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The way we fund services for older adults is being transformed as the structure of our population changes. The well-advertised "age wave" is delivering the promised rapid increase in the number of older adults, including those with complex chronic conditions. These older adults are having profound impacts through the ways they access and use health services, affecting how these services can be delivered in a meaningful and cost-effective manner.

At the same time, the way services for older adults are funded and delivered is evolving. Funding from the Older Americans Act has been flat for almost thirty years. State budgets have been stretched thin covering escalating Medicaid costs, and many local governments are struggling to meet the myriad demands of a growing population of older adults on their respective budgets. In response, new business models are developing to help check spiraling costs and produce new funding channels for aging networks tasked with serving older adults.

The confluence of these two trends helped spawn a new business model that delivers better and more cost-effective health outcomes for older adults while creating new funding opportunities for organizations that serve this expanding population. The evolution of this model has helped Bay Aging, an Area Agency on Aging serving rural southeastern Virginia, become a comprehensive service provider for Medicare Advantage. With forty years of experience bringing an array of services that support health into clients' homes, Bay Aging has historically provided services through public health plans. This new business model is gaining popularity with private providers, such as accountable care organizations (ACOs), as they endeavor to share in the savings associated with avoidable readmissions.

Pioneering a New Approach

To help address these challenges, Bay Aging, one of twenty-five Area Agencies on Aging in the state, spearheaded a partnership that led to the formation

of the Eastern Virginia Care Transitions Partnership (EVCTP) in 2013. This pioneering collaboration began in 2012 with funding from the Centers for Medicare & Medicaid Services (CMS) Innovation Center's Community-Based Care Transitions Program (CCTP). Originally, the CMS CCTP pilot included only Bay Aging and Riverside Health System. The team was tasked with helping consumers transition from hospital (or other care settings) to home in order to reduce hospital and nursing home readmissions. Specifically, CMS tasked CCTP funding awardees like Bay Aging with reducing avoidable 30-day all-cause hospital readmissions by 20 percent. Kyle R. Allen, DO, AGSF, who was then Riverside Health System's vice president of clinical integration, challenged Bay Aging to expand the scope of the pilot, admonishing the team to "Go big or go home." Dr. Allen is now vice president and enterprise medical director with CareSource in Ohio, where he continues to champion community-based care transitions programs.

This "go big" approach was buoyed by studies that showed more than half of hospital readmissions of Medicare patients occurring within thirty days of discharge resulted from social and economic factors, the physical environment, and health behaviors such as smoking, rather than for medical reasons. While recognition of social determinants as the primary driver in high readmissions rates gained traction, Bay Aging seized upon the opportunity to build upon the CMS pilot into what would become EVCTP.

EVCTP Launches in 2013

With Dr. Allen's encouragement and support, Bay Aging expanded the partnership to include five health systems, sixty-nine skilled nursing facilities, and four other area agencies on aging, thereby broadening the newly dubbed EVCTP to serve 20 percent of the state. EVCTP employed a team approach to facilitate close collaboration between medical and community services providers by using "certified coaches" to effectively transition patients out of hospitals and give them the skills and confidence to manage and control their health problems. EVCTP proved that, when given the opportunity to gain insight and health management skills, engaged patients are better equipped to manage their conditions, remain at home longer, and use fewer healthcare services thereby reducing healthcare costs.

Coaches Going into the Home

Many health systems employ "nurse navigators" charged with making follow-up phone calls with recently discharged patients in support of the hospital's quality control efforts. EVCTP's service delivery model used health care coaches to partner with patients and their caregivers, serving them less as case managers and more as motivational instructors. At the core of this model is the Care Transitions Intervention® (CTI®) program (www.caretransitions.org), which facilitates patients and their caregivers having a more active role in their care. EVCTP health care coaches empower patients to take charge of their own healthcare by providing motivational interviewing, fall prevention counseling, and chronic disease self-management techniques. Health care coaches also introduce other evidence-inspired programs to the home, including advance care planning, diabetes self-management, and nutritional counseling. Additionally, the certified coaches use the Healthy IDEAS Programs (www.healthyideasprograms.org) to empower older adults to manage their depressive symptoms through a behavioral activation approach that encourages involvement in meaningful activities. By partnering with the patient and/or their caregivers in their home, coaches develop relationships with patients allowing them to relax, open up, and have frank discussions about their real world challenges.

Coaches cultivate relationships with patients who meet the high-risk (for readmission) program criteria and who consent to CTI®. These patients receive a bedside visit from the assigned coach twenty-four hours prior to discharge, which helps ensure a successful transition from the hospital to the home or partnering skilled nursing facility. Within seventy-two hours of discharge, the coach conducts an in-home assessment and connects the patient to needed services including transportation to medical appointments, home-delivered meals, and even home repairs or remodels that will help facilitate independent living.

