Partnership
to Align Social Care

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

May 16, 2024 | 2:00-3:30 p.m. ET

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.”

Agenda

1. Welcome and Introductions
2. May 2nd Session Recap
3. Developing a Business Plan
4. Snapshot of a Community-Clinical Team: Beacon Community Connection
5. Open Discussion
6. Next Steps

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ECHO Session Recap

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What are some tools you can use to identify priority populations?

a. Identify people with rising risk for increased healthcare utilization or length of stay.
b. Identify people with poor clinical outcomes.
c. Use a roster referral of members screened for HRSNs.
d. Use Area Deprivation Index (ADI) Data to identify people with needs.
e. All of the above.

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True or False?

Health Plans are required to have at least one SDOH measure (for example, food, transportation or housing).

2023 HEDIS® SDOH Measure (Required for Health Plans)

- The percentage of [Health Plan] members who were screened, **using prespecified instruments**, at least once during the measurement period for unmet food, housing and transportation needs, **and** received a corresponding intervention if they screened positive.
- Percentage of members that **screen positive and receive a corresponding intervention within 1 month.**
- Required Domains
  - Food
  - Housing
  - Transportation

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The Joint Commission Health Care Disparities Requirements specifies that organizations must:

a. Designate an individual to lead activities to reduce health care disparities
b. Assess for health-related social needs
c. Provide information about community resources and support services
d. Develop a written action plan to address at least one of the health care disparities prevalent in the population
e. All of the above

Joint Commission Health Care Disparities Requirements

- Effective **January 1, 2023**:
- Requirements:

1. Organization **must designate an individual to lead activities** to reduce health care disparities for the organization.
2. Organization must **assess for health-related social needs and provide information about community resources** and support services
3. Organization must develop a **written action plan to address at least one of the health care disparities** prevalent in the population.

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Developing a Business Plan

HRSN Impact on Disease Tx - Diabetes

Diagnosis	Food Insecurity	Housing Insecurity	Utilities interruption	Transportation
Diabetes	Food Insecurity has a negative impact on the ability to adhere to recommended dietary changes. Non-adherence to recommended dietary modifications will impair the ability to achieve HgbA1C goal < 7	Management of diabetes requires storage of diabetes supplies to monitor blood glucose, insulin storage, and insulin supply storage. Housing insecurity limits the ability of the patient to store insulin, store insulin supplies, and monitor blood glucose levels. Housing insecurity directly impacts the ability to manage diabetes which reduces the ability to achieve diabetes management goal HgbA1C < 7.	Insulin to manage diabetes must be stored in a regulated temperature environment. Intermittent access to power and other utilities jeopardizes the access to insulin. Failure to have consistent utilities jeopardizes the management of diabetes.	Medication adherence is critically important to the management of diabetes. A lack of access to reliable transportation will impair the ability of the patient to adhere to the prescribed medication regimen related to access to reliable transportation to a local pharmacy to fill prescriptions. Failure to reliably fill prescriptions will lead to exacerbation of disease.

HRSN Impact on Disease Tx – Heart Failure

Diagnosis	Food Insecurity	Housing Insecurity	Utilities interruption	Transportation
Heart Failure	Food insecurity has a negative impact on the ability to manage heart failure. Condition is highly sensitive to salt intake and fat. Foods with low-nutritional value and high in salt will lead to increased exacerbation of disease. Patient requires interventions to address food insecurity to reduce the incidence of exacerbations of heart failure related to non-adherence with recommended diet.	Housing insecurity will lead to increased exacerbation of heart failure due to the potential exposure to temperature extremes of hot or cold during periods when housing is lost. It is imperative to stabilize housing to prevent exposure to temperature extremes which will lead to exacerbation of heart failure.	Heart Failure is sensitive to temperature extremes (heat and cold). Failure to have consistent access to utilities will expose the patient to temperature extremes. Exposure to temperature extremes will lead to worsening exacerbation of heart failure.	Medication adherence is critically important to the management of heart failure. A lack of access to reliable transportation will impair the ability of the patient to adhere to the prescribed medication regimen related to access to reliable transportation to a local pharmacy to fill prescriptions. Failure to reliably fill prescriptions will lead to exacerbation of disease.

