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

Peer Learning Opportunity

January 16, 2025 | 2:00-3:30 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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Agenda

1. Welcome and Introductions
2. Conversation with the Michigan Region IV Area Agency on Aging
3. Peer to Peer Learning Discussion
4. Health Equity Capstone Event
5. Next Steps

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Conversation with Michigan Region IV Area Agency on Aging

Christine Vanlandingham, CEO

Community of Care

Addressing health related social needs (HRSN) through the integration of social care and medical care in integrated health system physician practices.

Metrics, Evaluation Strategy and Outcomes

The John A. Hartford Foundation
BUSINESS INNOVATION AWARD
2023 RUNNER UP

2023 Aging Innovations Award
Health/LTSS Integration

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1974-2024

Corewell Health

MICHIGAN HEALTH ENDOWMENT FUND

Region IV
Area Agency on Aging

- Designated by the US Administration for Community Living (ALC) as **a planner and developer of coordinated system of services to meet the needs of older adults** (16 AAAs in Michigan; 622 in the US)
- **Hub for connectivity to community-based services** to address SDoH and long-term care needs with more than 100 partners including credentialed network of 70+ LTSS providers.
- **Prepaid Ambulatory Health Plan** (1915c Medicaid Waiver), fully capitated at risk, managing LTSS for adults age 18+ with nursing home level of care needs. (700+ members living in community.)
- **Duals Demonstration contracts** for LTSS Network/Case Management transitioning to **HIDE-SNP**
- **Health in All Policy Heath Equity framework**
- **Care transitions** -Nursing Home/Hospital to home
- Wide array of **HCBS services to meet the needs of older adults and caregivers** including the non-Medicaid population.
- **NCQA accredited Case Management for LTSS**; AIRS Certified information and access staff (Inform USA)

