CHRT

ANN ARBOR AREA COMMUNITY FOUNDATION

Vital Seniors Initiative

Final Report

November 15, 2021

CENTER FOR HEALTH
AND RESEARCH
TRANSFORMATION

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Executive Summary

In 2019, the Vital Seniors competition established a cohort of community-based organizations—local leaders in the field—dedicated to senior services. These organizations received support from the Ann Arbor Area Community Foundation (AAACF), from the Center for Health and Research Transformation (CHRT), and from the Vital Seniors Initiative learning facilitator, Sue Ann Savas, to drive senior service systems improvements in Washtenaw County.

Initially, CHRT's role in the initiative was to conduct applied research and help the cohort understand the interests and constraints of health systems and payers as the cohort worked on a long-term sustainability plan. But over the last three years, CHRT's role has grown.

A significant strength of the Vital Seniors Initiative has been the three pillars of support – the funder, the learning facilitator, and the healthcare analysts. Because of the fluid nature of this partnership, CHRT was able to pivot as the cohort processed learnings and developed new strategies to work toward shifting from a siloed service delivery system to a networked system, thereby creating an opportunity to pursue sustainable funding together.

Perhaps the most significant accomplishment of the last three years of the Vital Seniors Initiative is building the foundation for a community integrated health network which would allow social service providers, such as the Vital Seniors cohort, to be reimbursed for their work by payers and health systems.

To accomplish this, the cohort members established this shared vison:

- embrace the culture change required to become an integrated member of a coordinated service delivery system;
- establish the necessary infrastructure (technological, procedural, reporting, quality measurement, etc.) to successfully contract with health plans and health care providers; and
- develop a network of community-based organizations that have the capacity and geographic coverage area to serve the needs of the payers and health care providers.

The three years of funding from the AAACF established the foundation that enabled CHRT and the community-based organizations that comprise the cohort to successfully obtain additional grants from the Edward N. & Della L. Thome Foundation, the Michigan Health Endowment Fund, and most recently, the federal office of the Administration for Community Living to establish a regional service delivery network.

Key Learnings

A shared strategic direction is essential for systems change.

Data-driven decision making improves interventions.

Long-term sustainability is challenging, but achievable.

Our Journey So Far…

2019

- Identified senior service resources and mapped the location of these resources against senior resident density in Washtenaw County.
- Successfully applied to join the National Collaborative on Aging (NCOA) Network Development Learning Collaborative. Facilitated learning collaborative activities, strategic planning, and deliverables.
- Facilitated meetings with stakeholders to identify opportunities for a pilot project that would address senior needs.
- Adopted a data sharing and referral system that would allow cohort members to make closed loop referrals to services.

2020

- Secured a $100,000 grant from the Edward N. and Della L. Thome Memorial Foundation to pilot a coordinated service delivery model with Vital Seniors grantees.
- Completed the National Council on Aging's Network Development Learning Collaborative, a 10-month training program, which provided tools to help grantees create and manage a community integrated health network.
- Engaged with health plans who could refer clients to the network including BCBSM, Priority Health, and Physicians Health Plan.
- Assessed the cohort's readiness to move toward an integrated network in the following areas: capacity for change, strategic direction, operations, management, leadership, external market, and partnership development.

2021

- Designed and launched the *Home Nutrition+* pilot to test a shared service delivery model while responding to food and social isolation needs of vulnerable community members during the pandemic.
- Assessed their social needs of pilot participants while delivering medically friendly meals and providing referrals to community-based organizations for additional needs.
- Secured a partnership with Priority Health to contribute to the program design and provide referrals to the pilot.
- Delivered medically friendly meals to 102 older adults and individuals with disabilities diagnosed with either renal disease, diabetes or a heart condition. 59%t were from the Ypsilanti area; 32% self-identified as Black/African American; and 44% reported social isolation.
- Helped *Home Nutrition+* participants increase feelings of connectedness, maintain independence, and improve quality of life. External evaluation showed that the program improved wellness and reduced unnecessary hospitalizations.
- Received a $100,000 grant from the Michigan Health Endowment Fund to develop the foundational infrastructure and identify new partnerships to form a community integrated health network of home nutrition providers across several regions in the state of Michigan.
- Received a $50,000 grant from the Thome Memorial Foundation to enhance the design of the *Home Nutrition+* pilot.
- Received $291,000 grant from the federal Administration for Community Living (ACL) and a $60,000 matching grant from the Ann Arbor Area Community Foundation to formalize the community integrated health network to be able to contract with health payer entities to deliver care coordination services and address key social determinants of health related to food insecurity for adults aged 60+ and those with disabilities under the age of 60.

Shared strategic direction is essential for systems change

While the Vital Seniors grantees were awarded funding for individual projects, the highly collaborative approach built into the Vital Seniors Initiative pushed the grantees to move their work toward a greater goal of working together which would allow them to have a greater impact on the community that they serve. With this understanding, the grantees incorporated relevant programmatic design from their funded projects into a shared model of service delivery and designed the *Home Nutrition+* pilot.

