



PASSPORT TO HEALTH

celebrating lifestyle change

BUSINESS PLAN SUMMARY

JUNE 2021

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Funded by



Program Partners



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Background

The Detroit Area Agency on Aging (DAAA) contracted with Hedgepeth-Malcolm Consulting, LLC in September 2020 to develop a business plan to support the long-term sustainability of Passport to Health, a multi-faceted health promotion and disease management program designed to empower older adults in lifestyle behavior change through the promotion of healthy eating, physical activity and social engagement. This model was created to encourage older adults to take part in evidence-based and other programs to promote good health as well as to serve as a program that could support the sustainability of our funded network of community wellness service centers. Addressing social determinants of health in the aging population, through a robust network of both DAAA-run as well as external service partners is the goal of the Passport to Health (PTH) program.

Business Plan Process

In order to present an effective business plan, a thorough understanding of the program's history, target market, funding mechanisms, strengths and challenges had to be explored. To further inform the optimal future state, a review of best practices, to include optimal service and funding mixes, in similar-sized programs was completed. Finally, a deep dive analysis of current area programs (both substitutes and compliments), reimbursement opportunities, and potential alignment with other public and private initiatives supported the final plan. This data was captured through key informant interviews, a literature review, as well as a review of program outcomes and opportunities to date. The final plan has been summarized in this document with detailed sections dedicated to each of the key components of the business plan to include:

- 1) Program History, Description, Services and Key Partners
- 2) Analysis of the strengths, weaknesses, opportunities, and threats to the program
- 3) Target Market Analysis
- 4) Program Management, Staffing, and Technology Needs
- 5) Marketing Strategy/Business Case
- 6) Program Financing and
- 7) Program Adjustments/Recommendations

Program History

The Passport to Health was originally conceived through a partnership with the Detroit Area Agency on Aging, community service partners, and the Michigan Health Endowment Fund. Through a generous \$500,000 grant by the Health Endowment Fund the program was established. Passport to Health utilizes registered nurses as health coaches to work with older adults and other health and wellness staff to provide an initial assessment and ongoing health assessments, person-centered and SMART goal setting, follow-up assistance and an incentivized rewards program to drive them to evidenced-based and other programs, social and community engagement as well as tools to manage one or more chronic illnesses.

The program was implemented at two Community Wellness Service Centers (CWSC): St. Patrick Senior Center-Mid-Town Detroit and Neighborhood Service Organization's (NSO) Northwest Wellness Center at the Northwest Activities Center. Other supporting partners include the University of Michigan School of Public Health, Colleges of Nursing (Madonna University, Michigan State University and Wayne State University), and Michigan Complete Health, an Integrated Care Organization (Medicare/Medicaid Dual Eligible Health Plan). The initial grant period ran from January 2019 – March 31, 2021. The grant period was extended from the original time frame due to a delayed start up and the Covid-19 pandemic.

EXECUTIVE SUMMARY

Program Structure, Partners, and Services

The Passport to Health (PTH) program provides a base for the organization to leverage the depth and breadth of knowledge that DAAA and its employees have about the community in terms of the clients served, community leaders, and the reputation of community service providers. Utilizing a Community Based Organization (CBO) structure, the PTH program becomes the access point for clients seeking aging services and supports beyond the scope of current agency programs. Partnering with community service partners, such as Community Wellness Service Centers, for the provision of evidenced-based programming allows the program to present as a large supports network while not duplicating existing community services.

As opposed to a discrete program providing an all-or-nothing bundle of services, the Passport to Health program is a hub that supports payer engagement activities, provides ongoing assessment of client's needs, provides evidenced-based programs, and links clients to the additional services and supports necessary to maintain independent living. The program's ability to scale by adding additional referral sources and service partners allows for expansion that is both measured and driven by the needs of the clients served. As illustrated below, the PTH program will operate as a "hub" for various "spoke" referral sources, payors and service providers.



DAAA serves as the central link, providing the mechanism for admission, on-going assessment of client needs, linkage to needed services, as well as providing a central data platform for the exchange of key client information. DAAA brings vast experience in planning and advocacy as well as a central "clearinghouse" to link the aging population to necessary services. Core services provided by DAAA would include payer member engagement, care coordination, and assessments.

Target Market

A key factor influencing the future viability of the PTH program is defining the likely user of the PTH program, the prevalence of the chronic conditions supported by the program, and willing payers in the defined region. One of the key assumptions for implementation of the program was that DAAA and the two Community Wellness Service Centers would be able to market PTH to older adults with one or more chronic illnesses who could eventually have the cost of these services picked up through third party reimbursement by Medicare, Integrated Care Organizations, health care systems or other third-party payers.

Typical Client Profile

- Aged 60+
- Ambulatory
- One or more chronic illnesses
- At-Risk for out-of-home placement
- Seeking socialization and other community engagement
- Technology-proficient

By 2040, senior households in Detroit, which represented about 23% of the city in 2010, are projected to expand to about 35%. A significant increase for an area that is medically underserved with a high proportion of the area designated as Health Professional Shortage (HPSA) and/or Medically Underserved Area (MUA). While the aged population has health coverage near 100%, the type of plan, allowable benefits, breadth of in-network providers, and out-of-pocket expenses varies significantly. According to the most recent DAAA/Wayne State School of Medicine Dying Before Their Time study, 89% of adults aged 60 and above in the defined catchment area have at least one chronic illness, with 39% having three or more chronic illnesses. A growing aging population with a significant proportion afflicted with chronic illness and high rates of insurance coverage position PTH to grow in scale and service offerings in the future.

Value throughout the community care chain

The Passport to Health Program provides a menu of services that accommodates varying client acuity and engagement levels. As such, the approach to marketing and reimbursement will be tailored to the potential partner and payer. It is important to recognize that outside of pure economics, the PTH program presents intangible value. While exhibiting evidence of financial value to the prospective payor is key in crafting our go-to-market strategy, showing value in the following areas will be strongly considered and integrated into any partner or payer presentation.

