Partnership
to Align Social Care

A National Learning
& Action Network

Informational Webinar for *Community-Driven, Multi-Payer Health Equity Solutions: An ECHO Collaborative*

November 2, 2023 | 1:00-2:00 p.m. ET

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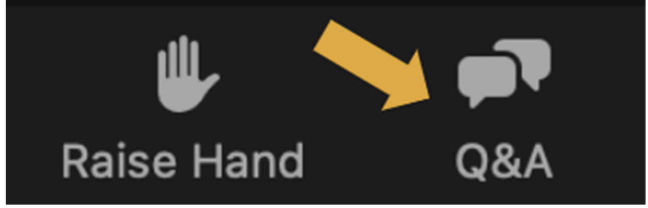
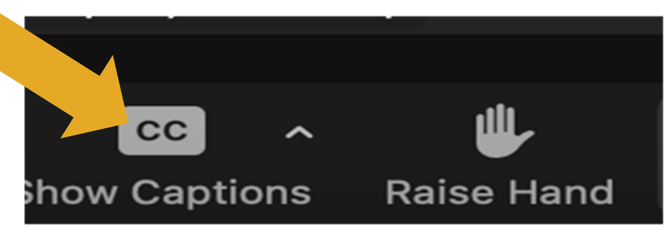
Administrative Notes

- ✓ This webinar is being recorded. The recording, slides, and follow-up material will be shared with all registrants
- ✓ Please use the Q&A tab at the bottom of your screen and we'll try address as many questions as possible at the end of the presentation
- ✓ Closed captions are provided for this session, can also click "Show Captions" to display automated captions





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Panelists

June Simmons, CEO
Partners in Care Foundation

Tim McNeill, CEO
Freedmen's Health Consulting

Kelly Cronin, Deputy Administrator,
Center for Innovation and Partnership
Administration for Community Living

Partnership to Align Social Care

Mission:

To enable successful **partnerships** and contracts **between health care and community care networks** to **create** efficient and sustainable **ecosystems** needed to provide **individuals with holistic, person-centered social care** that demonstrates cultural humility.

Vision:

A **sustainably resourced, community-centered social care delivery system** that is **inclusive** of all populations and **empowered by shared governance** and financing, multistakeholder accountability, and federal/state/local policy levers.

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Co-Designing a Social Care Delivery System

- **Group of diverse stakeholders** collaborating to **co-design partnerships** between health care and community-based organizations (CBOs)
  - Includes senior leaders from CBOs, health plans, health systems, national associations, and federal leaders engaged as liaisons
  - Includes **leadership and feedback from community leaders** throughout the process to elevate the voice of the community
  - Incorporates and supports the perspectives, needs, and priorities of historically marginalized communities to promote accountability and **guarantee a focus on health equity**

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Co-Designing a Social Care Delivery System
11 Health
Plans/Systems
15+ National
Thought
Leading
Organizations
20+ CBOs
and CBO
Networks
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20+ National
Associations
5 Federal
Agency
Partners
8 Funders

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Health Plans

Aetna CVS Health

Elevance Health

CareSource

Centene

Humana

United Healthcare

Well Care of New Jersey

Health Systems

CommonSpirit Health

Kaiser Permanente

Trinity Health

Mount Sinai

CBOs

AgeSpan

Aging & In-Home Services of Northeast Indiana, Inc.