HRSN Impact on Disease Tx - COPD

Diagnosis	Food Insecurity	Housing Insecurity	Utilities interruption	Transportation
COPD	Management of COPD requires the patient to adhere to a balanced diet. Persons with COPD should each small balanced meals on a regular schedule. Failure to adhere to a balanced diet could lead to exacerbations of COPD.	COPD is sensitive to temperature extremes (hot or cold). Persons with COPD must be maintained in a consistent temperature to prevent exacerbations of COPD. Housing insecurity places the person at risk of exposure to temperature extremes. It is imperative to prevent exposure to temperature extremes by stabilizing housing.	COPD is sensitive to temperature extremes (hot or cold). Persons with COPD must be maintained in a consistent temperature to prevent exacerbations of COPD. Utility interruptions places the person at risk of exposure to temperature extremes. It is imperative to prevent exposure to temperature extremes by stabilizing utilities.	Medication adherence is critically important to the management of COPD. A lack of access to reliable transportation will impair the ability of the patient to adhere to the prescribed medication regimen related to access to reliable transportation to a local pharmacy to fill prescriptions. Failure to reliably fill prescriptions will lead to exacerbation of disease.

Documentation Sample Essentials - Heading

- Date: February 5, 2024
- Start time: 10:15am
- Stop time: 12:22pm
- Total Time this Encounter: 2 hours and 7 minutes
- HRSN Addressed: Food Insecurity

Documentation Essentials – In Home Assessment

- In Home Assessment findings
  - Patient has food insecurity, and she reports that she often has only one meal per day. The meal usually consists of high carbohydrate noodles with a salt seasoning packet. She only receives $50 per month in food stamps. Conducted an interview to determine current access to food sources, SNAP benefits, and assistance in the home with supports. In-home assessment findings reveal the following supports:
    - Consumer is legally blind related to complications of diabetes
    - Lives alone and has difficulty completing ADLs without assistance
    - Receives limited personal care aide services for 8 hours per week
    - Receives $50 in SNAP benefits per month

  - Patient reports that she does not have money to purchase food and has limited ability to purchase and prepare food due to blindness.

Documentation Essentials – CHI Interventions

After completing the assessment, I informed the patient that we would pursue the following options to secure consistent food supports:

- Obtain support from a local emergency food bank distribution site
- Identify food bank and other resources for food that comply with dietary restrictions for diabetes
- Apply for an increase in SNAP benefits
- Submit an application to get on the waiting list for home-delivered meals that are medically tailored for diabetes
- Provide assistance with obtaining instructions on preparing diet-appropriate meals that can be prepared by persons with vision impairment
- Assist with completing an Medicaid waiver application for expanded personal care aide services to assist with meal preparation
- Reviewed audio resources from the American Foundation for the Blind diabetes program.
  - A Guide to Living with Diabetes and Vision Loss
  - https://www.afb.org/blindness-and-low-vision/eye-conditions/diabetes-and-vision-loss

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Business Plan Snapshot

Opportunity	Target Market	Competition	Execution	Company Overview and Team	Financial Plan
Problem Worth Solving Our Solution		Alternatives Advantages	Marketing Plan Operations Milestones & Metrics		Profit and Loss Statement Balance Sheet Cash Flow Statement

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Anonymized Business Plan

Opportunity

Problem & Solution

Problem Worth Solving

Freedmen's CHWs will provide community health w
medical and behavioral health providers across th
Freedmen's CHWs community care hub includes t

- Community Health Integration (CHI)
- Principal Illness Navigation (PIN)
- Principal Illness Navigation-Peer Support (
- Collaborative Care Management (CoCM)

Health Promotion and Health Prevention Services

- Health Behavior Assessment and Intervent
- Diabetes Prevention Program (DPP)
- Diabetes Self-Management Education and
- Medical Nutrition Therapy (MNT)

