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

The SASH™ Example

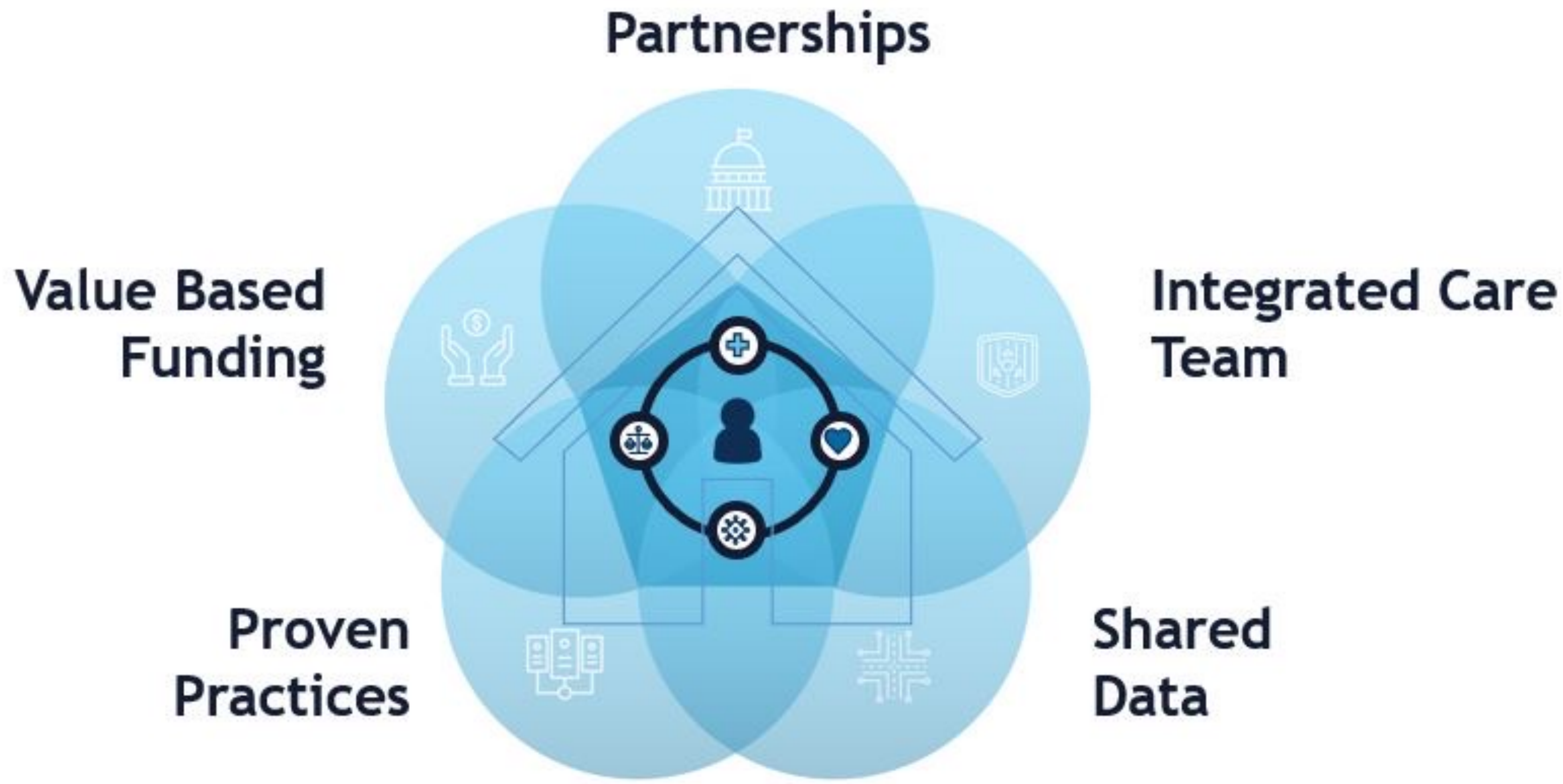
National Well Home Network,
Stefani Hartsfield

