Western New York Integrated Care Collaborative Addressing Social Determinants of Health: Nutrition and Food Insecurity

A Community Care Hub Innovation Brief
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This brief is part of a series of case studies of aging and disability network organizations addressing the nutrition and food insecurity needs in their communities by braiding funding streams and forming partnerships with other organizations. These case studies provide examples of how high-performing organizations use a variety of funding streams to address nutrition, food insecurity, and other health and social needs.

Overview of the Program

Western New York Integrated Care Collaborative (WNYICC) is a Community Care Hub (CCH) operating across the entire western New York region and offering a variety of services to support health and social needs. Services related to nutrition and food insecurity include in-home meal delivery, health coaching, medical nutrition therapy, and diabetes prevention.[1] This brief provides a brief history of WNYICC and details their nutrition offerings and funding sources.

Western New York Integrated Care Collaborative

WNYICC operates a network of over 50 community-based organizations (CBO) that provide direct services, including post-discharge meals, care coordination, medical nutrition therapy, and evidence-based programs (e.g., Diabetes Prevention Program, Falls Prevention, Chronic Disease Self-Management). They host a centralized information technology (IT) platform for all their CBOs to document assessments for health-related social needs (HRSN), deploy HRSN interventions, and document the outcomes of interventions for identified HRSNs. WNYICC centralizes the contracting process and provides training to CBO members on the interventions that are currently contracted. Additionally, WNYICC implements a continuous quality improvement process to ensure that all CBOs provide high quality services. This includes program and process evaluation via a quality assurance committee. Maintaining such a role is core to the responsibilities of a CCH. A list of the WNYICC network members can be found on their website: https://www.wnyicc.org/About/Network-Members.

WNYICC offers a variety of services to support health and social needs across the entire western New York region.

[1] https://www.wnyicc.org/Programs

Key Players

Health Care Plans and Providers

Entities such as Medicare Advantage plans and Medicaid Managed Care Plans pay WNYICC for a range of services.

Western New York Integrated Care Collaborative

WNYICC is a CCH operating across the entire western New York region. It is comprised of nine NY Connects local ADRCs and 40+ other CBOs.

NY Connects

NY Connects is the No Wrong Door (NWD) System in New York coordinated by the New York Office for the Aging. Several local ADRCs participate as network member agencies in the WNYICC CCH including:

Allegany County NY Connects
Chautauqua County NY Connects
Erie County NY Connects
Genesee County NY Connects
Livingston County NY Connects
Niagara County NY Connects
Orleans County NY Connects
Western New York Independent Living NY Connects
Wyoming County NY Connects

Readiness for Contracting as a CCH

WNYICC formed as a CCH in 2016 to make contracting with health care entities easier and more efficient for CBOs. The timeline below has details on CCH development. Multiple funding sources contributed to the development of the WNYICC including:

- Health Foundation of Western and Central New York
- John R. Oishei Foundation
- New York State Office for the Aging through a Chronic Disease Self-Management Education (CDSME) program grant from the Administration for Community Living (ACL)
- ACL: Scaling Network Lead Entities Grant

CCH's First Contract and Evidence of Impact

WNYICC's first contract as a CCH was a special supplemental benefit for the chronically ill (SSBCI) to provide post-discharge meals to Independent Health's Medicare Advantage (MA) plan members. WNYICC worked with Independent Health to conduct an evaluation of the

SSBCI post-discharge meal benefit to assess the impact of the meal benefit on readmissions. The evaluation revealed that persons with multiple chronic conditions benefitted most from the post-discharge meal intervention. Based on the evaluation data, Independent Health agreed to provide an expanded intervention that includes HRSN screening and ongoing health coaching.

CCH Nutrition and Food Insecurity Support

WNYICC provides a variety of support to individuals around nutrition and food insecurity. Their network provides care transitions meal support through contracts with regional MA health providers as detailed above. They provide a custom, post-discharge home-delivered meals program for hospitalized members that includes hot home-delivered meals and medically tailored meals. They also incorporate patient satisfaction surveys to facilitate member feedback to the health plan.

