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Community-Driven, Multi-Payer Health Equity Solutions: An ECHO Collaborative
Session 1

January 18 | 2:00-3:30 p.m. ET

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Administrative Reminders

- ✓ Please introduce yourself and your organization in the chat
- ✓ Recording and slides will be shared following this session of the Health Equity Learning Collaborative
- ✓ Please keep yourself muted unless you have a question. We will have time for questions, but feel free to raise your hand at any time.
- ✓ A live transcript of the meeting is available. To turn on closed captioning, click on the upward arrow next to Live Transcript and select “Captions.” The Captions option may also be available under the icon labeled “More.”

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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

Community-Clinical Team Profile

- An iterative tool to:
  - Leverage strengths within your implementation strategy
  - Establish priority populations and services based on market trends and desired clinical outcomes
  - Identify technical assistance and infrastructure needs to meet implementation goals
  - Support peer to peer exchange
  - Spur adoption of emerging practices for driving health equity

Point of Contact

<Name>
<E-Mail>

<Applicant Organization Name>

Geographic Coverage:

<insert here>

Community-Clinical Team

Community-Based Organization or Community Care Hub	<insert contact name and organization – if more than one, insert in this space>	<Insert e-mail addresses>
Healthcare Provider		
Health System or Hospital		
Health Plan		
Person with Lived Experience		

Target Population(s)

- Insert bullets

Target Service(s)

- Insert bullets

What We Know About the Market

- Insert Data Points

Primary Goals

Insert primary goals from application

Current Strengths

Insert strengths

Available Funding Sources

Insert available funding sources

Technical Assistance Needs

Insert technical assistance needs

Infrastructure Needs

Insert infrastructure needs

Community-Clinical Team Profile

- Action Needed
  - The Partnership will send the template by January 23rd
  - Complete the profile by February 12th
  - Send the profile and any questions you might have to: erobbins@freedmensconsulting.com
  - 1:1 follow-up calls with your community-clinical teams will occur between February 26th and March 29th – Stay Tuned.

AHRQ: Patient Safety Network Innovation Recognition

Timothy P. McNeill, RN, MPH

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Innovation Recognition

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- Enhancing Support for Patients' Social Needs to Reduce Hospital Readmissions and Improve Health Outcomes.
- Available: https://psnet.ahrq.gov/innovation/enhancing-support-patients-social-needs-reduce-hospital-readmissions-and-improve-health#2
- Innovator: Prime Healthcare. Network of 45 hospitals.
- Outcome: Innovation noted for reduction in readmissions and all-cause mortality rates at participating facilities.
- Innovation Patient Safety Focus:
  - Assessing, addressing, and lining SDOH factors to improve patient outcomes including safety.

Innovation Results

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- Outcome: Innovation noted for reduction in readmissions and all-cause mortality rates at participating facilities.
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Peer Reviewed Publication on the Innovation

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Title: Improving and Promoting Social Determinants of Health at a System Level.

Publication: **The Joint Commission Journal on Quality and Patient Safety**

Release Date: August 2022 (Volume 48, Issue 8, August 2022, Pages 376-384)

- Available: https://www.sciencedirect.com/science/article/pii/S1553725022001234?via%3Dihub#tbl0002

Innovation Background & Project AIMs

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- Background: Social Determinants of Health adversely affect health outcomes
  - Low socioeconomic status
  - Race and Ethnicity
  - Poor environmental conditions
  - Food Insecurity
  - Inadequate access to health care services
- Project AIMS: Address SDOH needs with clinical care to improve patient outcomes and assist safe discharge.
- Approach: Prime Healthcare Services Implemented a multi-state model to address SDoH needs as part of the hospital discharge process.
- Project Start date: 2018

Innovation Implementation Model

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- Assessment of claims history and readmission causes
  - Patient diagnoses
  - Procedures
  - Utilization
  - Clinical Outcomes
  - Referrals to community resources
- Implementation:
  - Creation of multi-disciplinary teams that include key community partners in the care continuum
  - SDOH Screening Implemented with documentation of key findings.
  - Access to a Strong Preferred Network of Community Resource Partners (CCH)
  - Care Coordination extended into community through the Preferred Network of Community Partners
  - Bidirectional Flow of Information and Real-Time Patient Monitoring