Bay Aging

Community Catalyst

Denver Regional Council of Govt

Detroit Area Agency on Aging

Healthy Living for Maine

Houston AAA/ADRC & Houston Health Department

Mid-America Regional Council

Ohio Association of AAAs

Partners in Care Foundation

Pathways Community HUB Institute

Piedmont Triad Regional Council

Region IV Area Agency on Aging

Trellis

Western NY Integrated Care Collaborative

YMCA of Metropolitan Milwaukee

YMCA of the USA

Associations/Agency

ADvancing States*

AHIP

AMA

American Academy of Family Physicians

American Hospital Association

America's Physician Groups

Assoc of Asian Pacific Cmty Health Organizations

Assoc of Community Affiliated Plans

Food is Medicine Coalition

Lutheran Services in America

National Association of Medicaid Directors*

National Association of Community Health Centers

Social Current

Special Needs Plan Alliance

USAging

Administration for Community Living (ACL)**

Center for Medicare & Medicaid Innovation (CMMI)**

Center for Medicaid & CHIP Services (CMCS)**

Office of the National Coordinator for Health IT (ONC)**

**Non-Voting Member/Liaison | **Federal Liaisons*

Other

Camden Coalition of Healthcare Providers

Center for Health Care Strategies

Center for Practical Bioethics

Clearlink Partners

Comagine Health

Concert Health

Duke-Margolis Center for Health Policy

Epiphany LLC

Eviset

Freedmen's Health

Gravity Project

Health Care Transformation Task Force

Independent Living Research Utilization

Independent Living Systems, LLC

Manatt, Phelps & Phillips, LLP

Rush University Medical Center

Winona Health

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Streamline Contracting

Facilitate Expanded Social Care Billing

Promote Community Care Hubs

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Funders

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Community-Driven, Multi-Payer Health Equity Solutions: An ECHO Collaborative

Learning Collaborative Timeline

- Application release: October 31, 2023
  - Overview: www.partnership2asc.org/heathequity/
  - FAQ: www.partnership2asc.org/FAQ
  - Example: https://www.partnership2asc.org/healthequity/example-participating-market/
  - Health Plan Outcomes: https://www.partnership2asc.org/healthequity/healthplanoutcomes/
  - CHI Implementation: https://www.partnership2asc.org/healthequity/chiimplementation/
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- Due Date: 11:59 pm EST, November 20, 2023
- December 2023: Pre-learning session and overview of the CHI codes and concepts of Multi-Payer Alignment of APMs to drive Health Equity (HCP-LAN HEAT Guide):
  - Reference: HCP-LAN HEAT Guide: *Advancing Health Equity through APMs, Guidance for Equity-Centered Design and Implementation*
  - Available: https://hcp-lan.org/workproducts/APM-Guidance/Advancing-Health-Equity-Through-APMs.pdf
- January 2024: Learning Collaborative Launch

Goal

- Implement an ECHO learning framework to implement and document **community-driven models of care that promote Health Equity goal achievement**, using Multi-Payer Alignment to the implementation of Community Health Integration (CHI) HCPCS codes.
- **Implement TeamSTEPPS** to support clinical integration to operationalize a market-driven strategy to achieve health outcome improvement.
  - TeamSTEPPS is an evidence-based framework to optimize team performance across the healthcare delivery system.
  - https://www.ahrq.gov/teamstepps-program/index.html

Priority Population Spotlight

- Participants will follow the CMMI recommendation on Equity.
  - CMMI Strategy Refresh: https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper
- "The term "equity" means "The consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment:"
  - Race and Ethnicity
  - Religious minorities
  - LGBTQ+
  - Persons living in rural areas
  - Persons affected by persistent poverty or inequality, regardless of race or ethnic group

Community-Clinical Teams

- The learning collaborative will bring together up to twenty (20) community-clinical teams, that include **at least one of each** of the following stakeholders on the team:
  1. **Community Care Hub/Community-Based Organization** *[Required at time of application]*
  2. **Medical Providers** (i.e., Group Medical Practices, Solo-Practitioners, FQHCs/RHCs, etc.) *[Required at time of application]*
  3. **Person with Lived Experience** *[Optional at time of application]*
  4. **Health Plan** *[Optional at time of application]*
  5. **Health System** *[Optional at time of application]*

Learning Collaborative Market Example – Houston, Texas

- The Community organizes a set of relevant stakeholders that are interested in improving health equity, using a multi-payer alignment approach.