Nutrition Services Provided by WNYICC

- Outreach
- Post-discharge home delivered meals
- Medically tailored meals
- Health coaching
- HRSN screening (food, housing, transportation)
- SNAP outreach
- Diabetes prevention
- Diabetes self-management
- Medical nutrition therapy

The success of the contract agreement with a major regional MA plan allowed WYNICC to coordinate with hospital discharge planners and receive daily notification of member admissions to solicit referrals and document meal delivery by their CCH through a centralized data system managed by WNYICC.

WNYICC relies on a complex network of home-delivered meals providers, including large and small independent meal providers, to provide meals to all regions covered by the network (including rural areas). Some WNYICC members are Area Agencies on Aging (AAA) that also administer the federal Older Americans Act (OAA) nutrition services. Additionally, the WNYICC network of CBO partners includes United Way, Meals on Wheels, food banks, and a range of other community-based direct service providers serving the entire western New York region. Through these connections they are also able to connect individuals with public benefits supports for nutrition.

WNYICC's regional service-provider network of community-based and governmental agencies strives to produce better health outcomes and quality of life for older adults, people with disabilities and/or chronic conditions, and their caregivers by providing comprehensive, cost-effective, and community-based integrated care.

Significance of this Partnership

This work is important because of the focus on integrating community-based social service organizations into the delivery of healthcare to Medicare and Medicaid recipients by forming a CCH of CBOs. WNYICC provides a model for a sustainable alternative to grant funding for CBOs that also leverages staff expertise and increases organizational capacity. These successes can result in the expansion of contracts between healthcare payers and AAAs, Aging and Disability Resource Centers (ADRC), and other CBOs to provide services to address social needs.

WNYICC is also linked with their regional Health Information Exchanges (HIE) called HEALTHeLINK to receive Admission Discharge Alerts (ADTs) for the meal delivery program, verify insurance on participants, and look up clinical information on clients for programs such as medical nutrition therapy.

Funding and Sustainability

Funding for this work includes a mix of OAA, Medicare, and Medicaid dollars. The chart below shows the services provided by WNYICC and the payer source.

Service[2]	Payer Source MA Medicaid Managed Long Term Services and Supports (MLTSS) Medicaid Long-Term Care (MLTC)	Type of Reimbursement Fee for Service (FFS) Per Member/Per Month (PM/PM) Value-Based Contract (VBP)
Meal delivery	MA	FFS
Community Health Coaching*, **	MA	FFS
Diabetes Prevention Program*	MA, MLTSS, Commercial	VBP, FFS
Healthy IDEAS program*	MA, MLTC – Launched with 2 health plans and a grant from the Health Foundation of Western and Central New York MLTSS	FFS, grant, VBP
Medical Nutrition Therapy*	MA	FFS
Falls Prevention Program*, **	MA, MLTSS	FFS, VBP
Diabetes Self-Management*, **	MA, Commercial	FFS
Caregiver Support Program*, **	MA	FFS
*HRSN screening: Incorporated into programs assessment.		
**Evidence-based health prevention workshops: included in program with wrap-around individual coaching.		

[2] https://www.wnyicc.org/Programs

Timeline

2014-2015

ACL BUSINESS ACUMEN LEARNING COLLABORATIVE

Local AAA and CBO leaders participated in the ACL Business Acumen Learning Collaborative

2016

INCORPORATION

WNYICC was incorporated with 10 local network members

2017

HEALTH FOUNDATION GRANT

WNYICCC received a grant from Health Foundation of Western and Central NY to support Network Development and hired Nikki Kmicinski to lead this development

2018

501(C)3 STATUS

WNYICC achieved 501(c)3 status and was approved as a Medicare provider

2018-2019

NCOA AND USAGING LEARNING COLLABORATIVES

WNYICC participated in the NCOA Medicare Reimbursement Learning Collaborative and in USAging's Aging and Disability Business Institute's Health Information Technology Learning Collaborative

2019

GRANT APPROVALS

WNYICC was included as a sub-grantee with New York State Office for the Aging for an ACL CDSME grant; WNYICC was awarded a grant from the John R. Oishei Foundation for continued business development; WNYICC executed its first contract with an MA Plan

2020

IT DEVELOPMENT

WNYICC transitioned all programs, processes, and systems to virtual and digital processes and program delivery

2021

ACL SCALING NLE GRANT

WNYICC was awarded ACL's Scaling Network Lead Entities grant

2023

EXPANSION

WNYICC network reaches 52 network members and has 25 executed contracts with health plans

Advice for Replication

> *"This work takes time so don't be discouraged. Continue to tell the story and benefits of forming and growing your network, as this work is just starting."*
> Nikki Kmicinski, WNYICC

Lessons learned from WNYICC experience in contracting include:

1. Start small with dedicated partners and grow as you go.
2. Consider the benefits of coming together to form a CCH, which has given rural CBOs an advantage in contracting with health care entities that want regional coverage.
3. Collaboration is key – contracting is a partnership.