The health case: The services have intrinsic value. They will achieve their stated outcomes related to health and well-being. If the PTH program can help the payer meet its health-related metrics, it may receive incentives or positive news that provides them with real value—market differentiation.

The social case: The service creates social value. It results in socio-economic benefits, irrespective of to whom they accrue, that exceed the costs.

The intangibles case: DAAA and by extension PTH possess a strategically valuable intangible through its relationships and intimate knowledge of and experience working in the community, access to evidenced-based program providers and with the available long-term services and supports.

EXECUTIVE SUMMARY

Financial Sustainability

As health care systems become more organized around quality and patient outcomes, a corresponding shift is driving change in the way social services are organized, delivered and financed. This leads to new opportunities that go far beyond traditional government programs and foundation grants, opening the door for collaborations at points of care where social service integration can improve an individual's health and quality of life while delivering positive financial outcomes for payers.

The PTH program offers unique value throughout the healthcare value chain. Whether a health plan (both public or commercial) or a provider of healthcare services to seniors who require connection with a program that directly can address social determinants of health, the community knowledge and service provider network the PTH program leverages has applicability. Dual-Eligible Integrated Care Organizations (ICOs) are particularly motivated by their risk-based contracts to seek relationships with providers who can also deliver services efficiently, effectively and with price predictability. Similar to the risk sharing of ICOs, agreements either directly with Medicare Advantage Plans or through agreements with Primary Care providers focused on the aging population provide ready payers and referrers for the types of services PTH will provide.

Recommendations

- 1 Reframe the Passport To Health Program as the gateway to a portfolio of programs and services that can be implemented inclusive of care coordination, assessments, caregiver support services, etc.
- 2 Market the program to payers who have members with one or more chronic illness who can still remain active and benefit from the program.
- 3 Promote the program to health care partners who will reimburse CWSC for the services.
- 4 Modernize the information technology platform used to measure health outcomes.
- 5 Stabilize the health and wellness staff at the Community Wellness Service Centers while still engaging nursing students who can add value to the program and get introduced to serving older adults.

Conclusion

The Passport to Health (PTH) program will support seniors to live longer more fulfilling lives by creating a network of community service partners that are committed to providing services and supports that are engaging, culturally appropriate, address social determinants of health and yield positive health outcomes. The program provides a base for the organization to leverage the depth and breadth of knowledge that DAAA and its employees have about the community in terms of the clients served, community leaders, and the reputation of community service providers. As opposed to a discrete program providing an all-or-nothing bundle of services, the Passport to Health can be a hub that supports payer engagement activities, provides ongoing assessment of client's needs, provides evidenced-based programs, and links clients to the additional services and supports necessary to maintain independent living.

Program History

The Detroit Area Agency on Aging (DAAA) applied to the Michigan Health Endowment Fund Grant-2018 Healthy Aging Initiative with the Passport to Health (PTH) program. DAAA was awarded \$500,000 grant on November 8, 2018. The PTH program was a two-year demonstration starting in January 2019 that sought to promote improved health and quality of life for older persons in Region 1-A (Detroit, Hamtramck, Highland Park, Harper Woods, and the five Grosse Pointes) to prevent the onset of health challenges and manage chronic conditions.

The PTH pilot model sought to empower 250 - 500 participants in a person-centered goal setting process that addressed their individual health needs. The model utilized health assessments, goal setting, coaching, follow up and a structured rewards program to incentivize the incorporation of wellness into participant's daily lives. The program was initiated with St. Pats and NSO as partner agencies. Through December 2020, the program had served 196 clients between both sites (St. Pat's – 134, NSO – 62).

Program Description

The Passport to Health Program (PTH) is a multi-faceted program that seeks to support and empower seniors in lifestyle behavior change through the promotion of healthy eating, physical activity and social engagement. Through the provision of ongoing health assessments, person-centered SMART goal setting, care coordination, and access to evidenced-based and other programming, the service provides older adults social and community engagement as well as tools to manage chronic illnesses and remain in independent living situations. Importantly, while the program's services are offered "a la carte" to match clients to services that further their healthcare goals, care coordination and linking is the key driver.

The program was implemented at two Community Wellness Service Centers (CWSC): St. Patrick Senior Center and NSO Northwest Wellness Center. Other supporting partners will include the University of Michigan School of Public Health, Colleges of Nursing (Madonna University, Michigan State University and Wayne State University), and Michigan Complete Health, an Integrated Care Organization.



Optimal Client Profile

- Aged 60+
- Ambulatory
- One or more chronic illnesses
- At-Risk for out-of-home placement
- Seeking socialization and other community engagement
- Technology-proficient

PROGRAM SERVICES AND GOALS

Program Services

As a multi-faceted program, PTH provides a menu of services that allows both clients as well as payers to determine their needs and reimburse accordingly. While the contractor of record, DAAA will contract out certain services to community partners. A list of available services that could be coordinated is shown below:

Service Continuum

<u>Core Services</u>	<u>Evidenced-Based Programs</u>
<ul style="list-style-type: none">▪ Member Engagement Support▪ Assessment/Reassessment▪ Community Navigation Services/Referrals▪ Care Coordination▪ Nutrition Services▪ Non-Medical Transportation▪ Telehealth Services▪ Health Education modules	<ul style="list-style-type: none">▪ A Matter of Balance (Falls Prevention)▪ Enhance Fitness▪ Diabetes PATH (Diabetes Self-Management Program)▪ Chronic Pain Self-Management Program▪ PATH (Chronic Disease Self-Management Program)▪ Diabetes Prevention Program (DPP)▪ Walk With Ease▪ Tai Chi for Arthritis for Fall Prevention

Given the current pandemic, it is envisioned that nearly all of the above services and supports could be provided in a virtual format. DAAA has procured and is prepared to distribute devices capable of utilizing virtual presence solutions (eg; Zoom, Microsoft Teams, etc.) to deliver the programmatic elements that can be adapted to home settings.