Corewell Health

65,000+
Team Members

9,000+
Employers Contracted by Priority Health

300+
Ambulatory/Outpatient Locations

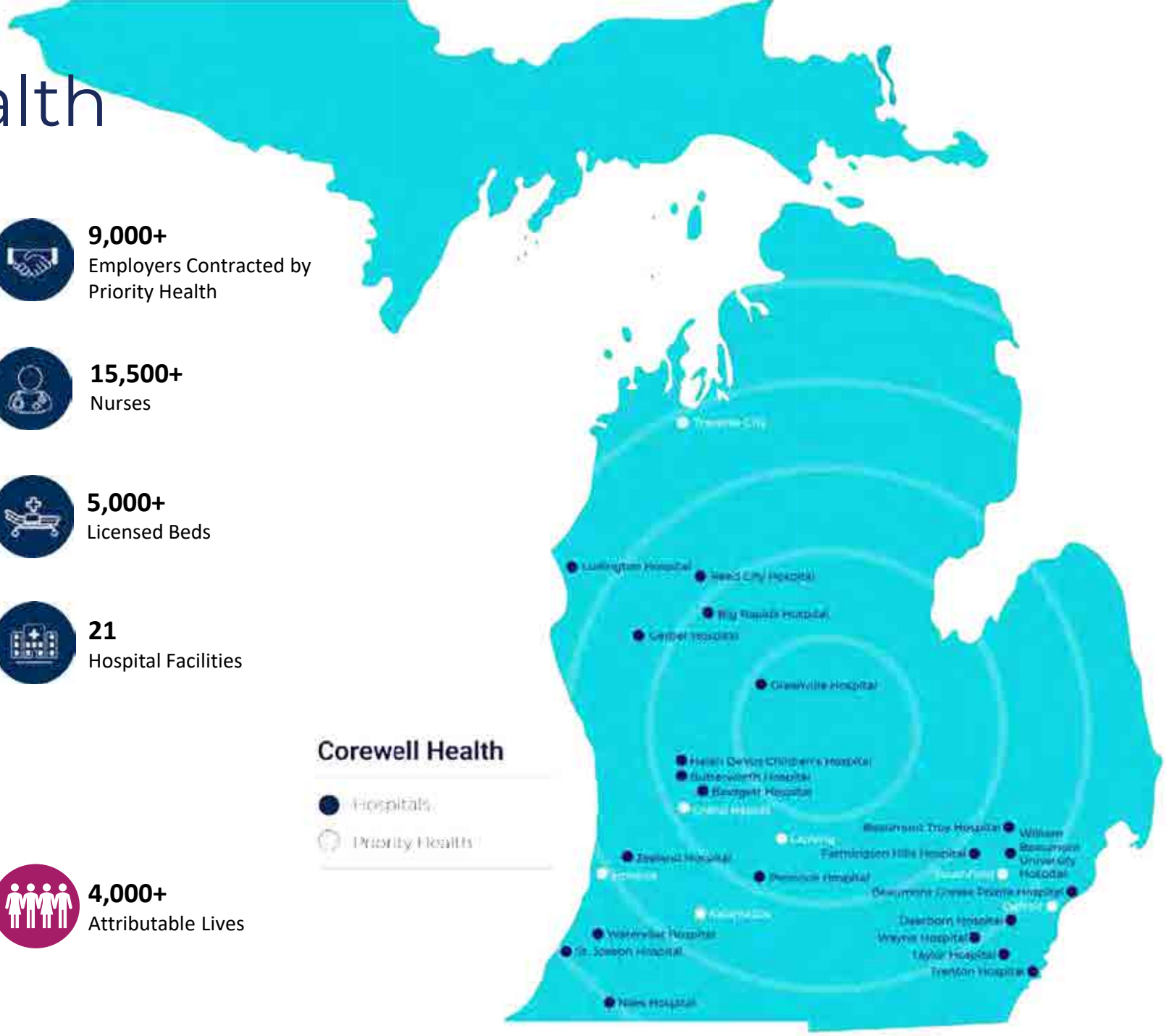
15,500+
Nurses

1.3+ Million
Health Plan Members

5,000+
Licensed Beds

12,000+
Affiliated, Independent and Employed Physicians and Advanced Practice Providers

21
Hospital Facilities



ACO

3 Entities in Partnership
Answer Health
Lakeland Care Network
Corewell Health West

4,000+
Attributable Lives

WHO WE ARE:

Contract/Partnership:

- Embeds AAA social care clinicians in medical care teams to address complex care needs of older adults
- Targets patients age 60+ with multiple chronic conditions high utilizers of ED and inpatient services

REGION IIZ
Area Agency on Aging, Inc.
SPECIALISTS IN AGING

At our core, we are here to ensure that older adults and people with disabilities can live life as independently as possible in the setting of their choice.

What guides us.

Mission: Offering Choices for Independent Lives

Vision: Through choice and range of service, every aging adult lives a quality life.

Core Values:

- *Dignity*
- *Empowerment*
- *Equity*
- *Independence*
- *Interdependence*
- *Person-centeredness*
- *Wisdom of age*

Corewell Health™

At our core, we are here to help people be well so they can live their healthiest life possible.

What guides us.

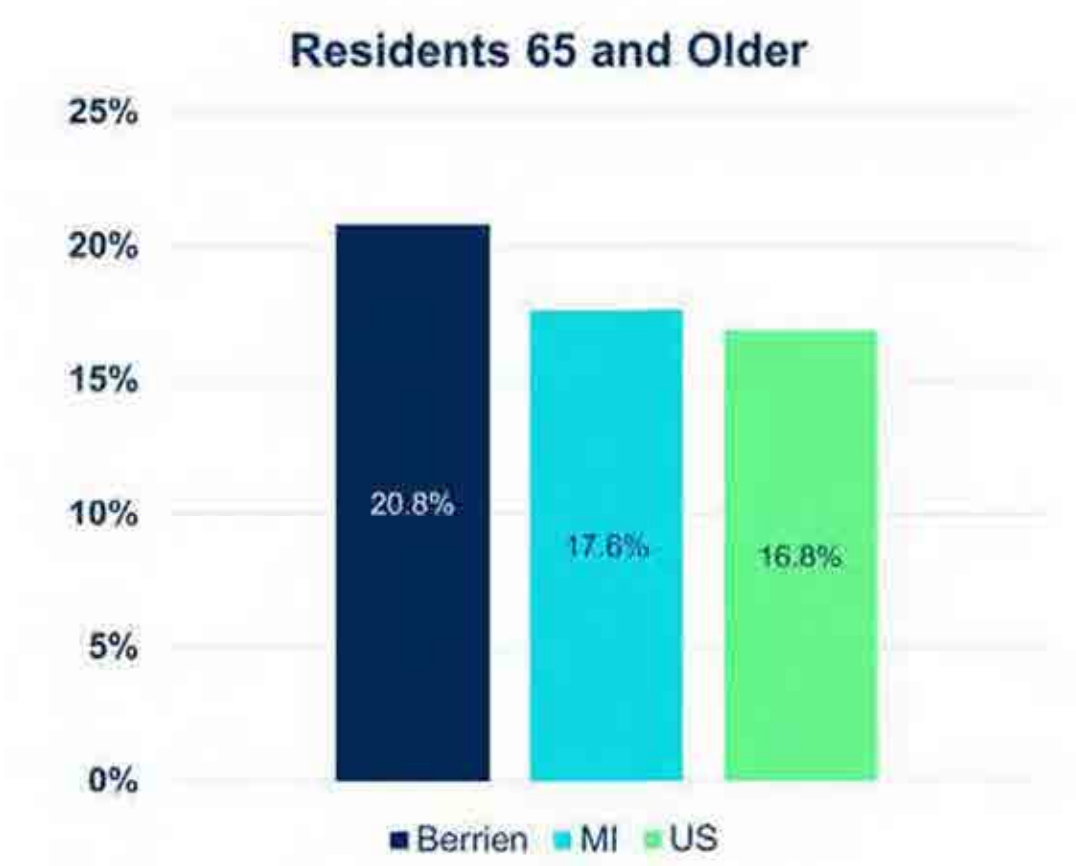
Mission: Improve health, instill humanity and inspire hope.