Freedmen's CHWs will deploy staff to implement th

- Interventions to address health-related soci
- Health navigation services
- Peer support for behavioral health and sub

Freedmen's CHWs operates as a multi-state commu
community-based organizations provide services t
Freedmen's CHWs contracts

The interventions are targeting the persons with th

- Health-Related Social Needs

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Execution

Marketing & Sales

Marketing Plan

The primary marketing strategy is to partner with local community-ba
providers transitioning to value-based contracting to screen and iden
to address health-related social needs or health promotion activities. W
processes to facilitate referrals to the Freedmen's Health CHWs netw
Health CHWs will conduct direct-to-consumer marketing that is tailore
healthcare provider and direct-to-consumer marketing will focus on in
disparities in a local market, highlighting the impact of HRSNs, and p
Door" approach to deploying hyperlocal solutions to the needs of the

Sales Plan

Operations

Locations & Facilities

Freedmen's Health CHWs has a headquarters location in Washingto
following address:

811 L Street, SE

Washington, DC 20003

Technology

Freedmen's Health CHWs has a HITRUST certified EMR solution by
will have a separate division within the AthenaHealth IT system. The d
AthenaHealth creates a firewall between each market to support imp
compliant, and certified Electronic Medical Record system to facilitate
technology solutions that help implement solutions to address needs

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Financial Plan

Forecast

Key Assumptions

Each market will start with a minimum base of 100 patients.

Each CHW will be expected to meet a 60% production minimum.

- 60% of CHW paid time must be spent doing billable services
- 40% of CHW paid time can be spent doing outreach and community engagemen time.

There will be a 10% administrative fee for revenue cycle management.

After the 10% administrative fee, the remaining funding for CBO interventions will be retu

The projections will be based on 100% collections.

- 95% of all persons, enrolled in Original Medicare, have a secondary policy, per K Foundation national data.

Projections will be based on the National Medicare rate.

- The assumptions do not factor in expected rate increases in subsequent years.

There will be one supervisor for every 10 CHWs.

The CHW Supervisors will be paid a rate of $35/hour.

- Supervisors are not providing billable services (100% Overhead expense).

CHWs will be paid at $25/hour

There will be a 2% salary increase per year for COLA.

The fringe will be set at 35%.

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Financing

Use of Funds

Sources of Funds

Statements

Projected Profit and Loss

	2024	2025	2026
Revenue	$185,610	$1,856,102	$3,712,205
Direct Costs	$129,472	$445,176	$2,401,093
Gross Margin	$56,139	$1,410,926	$1,311,112
Gross Margin %	30%	76%	35%
Operating Expenses			
Travel Stipend@$100/CHW	$2,400	$24,000	$240,000
Total Operating Expenses	$2,400	$24,000	$240,000
Operating Income	$53,739	$1,386,926	$1,071,112
Interest Incurred			
Depreciation and Amortization			
Gain or Loss from Sale of Assets			
Income Taxes	$10,748	$277,385	$214,222
Total Expenses	$142,620	$746,561	$2,855,315
Net Profit	$42,991	$1,109,541	$856,890
Net Profit / Sales	23%	60%	23%

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Group Model Business Planning - Key Assumptions

Pilot volume: ________ Minimum starting volume:_________	The projections will be based on X% of collections. KFF data shows that 95% of Medicare beneficiaries have a secondary policy.
Each CHW will be expected to meet a 60% production minimum. 60% of CHW paid time must be spent doing billable services. 40% of CHW paid time can be spent doing outreach and community engagement that is not billable time. Production expectation for Supervisors?______	Projections will be based on the National Medicare rate. • The assumptions do not factor in expected rate increases in subsequent years.
There will be a 10% administrative fee for revenue cycle management.	Overhead percentage?______
Fringe; ________%	CHW/Health Coach Rate ($25??) :________ CHW Supervisor Rate ($35??): ______