National WELL HOME NETWORK

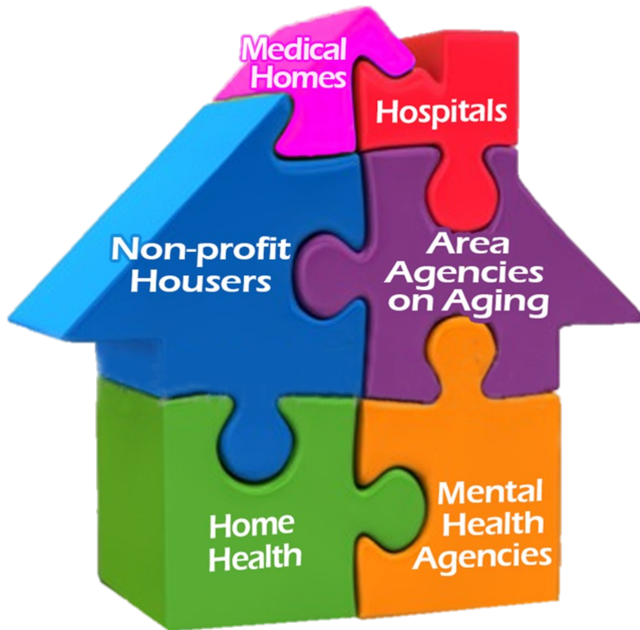
Our Vision

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



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.**

Chronic Condition Treatment

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)

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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 Jen, 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

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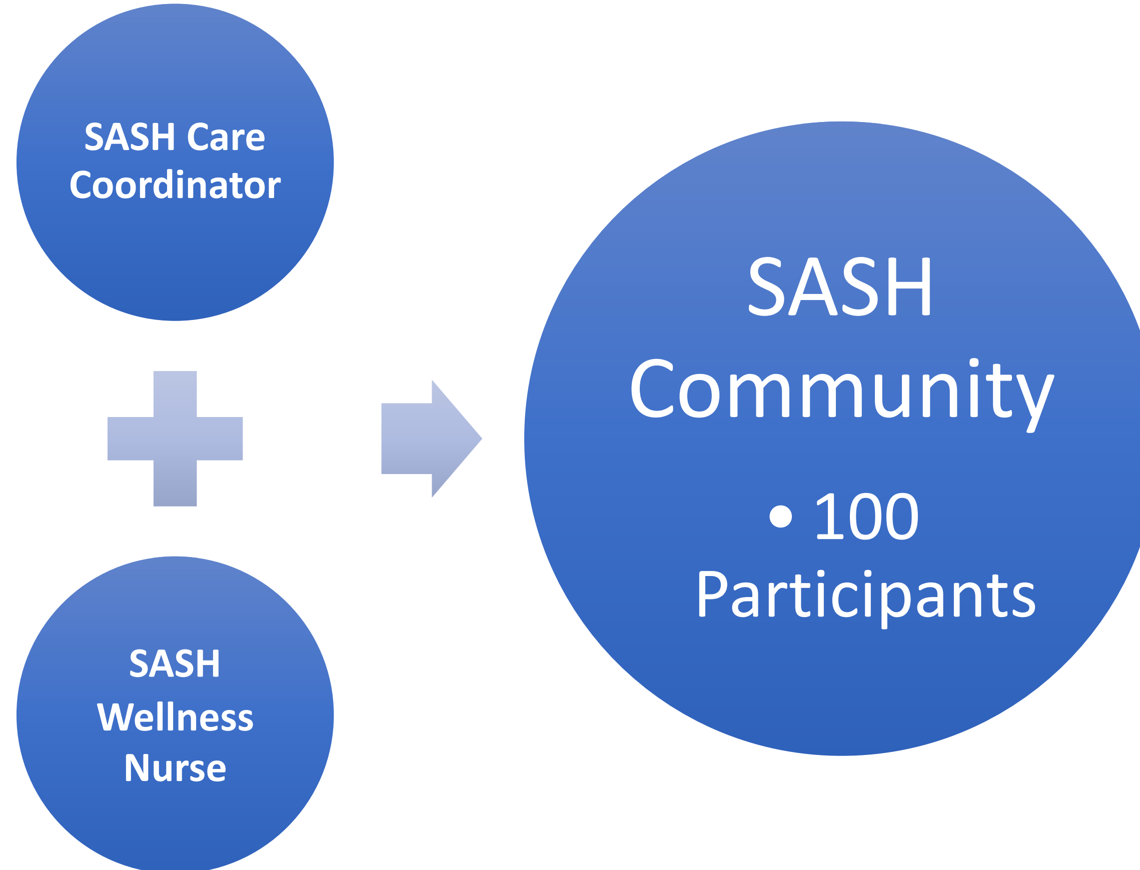
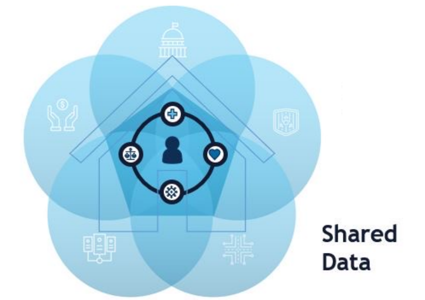
Core of the SASH Team