Vision: A future where health is simple, affordable, equitable and exceptional.

Values:

- *Compassion*
- *Collaboration*
- *Clarity*
- *Curiosity*
- *Courage*

Why this matters



Large population of medically complex older adults

- Berrien County is older than state and national average:
  - 32,097 residents age 65+
- Older adults living with multiple chronic diseases:
  - 48% of Berrien County adults aged 65-74
- Low-income adults with nursing home level of care needs:
  - 1,312 persons aged 55+ with NFLOC needs have incomes less than $25,000
- Seniors in Berrien County who have multiple chronic conditions experience some of the worst health outcomes in the region often resulting in increased disability and avoidable death.

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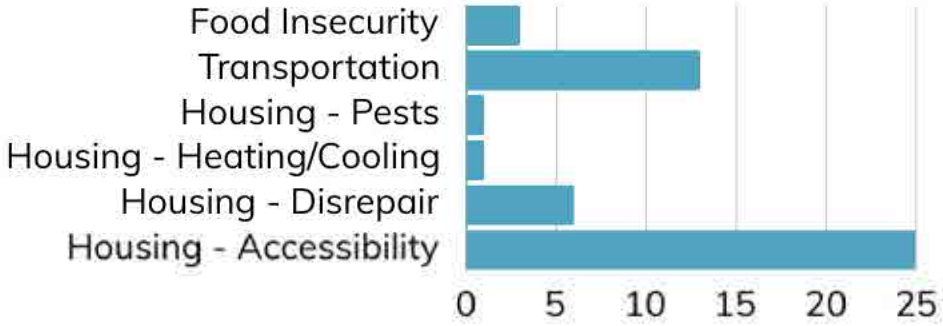
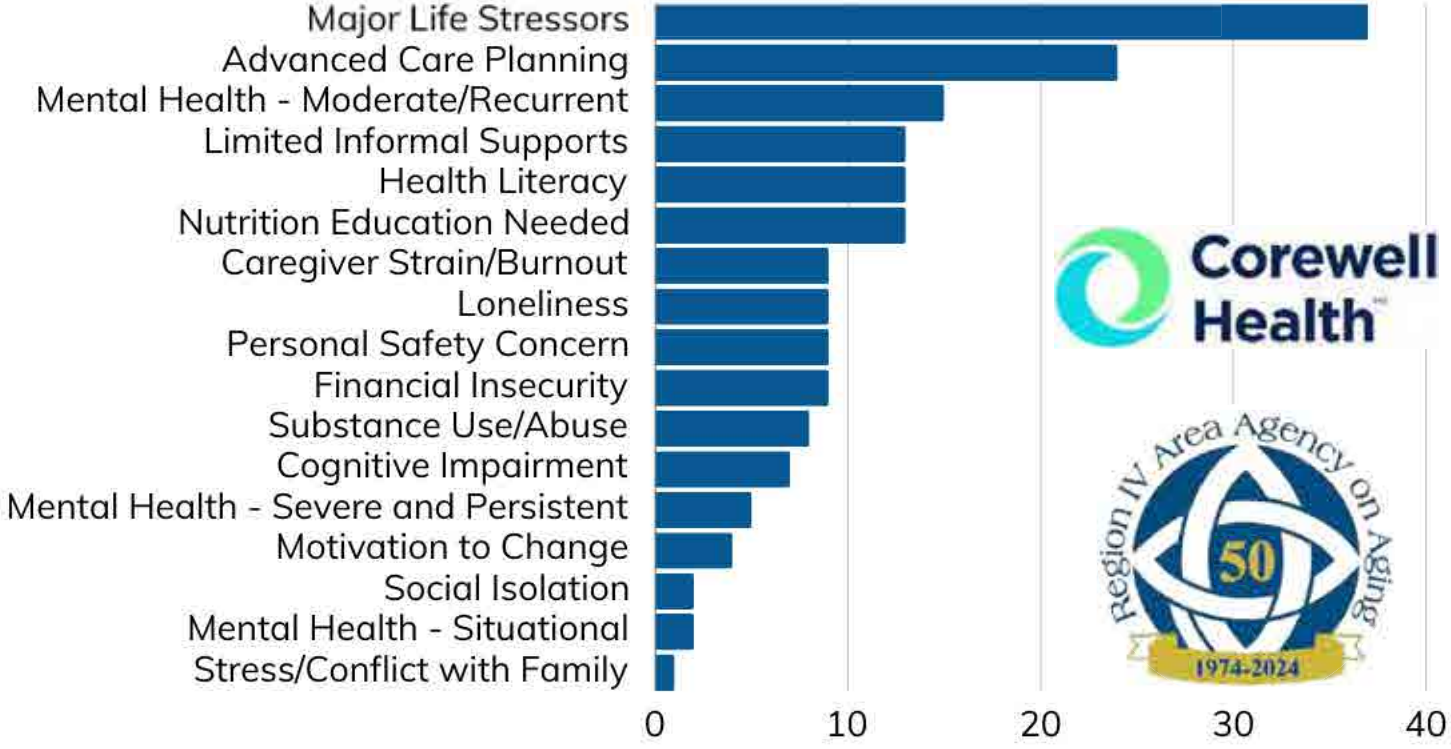
Data sources: US Census Bureau, Centers for Medicare and Medicaid

Health Related Social Needs





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SHARED VISION:

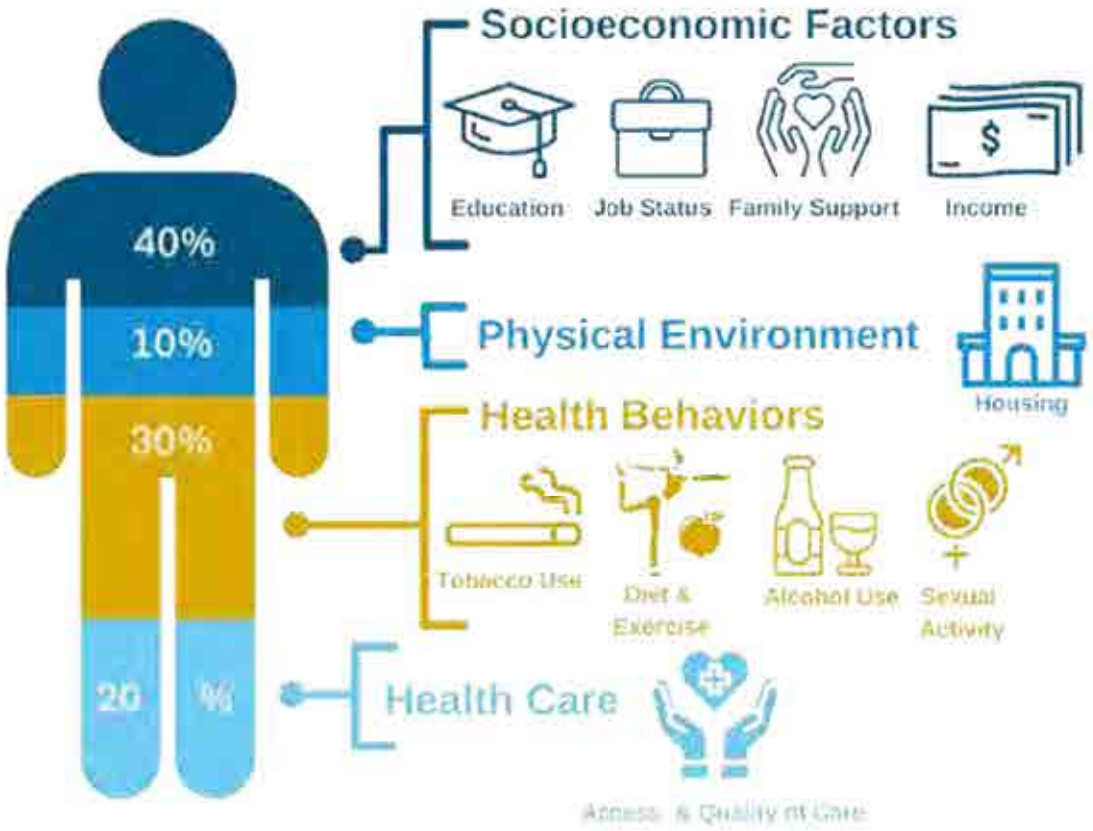
Integrate social care into the delivery of health care and unify the efforts of both medical and home & community-based organizations to improve health & reduce health care cost for older adults with complex care needs.