Key Assumptions #2

There will be a 2% salary increase per year for COLA. Other Items that should be considered as part of the business model assumptions. List________	3-year projected volume increase? Billing CHWs Supervisors Ratio of Supervisors to CHWs Business Plan should move to volume increase by year 3 to show the business model at scale. Sample: Labor force by year (FTEs) Year 1: 0.5 Supervisor, 2 CHWs Year 2: 2 CHW Supervisors, 20 CHWs Year 3: 20 Supervisors, 200 CHWs

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Beacon Community Connection

STRATEGY DEVELOPMENT AND IMPLEMENTATION TO RESOLVE SOCIAL DETERMINANTS OF HEALTH

Presentation to Health Equity Learning Collaborative
May 16, 2024

Holly Howat., Ph.D, Founder and Executive Director
Beacon Community Connections

Cian Robinson, M.S., Founder and President
Robinson Ventures

STRATEGY DEVELOPMENT AND IMPLEMENTATION

PLAN

Recognize an opportunity and plan for change

DO

Carry out a small-scale study of the change

CHECK

Review and analyze the results of the change

ACT

Take action based on what you learned to refine or expand

PLAN

ASSESSMENT	Understand the current context of healthcare and Social care in your community
VISION	Articulate your realistic goals and objectives to connect patients to social care supports and services
STRATEGY	Develop a written plan of action to implement immediately and share with stakeholders including patients
PRINCIPLES	Incorporate principles of health equity and social care into all planning aspects

Strategic Plan

Impact	Operational Priority	Strategic Objectives
Focus on Social Care as a Core Competency	**Quality Enhancement**	Reach new populations by analyzing data to identify unmet needs and opportunities.
Continue Thoughtful Growth Through Community Engagement	**Community Engagement**	Expand engagement and positive presence in the communities that are currently served.
Develop and Sustain a Solid Operational Foundation	**Financial Sustainability**	Diversify payment models with healthcare using data-driven insights.

Business Plan

- Confidentiality Agreement
- Executive Summary
- Company Description
- Products & Services
- Marketing Plan
    - SWOT Analysis
    - Competitive Analysis
    - Marketing Expenses
    - Strategy Chart
    - Pricing Strategy
    - Distribution Channel Assessment
- Operational Plan
- Management & Organization
    - Organization Chart
- Financial Plan
- Appendices

Business Plan

Pricing Strategy

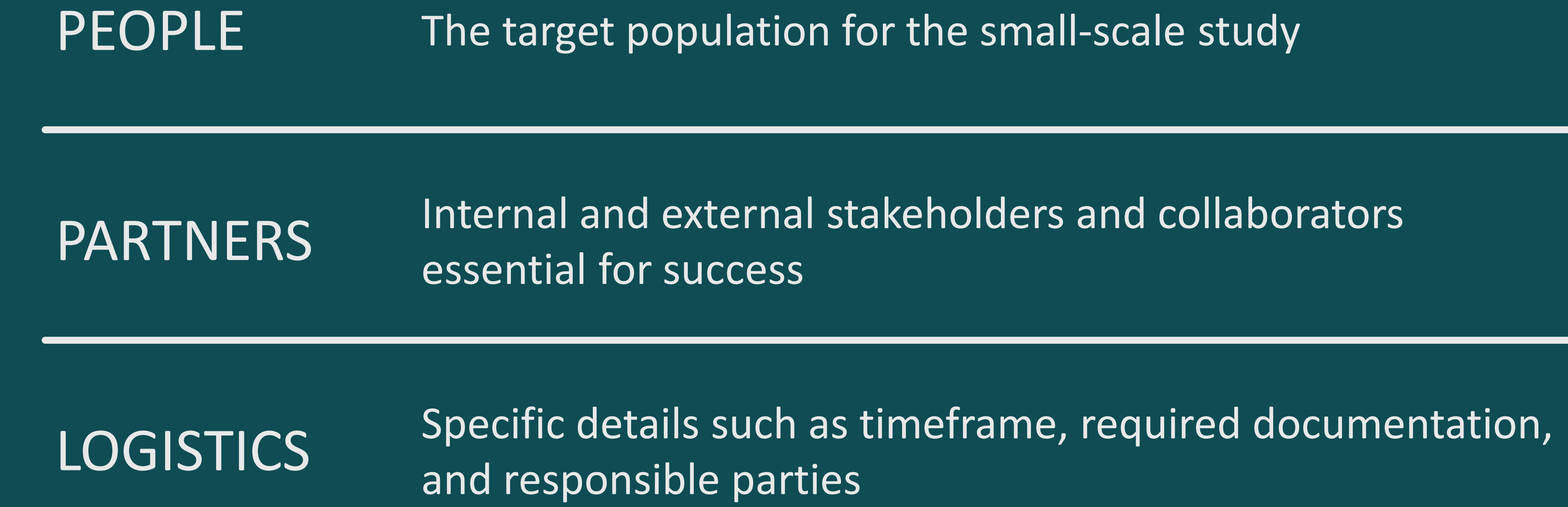
Target Market	**Health Systems & Clinical Providers**	
Fee-for-Service Current model	**Value/Risk Based** Future model	**Other:** Grant based

