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Emerging Community-Clinical Teams

September 5, 2024 | 4:00-5:00 p.m. ET

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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.”

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Case Studies (CHI/PIN/PIN-PS)

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CHI Services: Introducing Beneficiary

Monica is a 67-year-old woman experiencing food insecurity, which impacts her ability to access a nutritious diet to control her diabetes. Monica has an elevated Hgb A1C of 13.

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Sample Workflow for Integrating CHI Services

ACO executive

1. Identifies priority beneficiaries for intervention. Patients with an Hgb A1C greater than 9 have been included in the priority patient list.

ACO-affiliated provider

2. Conducts SDOH Risk Assessment conducted during the next E/M encounter. Patient reports that she has food insecurity and has difficulty adhering to diet and lifestyle changes for diabetes.

Community Health Worker

3. CHW identifies that Monica has lost her SNAP benefits and has difficulty preparing meals. CHW assists with SNAP enrollment and makes a referral to the Area Agency on Aging (AAA) for additional services.

AAA Case Manager

4. AAA Case Manager completes in-home assessment to determine ADLs and eligibility for Waiver Services. Direct assistance provided to enroll in Medicaid Waiver to secure long-term services and supports in the home.

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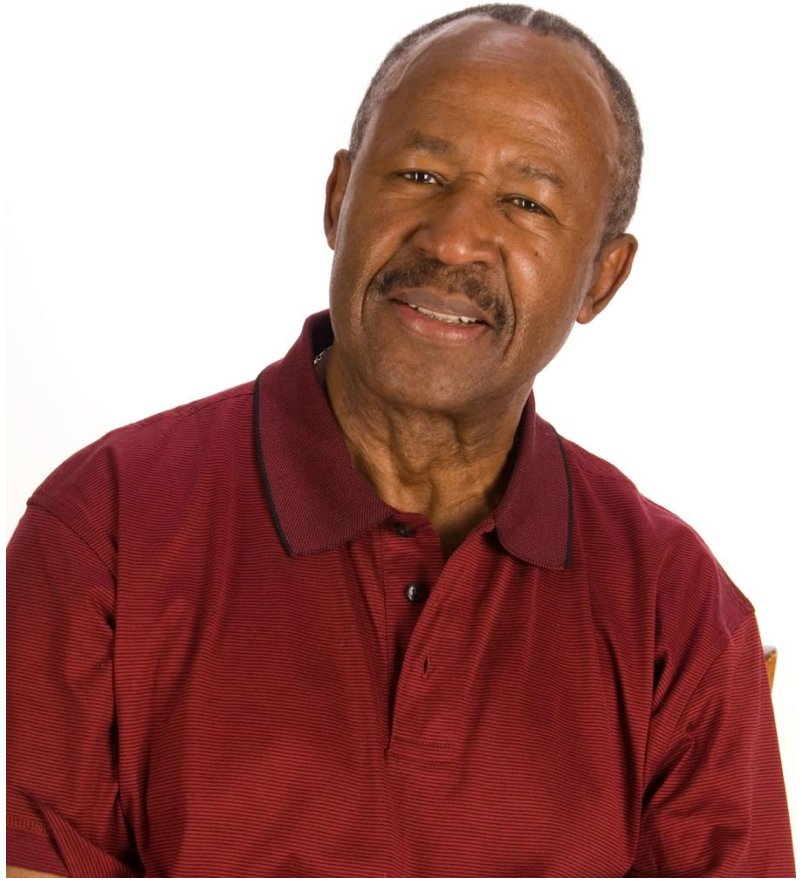
PIN Services: Introducing Beneficiary



Michael is a 68-year-old African American male with a history of Heart Failure, hyperlipidemia, hypertension, and stage 3b chronic kidney disease & Chronic Pain. Michael has frequent admissions and low-acuity ED visits for congestive heart failure.

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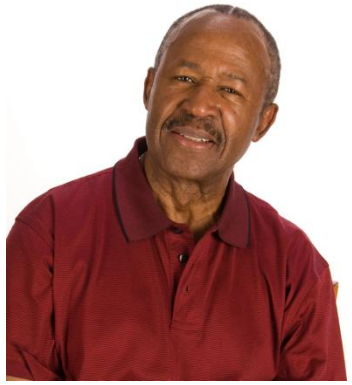
Sample Workflow for Integrating PIN Services



Physician

1. Conducts a detailed assessment and review of disease self-management capacity. Assessment identifies poor dietary choices, poor adherence to blood pressure regimen, and a sedentary lifestyle.

