

NWX-HHS-AOA-1

**Moderator: Lauren Solkowski
November 6, 2014
1:00 pm CT**

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode until the question and answer session of the call. To ask a question during that time please press Star than 1.

This conference is being recorded. If you have any objections you may disconnect at this time. Now I like to turn over the meeting to Lauren Solkowski. You may begin.

Lauren Solkowski: Great. Thank you. Good afternoon and thank you for joining us today for the Administration for Community Living's Targeted Technical Assistance Webinar Home and Community-based Services Brokerage Guide.

I am Lauren Solkowski as the operator mentioned with ACL and I will be facilitating the Webinar.

For our Webinar today we have invited Brenda Schmidthenner and Renee Sherrill with the County of San Diego Aging and Independent Services to present on the Home and Community-based Services Design Guide, a

Roadmap for Establishing a Brokerage for Home and Community-based Services.

So before we begin with our presentations I do have a few housekeeping announcements that I would like to go through.

If you have not done so yet please use the link included in your calendar appointment to get onto WebEx so that you can not only follow along with the slides as we go through them but also to ask your questions when you have them through the Chat function.

If you don't have access to the link that we emailed you, you can also go to www.webex.com. Click on the Attend a Meeting button at the top of the page and then enter the meeting number which is 668385454. That meeting number again is 668385454.

If you have any problems getting into WebEx you can call the WebEx Technical Support. And that number is 1-866-569-3239. Again that's 1-866-569-3239.

As the operator mentioned all of our participants are in listen-only mode. However we will - do welcome your questions throughout the course of the Webinar.

And there are two ways that you can ask your questions one of which through the Web using the Chat function in WebEx.

You can enter your questions and we will sort through them and answer them as best we can when we take a break after the speaker presentation.

And in addition to the Chat function after the speaker's wrap-up we will offer you a chance to ask your question through the audio line. When that time comes the operator will give us instructions as to how to queue up to ask your questions.

If there are any questions that we cannot get answered during the course of the Webinar we will be sure to follow-up to get them answered.

If you think of any questions after the Webinar please fill free to email them to me. And I'm going to enter my email address up here in the Chat box located on the screen throughout the Webinar.

As the operator mentioned we are recording the Webinar and we will be posting the recording, the slides as well as the transcripts on the ACL Web site as well as on N4As MLTSS network site.

I will enter all of these, the ACL Web site and the N4A Web site as well as my email address into the Chat box for your reference.

So with that I would like to introduce our speakers starting with Brenda Schmidthenner. Brenda is an Aging Program Administrator for the County of San Diego's Aging and Independent Services and Program Manager for the Long-term Care Integration Project.

She has provided administrative and supportive services to older adults and people with disabilities in the private nonprofit and public sectors for over 30 years.

Brenda is the Program Administrator for the largest community-based care and transitions program in the country. That is San Diego's Aging and Disability Resource Connection Team San Diego.

Brenda has served as a liaison between AIS and the Healthy San Diego Managed-care Health Plan since April 2011.

And she is the county's lead for the implementation of the Coordinated Care Initiative which is California's dual eligible demonstration.

And also with us today is Renee Sherrill. Renee is experienced in large-scale program development and project management.

She has worked for the county's health and human Services Agency HHSA for over 20 years. And she has led the development and implementation of numerous new initiatives including HHSA's Continuity of Operations Emergency Management Program, HHSA's Management Controls Initiative and the Mobilizing for Action through Planning and Partnerships Community Initiative for HHSA's six regions for public health accreditation.

So thank you so much to Brenda and Renee for being with us today and we're very much looking forward to your presentation.

So Brenda with that I will turn it over to you.

Brenda Schmidthenner: Thanks so much Lauren. We really appreciate the opportunity and invitation from the Administration on Community Living to participate in today's Webinar.

You see we really welcome the opportunity to share with you how our organization, Aging and Independent Services or AIS as we are more commonly known and our community of healthcare and long-term services and support providers in San Diego County California are really innovating to respond to this new world of rapidly changing service delivery and accountability.

After providing you with a brief overview of AIS I'd like to talk about how we lead an initiative to produce a home and community-based services brokerage guide.

We're going to walk you through the guide and then we'll be available to answer any questions that you may have.

Next slide please. Just a little bit about Aging and Independent Services, we are the area Agency on Aging for San Diego County.