Fee-for-Service:
Contracted Cost: $104,000 per 1.0FTE per 300 clients
Hourly Rate for Navigation is $50/hr.
Per Client Per Month Charge is $150

Valued Based Pricing Models: To be determined.

Grant Based: Please see the Appendix for a complete list of grants received. As a community-based nonprofit, Beacon will continue to pursue grants as a revenue stream, to help expand product/service offerings and geographies.

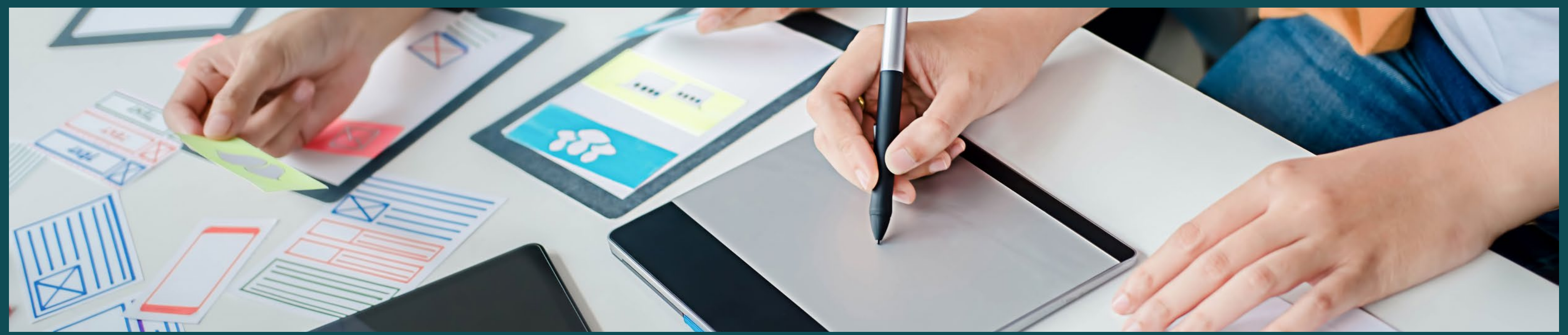
DO



PEOPLE	The target population for the small-scale study
PARTNERS	Internal and external stakeholders and collaborators essential for success
LOGISTICS	Specific details such as timeframe, required documentation, and responsible parties

Billable Alpha Test (BAT) Overview

- Target Population: Patients with palliative care needs enrolled in Medicare (traditional or advantage plan) N=5
- Health Partner: Palliative Medicine of Acadiana
- Community Care Hub: Beacon Community Connections
- Timeframe: Begin May 1st and continue for 2+ months
- Formal Partnership Agreements: MOU and BAA and negotiating ongoing contract



CHECK

FORMATIVE	Was the strategy implemented as designed and to the expected extent?
SUMMATIVE	Did the strategy have the intended outcomes for the patient participants?
DETERMINATION	Was the intervention successful, and is it replicable and/or expandable?
REFINEMENT	What changes need to made to the strategy to move forward?