The Care Transitions Intervention

At the heart of EVCTP is the Care Transitions Intervention® developed under the direction of Eric A. Coleman, MD, MPH, Professor of Medicine and Head of the Division of Health Care Policy and Research at the University of Colorado. The coach's intervention focuses on four conceptual areas, known as The Four Pillars®:

1. Medication self-management: the coach works with the patient to ensure he becomes knowledgeable about his medications and has an in-home medication management system.

2. Use of a dynamic patient-centered record: the

patient understands and utilizes the Personal Health Record (PHR) to facilitate communication and ensure continuity of care across providers and settings. The patient or informal caregiver manages the PHR.

3. Primary Care and specialist follow-up: with the coach's encouragement and support, the patient schedules and completes a follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

4. Knowledge of red flags: the patient is knowledgeable about indications that his condition is worsening and how to respond (www.caretransitions.org).

Through these home visits, care coaches interact with patients in a "real world" setting that gives valuable context to the intervention and bolsters the patient's confidence that she can manage and control most of her health problems. Indeed, coaches administer a pre- and post-care survey asking the patient to respond to a single statement: "I am confident that I can manage and control most of my health problems." On a scale of one to ten, where one is "not at all confident" and ten is "completely confident," patients had an initial enrollment score of 5.02 and an ending enrollment score of 7.88, an increase in self-confidence of 57 percent!

Improved self-confidence shows that the patient has taken control of the ongoing management of their health. These techniques also align with new evidence-based factors that represent the core health issues for older adults, known as the 4Ms. The 4Ms are:

- What Matters: Considering and acting on patients' healthcare goals and preferences
- Mentation: Assessing and managing cognitive and mood concerns
- Medication: Evaluation and use of appropriate, age-friendly medications
- Mobility: Assessing and implementing a mobility plan (Institute for Healthcare Improvement: ihi.org)

VAAACares® coaches work with patients and caregivers to develop a comprehensive mobility plan that begins in the home. For example, the coaches facilitate a mobility plan, from safely using walkers and navigating steps or ramps in the home, to leveraging outside transportation resources for visits to the doctor or grocery store.

Impressive, Independently Verified Outcomes

Increased patient empowerment was not the only impressive EVCTP outcome. From 2013 to 2015,

EVCTP completed nearly 26,000 home visits with Medicare patients discharged from partner hospitals. Hospital data, confirmed by CMS, revealed that EVCTP enrollee readmission rates for 2016 decreased to 9.1 percent, substantially lower than both the average target group readmission rate of 14.4 percent for that same year and the 2010 EVCTP enrollee readmission baseline of 23.4 percent (Super, 2017).

Similarly, through a 12-month pilot with 945 Medicaid patients, the average readmission rate dropped from 25 percent to 6 percent as a result of EVCTP program participation. Assuming an average readmission cost of about $10,000, this correlates to a savings of $1.5 million. Conversely, the EVCTP Medicaid pilot cost approximately $283,000 to implement.

Information Sharing and Reporting

The innovative EVCTP model not only reduced hospital and nursing home readmissions by empowering patients to actively manage and control their health problems, it also resulted in improved information sharing and data reporting among the partner organizations. To facilitate effective information exchange, EVCTP established agreements with the partnering hospitals for secure data-sharing systems that were integrated into health systems' electronic health records and health information exchanges, as well as a centralized source for billing and tracking readmissions. EVCTP coaches were able to access a shared in-patient tracking system to prioritize the scheduling of hospital and home visits. Coaches and supervisors regularly attended hospital readmissions meetings to discuss patients who were recently discharged and information to be shared with the patients' primary care providers and health systems.

EVCTP Evolves into VAAACares®

The tremendous success of EVCTP and the completion of the pilots ushered in an opportunity to expand the program and serve adults age eighteen and up. In 2015, Bay Aging led the expansion of care coordination and care transition services throughout the state by partnering with many of Virginia's other AAAs. Rather than forming a new and expensive LLC, the statewide program was branded as VAAACares® (Virginia Area Agencies on Aging — Caring for the Commonwealth) with Bay Aging serving as the lead agency and legal entity. While there was unanimous agreement among the twenty-five Virginia AAAs to expand the program statewide, not all signed the business affiliation agreements so traditional AAA service boundaries do not always apply for VAAACares.

The VAAACares program provides comprehensive care coordination, care transitions and many other services to support the health and well-being of its enrollees. Maintaining an independent database for reporting performance measures, tracking care episodes and patient outcomes, as well as other quality assurance measures, the program is a "one-stop shop" for referrals, billing, reporting, data analytics, training, and quality assurance. In addition to the dedicated care transitions system, VAAACares also offers logistics management services including:

- In-home assessments to determine the needs of the client.
- Person-centered planning to outline needs and establish the required delivery of services.
- Management and delivery of a broad range of home and community-based services provided by a credentialed network of direct service providers.
- Just-in-time delivery of community-based interventions to support the healthcare needs of targeted members in community settings.
- Ongoing performance monitoring of network direct service providers.
- Centralized invoicing and management of payment disbursements to the network of direct service providers.