We're a core partner in San Diego County's aging and Disability Resource Connection or ADRC. But we're also the county's umbrella agency under Health and Human Services for more than 30 different programs services for older adults and people with disabilities.

And so we provide services in a variety of ways. For example we contract for services under the Older Americans Act like home delivered meals and congregate meals, legal assistants and caregiver support.

We directly provide services through programs like adult protective services, in-home supportive services, the long-term care ombudsman program.

We have three different case management programs and veterans services under our agency.

We do focus heavily on health, prevention programs as well as health improvement programs. We offer care transition support, evidence-based care transitions and self-management programs as well as falls prevention.

We serve all of San Diego County and all of our services are free to eligible individuals.

Next slide please.

For years AIS has grappled with the fact that health care and long-term services and support operate in two very distinct systems of care.

They each conduct an assessment, each have their own care plan. And what's resulted is the siloed delivery systems that have proven to demonstrate a system of uncoordinated care with lots of service gaps and duplications and inefficiencies in service delivery.

Now unfortunately this doesn't come as any surprise to any of you but these two systems they speak different language. They have different cultures, different financing structures and different priorities.

The result is that the older adults and persons with disabilities are subjected to this fragmented delivery system that it's completely impossible for them to navigate.

And this system produces poor health outcomes, escalating health care costs. And most importantly it doesn't prioritize the needs and preferences of the individual.

Next slide please. So here at AIS we've long envisioned a new care delivery system that really is person centered and really does coordinate care across the continuum, a system that eliminates the complexity and the fragmentation that our clients are subjected to and that supports living in the manner and the setting of their choosing.

Next slide please. So to realize our vision in 1999 AIS began engaging stakeholders in designing a person centered coordinated system of care by establishing the Long-term Care Integration Project.

Healthcare providers including managed-care health plans, hospitals and physicians they've been key stakeholders in this process for the past 15 years.

Now today that stakeholder group has grown to over 800 and it includes consumers and caregivers as well as healthcare, social service providers and local state and national policy leaders.

Early on in the project we established these strategies for getting to this new system of care. We established an aging and disability resource connection.

We developed team San Diego to create virtual teams around individuals with multiple chronic conditions. And we have supported the coordinated care initiative or CCI which is California's dual eligible demonstration.

Next slide.

Now through the Long-term Care Integration Project AIS has partnered with healthcare providers to build that new delivery system.

For example in 2012 we were awarded the largest community-based care transition program in the country.

We partner with 13 hospitals and four large health systems. And we administer a program that targets over 1700 high risk fee for service Medicare patients each month to receive both hospital based and community-based support to reduce their risk for readmission.

And you see here what that program looks like. And it may look quite complex. But when you drill down to the program it really isn't.

You see patients are assessed for risk for a readmission and then they receive specialized nursing and pharmacy services during their hospital stay.

And then they are referred to AIS for coaching to activate health self-management and to a program that provides intense short term care coordination and long-term services and support.

Next slide please. Now that community-based care transition program has been really tremendously successful in reducing readmission rates.

And we attribute a good part of that success to our role in providing the Care Enhancement Program. This program provides intense short term care coordination, links these high risk patients to home and community-based services for long-term solutions and purchases services within the first seven days after discharge to ensure that those services are in place until long-term solutions can be set into motion.

Now this program has really demonstrated to our healthcare community the importance of long-term services and support. As a matter of fact if it were up to our 13 hospitals they would refer every medically and socially complex patient in their hospital to us.

Next slide please.

Another opportunity for partnership for AIS has been the opportunity to participate and partner with managed health plans under the new California demonstration, the Coordinated Care Initiative.

In San Diego County we have about 120,000 dual eligible beneficiaries and Medi-Cal beneficiaries that are enrolling in five managed care health plans.

We've established a strong working relationship with these plans for the past 15 years. And when it was time to establish an advisory committee for CCI the plans asked that that advisory committee and communication workgroup be established under the Long-term Care Integration Project.

Next slide please. So under this coordinated care initiative what's unique to California is that the four - there are four community-based long-term services and supports that have become managed health plan benefits for Medi-Cal beneficiaries and dual eligible's participating in a program called Cal-Medi Connect.

Those four long-term services and supports that have been managed in the community previously are now being managed by these health plans.