Housing Organization as Host

Shared Data



Median # of chronic conditions: 6

People with 3 or more diagnoses: 75%

Condition	% of SASH Participants
Hypertension	54%
Arthritis	51%
Chronic Pain	37%
Coronary Artery Disease	26%
Diabetes	24%
Hearing Impairment	22%
Depression	33%
Anxiety	27%
Schizophrenia	3%

% of SASH Participants 0 10 20 30 40 50 60

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.

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SASH – A System That Works

Darryl

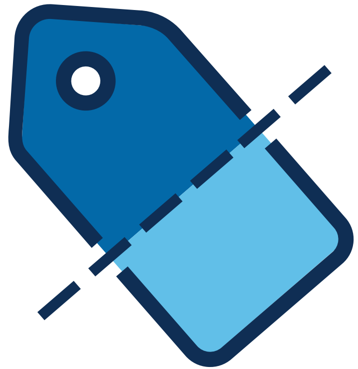
- Darryl had been happily living in affordable housing since he moved out of his parents home at 35.
- Recently his diabetes led to dangerously high glucose levels.
- He experienced bacterial infections, nerve damage and severe swelling in his legs.
- His typically happy demeanor declined at the prospect of live-in help.

SASH - A System That Works

Darryl

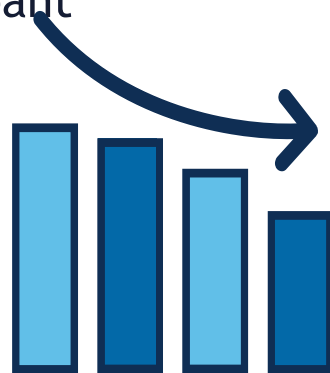
- Darryl chose to take diabetes classes at the hospital
- His Direct Support Worker accompanied him to events at the local high school, his point of passion.
- He started tracking his insulin levels.
- Eventually he felt comfortable enough to call his doctor independently.

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

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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%

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SASH Operating Infrastructure

Funding
- APM / ACO
  State Medicaid

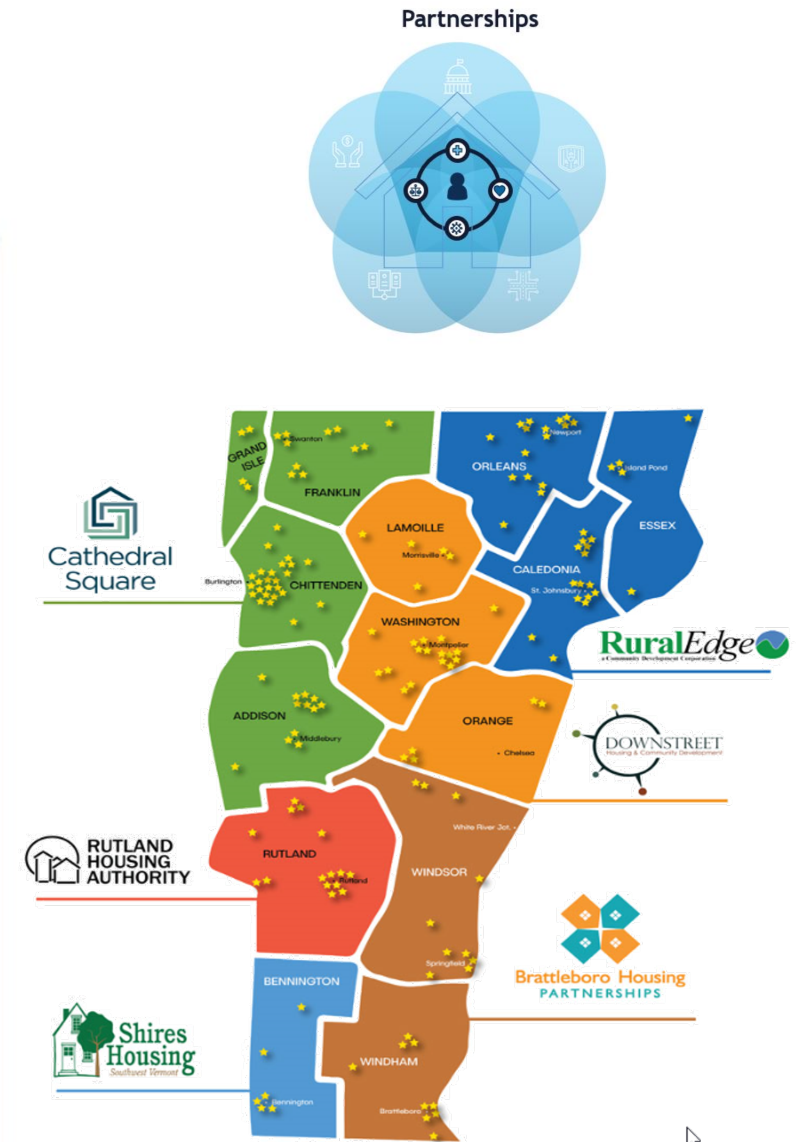
Administrative Entity
- SASH Statewide Administrator