Health System: Baylor St. Luke's Medical Center, Memorial Hermann-Texas Medical Center	CCH/CBO: Houston Health Department/UT Health Sciences CCH – CATCH, Houston Health Foundation
Healthcare Provider: Baylor St. Luke's MSSP ACO, Memorial Hermann ACO, Ibn Sina	Person with lived experience: AAA Advisory Member/Health Department Advisory member from the community
Health Payer: United Healthcare, Elevance Amerigroup, Medicare	

Power-Sharing and Equal Power of Team Members

- The learning collaborative participants will adhere to the **principles of Community-Based Participatory Research** emphasizing power sharing and participatory involvement of community members to achieve health equity goals.

Learning Collaborative Market Example – Priority Issue

- The community clinical team reviews the data regarding Disparities-Sensitive Measures in their community.
- Each member of the Community-Clinical Team is respected and given equal power in participation.
- After a review of the relevant data from **State and local health department resources, health system utilization data, healthcare provider data, and health payer data**, the community-clinical team determines that the most relevant **disparity sensitive condition impacting their community is diabetes**.

Learning Collaborative Market Example – Priority Population

- Adults with diabetes
- Persons with gestational diabetes
- Persons with diabetes and multiple chronic conditions
- Persons with diabetes and functional impairments that limit their ability to perform activities of daily living (ADLs)
- Persons with diabetes and comorbid behavioral health or SUD conditions

- A secondary priority for the Houston Community-Clinical Team includes persons in the household that are at elevated risk of developing disease:
  - Childhood obesity
  - Persons with prediabetes

Learning Collaborative Market Example – Social Needs

- The Community-Clinical Team determined that the following factors are potentially impacting health outcomes for the priority population:
  - Health literacy
  - Limited disease self-management skills
  - Food Insecurity
  - Access to care
  - Access to medication
  - Lack of completion of relevant health screening and preventive health measures (HEDIS)

Learning Collaborative Market Example – Multi-Payer Impact

- Priority Population Impacts Multiple Payers in the Houston Market:
  - Medicare (Original Medicare, Duals, MSSP ACO population)
  - Medicaid (Medicaid MCOs – Texas Star, Star-Plus plans, UHC)
  - Medicaid Waiver (Texas Star – Plus, UHC)
  - Special Needs Plans (United Healthcare)
  - Medicare Advantage (United Healthcare MA Plan)
  - Commercial Insurance
  - Uninsured (Texas Uncompensated Care Fund)

Health Equity Performance Measures

- The Community-Clinical Teams adopt at two or more aligned health equity performance measure set, stratified by Race, Ethnicity, language and other characteristics, to assess health equity performance.
- Priority measures should include at least one Disparity Sensitive Clinical Quality Measure
- Next the Community-Clinical Teams adopt a common methodology to measure the size of health disparities at baseline and then monitor month-to-month and and year-over-year changes.

Disparity-Sensitive Measure Selection – Houston Example

NQF#	Measure Title	Measure Description
575	Comprehensive Diabetes Care: HbA1c control (<8.0%)	The percentage of members 18 – 75 with diabetes who had HbA1c control (<8.0%)
630	Diabetes and elevated HbA1c – use of diabetes medications	The percentage of adult patients 18 – 75 with diabetes and an elevated HbA1c who are receiving diabetes medications
1902	Clinician/Group's Health Literacy practices based on the CAHPS Item set for addressing health literacy	The item set includes the following domains: communication with provider, disease self-management, communication about medications, communication about test results, and communication about forms.
272/274	Diabetes Short-Term and Long-term complications admission rate	Number of discharges for diabetes (short-term and long-term) complications per 100,000
285	Rate of lower extremity amputation among patients with diabetes	The number of discharges for lower-extremity amputation among patients with diabetes per 100,000 population

Measure Selection and Equity Spotlight

- ACOs, Health Plans, and Providers in Value-Based contracts are required to document clinical measures of the population.
- Anywhere MSSP ACO discovered that their percentage of patients with poor control of diabetes measure (HbA1c > 9%) was 8.24
- Further analysis showed that the same measure, for priority populations, was significantly different:
  - Dual Eligible/LIS beneficiaries (All Races and Ethnic Groups): 18.8
  - Black and Latino Population: 22.9
- Health Equity strategies will align medical and social interventions to move the priority population HbA1c > 9% to the mean for the population (8.24).