And they include in-home support services, the Multipurpose Senior Services Program, CBAS, Community Based Adult Services which is California's adult day health care system and long-term care skilled nursing services.

Next slide please. Now coincidentally AIS happens to operate two of these long-term services and support programs.

We operate the in-home Supportive Services Program that provides domestic and personal care services to over 25,000 low income seniors and persons with disabilities.

Now we've executed a memorandum of understanding with each of these health plans to deliver the in-home supportive services programs to their members.

We also have been the Multipurpose Senior Services Program or MSSP program site for over 20 years in San Diego County.

And this program is a care management program that arranges pays for and coordinates important services for clients to prevent avoidable nursing home placement.

Now we executed a contract, a revenue agreement with each of these health plans to operate that program.

Now in addition there is a requirement for the health plans to coordinate behavioral services. And those services are under our county umbrella as well and they now have an MOU to work together collaboratively to ensure behavioral health needs of the managed health plan members is met.

Next slide please. So beyond this required partnership under the Coordinated Care Initiative between AIS and the health plans there are many long-term services and providers, service providers in our community as well as AIS that are really well-positioned and have been actively seeking opportunity to partner with on a financial basis the managed health plans to deliver additional what's called care plan option services.

It was the opportunity and request from hospitals that were participating in the community-based care transitions program and these five managed health plans for assistance in connecting them with the long-term services and support, their home and community-based services that we began thinking about how we might make that happen.

So we started to think about what about establishing a community-based brokerage that could provide access to high quality home and community-based services through a network?

And a single referral entity would be a point of contact and the hub to receive request for services and then link those services for those complex individuals.

You see we know for a fact that home and community-based services reduce the overall per patient healthcare costs. That's been demonstrated nationally.

We know it reduces emergency room visits. We know that it prevents hospitalizations and readmissions as we've demonstrated through the Community Based Care Transitions program. And we also know that these home and community-based services reduce out of home placements and improve HEDIS measures for healthcare providers.

We also figured that if we established a brokerage perhaps a variety of home and community-based services who are not able to individually contract with health plans and hospitals and other payers would have the opportunity to deliver their very specialized services to people in the community that needed the services beyond their normal referral and business practices.

Next slide please. So here is how we envisioned a brokerage might work. You see it begins with a call to a single entity. That call would likely come from a healthcare provider or a payer. They have specific needs for their members for their patients.

They request for those members to be connected to specific services and supports that are needed.

Now that central hub, that brokerage, could serve the function of simply reaching out into the community and connecting the requester with the home and community-based service providers or it could serve as a hub to also provide assessments, care planning and up to 30 days of short-term care coordination.

So what's the benefit of using the centralized hub? Well all of those home and community-based services providers that served that member or patient would invoice the brokerage.

Their individual invoices would be paid by the brokerage. But the brokerage serving as the fiscal intermediary would then only submit one invoice to the requesting healthcare payer or provider thus reducing their administrative overhead as well as the time spent by their clinicians trying to reach out into the community and arrange for services for these high-risk individuals.

Next slide please. Now as you've heard AIS has really served as that neutral and trusted partner with both healthcare and home and community-based services providers in our county for many, many years.

So it really wasn't surprising as our Community-Based Care Transition programs matured and San Diego was selected as one of the counties to implement the Coordinated Care Initiative that both of these groups of providers reached out to us for assistance in helping bridge these two distinct systems of care.

So internally we started to think about how we might leverage our aging and disability resource connection which already serves as that no wrong door access San Diego for information and assistance and linkage to home and community-based services how we might build on that infrastructure and create a brokerage.

AIS already has a large number of contracts already in place with many of these home and community based service providers to provide services for our many programs including adult protective services in our case management program.

And those contracts we figure could easily be expanded so that any home and community-based services that met the qualifications of providing high quality services could be included in the network of providers.

So we brought an internal team within AIS together and we started to analyze what this concept might look like if it were built by an area agency on aging, if that were built perhaps on the infrastructure or - of an ADRC?

You see the needs had already been clearly identified to us by our community of healthcare provider payers in our community of home and community-based services. So we knew there was a need.

So we started to focus on what a viable model might look like and what would it take to really implement such a model?

And that analysis led to the development of two potential models for consideration, one as I spoke about would just connect the requester to the service providers and that streamline the fiscal process.

The second model would actually bring into play expertise of older adults and persons with disabilities by providing an assessment care planning and short-term service coordination. So at that point you would also be bringing in options counseling.