This intentional way of working together for the purpose of solving a complex problem is based on a collective impact model. Organizations participating in collective impact initiatives develop a shared vision of change for the community and commit to resolving problems and seizing opportunities collaboratively. Collective impact initiatives share key characteristics across participating organizations. These initiatives are often coordinated by a "backbone organization" that is responsible for building and reinforcing the shared vision and ensuring that participants stay focused and move forward. The end result of the collective impact model approach for the Vital Seniors partners led to three key outcomes:

Common Agenda

As the backbone organization, CHRT facilitated learning activities, strategic planning, and readiness assessments based on the extensive technical assistance provided by the National Collaborative on Aging Network Development Learning Collaborative (NDLC), to develop a shared product strategy.

Shared Measurement

As part of the intervention design, the grantees agreed on the benefits of a shared measurement system including establishing outcome measures, data collection procedures, and aligned reporting processes. CHRT, functioning in a project management role, led the collective decision-making process to test the RiverStar data system for the pilot.

Reinforcing Plan of Action

For sustainability of our collective impact initiative, CHRT will lead the development of a community integrated health network, utilizing a grant from the federal Administration for Community Living, that will also help expand the partnership and the geographic service area.

Our Impact

CHRT supported the grantees by building public will to work toward a shared vision and strategic direction—supporting the county's most vulnerable seniors—by:

- Facilitating dialogue and engagement around mutually reinforcing activities.
- Helping the grantees benefit from a national learning collaborative.
- Coordinating efforts to develop and implement data sharing and common measurement tools.
- Securing $442,000 in grant funding to advance sustainability work.

Data-driven decision making improves interventions

Previous studies have demonstrated the need for improved access to services and more effective ways to connect the most vulnerable seniors to needed care. CHRT's initial efforts focused on providing data to build and enhance the work of the Vital Seniors grantees as they integrated and coordinated their individual efforts and developed new tools to achieve the broader goal of systematic improvements in care for seniors.

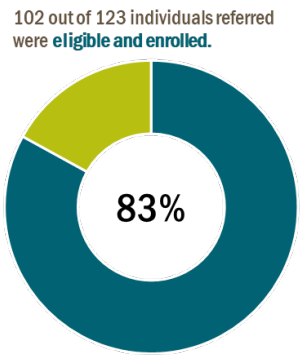
The learnings from both the NDLC on service models with the best return on investment and the COVID-19 public health crisis illuminated the opportunity to design and execute a pilot to address food insecurity and other social determinants of health (SDOH). CHRT researched best practices in this area and found that medically tailored meals have been shown to significantly improve health. This data inspired the cohort to pursue a pilot that provided home-delivered meals and referrals to local social services.

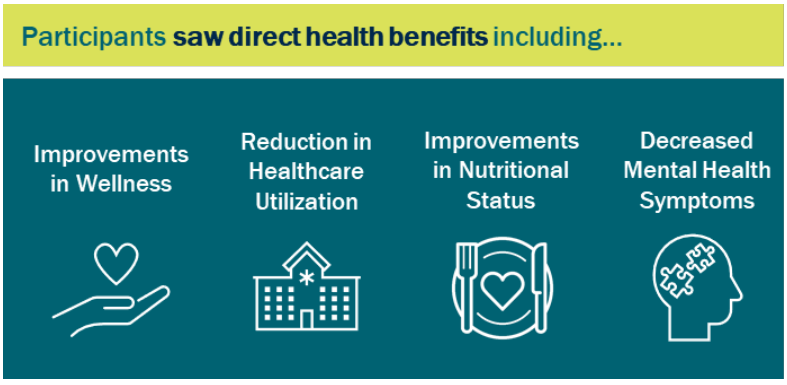
With common outcome measures and reporting protocols, the cohort was able to test the impact of a provider network of community-based organizations, including working with a health plan for referrals. The goal of this intervention was to fill in gaps in the senior service delivery system by offering medically friendly meals and a technology platform to address SDOH through direct referrals to community agencies.

Our Impact

CHRT led the development of the ***Home Nutrition+*** program as the intervention to address gaps in the current service delivery system. Providing meal delivery services is an effective entry point to recognize other unmet needs in seniors. In addition, this modality of service was chosen due its feasibility among the Vital Seniors organizations, replicable best practices, and evidence-based research on the benefits of medically tailored meals.

The services provided began with a social determinants of health assessment and referrals to our partners and other community-based organizations to address identified needs. Each participant received ten frozen meals, delivered to their home each week for a total of 12 weeks. These meals were tailored to address cardiac conditions, diabetes, or renal disease. Delivery staff followed guidance from "Ahead of the Curve" to assess any urgent needs at the time of delivery. Each partner organization provided a monthly phone check in to troubleshoot any food vendor issues and to support navigating any referrals provided. A closing survey was completed to assess [by participant self-report] health outcomes, social needs, and overall satisfaction with the program.