Impact on 30-Day Readmission Rate

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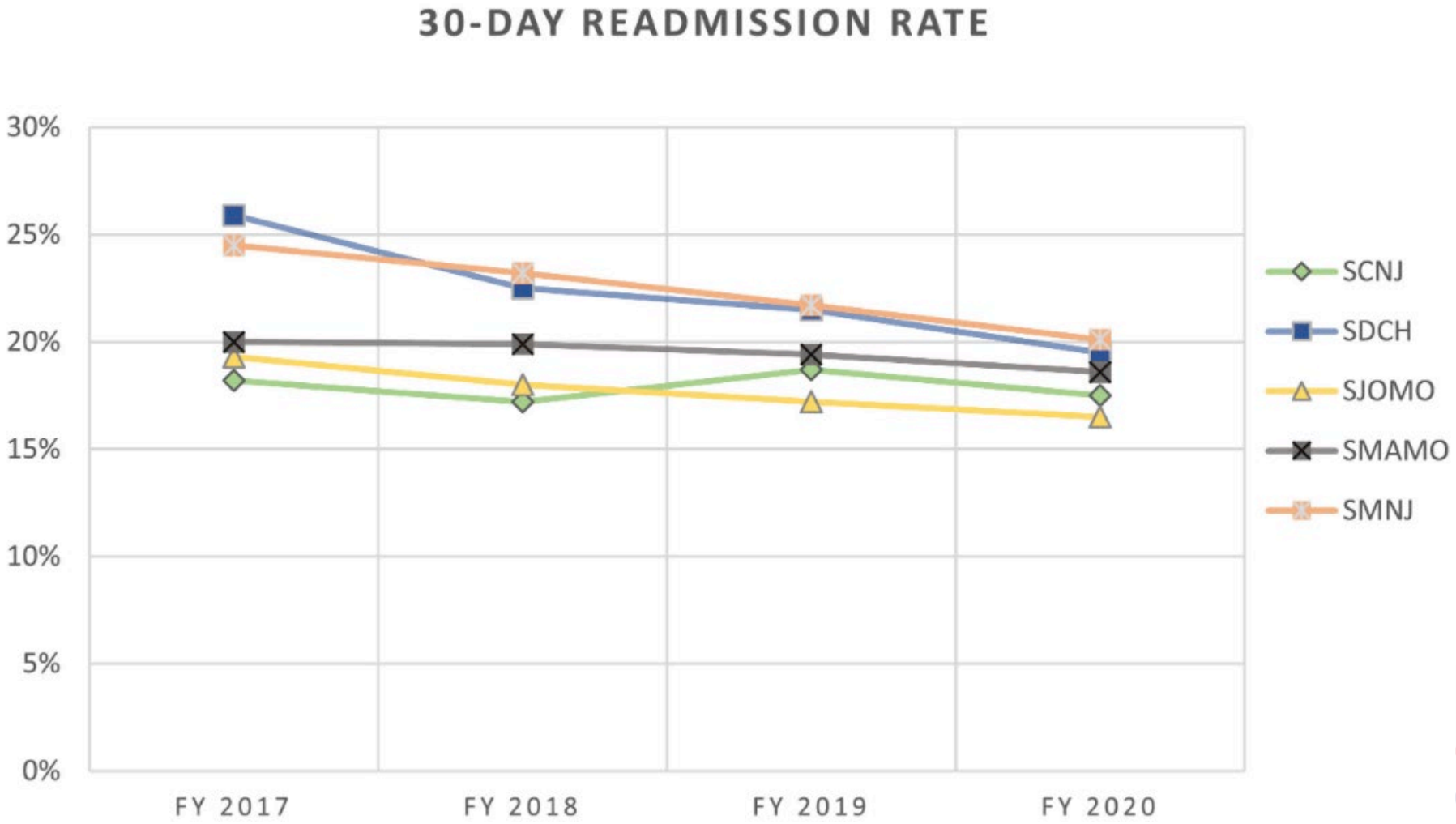

Common Readmission Causes Impacted by HRSNs

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- Health Literacy: Patients not following or understanding discharge instructions
- Medication Access: Not taking medication as prescribed, Unable to obtain medication due to copays, Unable to obtain transportation to the pharmacy to obtain medication.
- Inadequate resources to care for oneself
  - Inability to prepare meals
  - Food insecurity
  - Housing insecurity/unsafe housing
  - Hazards in housing leading to increased fall risk
  - Require assistance with ADLs and do not have resources to secure assistance

Key Steps to Replicate the AHRQ Recognized Innovation

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Thank you

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Next Steps

Reminders, Requests, and How to Get Involved

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2024 Curriculum Overview

Month	Topics
☑ January	Multi-Payer approaches to driving Health Equity through APMs (HCP-LAN HEAT Guide) and Team STEPPS 3.0
February	Community Health Integration (CHI) HCPCS Codes Overview and requirements
March	Application of implementation challenges for Chronic Care Management to the implementation plan for Community Health Integration (CHI)
April	Theory of Change: How APMs Advance Health Equity. Care Design
May	Implementing APMs to Advance Health Equity. Performance Measurement
June	Implementing APMs to Advance Health Equity. Payment Incentives and Structures
July	Designing APMs to Advance Health Equity and Implementation of Community Health Integration (CHI) HCPCS codes into CMMI APM and ACO Models
August	Incorporating changes into APMs to Advance Health Equity. APM Features to Advance Health Equity
September	Priorities for Multi-Payer Alignment and adoption of the CHI HCPCS implementation strategy
October	Designing Payment Incentives to Reduce Health Disparities in Quality of Care, Outcomes, and Patient Experience
November	Overarching Guidance for Designing and Implementing APMs to Advance Health Equity review and discussion
December	Capstone Event: Market Presentations of TeamSTEPPS 3.0 Implementation of the CHI HCPCS codes in a Multi-Payer Strategy to drive Health Equity

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Learning Collaborative Resources & Key Dates

- HELC Participant Learning Sessions, April 2024 – April 2025
  - Purpose:
    - Identify a priority population for Health Equity
    - Select one or more disparity sensitive measures to address among the priority population.
    - Determine the baseline outcomes for the disparity sensitive measure for the priority population
  - FIRST Thursday of the Month @ 2-3:30 p.m. ET

- HELC Participant ECHO Sessions, January 2024 – April 2025
  - Purpose: Implement the HRSN model of care using established HCPCS codes.
    - Start with a small cohort and use a rapid-PDSA model to refine your implementation approach to the model of care.
    - Use the HCPCS and experience, implementing a single model of care, to move to multi-payer alignment
    - Reporting of disparity sensitive measures are key to a VBC negotiation.
    - Engage payers in a multi-payer alignment to HCPCS that are incorporated into a VBC model or direct reimbursement of the HCPCS codes.
  - THIRD Thursday of the Month @ 2-3:30 p.m. ET

Learning Collaborative Resources & Key Dates

- Resources
  - 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/

- Joint Learning Sessions with ACL CCH National Learning Community
  - Purpose: Learn the implementation steps for a HRSN model of care that directly incorporates HRSN interventions into the claims using new HCPCS codes.
    - Thursday, February 1 @ 2-3:30 p.m. ET
    - Thursday, March 7 @ 2-3:30 p.m. ET

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Thank you!