Registered Dietitian

2. RD identifies that the patient has a diet that consists of fried food, high salt content, and ultra processed foods. Health education given on label reading and required lifestyle modifications.

Community Health Worker

3. CHW provides support building self-advocacy and emotional support to adhere to lifestyle modifications and diet changes. Supports patient in healthy heart ambassador program.

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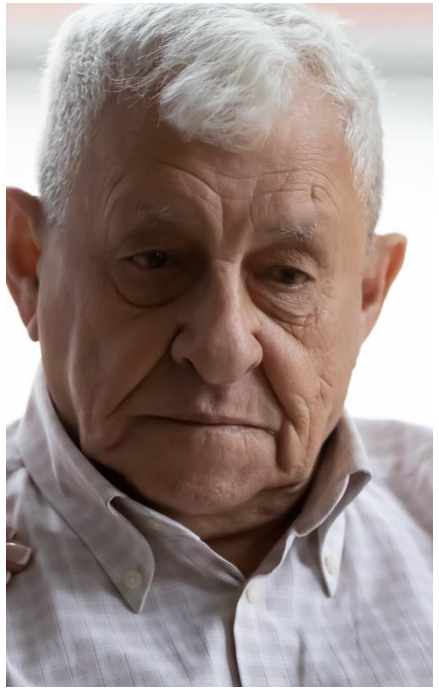
Dementia: PIN Services - Introducing Beneficiary



John is a 72-year-old male with a history of dementia. His primary caregiver reports that she can no longer continue providing support with John's ADLs and will be forced to put John in a nursing home if she cannot get outside help.

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Sample Workflow for Integrating PIN - Dementia

Physician

1. PCP notes that John has advanced dementia. The caregiver reports feeling "lost" and unsure of how to meet his needs. John and his caregiver require considerable support and navigation services to identify the necessary supports to remain in the home.

Community Health Worker

2. CHW meets with John and his caregiver in the home. The CHW identifies multiple fall hazards in the home and discusses available long-term services and support options. The CHW develops an intervention plan and shares the plan with all members of the care team. CHW implements PIN.

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Application of PIN using a RD and CHW as Auxiliary Personnel

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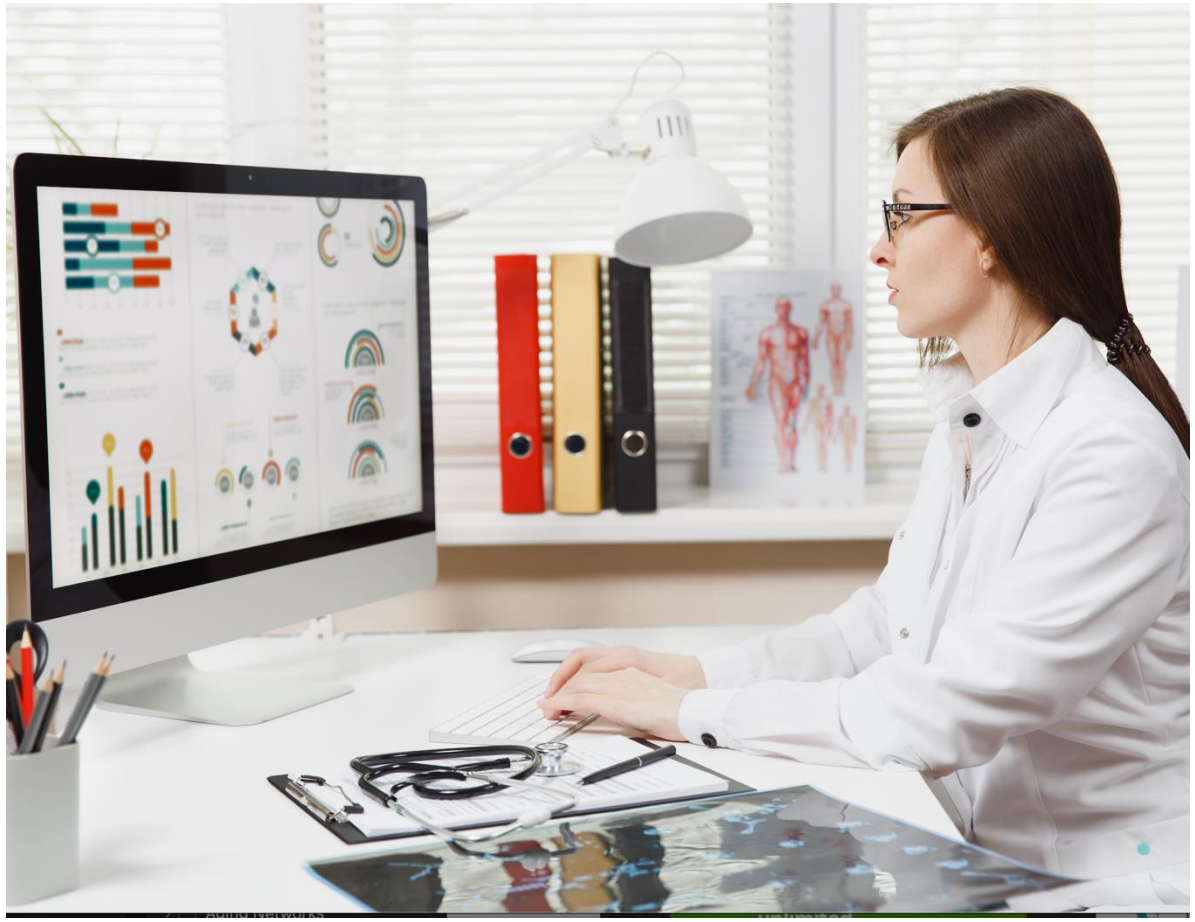
ACO REACH Executive

