a sustainable and healthy business model that responds to economic realities, policy shifts, and emerging health demands, as well as to the needs of our partners and the people we serve

Together4Health – Our goals

- Ensure that our participants experience the highest quality care
- Improve the health of vulnerable populations
- Reduce the per capita cost of health care
- Reduce health disparities
- Share accountability for the outcomes of patient care across the partnership
- Address social determinants (lack of housing, employment, food security, and social supports) that have a negative impact on health
- Continue to revise and improve the model, according to input from research partners who evaluate and report on network services, outcomes and disseminate findings



Heartland Health Outreach

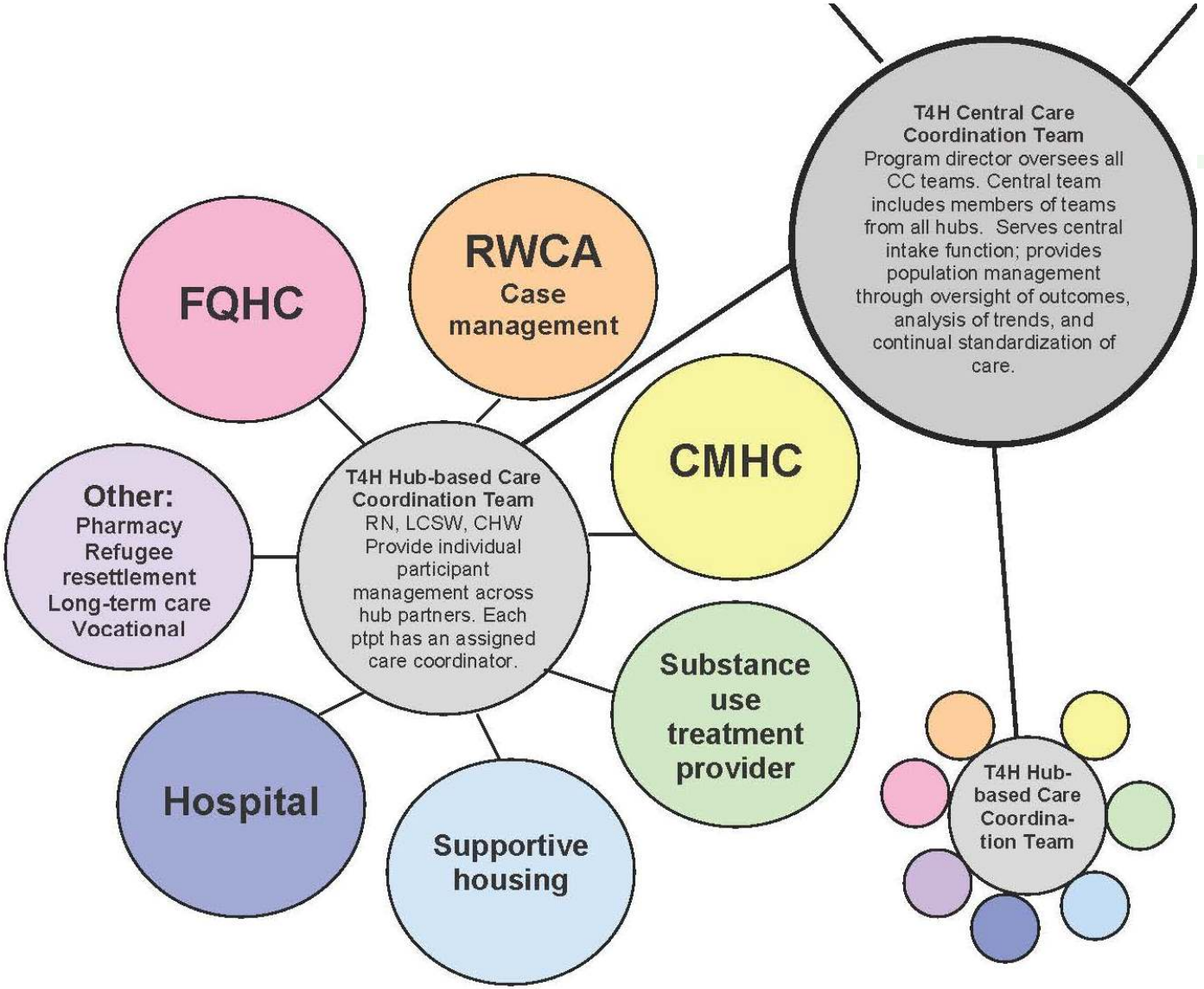
Who T4H will serve

- High Medicaid users already receiving services from T4H network providers
- 500 individuals first quarter of year one → 5000 by end of year three → 10,000 by end of 2016
- 100% people served will have a disability
- To begin 80% will have co-occurring serious mental illness → by year three majority of people served will have multiple chronic health illnesses without SMI

Our care coordination model

- Based on health home option
- Integrates holistic approach that promotes physical, mental, and social wellbeing, while improving access to care
- Addresses the social determinants of health, such as housing
- Health home hubs strategically located throughout Chicago

Together4Health – Health home model



Together4Health—Basic assumptions

- Care coordination provided by teams connected to health home hubs
  - Teams include RNs, LCSWs, and community health workers
  - Coordinated care teams both virtual and co-located within partner organizations
  - case loads from 30 to 100, determined by complexity, acuity and current connectivity to care
- T4H standardized clinical documents
  - Enrollment form
  - ROI and consent form
  - Integrated assessment, health activation & functional status measures
  - Care plan
- T4H shared policies that address ethics, care philosophy, and standards of care – attention to shared work flows
- T4H information sharing technology, tele-health and data set that will minimize duplicative procedures and maximize care coordination

Together4Health Financial Model

- Shared risk, shared revenue opportunity
- Owner capital investment
- Per member per month care coordination fee
- Intergovernmental transfer and payment reform
- Cost savings based on Medicaid savings and achieving health outcomes → estimated over three years to save over $11M

Together4Health – Moving from vision to integrated health home

- Build trust among and between partners
- Transparent communication among partners
- Strategic commitment and collaboration
- Data driven decision making based on mutual and shared interests
- Be a shared continuous improvement learning community willing to Plan, Do, Study and Act
- Shared risk and shared accountability
- Commitment to quality, innovation and access to information

Want to learn more?

Care coordination webinar

http://www.heartlandalliance.org/policy-and-advocacy/policy-issues/health-care.html

Chicago Health & Social Innovation Research Center

DHHS ASPE Case Study Reports

Commonwealth Foundation Case Studies