Next slide please. So after we completed this analysis we realized that internally we lacked the expertise to address some of the really important considerations including data sharing, legal implications and risk management.

So the timing for taking the brokerage conversation to the next level coincided perfectly with AIS being awarded the plan from the SCAN foundation for the long-term care integration project to serve as the regional coalition for San Diego County to support the transformation of long-term services and supports in California.

Now for those of you who are not familiar with the SCAN Foundation they're focused on advancing a coordinated and easily navigated system of high quality services for older adults that preserve dignity and independence.

So the grant that we were awarded from the SCAN Foundation allowed us to complete a deeper analysis of the issues and considerations that were uncovered during our initial AIS analysis.

Next slide please. So with funding from the SCAN Foundation grant we engaged Collaborative Consulting to convene a team of executive level thought leaders from our health care and home and community-based services community to provide guidance to design and operate a home and community-based services brokerage.

Now the goal of the design team was to consider organizational structures and operations that would facilitate access for healthcare payers and providers to high-quality home and community based service providers and to support the home and community-based service providers by taking away the cumbersome relationship or responsibility of establishing relationships and contracts with individual health plans, hospitals, ITAs, accountable care organizations and other healthcare entities.

Next slide please. So the design team was charged with creating a guide that could be used as reference for any community that might be interested in improving access to home and community-based services.

So the guides was meant to be a conceptual roadmap rather than a prescriptive model. The design team used the AIS analysis as a point of reference and then identified considerations for both the development and implementation of a brokerage by any lead entity.

So the consultants provide a guide as to the team on different legal structures and advised the group on several interventions that were in progress or had already been implemented across the country.

So I think I've provided sufficient background now to turn this presentation over to Renee Sherrill who's going to walk you through the actual guide.

Renee Sherrill: Thank you Brenda. Next - oh, you've got it. I trust that you've of all receives an electronic copy of the Brokerage Design Guide. I'll be walking through much of that right now.

For the guide and San Diego County case study we used six steps for the design process. And we adapted many of these concepts from discovery driven growth by Maria McGrath and Ian McMillan published by Harvard Business Press.

It's a book that talks about the best ways to go or some great ways to go about developing something when you have a high level of uncertainty. And in this case we did have a high level of uncertainty.

So I'll be walking through the case study in San Diego to demonstrate this process in the guide. If you have the guide in front of you, you might turn to Appendix B Page B1.

Next slide, so the first step is to design the service delivery model. And in order to do that you need to look at the existing state.

And Brenda did a great job of describing the background here in the county San Diego. One of the first things we asked ourselves was what is the need that we are primarily trying to address? And Brenda described it very well.

There is a need to access a wide array of home and community-based services, to improve healthcare outcomes and reduce costs.

And healthcare providers really don't always have the expertise in home and community-based services.

There's also a lack of financial alignment between health and community-based support. Funding is siloed and there's more funding available for healthcare than home and community-based services.

So we identified the need. Then we asked ourselves who are the customers who would be the primary users? And for us that would be healthcare providers and payers, consumers, their families and caregivers. And then the high risk medically and socially complex patients themselves.

We then asked who else might be interested or benefit. And of course the home and community-based service providers would be interested.

Our local Aging and Disability Resource Connection, the Administration for Community Living, California Department of Aging, California Department of Healthcare services, California Health and Human Services and the Centers for Medicare and Medicaid Services.

We then asked ourselves okay well how large is the population in need of home and community-based services?

And in San Diego County 17% of the population is over the age of 60. We have approximately 45,000 with one or more disabilities. And 189,000 in San

Diego County in 2010 have three or more chronic conditions so we define that as medically complex.

We then looked at current environment. What are some changes or just new developments that we might capitalize upon for the brokerage?

Well there are new financial models including incentives for accountable care organizations, new safety T claiming codes to help address the funding issues, the Community Coordinated Care Initiative and community-based care transitions programs that Brenda spoke about earlier, CMMI innovation projects.

The DSNIPS are already providing care coordination, the Affordable Care Act has growth in new populations.

There's a growing desire for community knowledge about palliative care. We have isolated seniors aging in place and there are many best practices occurring outside of San Diego County.

So once we identified the need in the current environment we looked at the unit of service and when you're looking at the unit of service that's a really interesting thing.