Program Goals

The model utilizes industry standard assessment tools, best practice care coordination models, and evidenced-based programs and services that lead to:

- Better chronic disease management
- Engagement of Seniors who are at-risk for hospitalizations and nursing home care
- Lower rates of depression
- Improved Prescription Adherence
- Reduction of Falls



Key Partners

The program utilizes a community-based organization (CBO) structure focused on the aging population. In this hub and spoke model, DAAA will provide the program design, management infrastructure, care coordination, program linkage, data platform and ongoing program assessment to ensure fidelity to the model and build capacity where necessary. Client Engagement and Evidenced-Based Program partners is provided through contracted services. Supporting partners will provide data analysis, supplemental staffing, and external validation to the program.



Detroit Area Agency on Aging (DAAA)

Established in 1980, the Detroit Area Agency on Aging (DAAA) is a nonprofit agency that serves older persons, adults with disabilities and caregivers residing in Detroit, the five Grosse Pointes, Hamtramck, Harper Woods and Highland Park. DAAA is one of 16 Area Agencies on Aging in the state of Michigan and 622 in the nation. DAAA assists older adults, adults with disabilities and caregivers by removing social, economic, physical and psychological barriers and creating aging friendly neighborhoods through nutrition, health and wellness and senior independence. Our programs and services include:

- **Information and Assistance (I&A):** call center to help find local resources
- **Nutrition Services:** hot, frozen and/or liquid nutrition for homebound seniors and adults with disabilities
- **Health and Wellness:** workshops to help improve fitness, reduce falls, control and monitor diabetes, and manage chronic diseases and heart disease
- **Clinical Services:** Care Management and home care support
- **Long-Term Care Ombudsman:** assistance and advocacy for long-term care facility residents
- **Medicaid-Medicare Assistance Program (MMAP):** free health insurance counseling for Medicare and Medicaid beneficiaries and their families or caregivers
- **Senior Community Service Employment Program (SCSEP):** on-the-job training for seniors who are 55 years or older
- **Community Wellness Service Center (CWSC):** community-based educational opportunities that promote healthy aging lifestyles
- **Caregiver Support Services:** provides Tailored Caregiver Assessments and Referral for the Elderly (TCARE), Caregiver Education, Training and Support
- **Grandparents Raising Grandchildren Committee (GRGC):** a collaboration of agencies working to support grandparents and kinship caregivers
- **Advocacy:** to help make sure seniors' voices are heard

KEY PARTNERS

Client Engagement and Evidenced-based Program Partners

Client engagement and evidenced-based program partners will execute the day-to-day operations of the program, including providing staff time, physical space, and additional resources to support the programs goals. St. Pat's and NSO have been pilot partners of the program and serve as a base for further partner expansion.



St. Patrick Senior Center

St. Patrick Senior Center provides a “home away from home” for over 2,000 older adults all year round. It is a community that seniors know is their home regardless of age; whether they are homeless or own a home, depressed or happy, isolated or social, or adjusting from work to retirement. The center provides comprehensive services to a diverse population of more than 2,000 seniors living throughout metropolitan Detroit. The programs and services offered by the Senior Center are as diverse as the population it serves.



Neighborhood Service Organization

Neighborhood Service Organization's (NSO) compassionate and professional staff provides services that have impacted countless children, youth, adults, seniors, families, and communities since 1955. They seek to deliver holistic care and wrap around/safety net services to address social determinants impacting health, education and economic stability. NSO's empowering programs and services provide assistance for: older adults with mental illness; children, youth, and adults with developmental disabilities; homeless recovery services; housing development; community outreach for psychiatric emergencies; and volunteer opportunities for individuals, groups, and organizations. Active at NSO since 1978, NSO's Older Adult Services (OAS) program helps older adults, living in group facilities and in nursing homes in Wayne and Oakland counties, to achieve the highest level of independence possible through a broad range of clinical, psychiatric, nursing and occupational therapy support. As a program partner, NSO will provide Evidenced-based Programs as necessary to support the PTH program.

Supporting Partners

Supporting partners provide additional resources to support program outcomes, to include nursing student trainees, data collection and analysis, and program guidance support.

Partner	Role
♦ University of Michigan School of Public Health – Dept. of Health Behavior and Health Education	▪ Provides data collection platform (RedCap) as well as ongoing data re-view and analysis
♦ Madonna School of Nursing ♦ Michigan State University School of Nursing ♦ Wayne State University School of Nursing	▪ Provides nursing student trainees as supplement to permanent staff
♦ Michigan Complete Health (ICO Plan)	▪ Refers program participants, where applicable ▪ Potential Funding Source

Core Competencies and Strengths

Agency Commitment and Experience: DAAA possesses significant name recognition among the aging population in the serviced area. This deep well of recognition combined with its extensive knowledge of the resources available to the aged population positions the agency to be successful in a complimentary program. Care Coordination is a core competency of DAAA and links the staff's commitment to the population with the supports necessary to maintain or improve health outcomes.

Community Based Service Orientation: Over its more than 40 years in existence, DAAA has built a network of innovative programs and service partners that support the region's aging population in remaining in their natural environment.

Best-Practice Models of Care and Evidenced-based programs: In addition to care coordination, the program will utilize evidenced-based programs which have been validated as yielding measurable gains in those who maintain fidelity to the model.

Perceived Challenges (Current and Future):

Operating Partner Consistency: Given the myriad of partnerships required to operationalize the program, it is important that partners be fully vetted and engaged with service delivery. The program's efficacy is only as strong as its downstream service providers. Funding should be linked to quality and service outcomes as opposed to pure capacity availability.

Program Funding: Currently the program is funded through a Michigan Health Endowment Grant. While this funding source has provided the program a substantial pilot period to operationalize and assess the value of the program, it is imperative that the positive outcomes yielded since implementation are marketed towards others in the healthcare payer and prevention value chain. While payers have greater flexibility to fund these types of programs, showing the value proposition to prospective payers could prove challenging.