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

Housing Organizations

Northwest Counties	Northeast Counties	Western Lake Region	Southwest County	Southeast Counties	Central Counties
6 Orgs	1 Org	1 Org	2 Orgs	5 Orgs	6 Orgs
43 Sites	31 Sites	18 Sites	7 Sites	14 Sites	27 Sites

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



Volume Matters

Questions

For More Information

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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.

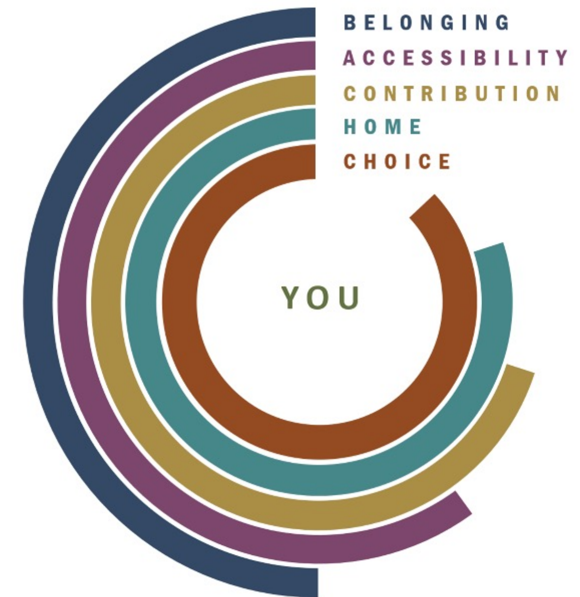
20+ Years

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.