ALIGNED OBJECTIVES:

Better health (reduced ED/inpatient utilization)	**Driving care to the right setting** (increased primary care)	**Improved patient experience / satisfaction**
HRSN barrier resolution through connectivity to community-based services/resources	**Maintenance of independence**	**Support for caregivers**

Value & Impact Expectations

- Stabilized health for seniors with multiple chronic conditions
- Increased Caregiver and Social Support
- Reduced Cost of Care Overall:
  - Right Care, Right Setting, Right Time
- Sustainability and Capacity Building through establishment of Payment Model



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Community of Care Evolution

Network of 100+ Community Based Organizations

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Two Corewell South Physician Practices
- HouseCalls (home-based primary care)
- Southwestern Medical Clinic – Niles RHC

- Contracts developed with two primary care practices for medical/social care integration
- Taps AAA network of 100+ community-based service providers to meet HRSNs
- Embeds AAA social care clinicians in medical teams
  - Weekly huddles
  - Shared Care Plan (one source of truth)
  - Patient Centered - Caregiver Focused
  - Blended and Braided Funds to Support Coordination of Home and Community-Based LTSS Services w/development of payment sustainability model

Integrated Workflow

ENGAGEMENT

- Care Team Huddles
- Patient AND Caregiver Education & Acceptance

PERSON-CENTERED ASSESSMENT & CARE PLANNING

- Patient AND Caregivers
- Holistic
- Guided AND Collaborative
- To vs. For

INTERVENTION

- Strength, Change, and Motivation-based
- CoC-rooted
- Iterative AND progressive