ACT

PEOPLE	With expansion, continue to consider populations to be served and their perspectives.
PARTNERS	With expansion, continue to invest in developing and deepening partnerships with community-based organizations.
FUNDING	Determine ongoing funding streams to ensure sustainability of the strategy.
DOCUMENT	Continue to document results and outcomes as well as aggregated results and findings.

FUNDING THE STRATEGY

POTENTIAL FUNDINGS SOURCES

Cost Avoidance

Grants and Community Funding

Social Care Billing Codes

Value-Based Care

Activity Based Costing Model

Variables List						
Direct Service Personnel	**Annual**	Hourly	With Fringe			
Navigators (CHWs)	$ 41,000	$20.10	**$25.22**			
Administrative Support Personnel	Annual	Hourly	Admin Load	Per Employee Per Hour	With Fringe	
Tech Lead	$ 48,000	$23.08	50	$0.46	$0.58	
Intake Lead	$ 48,000	$23.08	25	$0.92	$1.16	
Marketing Lead	$ 50,000	$24.04	50	$0.48	$0.60	
Supervisor Coordinator	$ 55,000	$26.44	8	$3.31	$4.15	
IT Coordinator	$ 60,000	$28.85	50	$0.58	$0.72	
Community Care Hub Director	$ 65,000	$31.25	50	$0.63	$0.78	
Managing DIrector	$ 70,000	$33.65	50	$0.67	$0.84	
Operations Director	$ 70,000	$33.65	50	$0.67	$0.84	
Executive Director	$ 120,000	$57.69	50	$1.15	$1.45	
	$ 586,000			**Admin Support Costs**	**$11.14**	
Fringe	**25.5%**					
Operations	**Annual Cost**					
Accounting Service Fees	$60,000					
Advertising and Marketing	$50,000					
Equipment	$25,000					
Furniture	$5,000					
General Operations	$32,000					
Group Benefits	$10,000					
Insurance	$12,000					
Meals and Entertainment	$6,000					
Navigation Fund	$25,000					
Office Supplies	$32,000					
Contractors	$70,000					
Health Insurance	$50,000					
Retirement	$40,000					
Taxes	$100,000					
Professional Development	$25,000					
Rent	$100,000					
Software and Technology	$50,000					
Travel	$15,000	Direct Service Staff	Direct Service Hours	Total Annual Hours	Hourly Ops Rate	
Utilities	$40,000					
TOTAL OPERATIONS	**$747,000**	40	1400	56000	**$13**	
		Direct Service Rate	Admin Support Rate	Operations Rate		
Margin Percentage	120%	**$25.22**	**$11.14**	**$13.34**	**$49.70**	**$59.64**

QUESTIONS AND COMMENTS

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Open Discussion

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Next Steps

Reminder: Change in Direction

- Starting in June from 2:00 to 3:30 EST
  - Emerging Community-Clinical Teams – 1st Thursday – JUNE 6
  - Advanced Community Clinical Teams - 3rd Thursday – JUNE 20

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Deciding Which ECHO Group to Join

Example ECHO Session Topics

Emerging Community-Clinical Team Topics	Advanced Community-Clinical Teams Topics
✓ Landscape analysis ✓ Partnership development ✓ Determining return on investment ✓ Value Proposition ✓ Contracting 101 ✓ Billing and Coding 101 ✓ IT systems ✓ Quality	✓ TeamSTEPPS framework ✓ Theory of Change: Alternative Payment Models (APMs) ✓ Using APMs to advance health equity ✓ Sustainability through multi-payer alignment ✓ Payment incentives to reduce health disparities ✓ Expanding target populations ✓ Blending and braiding services ✓ IT Systems ✓ Quality

If you have partnerships in place and already have one or more contracts with health systems or plans, join the **Advanced** Community-Clinical Team Call.

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

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/

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Thank you!

Tim McNeill, RN, MPH

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Follow-Up Survey: