Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

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

April 18, 2024 | 2:00-3:30 p.m. ET

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# A Few 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.”

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# Agenda

1. Welcome and Introductions
2. Session Recap – January to Present
3. Open Discussion with:
   - Detroit Area Agency on Aging
   - Chinese American Service League
4. Next Steps

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# ECHO Session Recap

Partnership to Align Social Care
A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# January 2024

--*with the National Learning Community (January 4th)*

- Accountable Care Organizations (ACO)
- How to use ACO data
  - Link to finding ACOs in your State and ACO Quality Data: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-data
- Snapshot of Priority Populations for:
  - Community Health Integration
  - Principal Illness Navigation
  - Principal Illness Navigation-Peer Support
- Referral Process Options (e.g., EMR data, Patient Lists, Referrals from Case Managers, Discharge Planners, and Physicians)

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# January Health Equity Learning Collaborative Session (January 18)

- Multi-Payer Approaches to Driving Health Equity through APMs (HCP-LAN HEAT Guide)
- Open Discussion of:
  - Choosing your Target Population(s) and Service(s)
  - Building Your Community-Clinical Team Profile

Partnership to Align Social Care
A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO

# February 2024

--*with the National Learning Community (February 1st)*

- Case study with a focus on implementation
  - http://abc11.com/society/elderly-cancer-patient-calls-911-because-he-has-no-food-/718448/
- Discussion included:
  - Potential  impact of food insecurity on his clinical health outcomes
  - CHI Services that could have been deployed to avert the use of 911 to address his food insecurity
  - Social care interventions that could address needs
  - CHI services that can be deployed to support a hospital discharge, a discharge from a Skilled Nursing Facility (SNF) or to help a person in the ED with HRSNs
  - Identifying the time spend to address HRSNs in the CHI time aggregate for the calendar month
  - Whether your organization can be reimbursed for the time spent attempting to address the HRSNs, even if you were unsuccessful in addressing the identified social needs

Partnership to Align Social Care

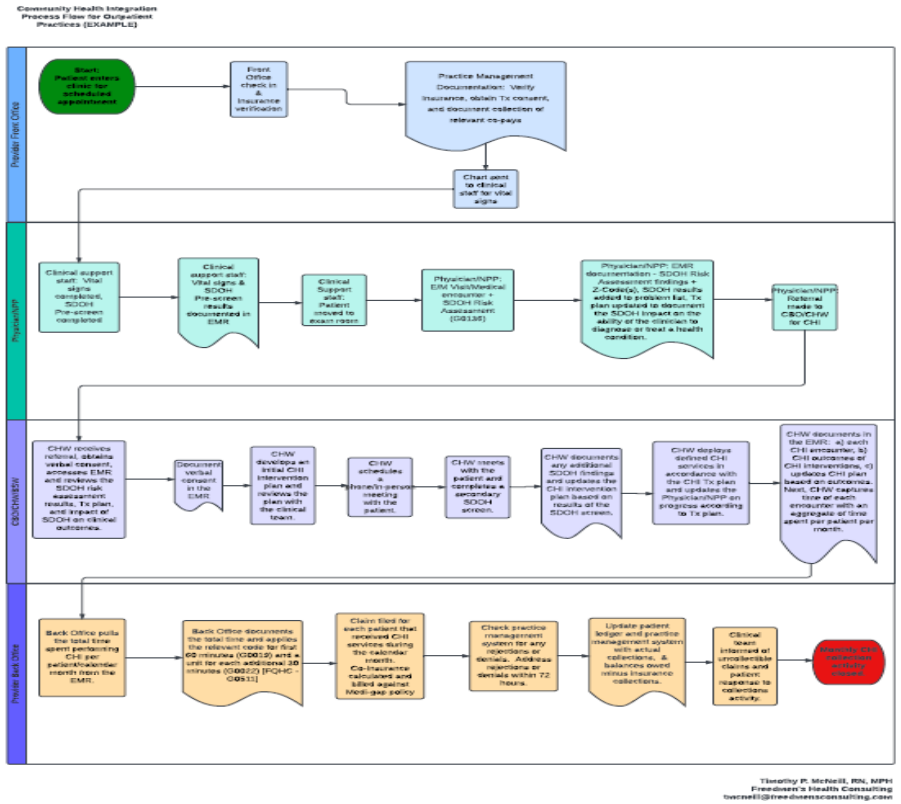
A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO

# February Health Equity Learning Collaborative Session (February 15th)




Process Workflow: Outpatient Medicare

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# March 2024

--*with the National Learning Community (March 7th)*

- Principal Illness Navigation Clinical Application
  - Conditions and Services
  - Rates
- Healthy IDEAS Case study
- Nuts and Bolts of the Management and Business Model for Community Health Integration and Principal Illness Navigation

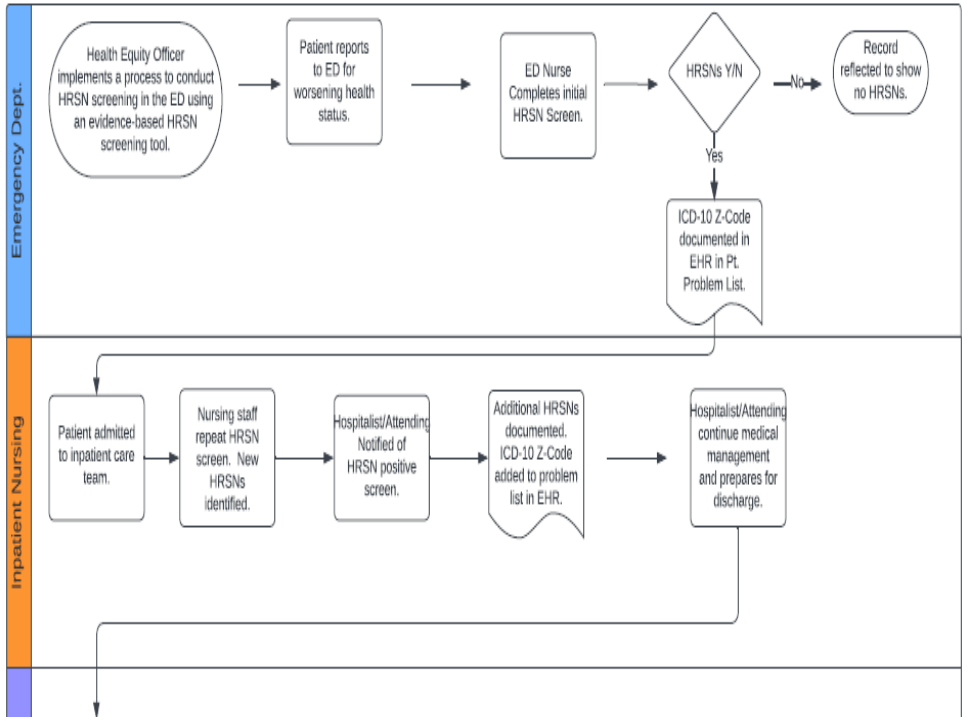
Partnership to Align Social Care
A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO

# March Health Equity Learning Collaborative Session (March 21st)




- Process Workflow: Care Transitions
- CMS Health Related Social Needs FAQ

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# April Health Equity Learning Collaborative (April 4th)

- Open Learning Session
  - Keynote: Caregiver Assessment
  - Open Mic

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# Health Equity Learning Collaborative Goals

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# Shared HELC Goals:

- Use the ECHO® learning framework to deploy community-driven models of care to achieve agreed-upon health equity goals.
- Implement the CHI HCPCS codes through **Multi-Payer Alignment** models.
- 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

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO

# Health Equity Community-Clinical Team Snapshots

THE SENIOR Solution

Detroit Area Agency on Aging — The Senior Solution

Serving Detroit, Hamtramck, Harper Woods, Highland Park & the 5 Grosse Pointes

1333 Brewery Park Blvd. Ste. 200 | Detroit MI 48207 | 313-446-4444

www.DetroitSeniorSolution.org

## Detroit Area Agency on Aging

Chinese American Service League
華人諮詢服務處

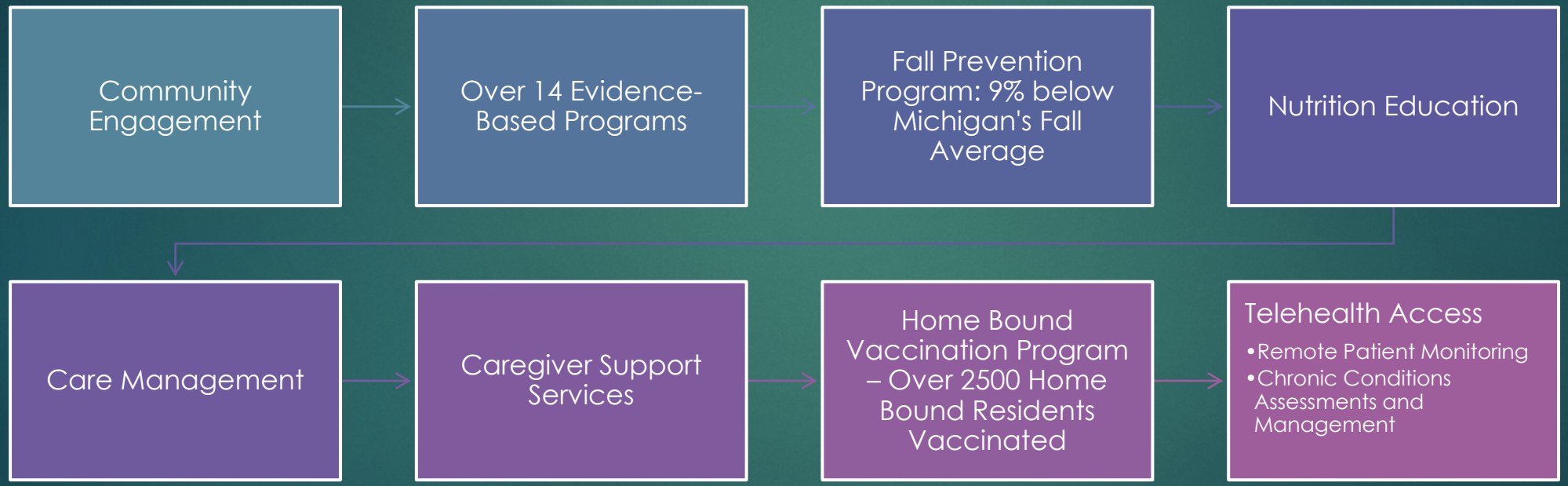
## Chinese American Service League

# Detroit Area Agency on Aging Community Care Hub Initiative

ORGANIZING SYSTEMS TO INTEGRATE

HEALTH-RELATED SOCIAL NEEDS WITH MEDICAL CARE

# DAAA History of Success



# Detroit Area Agency on Aging

Medical Provider Partnership

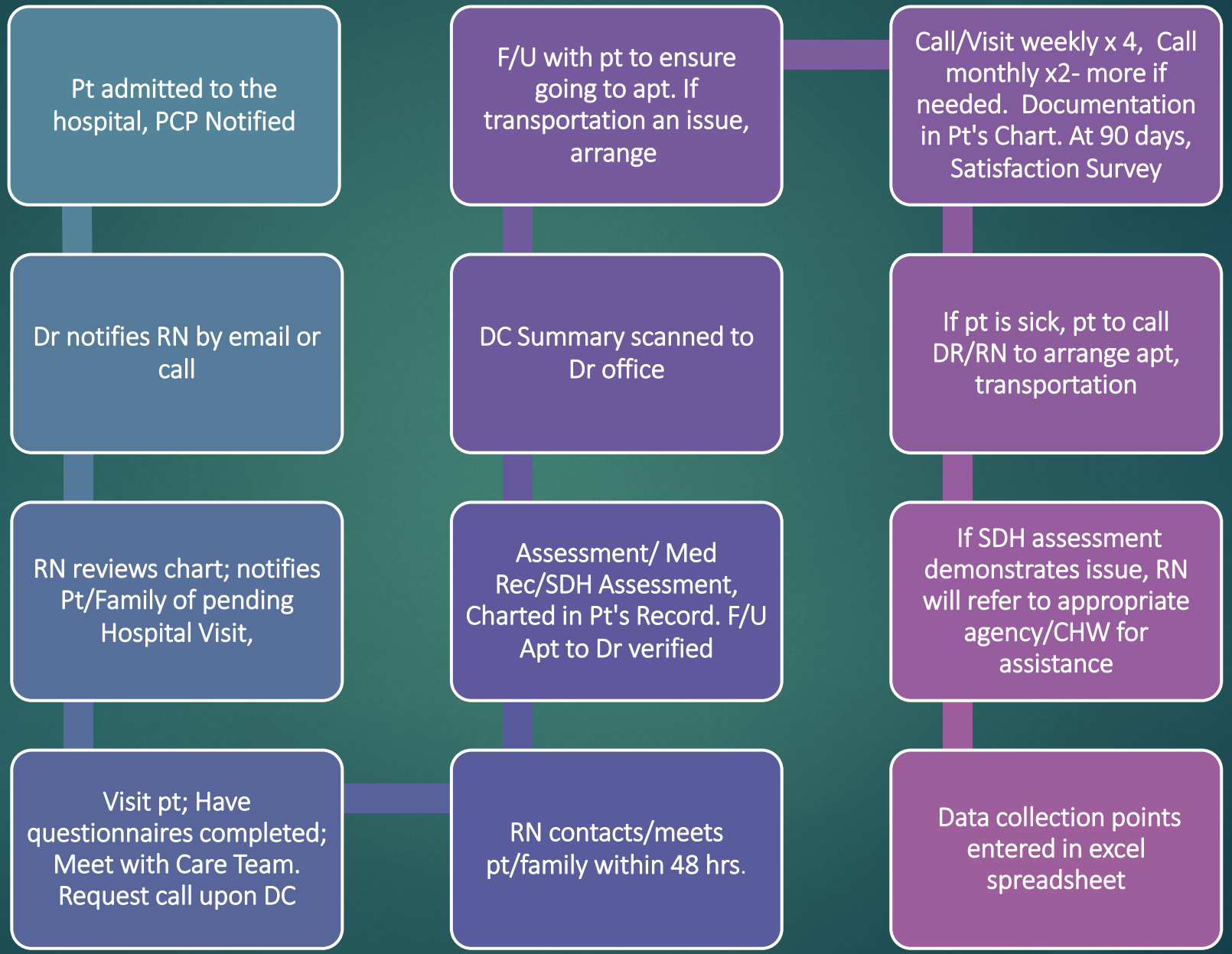
Federally Qualified Health Center

Health Centers Detroit Medical Group

Anthony Clarke, MD

# Detroit Area Agency on Aging Care Transitions Pilot

APRIL 2024- OCTOBER 2024


Pt admitted to the hospital, PCP Notified
Dr notifies RN by email or call
RN reviews chart; notifies Pt/Family of pending Hospital Visit,
Visit pt; Have questionnaires completed; Meet with Care Team. Request call upon DC
RN contacts/meets pt/family within 48 hrs.
Assessment/ Med Rec/SDH Assessment, Charted in Pt's Record. F/U Apt to Dr verified
DC Summary scanned to Dr office
F/U with pt to ensure going to apt. If transportation an issue, arrange
Call/Visit weekly x 4, Call monthly x2- more if needed. Documentation in Pt's Chart. At 90 days, Satisfaction Survey
If pt is sick, pt to call DR/RN to arrange apt, transportation
If SDH assessment demonstrates issue, RN will refer to appropriate agency/CHW for assistance
Data collection points entered in excel spreadsheet

# Pilot Goals

- To decrease readmissions to the hospital within 90 days of discharge from the hospital.
- To increase medication compliance
- To have the patient seen within 7 –14 days of discharge from the hospital.
- To decrease HRSN scores of patients during the 90 days
- To increase patient satisfaction scores
- To provide transportation if needed to attend appointments during the 90 days.
- To develop a person-centered care plan to encourage patient participation in optimal outcomes

# Detroit Area Agency on Aging Home-Based Primary Care Initiative

A CALL TO ACTION

# Home-Based Primary Care/ Community Care

*Preliminary Steps

-- Conduct a Literature Review and Collect Historical DAAA data

- Consult with Experts

- Conduct Survey of Community

- Develop a Business Plan which includes a Model of Care

- Seek Seed Money/Grant Funding for Start-up

# Model of Care Inclusion Points

Two Arms of Practice

- Participants already followed by PCP but are homebound
- Participants not followed by a PCP and are homebound