Technology Platform: To best support the demands of potential payers, the program should be supported by an integrated Care Management Platform that allows for data analysis as well as the secure exchange of health information with other health record platforms.

On-going Client Engagement: Since inception 196 clients received initial baseline assessments. Due to a myriad of factors, most prominently the Covid-19 crisis, 48 clients have received annual assessments after one year of program enrollment. In order to support ongoing engagement, the program will utilize a rewards-based system on the MySeniorConnect platform, allowing clients to earn prizes based on program activities completed.

PROGRAM ANALYSIS

SWOT Analysis

Strengths

- Engaged Partner Base
- Implementation of Evidenced Based Programming
- Existing care coordination competency

Weaknesses

- Lack of Program Funding beyond demonstration period
- Incomplete Patient Data Sets
- Inefficient Technology Platform

Opportunities

- Strong Value Proposition to health plans
- Large untapped market base

Threats

- Lack of Sustainable Funding
- Health Plan Acceptance
- Covid – 19
- Transient Staff Support (Nursing Students)

Long Term Vision

The PTH program will support seniors to live longer more fulfilling lives by creating a network of community service partners that are committed to providing services and supports that are engaging, culturally appropriate, address social determinants of health and yield positive health outcomes.

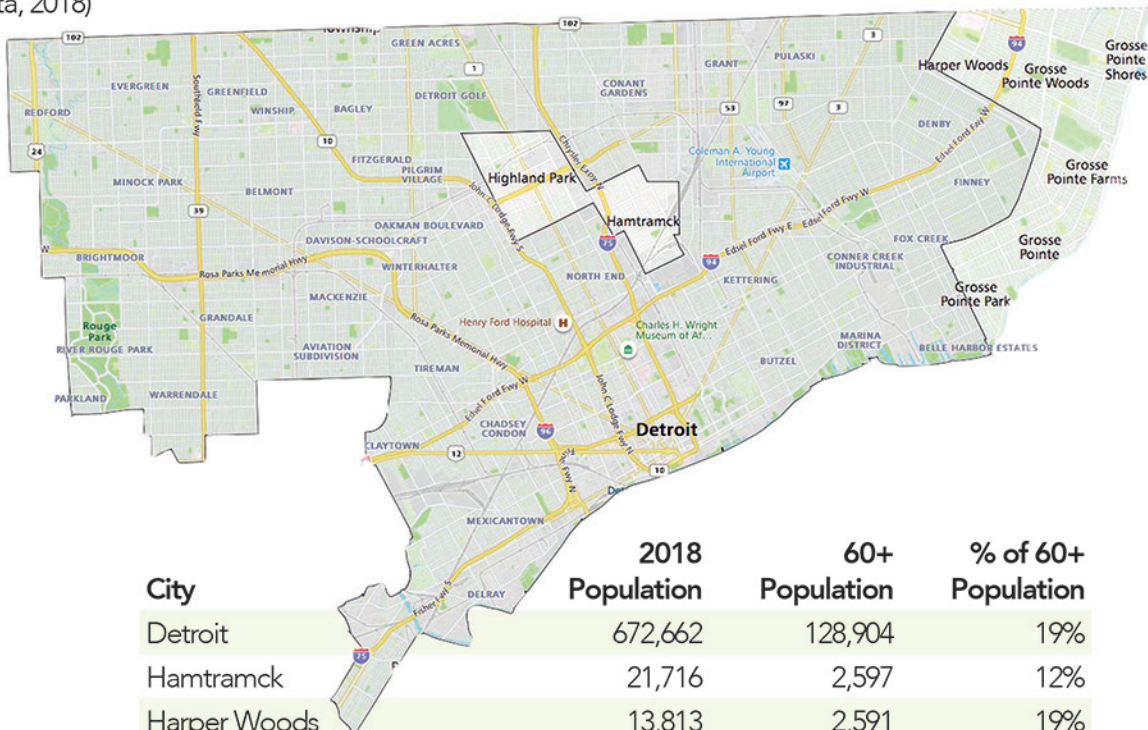


Population Statistics

Worldwide, the aged population is increasing. Older people's health and social care needs are often complex requiring several health and social care providers and involves multiple transitions between care settings. These care transitions tend to negatively affect the continuity of care including lack of communication between care providers, errors in medication lists and insufficient quality of discharge protocols. Subsequently, managing the health and social care of this population has become a major challenge.

Today, there are more than 46 million older adults age 65 and older living in the U.S.; by 2050, that number is expected to grow to almost 90 million. Between 2020 and 2030 alone, the time the last of the baby boom cohorts reach age 65, the number of older adults is projected to increase by almost 18 million. This means by 2030, one in five Americans are projected to be age 65 and over.

DAAA's service area, defined as the communities of Detroit, Hamtramck, Harper Woods, Highland Park and the five Grosse Pointes, has a 2018 population of 762,586. Of this total, the estimated number of residents over the age of 60 is 148,458, or 19% of the total catchment area population. (American Community Survey Data, 2018)



City	2018 Population	60+ Population	% of 60+ Population
Detroit	672,662	128,904	19%
Hamtramck	21,716	2,597	12%
Harper Woods	13,813	2,591	19%
Highland Park	10,806	2,616	24%
Grosse Pointe	5,170	1,409	27%
Grosse Pointe Farms	9,146	2,254	25%
Grosse Pointe Park	11,094	2,547	23%
Grosse Pointe Shores	2,847	970	34%
Grosse Pointe Woods	15,332	4,570	30%
Totals	762,586	148,458	19%

TARGET MARKET ANALYSIS

Population Statistics (cont.)

By 2040, senior households in Detroit, which represented about 23 percent of the city in 2010, are projected to expand to about 35 percent. A significant increase for an area that is medically underserved with a high proportion of the area designated as Health Professional Shortage and/or Medically Underserved Area. Significantly 94% of the persons residing in the catchment area reside in a Health Professional Shortage Area.

Given the region's growing aged population and designation as a medically underserved area, programs for the population should be designed to support the shortages of Health Professionals as well as link persons to healthcare supports. DAAA's Dying Before Their Time III Report has found that poor access to care has resulted in older adults in the service area having a premature, excess death rate two or two and a half times greater than that in the remainder of the State of Michigan.

Health Insurance Coverage Prevalence

In 2019, 8.0% of people, or 26.1 million, did not have health insurance at any point during the year, according to the CMS Current Population Survey Annual Social and Economic Supplement. The percentage of people with health insurance coverage for all or part of 2019 was 92.0 percent. (Keisler-Starkey, 2020). Michigan, by contrast has an insured rate of 94.2%.

While the aged population has health coverage near 100%, the type of plan, allowable benefits, breadth of in-network providers, and out of pocket expenses varies significantly. For purposes of this plan, the focus will be on those with public coverages (Medicare and Medicare/Medicaid) as well as Blue Cross Blue Shield of MI, the dominant commercial market insurer in the region.

Chronic Illness Penetration

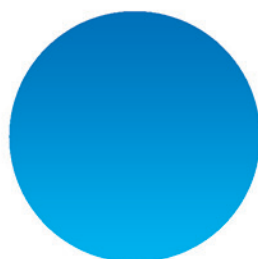
Chronic Illnesses are defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. Chronic Illnesses such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States.

The prevalence of chronic illness among the senior population nationally is a key driver for the development of programs to support the population. Sample national statistics are shown below:

- Approximately 80% of older adults have at least one chronic disease, and 77% have at least two. Four chronic diseases—heart disease, cancer, stroke, and diabetes—cause almost two-thirds of all deaths each year.
- Chronic diseases account for 75% of the money our nation spends on health care, yet only 1% of health dollars are spent on public efforts to improve overall health.
- Diabetes affects 12.2 million Americans aged 60+, or 23% of the older population. An additional 57 million Americans aged 20+ have pre-diabetes, which increases a person's risk of developing type 2 diabetes, heart disease, and stroke. In a 2007 Centers for Disease Control and Prevention program for people at high risk for developing diabetes, lifestyle intervention reduced risk by 71% among those aged 60+.
- 90% of Americans aged 55+ are at risk for hypertension, or high blood pressure. Women are more likely than men to develop hypertension, with half of women aged 60+ and 77% of women aged 75+ having this condition. Hypertension affects 64% of men aged 75+.

Chronic Illness Penetration (cont.)

According to the most recent DAAA/Wayne State School of Medicine Dying Before Their Time study, 89% of adults aged 60 and above in the defined 1-A catchment area have at least one chronic illness, with 39% having three or more chronic illnesses. (DBTT, 2020)



1-A Catchment Area
60+ Population
148,458

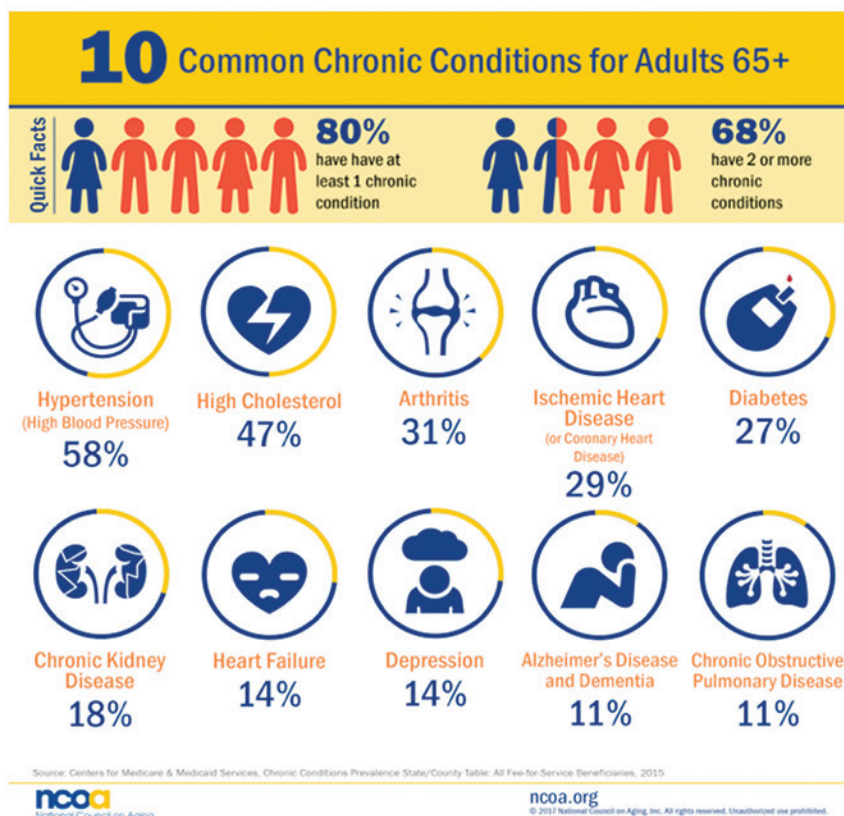


Persons with at least
1 chronic illness
132,128 (89%)



Persons with 3 or more
chronic illnesses
57,899 (39%)

Ameliorating and supporting persons with chronic diseases requires robust care coordination, significant social and physical engagement, and continuous monitoring.



PROGRAM MANAGEMENT AND STAFFING

Program Management

Community Based Organizations (CBOs) are community partners that are uniquely positioned to identify the most suitable services and supports based on community needs. It is important for CBOs to demonstrate their essential knowledge of local geographies, communities, and residents to health plan and system partners. As community partners, they add an array of programs and services that attract membership and compete with other local activities. Through affiliations with agencies that provide services to the identified population, CBOs bring a robust set of services and supports to payers. Utilizing a hub-and-spoke structure allows the CBO to amplify their value to potential funders by presenting as a one-stop option to access community programs that drive positive health outcomes. (NCOA, 2020)

As the healthcare system shifts towards a value-based model with a focus on Social Determinants of Health (SDOH), DAAA as a CBO and by extension the PTH program, can provide an important role in coordinating care amongst the myriad of healthcare providers, payers, community agencies, and family supports to achieve each client's life goals.