Learning Collaborative Market Example – Root Causes

- Next, the Community-Clinical Teams work to identify all possible root causes that contribute to health disparities related to diabetes outcomes.
  - Social Determinants of Health (i.e., lack of safe, walkable communities that allow persons to maintain an exercise regimen)
  - Health-Related Social Needs (i.e., food insecurity or lack of access to recommended dietary choices that meet diabetes management guidelines)
  - Limited Health Literacy (Community-Based Evidence-Based Health Education Programs)
  - Limited disease self-management capacity
  - Access to preventive health care services and medication

Community-Driven Intervention Model

- Evidence-based screening protocols for HRSNs
- Z-code reporting of identified needs, reporting and monitoring identified needs (**must include tracking of race, ethnicity, socioeconomic status, and geography**)
- Deploying interventions to address priority social needs (health literacy, disease self-management capacity, food insecurity, transportation/access to care, etc.).
  - Aligning Clinical and Social Interventions to achieve improvement in selected quality measures
- Reporting HCPCS/CPT codes (CHI/PIN) to capture the labor related to addressing identified needs.
- Monitoring the outcomes of the interventions at the individual and population level.
- Population health analysis of outcome data to determine the impact on health disparities.
- Gathering input from diverse stakeholders on suggested methods to drive improvement month-to-month & year-over-year.

Multi-Payer Alignment

- Key focus of the learning collaborative is to achieve multi-payer alignment to a single model of care that is driven by the community stakeholders to address health and social needs impacting their local community.
- Through implementing the model of care using available HCPCS/CPT codes, other health plans can adopt the community-driven strategy to achieve health equity goals and value-based contracting goals at the individual plan level.

Market Example Texas: Multi-Payer Alignment

- Texas Health and Human Services mandates that all Medicaid Managed Care Plans achieve a goal of **50% of MCO provider contracts move to value-based contract.**
- Available: https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/value-based-care
- The Community-Clinical Team engages in Medicaid MCO value-based contracting using the HCP LAN APM Framework, using the single model of care that was deployed to improve outcomes for the priority populations.
  - HCP-LAN Category 2: Pay for Reporting social needs with bonuses for quality performance to improve Health Equity.
  - http://hcp-lan.org/workproducts/apm-framework-onepager.pdf

Health Plan Benefits for Participation

- Improved HEDIS performance
- Improved CAHPS scores
- Increased collaboration with community to drive HEDIS measure improvement
- Health plan partnerships with community to define and implement programs to drive improvement towards health equity goals
- Community partnerships to support NCQA Health Equity or Health Equity Plus Accreditation
- Improvement in Value-Based Contracting goals (internal goals or Medicaid required goals)
- Identification of additional resources (public/philanthropic) to meet member health and social needs

Learning Collaborative Alignment with National Quality Requirements

Health Equity/HRSN Regulatory Requirement	Organizations Impacted
NCQA Social Needs and Intervention (SNS-E) HEDIS Measure	All Health plans with NCQA Accreditation
NCQA Health Equity Accreditation Requirement	Medicaid MCOs in twelve (12) States
Joint Commission Health Disparities Accreditation Requirement	All hospitals with Joint Commission Accreditation
CMS FY2024 IPPS Rule requiring Hospitals to conduct HRSN screening for hospital admissions	All hospitals that accept Medicare and Medicaid reimbursement
Medicare Advantage Special Needs Plan mandate to complete HRSN screening in Health Risk Assessments for all plan members	All Medicare Advantage Special Needs Plans
CMS/CMMI Strategy Refresh	Participants in a CMMI Alternative Payment Model (i.e., ACO REACH, Kidney Choices, etc.)

