

Partnership
to Align Social Care

A National Learning
& Action Network



Health Equity Learning Collaborative and CCH National Learning Community *Joint ECHO Session 2*

February 1, 2024 | 2:00-3:30 p.m. ET

A Few Reminders

- ✓ Recording and slides will be shared following this session with all participants of the CCH NLC and the HELC
- ✓ Please keep yourself muted until open discussion and Q&A
- ✓ 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.”

Welcome and Introductions

LET'S 
 CHAT

Using chat, tell us:

- *Your Name*
- *Your Organization*
- *What is one “ah-ha” moment you experienced from our Joint ECHO Session #1 on January 4th?*



Agenda

1. Quick Recap of Session #1
 - Accountable Care Organizations
 - Community Health Integration and Principal Illness Navigation Services
2. Recap of January ECHO Session Case Study
3. Implementation Case Study Discussion
4. Reminders

ECHO Learning Framework

- Overview of the ECHO Learning Framework can be found at:
 - <https://hsc.unm.edu/echo/what-we-do/about-the-echo-model.html>
- Hallmark tenet of the ECHO Learning Framework
 - *“All Teach, All Learn”*
- Participants engage in a virtual community with their peers where they share support, guidance, and feedback
- Goal: Collective understanding of best practices to address complex issues derived from interactive discussions in a virtual group setting



Disclaimer

"Project ECHO® collects registration, participation, questions/answers, chat comments, and poll responses for some ECHO programs. Your individual data will be kept confidential. These data may be used for reports, maps, communications, surveys, quality assurance, evaluation, research, and to inform new initiatives."

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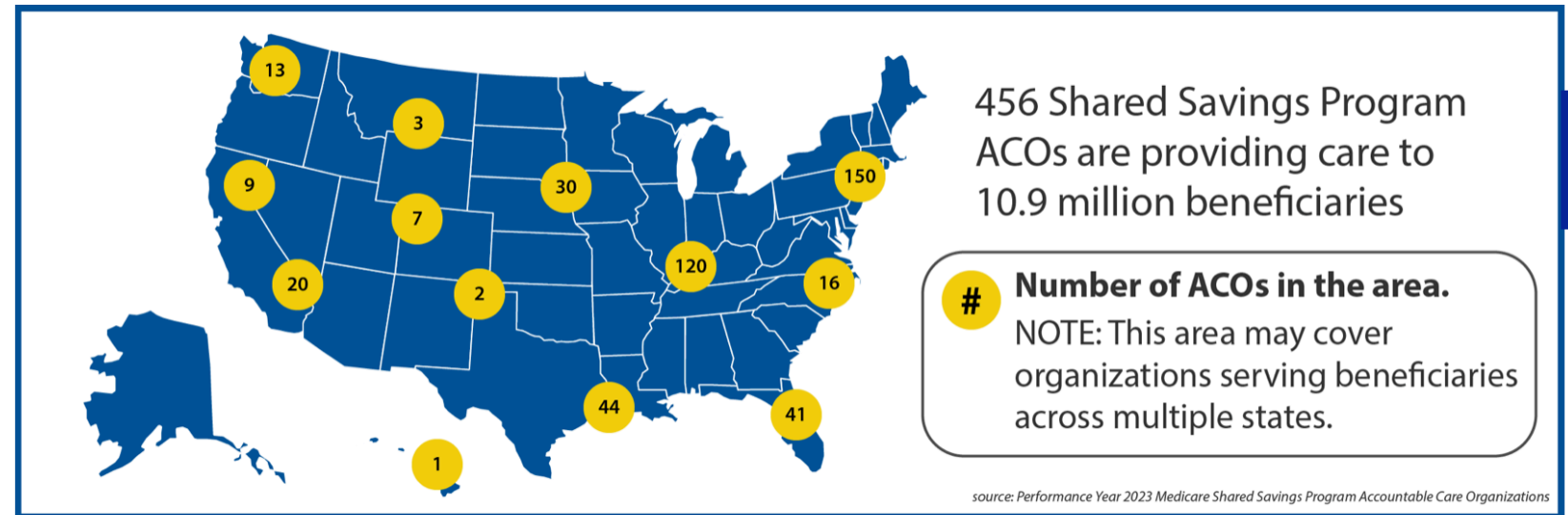
Accountable Care Organizations



Review: Accountable Care Organizations

Groups of providers and suppliers participating in one-sided or two-sided risk models with CMMI for total cost of care for Medicare Fee for Service beneficiaries.