CBO-Like Structure

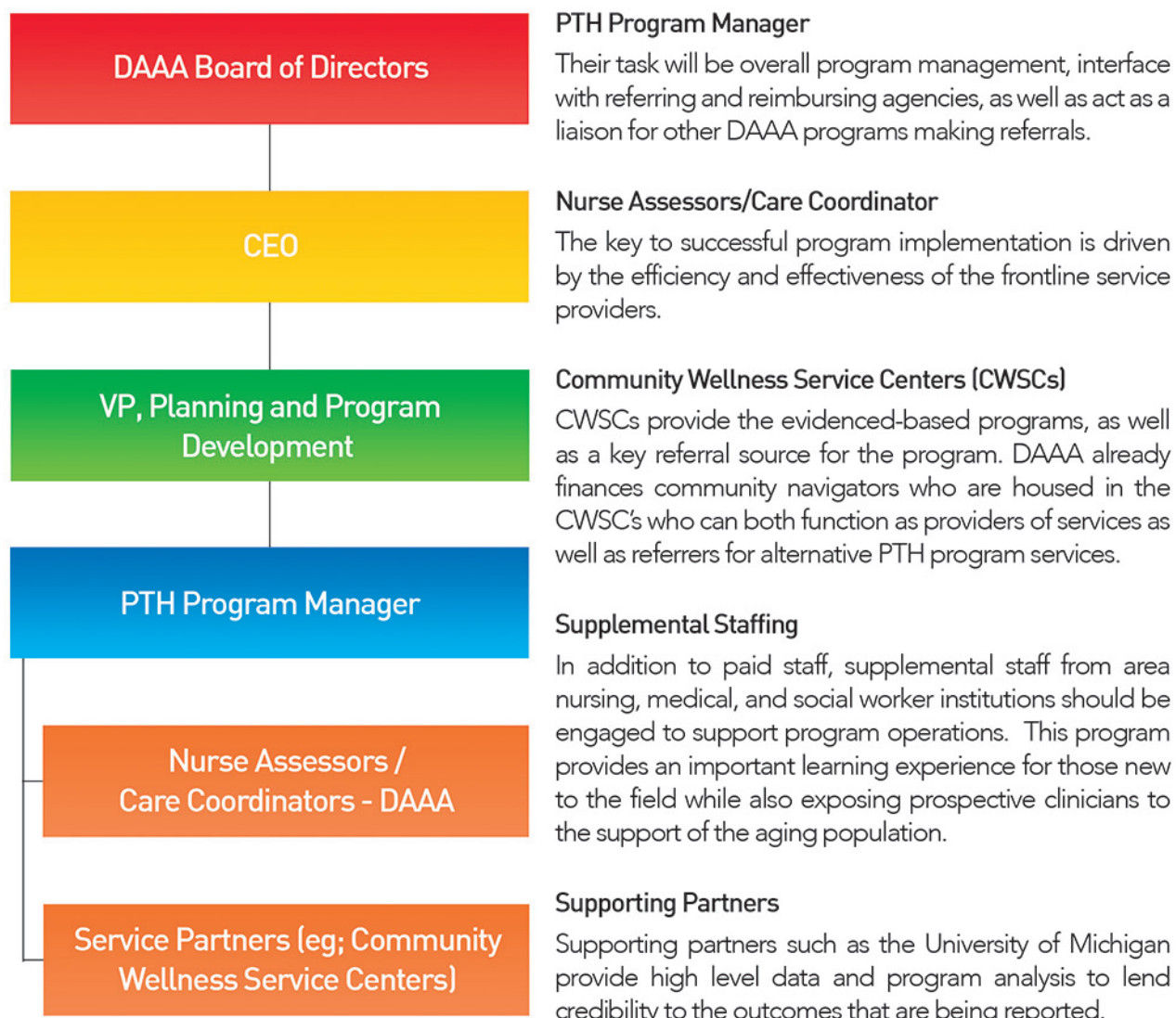


DAAA serves as the central link, providing the mechanism for admission, on-going assessment of client needs, linkage to needed services, as well as providing a central data platform for the exchange of key client information. DAAA brings vast experience in planning and advocacy as well as a central “clearinghouse” to link the aging population to necessary services. Core services provided by DAAA would include payer member engagement, care coordination, and assessments.

CB0-Like Structure (cont.)

DAAA would be the contractor of record with various payers. Programmatic partner agencies, such as Community Wellness Service Centers (CWSCs), would provide all of the resources necessary to provide the evidenced-based programs. In addition, PTH may refer to programs housed inside the CWSCs but not directly connected to PTH. Importantly, CWSCs are a key link in the ability for the program to have meaningful client engagement and positive health outcomes.

Program Staffing



TECHNOLOGY PLATFORM

Technology Platform

As the program evolves a key facet of providing a suite of optional services is the ability to seamlessly exchange health data to all on the care team. For the client, a single distribution point to inform all care team members lessen the burden of navigating complex systems of care, seemingly providing the same information on multiple occasions; a significant factor in client's becoming disengaged from our current healthcare system. For payers, knowledge of who and what they are paying for and the ability to tie those dollars back to outcomes will be key to showing the programs value proposition over time.