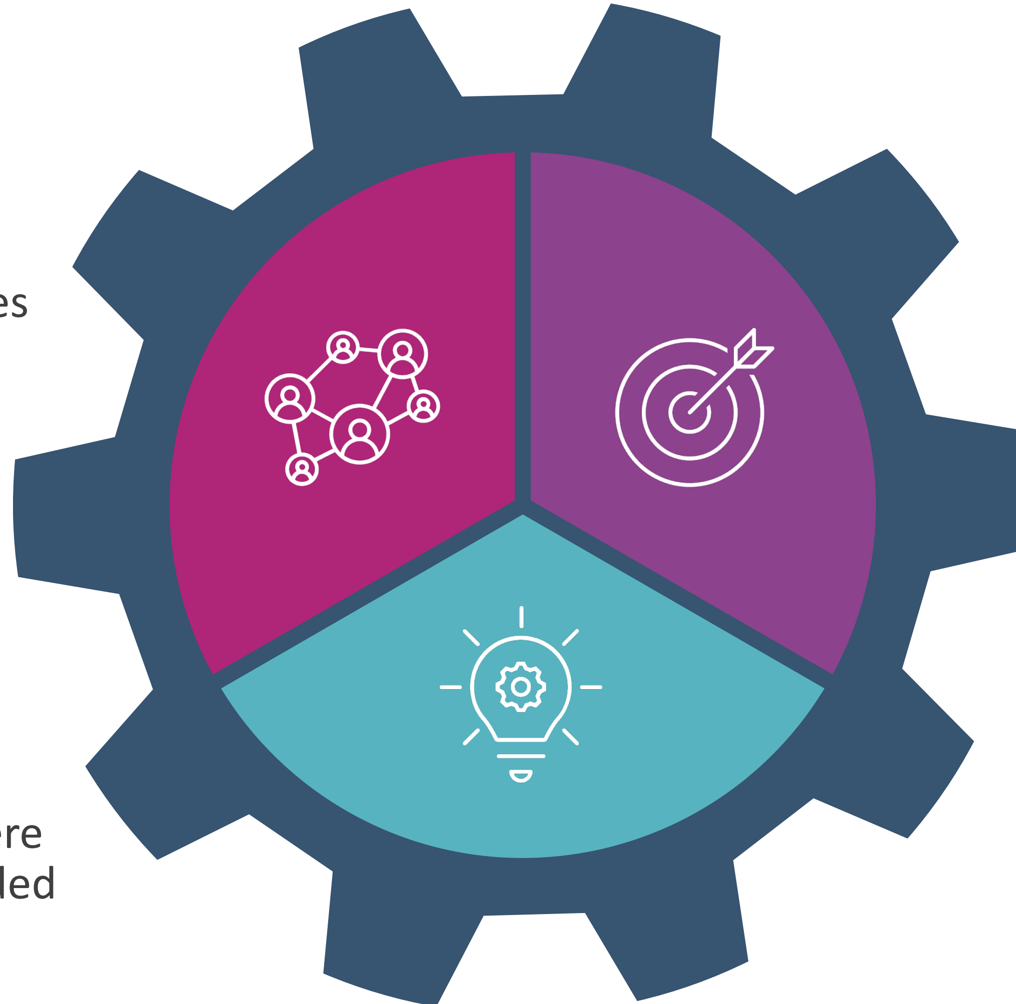


Transformation is not a new thing for us.

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

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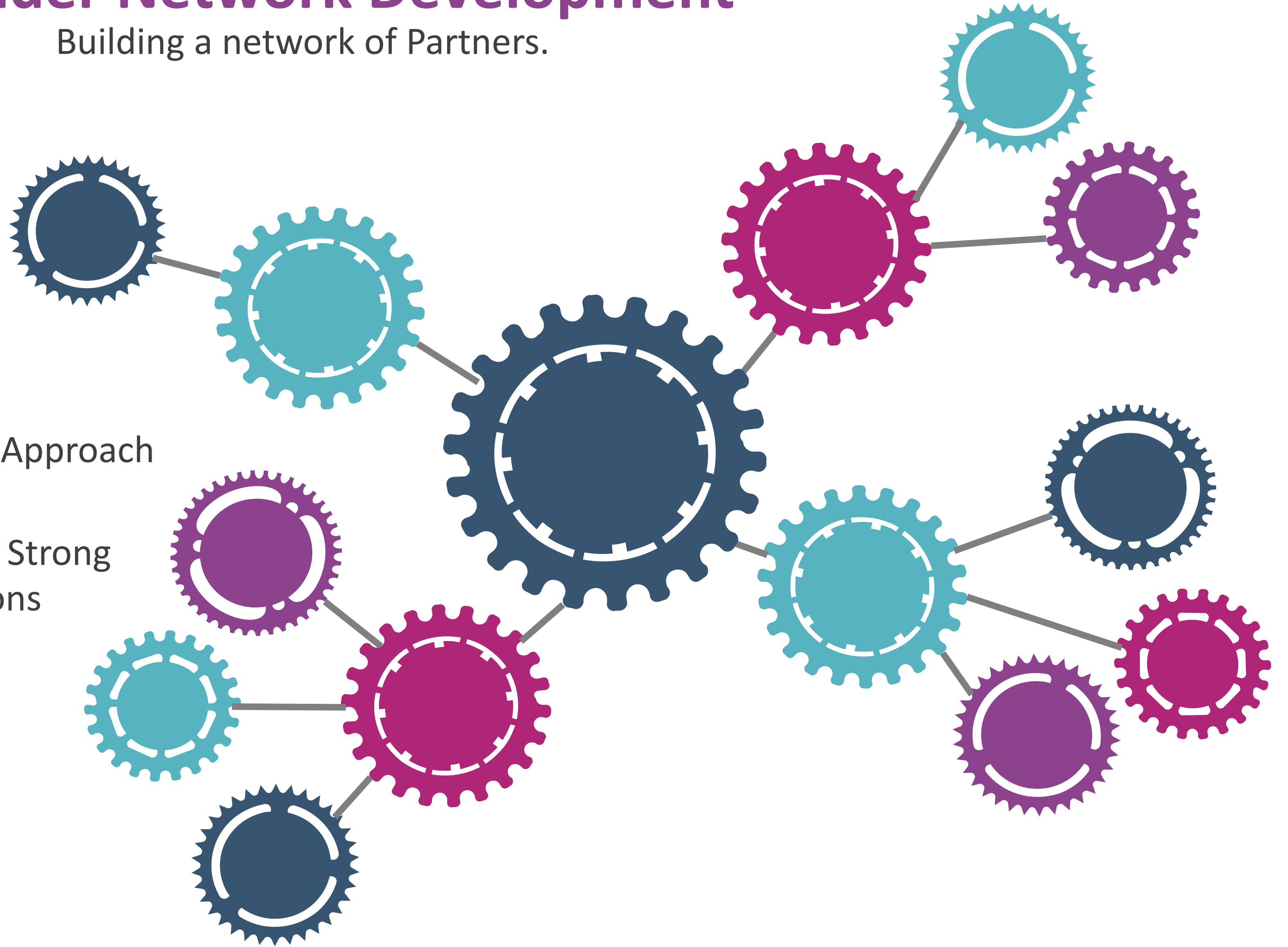
Provider Network Development