You can end up with some real innovative concepts if you think about how you're going to bill. It can really change how you deliver service.

For example I don't know how many of you have been hearing about Taylor Swift but she's actually moving from streaming and having people pay per listens to she's stopping that and moving to actually buying her album so how you deliver that service is different.

So we asked ourselves how might we charge for brokerage services? We could charge per hour, just a flat rate. That would require robust tracking though and we'd have to be able to prove the hours spent.

We could charge per referral but that could be high risk because one client could require connections to up to ten home and community based service providers while the other client only needed connections to one.

And if we were - received a lot of high needs folks we might not be able to beat - that might not be cost effective.

We could charge for service access. It would be a flat rate. We could do fee-for-service. We can do a capitated rate which is very high risk. We could do a sliding scale based upon the volume of the clients or we could share the risk and benefit with our partners.

So in our case we didn't come up with anything innovative but we did do - did look through different ways that we might charge.

Then we looked at our service delivery model. And Brenda briefly described the two models that we thought about. We thought about referral only where and we just created a process map. It's right in your guide their on Page B4 if you have it in front of you.

So we outlined step-by-step what it would look like if when the healthcare provider called the brokerage all the way through contracting and the fiscal reimbursement.

We did that for referral only and then we also did it for the assessment and short-term service coordination's model.

Then after we designed those models we stepped back and said okay, are these models going to add value against the existing states?

So we compared model A to model B and the existing state of uncoordinated network of providers in four areas. We looked at the speed of the service, the cost of the service, availability of service and quality. And we had no data at this point. Everything's theoretical.

So we compared the potential value of the two models against the current state relative to one another since there is no data.

So looking at the B, one call from the provider would link the provider payer and the client to multiple services for the referred individual.

So there was no need for the healthcare provider or payer to track down providers. That's was the same in model a referral only as short-term service coordination.

In addition the assessment and short-term service coordination added identity potential identification of additional needs.

If the healthcare provider is focusing on health the brokerage might offer additional services that might help the client. There would also be ongoing coordination and follow-up.

In the existing states the healthcare provider payer would have to find the resources, make multiple calls, confirm with the patient, provide post service

follow-up when possible. And that's not always possible. And they wouldn't necessarily assess for needs outside of medical services.

So when comparing the two potential models against the existing state when it comes to speed of access the brokerage both models were better. They weren't duplicative and they weren't worse than the existing state.

Moving on to the cost of the service in model A referral only staffing costs are similar to case management staff but a little bit lower.

In model B it would be case management staff costs. And in the existing state oftentimes medical staff time is used for service coordination. So it's - and there are higher healthcare costs due to increased admissions and readmissions, ER visits, et cetera.

Some physicians are being paid for very short-term health-related not social service care and transition for patients post hospital discharge.

Also many contracts, the cost of accessing many contracts and processing the invoices would be there. So the cost of service for models A and B we're definitely better than the current state.

Looking at availability one call in models A and B connects the client to multiple resources.

In the existing state the providers aren't always aware or understand the home and community-based services. So the availability is much higher with the brokerage.

When you look at quality in model A referral only knowledgeable referral staff would be helping the clients.

There would be high-quality contract requirements related to service provision. And there would be potential provider screening. And there would also potentially be an IC data infrastructure.

When you look at assessment and short-term service coordination model in addition to model A there would be high-quality service coordination by experienced staff.

In the existing state high paid healthcare professionals are working outside of their areas of expertise being pulled away from their clinical work.

So when you're looking at quality the brokerage was better again. So in all four areas looking at overall value of the potential model the brokerage was better.

And at this point we've done a real quick and dirty assessment and not spent money other than staff time. So we're not into implementation yet. We're just looking at value-added.

Then we moved on from the customer experience perspective and did the same type of assessment. We looked at five areas -- awareness of service, access to service, use of service, payment and discontinuance of the service relationship. In this case that was when the payer ceases a contractual relationship with the service provider.

So looking at awareness in model A the brokerages provide education to healthcare providers about the value of home and community services. And

they would also provide information about what home and community-based services are available.

Additionally they would provide education to consumers in the community. That would be in the referral only as well as the assessment and short-term service coordination.

In the existing state healthcare providers and payers have little awareness of home and community-based services network, the fees and the services and the geographic coverage. So in awareness to service the brokerage was better than the existing state.