For program success, a Commercial Off the Shelf (COTS) modular software solution is best optimized to provide seamless integration of demographic data across programs and services, exchange protected health information, as well as allow for analysis of programmatic outcomes and meet regulatory reporting mandates. The solution should at a minimum:

- Provide a Meaningful Use (MU) Certified EHR
- Allow for secure Protected Health Information Exchange
- Support reporting to the statewide Health Information Exchange - MIHIN Provide Data Warehouse Capabilities
- Allow for robust reporting and data analysis
- Interoperable with partner EHRs
- Utilization Management Module
- Claims Management Module



Marketing Strategy

The Passport to Health Program provides a menu of services that accommodates varying client acuity and engagement levels. As such, the approach to marketing and reimbursement will need to be tailored to the potential payer. It is important to recognize that outside of pure economics, the PTH program presents intangible value. While exhibiting evidence of financial value, Return on Investment, to the prospective payer is key in crafting our go-to market strategy, showing value in the following areas will be strongly considered and integrated into any sales presentation.



Marketing the program will include several important components:

- Return on Investment (ROI)
- Client Stories and Use Cases
- Payer-specific service offerings and value proposition
- Alignment with known measures in payer incentive/value-based reimbursement agreements

BUSINESS CASE

Client Stories and Use Cases

Thinking about the typical client profile served by the payer and developing stories or use cases will help to provide both context as well as an emotional visualization of the sample client. Emotion is essential, especially in healthcare. Emotion also makes the complicated world of healthcare more understandable.

Use Cases Example

Client: John Thompson is a 72 year old recently widowed male.

Retired Steel Fabricator. Overweight. Heart disease, Diabetes, and High Blood Pressure. Suffered heart attack in August 2018. Inconsistent primary care since October 2018

Payer: Medicare Advantage Plan A

Member Engagement Support: The PTH program could support your plan in finding those members who are difficult to engage by making phone calls and home visits. Nearly one in three seniors in our region live alone. Through our direct outreach programs, knowledge of the senior environment, meals program, and information and assistance center we touch nearly every senior in the region. Our staff of dedicated nurses and social workers understand the process of aging and have committed themselves to being both empathetic and encouraging to help the population.

Community Navigation/Care Coordination: DAAA will provide an initial assessment to understand Mr. Thompson's current health status. Craft a plan of care that blends his goals with services and supports that will lead to positive health outcomes. Importantly, we will link him to a primary care physician. If he doesn't have one, we can enroll him in our Telehealth Program.

Evidenced Based Program: With our partner St Pats, we can get Mr. Thompson enrolled into a diabetes prevention program (DPP), where he'll learn to eat healthy meals, increase physical activity, manage stress, stay motivated, and solve problems that can get in the way of healthy habits. In addition, to formal programming, Mr. Thompson will have the opportunity to participate in social events.

Importantly, as an unlinked set of services, the payer could choose anyone of these standalone or stack them to provide the best value. Reimbursement stratification to allow for mixing and matching will satisfy payers concerns that they are paying for only the services that are being provided. For example, they choose to pay for the member engagement support and 1) an enrollment fee for admitting Mr. Thompson in DPATH and 2) a fee if he attends 50% of the 6 sessions. Selling this based on a pre-set number of clients that payers guarantee funding for will be most efficacious for program growth and sustainability.

Payer-Specific Service Offerings and Value Proposition

The matrix below provides an illustration of the potential services that may be reimbursed by each payer as well as

	Typical Client Acuity	Prospective Services	Value Proposition
Managed/ Integrated Care Organizations	<ul style="list-style-type: none"> ■ Nursing Home Level of Care ■ Eligible for Home-based supports 	<ul style="list-style-type: none"> ■ Member Engagement Support ■ Assessment ■ Care Coordination ■ Nutrition Services ■ EBP's 	<ul style="list-style-type: none"> ■ Additional resource available to support and engage those at risk for nursing home placement ■ Alignment with HEDIS performance measures ■ Market Share Growth
Medicare Advantage Plans	<ul style="list-style-type: none"> ■ Ambulatory ■ Living Independently ■ Recent Hospital Discharge 	<ul style="list-style-type: none"> ■ Member Engagement Support ■ Care Coordination ■ Nutrition Services ■ Transportation ■ EBP's 	<ul style="list-style-type: none"> ■ Additional Member Benefit ■ Discrete service offerings to support ongoing health maintenance ■ Prevention
Commercial Plans	<ul style="list-style-type: none"> ■ Ambulatory ■ Living Independently ■ Recent Hospital Discharge 	<ul style="list-style-type: none"> ■ Member Engagement Support ■ Nutrition Services ■ Transportation ■ EBP's 	<ul style="list-style-type: none"> ■ Additional Member Benefit ■ Discrete service offerings to support ongoing health maintenance ■ Prevention

PROGRAM FINANCING

The key component in any healthcare program that seeks to bridge the gap and address social determinants of health is funding. Unlike traditional fee-for service healthcare services, programs such as Passport to Health are still relatively new and don't have a one-size-fits all funding approach. There are various funding methods that could be used to support this program and its service partners. As shown below, the continuum can span simple unit cost or fee-for service payments all the way to "risk-based" scenarios such as Per Member Per Month (PMPM) or Capitation

Types of Funding Methods

Definitions

Cost	PTH calculates the total amount it spent to deliver one or more services for a client, and the payer reimburses PTH for those costs.
Fee for Service (FFS)	A payment approach in which a specific amount is paid when a particular service is delivered; generally, the payment amount differs depending on which discrete service is delivered. In this instance, if a service partner is providing the service PTH could charge a rate to the payor that includes some administrative fee.
Per Diem	A payment that is made for each calendar day on which services are provided to a particular client—but not on how many services were delivered on each calendar day.
Per Episode (bundled payment)	A form of payment that covers a defined group of services over a specified period of time. Episode-based payments, paid prospectively or retrospectively, can be made to a single provider or to more than one provider involved with the care episode, in which case the payments can be referred to as bundled episodes.
Per Member Per Month (PMPM)	A specific, pre-determined payment made by the payer to the PTH program per assigned member each month regardless of the number, amount or intensity of services provided. While the PMPM payment is fixed, the potential costs may vary significantly based on the type, frequency and intensity of services the provider is contractually obligated to deliver. As a result, a PMPM will shift the risk of this cost variability to PTH. We have assumed a very well-defined, narrow and manageable set of services and predictable variability in provider costs. If this variability rises, the PTH's risk will correspondingly increase and vice versa.
Full-Time Equivalent (FTE)-based	A form of compensation in which PTH would be paid for a specified number of their employees (FTEs) for a defined period of time at a fixed rate per FTE unit. The fixed rate per FTE unit is typically based on a predetermined volume (caseload) adjusted by the required functions and tasks, as well as the FTE qualifications. Example: An ICO contracts with PTH for service coordination and pays PTH for five service coordinators who are assigned 70 program participants each (1:70 caseload ratio).
Capitation	Fixed, prospective payment made to cover the cost of care for a defined population over a specified time period. A specific dollar amount per member per month is paid to providers, and in return they provide whatever quantity of services is needed to meet the defined patient population's health needs. (The term capitation means that the payment is made per person, or per capita, rather than per service.)