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



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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

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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.

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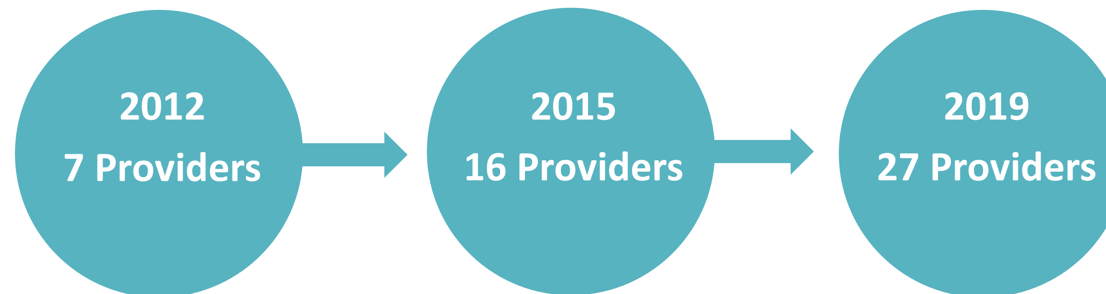
The Impact

Competitive Integrated Employment Case Study Results

*results occurred after two years of implementation.

PROVIDER SUCCESS IS GROWING!



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The Impact

Competitive Integrated Employment Case Study Results

PROVIDER A
FEE-FOR-SERVICE

PROVIDER B
SUPPORTED EMPLOYMENT OUTCOME-BASED

	Provider A	Provider B
NUMBER OF MEMBERS	50	47
TOTAL HOURS WORKED	1385.75	2030.45
AVERAGE HOURS WORKED	27.72	43.20
PAYMENT METHOD	Fee-for-Service (FFS)	Supported Employment Outcome Based (SEOB)
# HOURS JOB COACHED	1264.50	220.75
TOTAL PAID	$35,760.06	$18,855.85
IF IN OTHER PAYMENT MODEL, WOULD HAVE BEEN PAID	$14,864.32 (SEOB)	$7,174.38 (FFS)
DIFFERENCES OF PAYMENT MODELS	Focuses on paying for services of Job Coach and eliminates incentive to increase hours worked.	Focuses on paying for member hours worked and incentivizes increasing hours worked, fading of support needed, and quality employment.