Community of Care Engagement

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Project development

Stakeholder Engagement – Logic Model

Tearless Logic Model

Target Population(s) Who benefit	Inputs Resources dedicated or consumed by our efforts	Activities What we do in quantifiable terms, what activities will produce change?	Outputs What will we produce, how do we count it, what services will lead to change?	Short Term Outcomes Initial change in knowledge, attitude, beliefs, skills, who or what changes, what outcomes are we held accountable?	Intermediate Outcomes Resulting behavior change, who changes and how, what outcomes are we held accountable?	Long Term Outcomes Changes in policy, programs, practices what's possible and who cares, what outcomes are we held accountable?	Anticipated Impact In a perfect world. If we got it right...
-Adults over 65, living within Berrien County, have been in the emergency department or inpatient within the last 7 days, and who have a risk complexity score of 14 and above.	-Project Manager 1 FTE	-Convene key stakeholders to create shared vision and comprehensive implementation plan	Develop a process for: -Onboarding of staff and stakeholders -Identifying participants -Onboarding participants and their caregivers -Identifying and documenting individual health goals and barriers. -Documenting services in place and connecting with medical care plan -Communication between medical providers and care management -Capturing and reporting data	-Clinical and community-based stakeholder commitment to implement the plan	-Payors engaged in and committed to exploring payment model solutions to sustain project positive outcomes	-Replicability: Creation of a playbook documenting our process to guide other communities across the globe.	-The creation of a person-centered, complex care ecosystem where older adults are linked with proper medical and community-based services.
-Medical Staff: PCP physician and care manager, Inpatient physician and discharge planner, emergency room physician and discharge nurse.	-Project Lead Team .5FTE	-Provide education, awareness, and support for Primary Care Providers to fully utilize not only the risk complexity score but the SoDH wheel as a prompt to connect participants with home and community-based supports.	Reporting -Reduced utilization -PCP engagement -Care plans created and followed -Patient reported outcome measures -caregiver burnout pre/post tests -Unmet needs: list and dollar amount	-Community Partnerships and resources identified		-Goal: advancing participant health towards prevention and staying healthy	-Integration of SDoH needs into the delivery of health care.
-Care Management: seamless care coordination and documentation with physician and CBOs	-Support Personnel .1FTE	-Engage consultant services: evaluation to direct/re- direct team efforts & development of implementation phase evaluation approach and documenting results -actuarial for financial forecasting model validation		-Barriers to accessing services identified and partnerships created to overcome barriers		-Goal: supporting participants in their home with community-based organizations and long term supports and services	-CBO's have limited access to EPIC and can document into a patient's chart for better care coordination.
-Health plans or payors within the healthcare system: reduction of care costs	-Community-based care manager .5 FTE year one and 1 FTE year two.	-Investigate telehealth options for communication		-Education of participants and their caregivers on solutions to health and SDoH needs.		-Reduced Caregiver burnout	-Create a seamless connectivity from the clinic setting to care management, and to communicate inside the EHR.
-Hospital System: reduced utilization/ improved pt experience	-Community Stakeholders	-Develop financial sustainability model				-Reduced utilization across care settings	-
	-Consultant Services: ~Evaluation ~Implementation ~Actuary					-Healthcare changes to care management to include social care clinicians embeded in medical care teams	
	-Information technology EPIC healthy planet; telehealth equipment/services						
	-Data from Planning Grant on: ~Gaps ~Barriers ~Community Needs Assessment ~Research from Other models						

Metric development, tracking and process

Defining Metrics

- Importance of selecting appropriate metrics
- Types of metrics (clinical, operational, patient-reported, caregiver, systems change, financial, sustainability, provider/care manager…)
- Specific metrics for evaluating complex patient care in a community of care ecosystem

Process of Evaluation

- Establishing baseline measurements
- Data collection methods and tools
- Analyzing and interpreting data
- Reporting and dissemination of findings

Metric development tracking and process

- Institutional Research Board (IRB) Approval
- Engage University Research Team
- Stakeholder Engagement
- Evaluation plan development and execution

Evaluation Groups and Measurements	Data Collection	Frequency
Corewell Primary Care Patient Evaluation	EPIC data collection: collected by Jordan; de-identified data shared with Andrews University	baseline; 6 mo; 12 mo; 18 mo
Demographics - age, gender, ethnicity, etc.		
-# of primary care visits, including walk in care		
-# of ED visits		
-# of hospital admissions		
-# of 30-day readmissions		
-# of days of hospitalization		
-# SDoH barriers	*SDoH Wheel score & AAA SDoH measure*	
-patient Complexity Score	points for health and SDoH	
CoC Patient Interview: Alliance; Activation; Emotional Well-being	telephone survey with CoC patients	baseline; 12 mo; 18 mo
Kim Alliance Scale-Revised (KAS-R)		
- collaboration		
- integration		
- empowerment		
- communication		
The Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)		
Patient Activation Measure (PAM-13)		
- takes active role in health care decisions		
- understands health care processes		
Hospital Admission Risk Monitoring System (HARMS-8) #14,15,17, 18		
- medication knowledge and compliance		
- challenges with activities of daily living (ADLs)		

Metric development tracking and process

Caregiver Evaluation	Surveys sent to caregivers of CoC patients	baseline; 9 mo; 18 mo
Caregiver Burden Self-Assessment		
- caregiver stress		
- caregiver burden		
Caregiver Patient Activation Measure (Caregiver PAM-13)		
- knowledge of healthcare		
- skills in managing healthcare		
- confidence in managing healthcare		
Demographics - age, gender, ethnicity, etc		
- caregiver use of supportive services	create questions	
- web access/usage by caregivers & patients	adapt questions from CBO survey	
- barriers to community services	create questions	
AAA & Corewell Care Manager Evaluation	Survey and focus groups for AAA & House Calls staff	9 mo; 18 mo
FOCUS GROUPS		
- care manager engagement		
- CM strategies to maximize existing structures		
- ID duplicate efforts and streamline workflows		
- create structural connectivity between Corewell & AAA		
- create mechanism for inpt discharge to AAA & home-based care		