When we're looking at access if you have almost immediate access and that's similar to the speed where we were looking at in the earlier assessment, for both models A and B there would be delays related to having to look up providers and contact multiple providers in the existing state. So the brokerage was better again.

In looking at use of service a single call from the provider connects their clients to multiple resources in both models A and B.

And in the existing state their provider has to make multiple calls so the use is easier.

For payment as Brenda said a single invoice per month. For a provider for all of their clients for all of the services is a huge savings over having to be invoiced for every service for every client.

In addition contract monitoring would be provided and contract, there would be one contract with the brokerage rather than a contract with each provider.

When you're looking at this continuance of the relationship there would be a single contractor no contract for the brokerage where under the existing state you would have multiple contracts to have to terminate.

So if I'm the customer experience in looking at the business case both models of the brokerage was better than the existing state.

So once we did that we stepped back and looked at performance metrics and we asked ourselves in five key areas how do we anticipate performance to be?

We looked at reduction in per patient health care costs overall, reduction in ER utilization, reduction in hospitalizations and readmissions and reduction in out of home placements and improved HEDIS measures for the population served.

So we compare model A with model B with the existing states. Again there is no data at this point so we compared them relative to one another. And we asked ourselves do we expect it to perform better, worse or the same?

And for all five metrics the existing state we anticipated would score the lowest combined with - compared to model A which was referral only. And we assess that as medium and model B where we add short-term service coordination and assessment. We anticipated that it would score the best.

All of this work at this point we are doing on our own. We did this before we received the contractor and the design team.

Once we got the design team in they looked at all of this and gave us feedback and enhanced it.

In addition when it came to the metrics they identified potential additional metrics. In your brokerage design guide there is a list of tables included.

Once we did this we stepped back again and at a high level we asked ourselves okay do the brokerage models of those promising do they provide a significantly higher level of service so that enough customers will really care?

Does it change the cost benefit ratio for the customer? And does it change the standards that customer used to judge value? And in all three cases we said absolutely yes.

It's a significantly higher level of service because it - currently there is no single access to the full array of services. It changes the cost benefit ratio because especially for those healthcare providers or payers that are required to demonstrate care coordination and reduce healthcare costs.

Also for those that are not mandated to provide this we anticipate a positive return on investment.

We also anticipate and the data is showing that home and community-based services reduce readmissions and the related penalties and the length of office visits, length of stay and intensity of care needs.

So that's our business case. And at this point we haven't spent very much money yet - money at all. We've done a good assessment. We've outlined our model and we think the models are going to add significant value.

Next slide please. So I camped out on that slide. That's the bulk of our time. The next slide we'll go through fairly quickly.

Step two is to identify the requirements. And here is where our design team really helped us. We identified - we created a little worksheet for startup requirements and that's in your guide.

And for each step in the service delivery process we've asked ourselves what needs to be in place and what do we need to do to get it in place?

After that we looked at workforce consideration. What are some considerations for staffing levels?

Volumes might fluctuate. There might be anticipated turnaround times. There might be contractual requirements related to turnaround times. There might be a high-level follow-up and we might want to be talking about the capacity.

So we identified strategies for flexible staffing. We needed to be able to quickly adapt to the ebb and flow. And you can see in the design guide there is a list of ideas for making sure your staffing is flexible.

We also identified the required employee skill set. So in the guide you'll see it's a job skills list, skills needed and educational requirements.

We looked at how we might manage the processes better and cross train.

Then we moved on to legal and contracting requirements looking at legal and liability considerations such as who is responsible to follow-up if the service - if the service is inadequate to meet the outcomes and identifying what to do if something goes wrong? What would the exposure be if the brokerage might carry?

We looked at legal documentation requirements for clients, home and community-based service providers, referral sources, payers and healthcare providers. We needed to identify insurance requirements, service provider accountability and regulatory oversights.

Then we asked ourselves what would be contracting considerations? We identified some general considerations, some challenges that we might need to determine how the brokerage members will ensure sufficient volumes. Reimbursement would be the biggest concern.

And we looked at the content required for contracting. And we had a really complete list I think there related to contract content.

We then moved on to talk about data sharing consideration. One of the things that was mentioned quite a bit was the need for an electronic centralized system.

And along with that came a whole slew of considerations around challenges for delivering data, differing levels of provider sophistication the difficulty to establish that, the importance of it, the extent of data sharing. The HIPAA obviously came up.