National Participation



To learn more about the number and geographic location of Shared Savings Program ACOs, reference [Program Data](#).

What Did You Learn?



What is your preferred target population for implementing a CHI initiative?



What Did You Learn?



Which referral process options do you think will work the best for CHI implementation?



What Did You Learn?



Use chat or come off mute:

- Name some additional referrals sources you think might work well.
- What do you recall about the pros and cons of using rosters to generate referrals?
- What are the pros and cons to using individual referrals?

Review: Referral Process Options

- EMR Data to perform patient stratification
- Roster referrals based on disease state or other factors
- Patient lists
- Individual patient assessments
- Case management referrals
- Physician referrals
- Hospital discharge planner referrals
- Other sources...

Review: Pros and Cons

Roster/List Referrals

- Pros
 - The ability to identify large numbers of patients that are potentially eligible for the service.
 - Promise of scale
 - Increased efficiency in referral management
- Cons
 - Requires a secure method of exchanging the data.
 - Requires outreach and engagement to the persons on the list.
 - Additional labor required to engage individual persons to deliver service.

Individual Referrals

- Pros
 - Individual needs are identified at the time of the referral.
 - Data shows that a direct referral generally leads to increased adherence to the referral.
 - “My doctor ordered this service for me”
- Cons
 - Less efficient
 - Requires continual reminders to referrals sources to maintain referral volume.
 - Takes time to build the patient volume.

Review: Analyzing ACO Data

- ACO Patient Population
 - All persons in a ACO are enrolled in Original Medicare
- ACO Objectives
 - Improve clinical quality
 - Reduce total cost of care
- Link to finding ACOs in your State and ACO Quality Data:
 - <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-data>

What Did You Learn?



True or False?

The new Community Health Integration codes can be used for any health-related social need even if the need indirectly impedes the ability to treat or diagnose a health condition.



What Did You Learn?



Which conditions qualify for PIN?



What Did you Learn?

LET'S 
 CHAT

Use chat or come off mute:

- How does PIN apply to certain conditions (e.g., arthritis, people with dementia)?



What Did You Learn?



True or False?

Principal Illness Navigation-Peer Support is limited to people with behavioral health need.



Review: Priority Populations for Each Intervention

Community Health Integration	Principal Illness Navigation	PIN-PS
<p>Health-Related Social Need that directly impedes the ability to treat or diagnose a health condition.</p>	<p>A major health issue that is intended to last at least 3 months in duration. The person would benefit from having an assigned person to work with the beneficiary and caregivers to provide navigation supports to help achieve optimal health outcomes.</p> <p>Health-related social need can be present but is not required to receive this benefit.</p>	<p>Limited to the behavioral health population. Case management services is not part of the core services.</p>

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Joint ECHO Session #1 Case Study Discussion

Recap: Local ACO

- A Medicare Shared Savings ACO (Local ACO) has participated in the MSSP program as a one-sided risk model.
- Beginning in CY2024, the MSSP must move to a two-sided risk model.
- For the first four years of participation, the MSSP ACO has not generated any shared savings.
- The ACO is a high-revenue ACO with two participating hospitals in the ACO provider list.
- ACO leadership want to work with CBOs to address needs of the population.

Recap: Key ACO Data Elements

ACO Demographics

Total Medicare Beneficiaries: 7,324

- ESRD 160
- Non Duals 5,953
- Duals 1,211

Age distribution

- 0 – 64: 925
- 65 – 74: 4,562
- 75 – 84: 1,334
- 85+ - 503

Percent Dual – 18.7%

ACO Quality Measures

- 30-Day Readmission Rate 16.2%
- All Unplanned admissions for patients with multiple chronic conditions: 41.23
- Screening for Depression: 91.02
- Remission for depression within 12 months: 0.0%
- Diabetes poor control: 15.24 (A1c >9.0%)
- Controlling High Blood Pressure 64.32

****Question: What populations in the ACO could be targeted for HRSN screening / interventions?***

What Did You Learn?



If you attempt to implement a project with an ACO using CHI/PIN codes, how would you initially start?





CBO

- I will begin receiving referrals for screening and addressing HRSNs?
- Who completes the SDOH assessment?
- A consent is required. Can the CBO obtain consent?
- What are the methods of obtaining consent?
- How are copays handled?
- What if the patient does not accept the service?
- What if the patient tells me that they do not want to pay the copay but they want assistance?

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Implementation Case Study Discussion



Case Study: Fayetteville, NC

- Clarence Blackmon is an 81 y/o male with a history of cancer.
- Recently discharged from the hospital after an extended hospitalization for cancer treatment.
- Lives alone in an apartment.
- Medicare Eligible and a Veteran.
- Discharged home with food insecurity.
- Discharge weight 115 lbs.
- Please use the following link to watch the short video:
<http://abc11.com/society/elderly-cancer-patient-calls-911-because-he-has-no-food-/718448/>

Reports having no food at home after hospital discharge.





Consumer called 911 for help

MAN CALLS FOR HELP

“What I need is someone to get to the grocery store and bring me some food because I need to eat something.”

video.title



911 dispatcher brought him food for 2 weeks





What are the other potential hazards?



You are the CBO

Patient assigned to you for CHI. What actions do you take?

- What is the potential impact of food insecurity on his clinical health outcomes?
- List the CHI Services that could have been deployed to avert the use of 911 to address his food insecurity?
- What social care interventions could address his needs?
- Can CHI services deploy to support a hospital discharge?
- Can CHI services be deployed to support a discharge from a Skilled Nursing Facility (SNF)?
- Can CHI services be deployed to support a person in the ED with HRSNs?
- Would the time spent identifying the resources required to address his HRSNs be counted in the CHI time aggregate for the calendar month?
- Can your organization be reimbursed for the time spent attempting to address the HRSNs, even if you were unsuccessful in addressing the identified social needs?

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Reminders



Upcoming Meetings

- **HELC ECHO Peer Learning Session**
 - **February 15, 2024 @ 2-3:30 pm ET**
 - Participants: Health Equity Learning Community Participants
- **NLC Small Group Discussion**
 - **February 22, 2024 @ 2-3:00 pm ET**
 - Participants: CCH National Learning Community Participants
 - Focus: Peer-learning, CCH Action Plans
- **Joint NLC-HELC ECHO Session**
 - **March 7, 2024 @ 2-3:30 pm ET**
 - Participants: HELC and NLC Participants
 - Focus: CHI/PIN Implementation

CCH National Learning Community Reminders

- Next NLC Small Group Meeting: February 22 at 2:00pm ET
- Individual TA is available for NLC members to request
 - [Individual TA FAQ](#)
 - [TA Request Form](#)

Until then, please continue to engage with us and your peers in the [TA Community](#).



HELC Reminders & Requests

- ✓ Next HELC ECHO Peer Learning Session: February 15 @ 2:00-3:30pm ET

- ✓ Make sure that the Partnership has contact information for all HELC participants and Community-Clinical Team Members as they are committed.
 - **If you haven't yet, please fill out:** <https://forms.gle/7VfVEu1hzGqnMDBJ7>
 - Stay tuned for updated information on site profiles

- ✓ Reach out to healthequity@partnership2asc.org if you have questions or changes to Community-Clinical Team Members.

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Thank you!

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