- ACO Clinical Quality measures show an increase in the number of patients with a HgbA1C greater than 9.
- ACO implemented health-related social needs screening.
- Data cross-referenced to show persons with a HgbA1C greater than 9 and 1+ HRSN.
- List of priority patients distributed to ACO Providers.



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ACO Patient – Diabetes/Obesity/HTN

- Jill is a 67 y/o female with a history of obesity IDDM, HTN, and Stage III kidney disease visiting her ACO REACH physician to discuss the status of her chronic kidney disease.
- Jill has a Hgb A1C of 13, on a long-acting insulin, and has made several unsuccessful attempts to lose weight and has uncontrolled hypertension.
- Jill reports a need for health navigation:
  - Confusion on the link between obesity and diabetes.
  - Confusion regarding diet choices, reading labels, meal prep, and weight loss drug options.
  - Does not understand the different between a GLP-1 or an SGLT2 and why it is important for her health.

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ACO REACH Multi-disciplinary Team: QHP + RD + CHW

- Qualified Practitioner (MD, NP, PA, CNS):
  - Principal Illness Navigation Services referral to address complications related to diabetes.
- RD:
  - Assessment / Person-Centered Plan
  - Health Education: Menu planning, weight loss education, review of GLP-1 drug coverage and SGLT2 options, and lifestyle modification reinforcement.
- CHW:
  - Facilitating Behavior Change: Accompanies Jill to grocery store to help reinforce menu planning provided by the RD.
  - Supports transportation to pharmacy to obtain medication each month.

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PIN Case Study Billing Analysis

- PIN Billing is performed by the Qualified Healthcare Provider.
- The billing is based on the aggregate of time spent by auxiliary personnel.
  - RD
  - CHW
- Total time is billed per calendar month.
- The CMS Rules specifically state that providers can contract with CBOs to provide CHI/PIN services.
  - Third party agreement defines the revenue pass through to the CBO for CHI/PIN billing
  - Pilot implementation sites have been paying CBOs 90% of CHI/PIN revenue collections.

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Case Study Follow Up

Documentation Discussion

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Open Discussion

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LET'S CHAT

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Next Steps

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Reminder

- **September HELC Sessions** (returning to ECHO curriculum)
  - ~~**September 5** @ 2:00-3:30 p.m. ET, HELC ECHO Session for **EMERGING Community Clinical Teams**~~
  - **September 19** @ 2:00-3:30 p.m. ET, HELC ECHO Session for **ADVANCED Community Clinical Teams**

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Upcoming Session Topics

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

- **Deciding which track to join?** If you have partnerships in place and already have one or more contracts with health systems or plans, join the **ADVANCED** Community-Clinical Team calls.
- If you are still working to establish partnerships, the **EMERGING** sessions may be best. You and/or your team members are welcome to join both sessions each month.
- Questions? Email acampbell@partnership2asc.org.

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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

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More Information About the HELC

- 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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Next Steps

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Reminder

Next Session for the EMERGING Community-Clinical Teams is July 18th from 2 to 3:30 EST

Starting in August:

- Emerging Community-Clinical Teams – 1st Thursday
- Advanced Community Clinical Teams - 3rd Thursday

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Next Session Topic

Example ECHO Session Topics

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

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- 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!

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