Metric development tracking and process

SYSTEMS OF CARE PROCESS EVALUATIONS	Quantitative survey & focus groups with medical/AAA staff	9 mo; 18 mo
Surveys		
- knowledge of systems/services		
- confidence in community systems/services		
- extent of collaboration		
- changes to systems of care		
- ability to coordinate care		
- integration of CBO into EPIC		
Focus Groups		
- barriers to systems integration		
working		
- barriers to community services		
- what needs changes		
- how to achieve change		

Impact & Outcomes - **Improved Health, Lower Costs**

86% reduction in unplanned inpatient hospitalizations

63% reduction in ED to Inpatient

80% reduction in Length of Stay

100% reduction in ED to Nursing Home Placement

93% Caregivers indicate they now feel supported in their caregiving role

[The majority of patients (61%) needed their caregiver to regularly perform five to 10 tasks]

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Southwest Michigan Care Continuum Transformation Final Report

Total Cost of Care Reduction = 63%

Total Savings 6 months post intervention = $1.7 million

Andrews University

Study by Andrews University
Center for Community Research
Institute for Prevention of Addictions

Curtis VanderWaal, PhD
Shannon Trecartin, PhD
Morgan Williams, BSW Candidate

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6-Month Adjusted Average, n=93
Cost Savings Summary

	ED Costs per Patient 6 month avg	Total ED Costs 6 month avg	Unplanned Inpatient Costs 6 month avg	Total Unplanned Inpatient Costs 6 month avg	Total Combined Cost 6 month avg
Pre-CoC Enrollment	$2,410	$238,635	$24,944	$2,469,490	$2,708,125
Post-CoC Enrollment	$1,052	$104,126	$8,951	$886,153	$990,280
Total Savings	$1,358	$134,509	$15,993	$1,583,337	$1,717,845
Percent Reduction	56%	56%	64%	64%	63%

Why partnership works

Melinda Gruber
VP Continuing Care Services
Corewell Health South

> Utilizing a care model that integrates social and medical care clinicians as one patient-centered team has generated significant value to our patients, caregivers, and care teams.
>
> With this model, each team member has a better understanding of the patient/caregiver's goals and challenges. The care plans are enhanced with needed perspectives that improve outcomes and reduce costs.

- Allows providers and patients to prioritize care goals and create a plan around chronic diseases that require more attention
- Utilizes subject matter experts on Health-Related Social Needs in order to achieve disease related goals
- Provides for a more pro-active and tailored (personalized) approach to complex needs
- Improves patient & caregiver satisfaction
- Reduces TPCC by efficient use of community-based services and reducing inpatient and emergency department utilization, SNF admission, and outpatient services
- Expands the team for team-based care and extends care beyond routine visits and into the home
- Increases touch with patients
- Reimburses team for non-face to face work
- Improves quality outcomes

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Quotes from the Field

> Participants have a greater voice in their care. Previously they didn't know how to advocate for themselves... I like that the AAA Care managers ask the patient what their goals are and follow a plan to achieve those goals.
> Sometimes the patient's #1 goal is not what we feel they need medically; they may be anxious about something else.

Laura Wohler
Director of Clinical Services

How has CoC changed the way services and care are provided?

> The care needs of these complex patients are so vast, it's like trying to catch a waterfall in a teacup.
> The AAA care managers see the patient through different eyes. Our [primary care] follow up visits are 3 months or more so having the AAA care manager visits in between are critical… the AAA care managers are a safety net.