Moving on to confidentiality considerations definitely related to HIPAA compliance and business sharing, the needs for business associate agreements. That's to share that information seamlessly while still protecting patient confidentiality, levels of access to records and liability breaches.

So we've looked at a lot of different things. We moved on to risk management and our team identified a lot of risks and again identified some potential mitigation. That is in the guide on Page B 16.

So I we had a great team, very knowledgeable, providing a lot of information for us. Along the way we were documenting unknowns.

And that's a critical step as you bring people together you - and have the discussion they're very valuable and fruitful and you identify a tremendous amount of the unknowns. So it's really important to track those throughout the process.

Next slide please. So then we moved on to assess viability. That's a critical step needed. We early on we assessed whether or not it would be valuable. And now we need to look at is it going to be viable?

So the first step is looking - doing a market analysis of community readiness. We have not completed that in our county but we have identified how we might go about that.

We are looking at using the US Census American Community Survey from 2000 to 2015 to test five year estimates. And it includes population data with disability breakouts by those with hearing and vision cognitive ambulatory, self-care or independent living difficulties.

We want to take a look at that and overlay it with local home and community-based service provider information and do that on GIS mapping so we can get a sense of okay here's the potential need and in the specific geographical areas here's the potential capacity.

Once you do a market analysis it's important - we did an environmental scan and current solution. So rather than try to recreate the wheel what is out there that's already working? And our consultant did this.

They contacted three different organizations. They contacted Direction Home Ohio. This is a cooperative of in-home and care transition specialists. Their legal structure is an LLC. They're for benefit for profit.

There owned by 12 AAAs each of whom are members or owners of the LLC. And their board is made up of the CEO of each AAA.

They also contacted the Coordinated Care Alliance. Their legal structure is - it's in Illinois. It's comprised of care coordination units throughout Illinois.

They have a network of 25 members. Their legal structure is a corporation. They're a 501c3 not-for-profit. And their board is they have a representative from each member organization.

The third organization they spoke with was San Francisco Network of Aging and Disability Community Based Organization.

It's a county organization selected by ACL to receive targeted technical assistance just to build business capacity. They are in the process of forming and they're looking at a structure similar to an MSO.

Additionally you'll need to look at financial viability. And again there's no need to re-create the wheel there.

We have two links in the Brokerage Design Guide. The SCAN Foundation has a budget and financial planning tool that's very robust along with the aging and disability research connection service cost tool. And again throughout this step of assessing viability it's very critical that you document unknowns.

Next slide please. So the fourth step is to look at your legal business model. And our consultant again did some research here for us. They identified legal entities, tax status exemptions and organizational structures.

And the brokerage guide I won't go through detail there but there are - they identified - they did some explanation of a limited liability company, a type of limited liability called an LC - L3C and an S corporation.

They identified pros and cons of the LLC, pros and cons of the S corporation, a little brief description about tax exemption and 501c3 and then the differences between the 501c3 and the L3C which is kind of a combo for-profit and not-for-profit.

Additionally a AAA or in a DRC could operate a brokerage.

Next slide please. So step five and six are the last two steps. And that's where you take a look at all of the unknowns that you've been documenting and you identify which of those uncertainties are make or break and from those make or breaks which of them are going to be fairly quickly resolvable or inexpensively resolved and put those first and structure your creative plan to resolve those unknowns so that you can determine whether or not it's a viable process for you at the lowest investment.

The next step is to look at a marketing strategy. And in the design guide on Page B19 our design team came up with a list of target audiences and key messages for each of those target audiences grouped by healthcare provider, provider payer, payer, home and community-based service provider individuals and caregivers and others.

And once you identify your marketing strategy that's - the final step is to develop an implementation plan.

And our design team came up with some ideas especially of piloting, considering piloting a small brokerage with a single health plan to start small and see if it works.

And next slide. So our design guide we submitted it to the SCAN Foundation. We posted it to the Long-term Care Integration Project Web site and we're currently distributing it widely for communities interested in improving home and community-based service access.

Next slide, so what we learned it was - for us it was very exciting. Early on we learned quite quickly that there's strong support in San Diego County for home and community-based services brokerage.

There we do need to assess the potential demand and capacity to meet that demand. So that's where we are for now.

Next slide please.