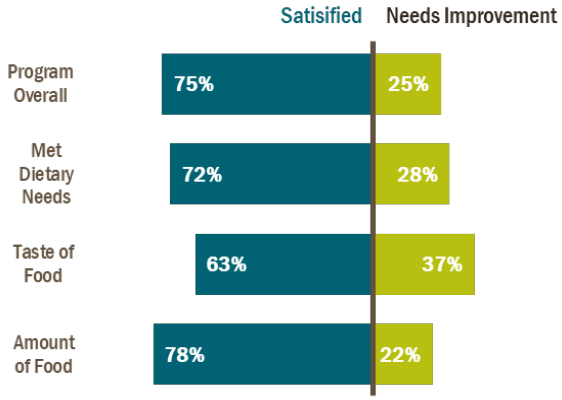
In talking about the program, participants reported:

"It's an excellent program. It was very helpful in getting me on my feet."

"The word that comes to mind is "deal." It's a great service for us. We can just pull one and eat them."

Fantastic, especially if people can't get around. You can't beat that! It has the nutritional value there, and it met my dietitian's requirements. I can't say anything bad about it."

The Home Nutrition+ program **met the needs** of program participants.



Long-term sustainability is challenging, but achievable

Among the most important goals of the Vital Seniors Initiative is developing a sustainable revenue stream to meet the SDOH needs of older adults. Additionally, services that allow older adults to age comfortably and independently are more cost-effective than services delivered in nursing homes and long-term care facilities. By building a community integrated health network, CHRT can help the Vital Seniors cohort achieve both of these goals.

Community integrated health networks are advantageous to both the service recipients and the organizations who provide the services. Not only do seniors receive care from the community-based organizations they know and trust, but the community-based organizations are assured a sustainable funding source for the work.

Our Impact

Through the three-year Vital Seniors Initiative, CHRT had the opportunity to implement two critical strategies that put in motion planning for the development of a community integrated health network for the aging service sector in our county.

First, CHRT convened and facilitated engagement between the grantees, health plans, and local health systems. CHRT brought together leaders from BCBSM's Medicare Advantage plan, Trinity Health, and Michigan Medicine and facilitated discussions around collaboration through potential pilot program opportunities.

Because the COVID-19 crisis elevated the need for social services, and home-delivered meals, CHRT worked quickly to operationalize the *Home Nutrition+* pilot. A major outcome of this pilot was the opportunity to work directly with Priority Health on the operational plan and the data sharing/legal agreements to accept health plan member referrals for enrolling in the pilot.

Second, CHRT secured a spot in the NCOA Network Development Learning Collaborative. CHRT served as the lead with representatives of the Vital Seniors cohort and participated in this ten-month training program with ten other networks across the country.

The impact of this opportunity was twofold. First our collective had access to health care experts and received tools to create and successfully manage community integrated network partnerships. And the invaluable learnings from the NCOA positioned our cohort to propose an effective network model and successfully receive funding from the federal office of the Administration for Community Living.

In addition, there are five foundational elements that CHRT employed to position the Vital Seniors Initiative cohort to transform into a regional network:

Next Steps

The long-term goals of this work have gained interest from Priority Health and Physicians Health Plan; as well as the Southeast Michigan Senior Regional Collaborative - a collaborative of 30+ non-profit organizations and public entities. In our work with Priority Health on the *Home* Nutrition+ pilot, we learned a key to successful health payer partnerships is reaching a large geographic footprint, thereby creating a convincing value proposition. With funding from the ACL, additional AAACF and Thome Foundation funding, CHRT will serve as the network lead entity to design the business structure and business plan that will further develop the value proposition to support expansion to a regional network of service providers. This network will utilize a unified and consistent approach to program delivery across the targeted geographic area, supported by technology across providers for data driven decision making. The literature provides the evidence that expanding the health care team to include community-based organizations will improve health outcomes.

The Vital Seniors competition has spurred significant movement in the aging sector. The lessons learned around true systems work and collective impact will be a model for growing the community integrated health network, as well as a rich case study that can be applied in other community innovations. Locally, we will see the immediate application of these learnings as the newly formed Healthy Aging Collaborative supports the Washtenaw County Commission on Aging to develop and execute a community-wide healthy aging strategy. In addition, the needs of older adults will be prioritized as interest increases around the presence of health inequities demonstrated by unmet social needs. There is a known gap between medical care and social care; and local, state, and federal initiatives have acknowledged the need to leverage care coordination mechanisms to better integrate clinical care with community-based social services, including the benefits of a community information exchange. A robust community information exchange system can support the movement across the state to expand delivery of long-term care services and supports in the home setting. Lastly, the impact of the Vital Seniors Initiative will be realized during the development of the network and will allow for a replicable model that can be successful in other communities beyond Washtenaw County.

Special thanks to the Glacier Hills Legacy Fund Committee and the Ann Arbor Area Community Foundation for the opportunity to support your vision over these last three years.