MCOs and Medicare Advantage Plans are particularly motivated by their risk-based contracts to seek relationships with programs, such as PTH, who can also deliver services efficiently, effectively and with price predictability. Further, as they are “at-risk” they seek partners that support the performance measures important for them to garner maximum reimbursement. They would seek to partner with programs that have the ability to efficiently assess risk, set reasonable prices, and still maintain capacity and solvency.

Passport to Health should first seek a fee-for-service funding arrangement where rates paid by each payor are specific to the services provided. I would expect that this funding could either be fee-for-service or a set amount of dollars to support the program. For instance, if a payor contracts for evidenced-based services and care coordination, a unit cost rate would reimburse each separately. A sample client example is shown below.

Sample Financials

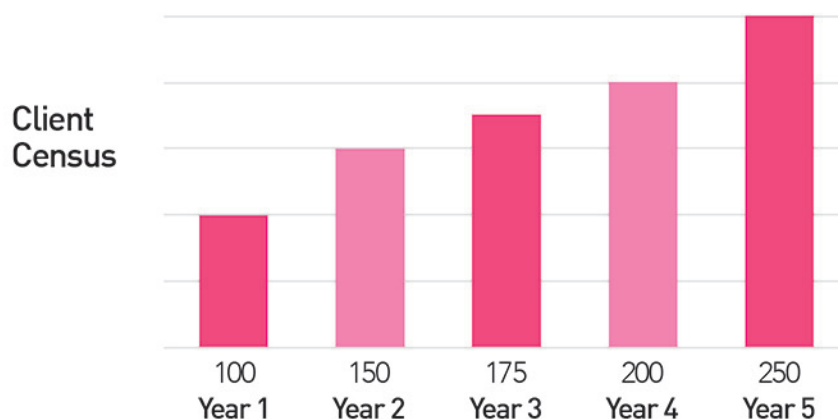
For purposes of this document, we have completed an abbreviated financial pro-forma based on the below case example and projected program enrollment.

Jim Smith

Service	Frequency	Rate	Annual Revenue
Assessment	Per Diem (4 times per year)	\$200	\$800
Care Coordination	Monthly Contact Rate (Minimum of 1 hr/month for 12 months)	\$120	\$1440
PATH EBP	One cycle of program (1 hr/week for six weeks)	\$500	\$500

Projected Enrollment

Based on the current program enrollment and projected demand for services the following client enrollment and direct staffing numbers are being utilized to project program revenue and costs.



PROGRAM FINANCING

Passport To Health Program Five Year Pro-Forma

Revenue	Year 1	Year 2	Year 3	Year 4	Year 5
Projected Enrollment	100	150	175	200	250
Service Revenue					
Assessment	\$80,000	\$120,000	\$140,000	\$160,000	\$200,000
Core Coordination	\$144,000	\$216,000	\$252,000	\$288,000	\$360,000
Evidence-based Programs	\$50,000	\$75,000	\$87,500	\$100,000	\$125,000
Gross Service Revenue	\$274,000	\$411,000	\$479,500	\$548,000	\$685,000
Less:					
Uncollectable Accounts (7%)	\$19,180	\$28,770	\$33,565	\$38,360	\$47,950
Net Service Revenue	\$254,820	\$382,230	\$445,935	\$509,640	\$637,050
Expenses	Year 1	Year 2	Year 3	Year 4	Year 5
Projected Direct FTEs	1	1.5	1.75	2	2.5
Total Direct Staff Costs	\$181,250	\$229,500	\$253,725	\$277,988	\$324,603
Total Other Direct Costs	\$49,200	\$65,800	\$74,100	\$82,400	\$99,000
Total Direct Costs	\$230,450	\$295,300	\$327,825	\$360,388	\$423,603
Total Indirect Costs	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500
Total Direct and Indirect Costs	\$232,950	\$297,800	\$330,325	\$362,888	\$426,103
Administrative Overhead	\$23,295	\$29,780	\$33,033	\$36,289	\$42,610
10% of direct and indirect costs					
Total Program Costs	\$256,245	\$327,580	\$363,358	\$399,177	\$468,713
Program Surplus/Deficit	\$1,425	\$54,650	\$82,578	\$110,463	\$168,337

Utilizing the current model as the baseline, this business plan seeks to identify programmatic adjustments and recommendations that best positions the Passport to Health program to thrive in the future. With program growth, financial sustainability (outside of grant funding), and enhanced health outcomes from program participants as the goals we present the below recommendations:

Recommendations

- 1 Reframe the Passport To Health Program as the gateway to a portfolio of programs and services that can be implemented inclusive of care coordination, assessments, caregiver support services, etc.
- 2 Market the program to payers who have members with one or more chronic illness who can still remain active and benefit from the program.
- 3 Promote the program to health care partners who will reimburse CWSC for the services.
- 4 Modernize the information technology platform used to measure health outcomes.
- 5 Stabilize the health and wellness staff at the Community Wellness Service Centers while still engaging nursing students who can add value to the program and get introduced to serving older adults.





**PASSPORT
TO HEALTH**
celebrating lifestyle change

Business Plan Summary



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