Monthly Home Visits by Nurse Practitioner

Telehealth Support

Remote Patient Monitoring

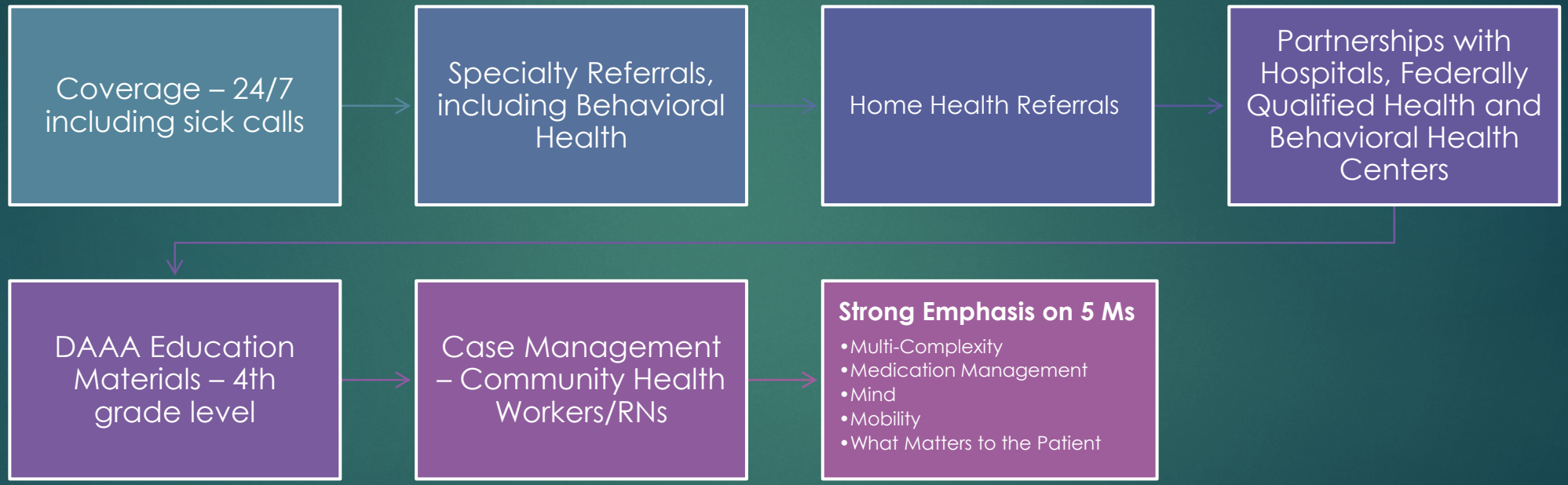
In-Home Lab Draws and Radiologic Testing

E-Prescribe

Insurance Contracts/Billing

EMR that communicates with various platforms- both ways

# Model of Care Inclusion Points



# Infrastructure

| | | | |
|---|---|---|---|
| Insurance | Legal | Policies and Procedures that comply with regulations | Quality Program |
| Firewall to make sure no duplicate billing or duplication of service occurs | Marketing materials | Robust Billing system | Ongoing Credentialling |
| Documentation system that links all DAAA programs together | Data Collection | Space | Stakeholder Partnerships |

# Case Management

01

Engagement, Engagement, Engagement

02

Assistance to access community resources

- Housing
- Home Repairs
- Utility Management
- Food
- Caregiver Support

03

Transportation

04

Education

05

Support

- Documentation
- Communication

# Feedback/Questions

KATHY TURRISI, RN, MSN

EMAIL ADDRESS: TURRISIK@DAAA1A.ORG

WORK PHONE: 313-920-7218

# Chinese American Service League

Serving Chicago's Chinese-speaking population for 45 years


Chinese American Service League
華人諮詢服務處

# Chicago, IL


# 78,631 Chicago Chinese-Americans

72% live in/around Chinatown

- 71% foreign-born
- 43% limited English
- 23% 65+

This Photo by Unknown Author is licensed under CC BY-SA

# Target Populations

- Development of a SDoH service model to serve those experiencing language and cultural barriers when seeking appropriate, quality care
- Leveraging and expanding service model to other marginalized groups in our service areas

# Target Services Historically

Initially offered minimal, but essential social services (e.g., social benefits application assistance)

# Target Services Historically

Changes in community needs + more funding/contract opportunities led to more services:

- Child & youth, older adults, employment, citizenship and immigration

# Target Services 2019 onwards…

- Large group of older adults served by CASL, ADRD symptoms
  - ACL Grant
  - Alzheimer's Program in 2019
- Pandemic □ rising behavioral health needs
  - High Suicidal Ideation in AAPI (15-35)
  - Rising rates of domestic violence and child abuse
  - Anti-Asian Hate
  - Anti-hate + Behavioral Health Program +Legal Program established in 2020
- Uninsured, underinsured, limited access to healthcare
  - can't refer the BH/CH clients out
  - APN hired in late 2023 for medication administration, limited primary care/prevention/education

# Steps Towards Implementation

- SDoH Surveys/PRAPARE
- Seeking partnerships with hospitals, healthcare entities, ACO plans to assess and address SDoH needs with our culturally and linguistically competent staff
- Seeking funding opportunities to hire another primary care provider to implement CoCM and BHI codes
- Change Management (for CHANGE IMPLEMENTATION) → Instead of Referral among Programs Only, staff will have a paradigm shift to serve clients as a multidisciplinary team to address their SDoH needs
  - Continue to expand partnership and foster collaboration with external partners to meet the needs of the community members

# Lessons Learned So Far

- Funding
  - Capacity, infrastructure, and seed grants
- Importance of outreach/education/partnership

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®


## Using chat or raise your hand:

- *What is one "ah ha" moment you had after listening to the Detroit AAA and CASL?*
- *What is one action you plan to take as a result of what you learned?*

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# Next Steps

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# Change in Direction

- <u>May Sessions</u>
  - May 2 – Implementation Challenges of CCM
  - May 16 – Business Planning
- <u>Starting in June</u>
  - Emerging Community-Clinical Teams – 1st Thursday
  - Advanced Community Clinical Teams - 3rd Thursday

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# Community-Clinical Team Calls and Profiles

Partnership to Align Social Care
A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# Community-Clinical Team Profiles

## Complete

1. AgeOptions
2. Beacon Community Connections
3. Chinese American Service League
4. Detroit Area Agency on Aging
5. Houston Health Department/Harris County Area Agency on Aging
6. Impact Health
7. Partners for Advancing Community Health
8. Piedmont Triad Regional Council
9. The Arc of Mid-Ohio Valley
10. The Arc of West Virginia
11. Washington State Dept of Social and Health Services

Partnership to Align Social Care
A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# Community-Clinical Team Calls

## Complete

1. AgeOptions
2. AHN Foundation
3. Beacon Community Connections
4. Chinese American Service League
5. Detroit Area Agency on Aging
6. Houston Health Department/Harris County Area Agency on Aging
7. Impact Health
8. Partners for Advancing Community Health
9. Piedmont Triad Regional Council
10. The Arc of Mid-Ohio Valley
11. Virginia Community Health Worker Association
12. Washington State Dept of Social and Health Services

Partnership to Align Social Care
A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO

# Selecting Your Group

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 | | |

Primary Goals
Insert primary goals from application

Target Population(s)
- Insert bullets

What We Know About the Market
- Insert Data Points

Current Strengths
Insert strengths

Target Service(s)
- Insert bullets

Technical Assistance Needs
Insert technical assistance needs

Infrastructure Needs
Insert infrastructure needs

- Complete Community-Clinical Profile by **May 15th**
- The Health Equity Planning Team will work with you to self-select a group based on your profile

Partnership to Align Social Care
A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO

# Profiles

## SPOTLIGHT:

- Southwest Washington Accountable Community of Health partnership with Skamania Community of Health, Skyline Health System, Amerigroup, and Washington State Department of Social and Health Services

Rachel Revisky
Rachel.revisky@dshs.wa.gov

# DSHS and SWACH HELC

*Attached proposal outlines work in detail

## Geographic Coverage:

Southwest Washington- Skamania County

## Community-Clinical Team

| | | |
|---|---|---|
| Community-Based Organization or Community Care Hub | Southwest Washington Accountable Community of Health SWACH | nichole.peppers@southwestach.org |
| Healthcare Provider | Skamania Community of Health | nichole.peppers@southwestach.org contact email to change 2/14 |
| Health System or Hospital | Skyline Hospital System | TBD |
| Health Plan | Amerigroup | TBD |
| Person with Lived Experience | DSHS Service Experience Team | nicole.dronen@dshs.wa.gov |

## Target Population(s)

- 55 plus, older adults
- Medicaid/Medicare
- Current Opioid prescriptions
- Those who suffer from chronic pain

## Target Service(s)

- Chronic Pain Self -Management Education Programs CPSMP
- SDOH with OUD component

## What We Know About the Market

- Opioid overdoes have increased 50% in WA since 2019
- Currently SDOH screenings are used but don't focus on opioid use disorder indicators
- CPSMP is a proven method to reduce pain and evidence-based practice for those who may be dealing with opioid dependency
- Healthcare reform is focused on ACHs building equity
- Supporting local health improvement planning
- Older adults over 55, had 40% more likelihood of an unlikely overdose according to data from 2022 Intentional drug overdose data (SUDORS).

## Primary Goals

- Reduce opioid prescription use
- Address chronic pain in older adults though self-management resources to reduce SDOH challenges
- Increased Awareness and accessibility to CPSMP courses
- Assess training sustainability and capacity for CPSMP in geographical region
- Identify screening tool for those with opioid addiction (OUD tool in the SDOH)

## Current Strengths

- Legislature awareness on the issue
- Access to current data
- Opioid overdoses have increased 50% in WA since 2019
- WA State Umbrella license for CDSME SMRC programming
- Access to patients and clients thru pathways program
- DSHS currently has funded Skamania County for CPSMP workshops thru June 2024
- MTD 2.0 in WA is currently looking at SDOH's alongside incorporation of OUD's

## Available Funding Sources

Skamania is currently funded for CDSME/CPSMP workshops under MTD 1115 funds, this was a joint effort with SWACH.

There may be an opportunity to leverage MTD 2.0 funds thru Health Care Authority

## Technical Assistance Needs

Assistance securing commitment from insurance and hospital system providers and how to further next phase. This project has taken significant time to gain buy in.

## Infrastructure Needs

SDOH and OUD tool development for clinic use

Data collection process for CPSMP workshop referrals

Support form insurance and hospital provider

Partnership to Align Social Care
A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO

# Trends as of March 26th (n= 7)

## Target Populations

- I/DD
- Chinese-Americans and Community Members from Southwest and South Side of Chicago
- 55+
- Medicare/Medicaid
- Current Opioid Prescription
- Persons who suffer from Chronic Pain
- Adults with Medicare
- Adults with Medicare/Medicaid
- Adults 18+
- Older Adults
- Anyone of any age with any disability
- Veterans
- Caregivers
- Persons diagnosed with diabetes or heart conditions
- Persons experiencing a fall leading to an ED visit or hospital stay

Partnership to Align Social Care
A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# Trends as of March 26th (n= 7)

## Target Services

- Resources and Referrals
- Alzheimer's Program Prevention and Intervention
- Behavioral Health Program Prevention and Intervention
- Chronic Pain Self-Management Education Program
- SDOH with OUD component
- Care Coordination
- Transportation
- Nutrition, Care Transitions
- In-Home Services
- DPP
- DSMES
- Group Education
- SDOH Screenings
- Care Transitions
- CHI, PIN
- Fall Prevention

Partnership to Align Social Care
A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO

# Trends as of March 26th (n= 7)

## Types of Available Funding Sources

- ACL grant funding
- ARP Act Funding
- Insurance plans through billing
- City Funding
- State Funding
- 1115 Medicaid Funding
- None

## Infrastructure Needs

- SDOH and OUD tool development for clinic use
- Data collection process for CPSMP workshop referrals
- Coordination with Area Agency on Aging
- Funding to test the Medicare rule
- Pilot site training
- Technology to manage process flows and capture outcome measures
- Revenue Cycle Management Processes
- Staff training

Partnership to Align Social Care
A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO

# Trends as of March 26th (n= 7)

## Technical Assistance Needs

- Integrating HUB model with Medicare Physician Fee Schedule Rule
- CBO provider status
- Becoming a Medicare provider
- Understanding PCMH incentives for CBO participation
- Market analysis
- Cost-Benefit Analysis
- Return on Investment Analysis
- Readiness Assessment of Technology with CBOs
- How to work within the EMR (charting, billing)
- How to build a team
- How to identify target populations and services
- Developing referral processes
- Developing billing processes
- Establishing a process workflow
- Identifying and implementing operational changes (Staffing, Technology)
- Understanding the role of, and securing a commitment from, insurance plans and hospital systems
- How to gain buy-in quickly and efficiently

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# Learning Collaborative Resources

- HELC ECHO Sessions Recordings & Resources: https://www.partnership2asc.org/healthequity/helc-resources/
- Partnership CHI/PIN Implementation Resources and Events: https://www.partnership2asc.org/implementation-resources/
- Freedmen's Health Consulting Implementation Resources: https://communityintegration.info

Partnership to Align Social Care
A National Learning & Action Network

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

FREEDMEN'S HEALTH I
HEALTH IS FREEDOM

Project ECHO®

# Learning Collaborative 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/

Partnership to Align Social Care

A National Learning & Action Network

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

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

# Thank you!

Tim McNeill, RN, MPH

tmcneill@freedmenshealth.com