John A. Hartford, Foundation Business Innovation Award Winner

The National Association of Area Agencies on Aging (n4a) established *The John A. Hartford Foundation Business Innovation Award* in 2016 to recognize community-based organizations (CBOs) that have successfully partnered with health care entities. The award recognizes CBOs that have a track record of developing transformative initiatives integrating health plans, health care, and long-term services and supports to improve quality of life for older adults and/or people with disabilities. At n4a's forty-second Annual Conference & Tradeshow in 2017, Bay Aging's leadership in developing VAAACares was recognized for uniting Area Agencies on Aging across Virginia in this innovative business collaboration.

Bay Aging's VAAACares program has also been recognized by the Archstone Foundation, the Aging & Public Health Section of the American Public Health Association and Virginia Chamber of

Commerce's Health Care Innovations Award for Patient Outcomes.

Duals Demo Success Leads to MLTSS Contract

The success of both the Medicare program and Medicaid pilot resulted in contract opportunities when the Dual Medicare and Medicaid Eligible Demonstration Project (Duals Demo) was initiated. Virginia's move to managed long-term services and supports (MLTSS) now provides the VAAACares partnership with an additional platform to market its services to Medicaid managed care plans. Commonwealth Coordinated Care Plus (Virginia Department of Medical Assistance Services), a statewide Medicaid MLTSS program that launched in August 2017, will serve approximately 214,000 Virginians with complex care needs through an integrated delivery model with support from VAAACares. The program is also exploring opportunities with Medicare Advantage clients.

n4a Business Institute Shares Best Practices

An interest in sharing best practices with other AAAs and Community Based Organizations (CBOs) around the country prompted the n4a Business Institute to convene a group of leading AAAs, including Bay Aging, to share and build upon innovative new business models (such as VAAACares) with their colleagues. The Trailblazers Learning Collaborative (TLC) is one n4a Business Institute think tank for prototyping and working together to address the challenges and opportunities of contracting with health care providers. TLC represents the leading edge of the Aging and Disability Networks, the first group of community-based organizations to tackle next-generation CBO-health care partnership issues. TLC is organized into two workgroups: health systems and health plans. The workgroups meet twice monthly via conference call to brainstorm and continue preparations to address the coming age wave with innovative new business models.

Capitalizing on the Perfect Storm

The evolution of VAAACares from its humble origins as a small CMS CCTP pilot partnership between Bay Aging and Riverside Health System to a statewide program that has the potential to serve over 200,000 Virginians was not without challenges and missteps. Bay Aging and the partnering AAAs faced staffing challenges expanding the program across Virginia. Additionally, developing the information technology infrastructure and learning to chronicle outcomes data in accordance with stringent reporting requirements helped VAAACares focus on impacts that clarified the program's value to stakeholders. The program's progression continued with the duals demo which, in turn, prepared Bay Aging for the MLTSS and further integration of Eric Coleman's Care Transitions Program as a foundational element of VAAACares.

Throughout this progression, VAAACares' exceptional client impacts such as better health outcomes, patient empowerment, and improved client confidence have consistently exceeded expectations. Likewise, the well-documented financial benefits realized through this innovative business model demonstrate that unnecessary healthcare costs can be eliminated while simultaneously helping patients and caregivers lead happier, healthier lives. Bay Aging stands ready to help health care providers and health plans around the country to capitalize on this perfect storm and harness the impacts of the innovative VAAACares business model in the communities they serve. •CSA

Kathy Vesley-Massey is president and CEO of Bay Aging, a nonprofit Area Agency on Aging (AAA) serving rural southeastern Virginia. In addition to traditional aging programs, Bay Aging provides senior housing, public transportation, and in-home transitional health care. In 2017 she was awarded The John A. Hartford Foundation Business Innovation Award for forging a statewide coalition of AAAs, named VAAACares®. Prior to joining Bay Aging, Kathy served in Virginia state leadership positions including deputy commissioner of the Department for the Aging, and acting commissioner of the Department for the Deaf and Hard of Hearing. Contact her at kvesley@bayaging.org or (804) 758-2386, ext. 1217.

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RESOURCES

Administration for Community Living: https://www.acl.gov/
The Care Transitions Program: https://www.caretransitions.org
Healthy IDEAS Programs (Identifying Depression & Empowering Activities for Seniors): https://www.healthyideasprograms.org
Institute for Healthcare Improvement: https://www.ihi.org
The John A. Hartford Foundation: https://www.johnahartford.org/
National Association of Area Agencies on Aging's (n4A) Aging and Disability Business Institute: https://www.n4a.org/businessinstitute