Ruth McDowell
Physician Assistant

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Current State - FFS Billable Codes

- Encounters documented in health system EMR
- EMR flow sheet calculates minutes from start and stop times entered
- AAA generates monthly invoice based on report received by health system
- AAA Social Care Clinicians enter codes and related diagnosis in last encounter
- Health system submits claims and reimburses AAA once Medicare pays

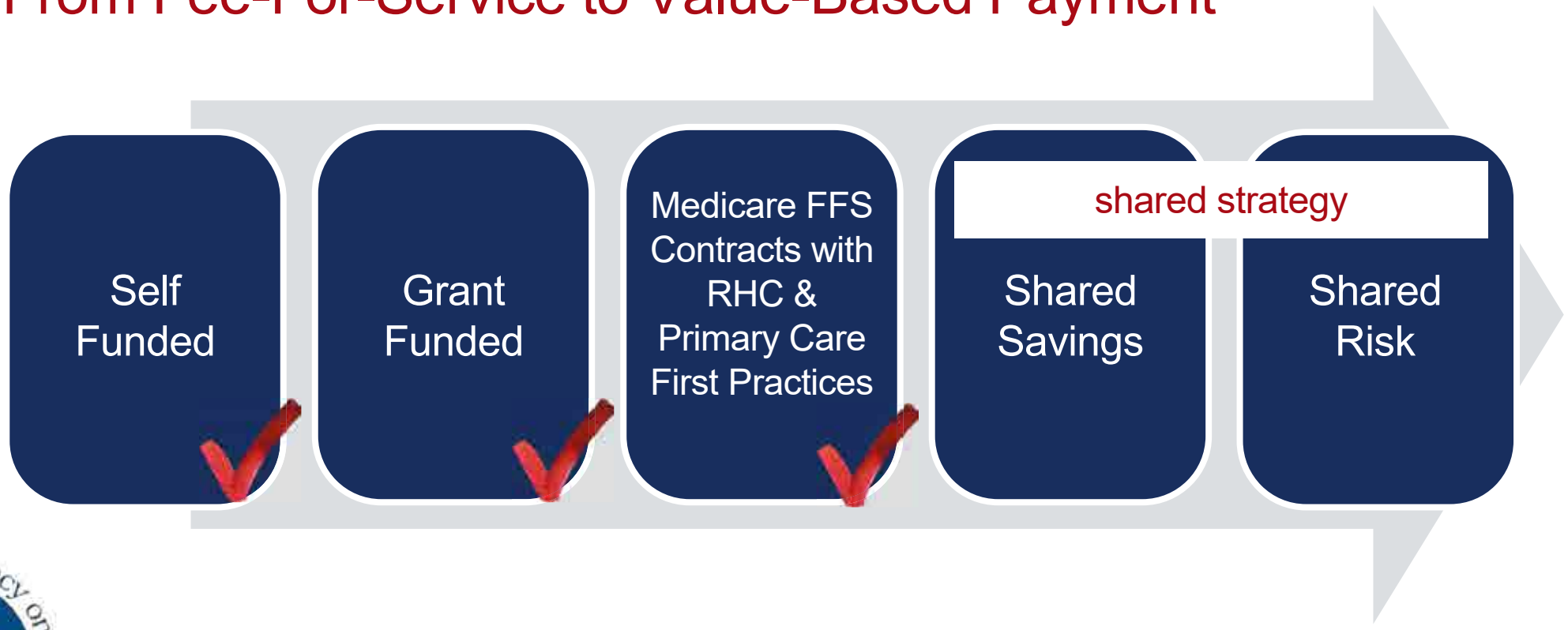
Billing Code	Code Description	Summary Requirements
HCPCS G0506	Comprehensive Assessment & Care Planning	• Patient enrolled in person • Systematic assessment & care planning personally performed by the billing provider • Add-on code to the standard E&M code (99212-99215), AWV or IPPE initiating visit
CPT 99490	Standard CCM	• 20+ minutes of care management outside of office visits performed by clinical staff • Care plan established and regularly reviewed
CPT 99439	Non-complex Add-on	• Additional 20 minutes of "non-complex" CCM • Reportable up to 2x per month (after 99490)
CPT 99487	Complex CCM	• 60+ minutes of care management outside office visits • Care plan created and/or significantly revised
CPT 99489	Complex Add-on	• Billed incrementally for each additional 30 minutes spent beyond the first 60 minutes for Complex CCM case

https://www.cms.gov/files/document/chronic-care-management-toolkit.pdf

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Payment Evolution Journey

From Fee-For-Service to Value-Based Payment



Questions?

Christine Vanlandingham, CEO
Region IV Area Agency on Aging
cvanlandingham@areaagencyonaging.org

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Next Steps

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Reminder

- **February HELC Sessions**
  - **February 6** @ 2:00-3:30 p.m. ET, ECHO Session
  - **February 20** @ 2:00-3:30 p.m. ET, ECHO Session Office Hours

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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

tmcneill@freedmenshealth.com