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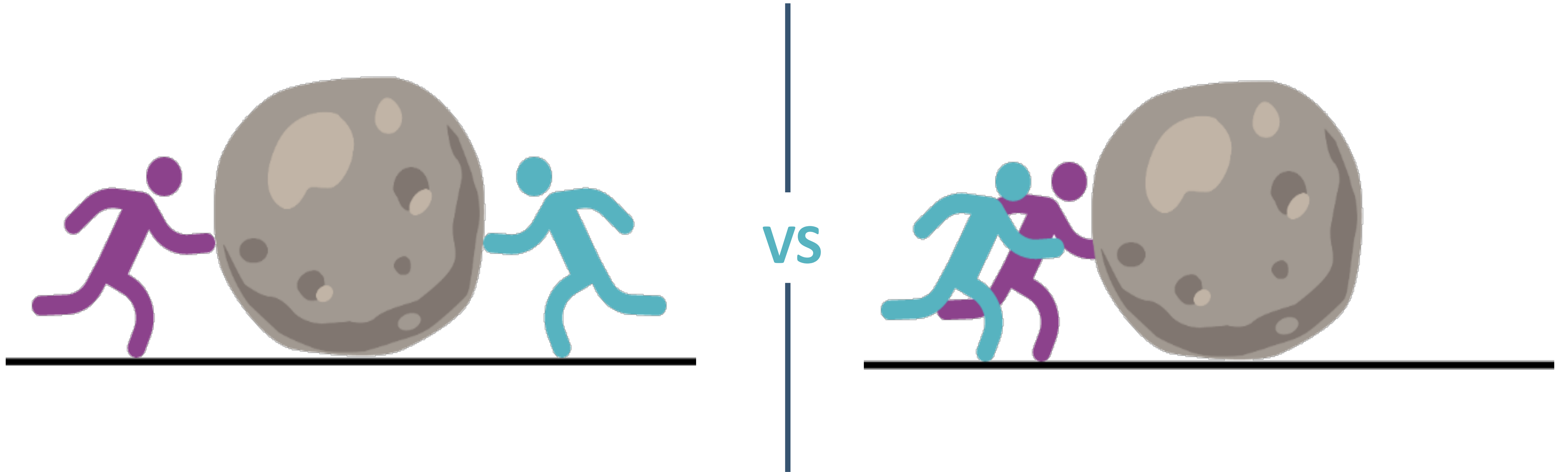
The Power-With Approach

With stakeholders and funders.



Community Supported Living

Expansion into New Region

Co-Created with Provider

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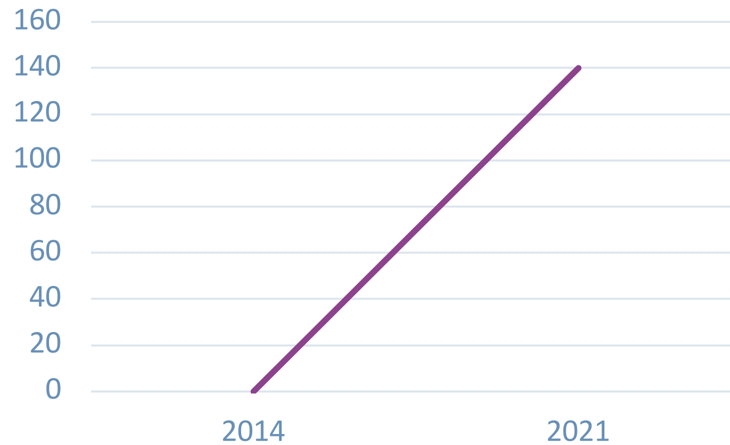
The Impact

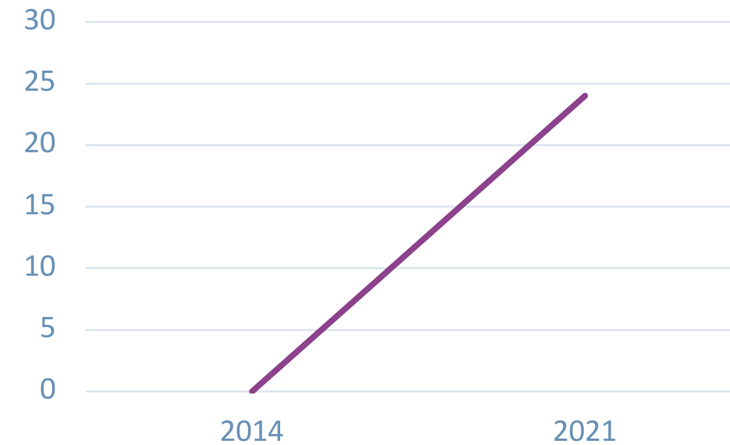
GSR 7 & 14 Expansion Case Study Results

100% Growth



GSR 7

100% Growth



GSR 14

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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.

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Questions?

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