Tools and Resources

Western New York Integrated Care Collaborative Annual Report. This is the WNYICC 2021 Annual Report. The report audience is WNYICC's network members, however, recently the team has been leveraging the report as marketing material for potential health care partners.

Benefits of Joining the Network. This two-page reference from WNYICC outlines the benefits of joining their network. It is shared with new potential network members providing a brief overview of network member benefits as well as the mission, vision, and core services of the CCH.

ACL: COVID-19 Care Transitions Spotlight: Western New York Integrated Care Collaborative. This spotlight on the WNYICC provides information on sustaining their care transitions program before and during the COVID-19 pandemic.

Sustainability Spotlight: Western New York Integrated Care Collaborative Contracting for Health and Well-Being Coaching. This spotlight describes how WNYICC developed contracts with a Medicare Advantage plan to screen and address health-related social needs using health coaching codes.

Business Acumen Case Study: Building the Western New York Integrated Care Collaborative. This brief authored by the Health Foundation for Western and Central New York provides an overview of how the CCH developed.

ACL Contracting Spotlights. This document describes the work of three CCHs, including WNYICC.

Federal Websites

ACL No Wrong Door Webpage

ACL Community Care Hub Webpage

ACL Advancing Partnerships to Align Health Care and Human Services Webpage

ACL Nutrition and Aging Resource Center

Glossary of Terms

Aging and Disability Resource Center (ADRC): ADRCs are local NWD System partners designated by a state to provide a coordinated and integrated way for older individuals, individuals with disabilities and their caregivers to access LTSS. ADRCs are defined in the OAA as networks or consortiums of AAAs, Centers for Independent Living (CIL), CBOs, or other entities.[3]

Area Agency on Aging (AAA): These agencies address the needs of older adults at the regional and local level through services and supports (like home-delivered meals and homemaker assistance) to support independent living.[4]

Center for Independent Living (CIL): These centers provide tools, resources, and supports for integrating people with disabilities fully into their communities to promote equal opportunities, self-determination, and respect.[4]

Community-based Organization (CBO): CBOs in the aging and disability network are present in every community across the U.S. and have unmatched expertise in local culture and needs; service coordination and delivery; and securing benefits, services, and supports that maximize independence and functioning.[5]

Community Care Hub (CCH): A CCH is a community-centered entity that organizes and supports a network of community-based organizations providing services to address health-related social needs. A CCH centralizes administrative functions and operational infrastructure, including, but not limited to, contracting with healthcare organizations, payment operations, management of referrals, service delivery fidelity and compliance, technology, information security, data collection, and reporting. A CCH has trusted relationships with and understands the capacities of local community-based and healthcare organizations and fosters cross-sector collaborations that practice community governance with authentic local voices.

Long-Term Services and Supports (LTSS): LTSS includes a continuum of services provided in the home and community or an institutional setting. These supports help older adults and individuals with disabilities manage tasks that would be difficult or impossible to perform on their own, such as personal care (e.g., bathing, dressing, and toileting); complex care (e.g., medication administration, wound care); home care (e.g., help with housekeeping and meal preparation), and transportation.[6]

No Wrong Door (NWD): A NWD System is a network of state agencies and community-based organizations (CBO) promoting access to LTSS through coordinated points of entry. NWD Systems assist individuals navigating health and social care services through outreach, streamlined assessments, person-centered plans, information and referral to state and community-based resources, and a governance structure that ensures these functions are available and coordinated across the state.

[3] Older Americans Act
[4] https://acl.gov/programs/aging-and-disability-networks
[5] https://acl.gov/news-and-events/news/addressing-social-determinants-scaling-partnerships-community-based
[6] AARP LTSS Scorecard

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