Learning System to Align Health and Social Care

- Multi-pronged approach to learning a collaborative and holistic model of care that builds upon existing community capacity to address HRSNs
- Intended to meet CBOs, CCHs, and their health care partners where they are in journey to screen, refer, coordinate, deliver, and finance services
- Coordinate across various organizations providing relevant TA to implement a comprehensive approach that reaches a broad group of aging and disability CBOs, CCHs, and health care organizations

Technical Assistance Opportunities in 2024

- Community Care Hub National Learning Community
  - For CBOs – current and emerging hubs with existing health care contracting capacity
- Community Care Hub 101 Learning Series
  - All CBOs interested in or early in their hub development
- Health Equity Learning Collaborative (Partnership to Align Social Care)
  - For more advanced hubs and their health care partners to collaborate on team based learning and multi-payer alignment
- ECHO learning series on care transitions with CBOs and hospital partners
  - All CBOs serving older adults/people with disabilities with hospital partners learn how to collaborate on HRSN screening, referral, transition support, and service activation/coordination
- Housing and Services Partnership Accelerator
  - Support state teams coordinating across organizations that provide services and resources that help people find – and keep – stable housing in the community
- Multi-state IT learning collaborative on interoperable referral systems

Learning System to Align Health and Social Care

November 23'

- Accepting applications for ACL's 2023/2024 Community Care Hub (CCH) National Learning Community
- **CCH 101 Learning Series hosted by Center of Excellence to Align Health and Social Care**
  - **Timeline**: 2 months
  - **Audience**: New and emerging CCHs

December 23'

- Announce funding opportunity for CCHs through Center of Excellence
- **Launch of ACL's Housing and Services Partnership Accelerator**
  - **Timeline**: 12 months
  - **Audience**: Up to 4 states with Medicaid 1115 demonstrations or 1915(c) waivers to address housing stability

January 24'

- **Launch of Community Driven, Multi-Payer Health Equity Solutions: An ECHO Collaborative**
  - **Timeline**: 12 months
  - **Audience**: Up to 20 community/ clinical teams
- **Launch of ACL's 2023/2024 CCH National Learning Community**
  - **Timeline**: 8 months
  - **Audience**: Up to 30 CCHs serving aging and/or disability populations
- **Launch of ACL's Care Transitions ECHO Series**
  - **Timeline**: 9 months
  - **Audience**: Aging and disability network organizations and their hospital partners

February 24'

- **Launch of Multi-State Learning IT Collaborative Series**
  - **Timeline**: 6 months
  - **Audience**: State agency leadership (e.g., SUAs, CIOs, Medicaid)

March 24'

- Award grants for up to 20 CCHs through Center of Excellence
- *Ongoing participant engagement in various Learning System activities*

HELC Overview Reminder & Questions

- Application release: October 31, 2023
  - Overview: www.partnership2asc.org/heathequity/
  - FAQ: www.partnership2asc.org/FAQ
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  - Available: https://hcp-lan.org/workproducts/APM-Guidance/Advancing-Health-Equity-Through-APMs.pdf
- January 2024: Learning Collaborative Launch

Contracting to Align Health and Social Care Ecosystems: A webinar series sharing leading practices

Learn more at www.partnership2asc.org/contractingwebinarseries2023

Oct. 10, 2023 2-3 pm ET	Designing the payment structure: A health plan's guide to paying CBOs & CCHs for social care
Nov. 14 2023 12-1 pm ET	Defining core activities: Developing an effective scope of work for contracted partners
Dec. 12, 2023 12-1 pm ET	Operationalizing contracts: Improving contracting implementation and collaboration

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How to Get Involved in the Partnership…

- Sign up for our email list: https://www.partnership2asc.org/sign-up/
- Follow the Partnership on social media:

www.linkedin.com/company/partnership-to-align-social-care

@partnership2asc

- Reach out directly to:
  - ✓ *Support the Partnership*
  - ✓ *Ask about getting involved in leadership/workgroup activities*
  - ✓ *Share your expertise/experiences*

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