Brenda Schmidthenner: Well thanks so much for all of you for listening in and I hope you found value in the process that we went through here in San Diego to really do some analysis of how do we improve access to home and community-based services and support our community of healthcare payers and providers in this very new delivery system and system of accountability.

You know, we did find this process to be very valuable and insightful. It created even stronger relationships between these two distinct systems of care.

And it certainly gave us a lot to think about and a lot to consider before anything moves forward.

We're at the process now of really going back and trying to answer many of those unknowns that you heard from Renee because in every step of the process we found that there were unknowns that needed to be answered satisfactorily before really moving forward.

We also are really in the process of talking with our communities to find out what is the interest of various entities in actually serving in some sort of a brokerage capacity and under what structure they might be interested in doing so.

Internally at AIS we're also considering because of our status in the community is this something that would benefit our community if we were to take on through our Aging and Disability Resource Connection.

So I believe we have a few minutes left for questions. And Renee and I are happy to try to answer any that you may have.

Lauren Solkowski: Excellent. Thank you so much Brenda and Renee. So now we will open up for Q&A. Operator if you could please provide instructions for asking a question through the audio line?

Coordinator: Thank you. We will now begin the question and answer session. If you'd like to ask a question please press Star 1 and record your name clearly.

Lauren Solkowski: Okay thank you. While we're waiting for questions to come in I received a couple of questions via chat concerning accessing the guide that Renee was just speaking to.

And you can find - you can download that guide on the San Diego Long-term Care Integration Project. And I have posted a link to that site in the chat box.

If you don't see it there that web address is www.sd.LasInLongTermCareIntegrationProject.org. C as in care, I as in integration, P as in project.org.

So that is www.sds.ltcip.org. And you can scroll down towards the bottom of that page and you can access the guide there.

I'm checking to see if we have questions. I'm not showing other questions in Chat. Operator have we had questions come in through the audio line?

Coordinator: We have no questions at this time.

Lauren Solkowski: Okay thank you. Okay I just had a question come in via the Chat. So the question is what are your findings so far and how the costs of the brokerage are covered?

Renee Sherrill: I'm not sure if the question is referring to staffing? As I said we certainly have not established a brokerage here in San Diego County. We're still very much in the investigative stage.

But we have decided based on our analysis internally that model B where there's a level of assessment and care planning as well as short-term coordination would be of great value to our community.

And so our staffing would include social workers that are experienced with the community of home and community-based services and probably most likely come from a background of care management.

Lauren Solkowski: Okay thank you. Let's see, I have another question. What would you list as high quality standards? What kinds of home and community-based services do you anticipate payers would want to pay for and are there - other than the assessment and care planning?

Brenda Schmidthenner: Well, you know, as far as high-quality providers those would be entities that provide services that have received good customer satisfaction ratings as well as they meet the qualification standards.

So for example if the service delivery requires a registered nurse that that organization demonstrate that they have a staff that have that required licensure.

So it really would be a matter of meeting the insurance requirements and the liability requirements that would be necessary to ensure the good quality.

Renee Sherrill: Also our contracts have performance requirements. We have a lot of contracts for home and community-based services right now.

And in the brokerage guide on the very last page on B12 to answer the second part of your question we do have a list of home and community-based services support types of needs developed by our design team.

Lauren Solkowski: Great. Thank you.

Let's see I'm not showing any other questions in the Chat. Operator are there questions on the audio line?

Coordinator: We have no questions.

Lauren Solkowski: Okay. Thank you. I just wanted to double check. Okay well since I'm not showing any other questions I wanted to thank you so much to our speakers for participating today and sharing all that wonderful information.

Again if you have any trouble finding the guide or other questions that you think of after we conclude the Webinar please feel free to email them to me.

My email address is Lauren L-A-U-R-E-N.Solkowski. That's S as in Sam, O-L-K-O-W-S-K-I@acl.hhs.gov. So please email me your questions or comments and we'll respond to you.

Okay so I thank - so just thank you again to Brenda and Renee. And I think we will conclude our Webinar for today.

Brenda Schmidthenner: Well thank you. And you also have our contact information both mine and Renee's on the final slide and feel free to reach out to us directly with questions, be happy to help you out.

Lauren Solkowski: Excellent. Thank you both so much and everyone enjoy your day.

Brenda Schmidthenner: Thank you.

Coordinator: This concludes today's conference. Please disconnect at this time.

END