Partnership to Align Social Care

A National Learning & Action Network

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

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Project ECHO®

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

January 9, 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. Highlighting Metrics as a Value-Added Clinical Partner
3. Discussion
4. Next Steps

Highlighting Metrics as a Value-Added Clinical Partner

Performance Metrics

- Process Outcomes:
  - Annual Wellness Visits
  - Transitional Care Management Visits
  - Quarterly Preventive Health Visits
- Financial Outcomes
  - Billed Medical Encounter increase: AWVs
  - Billed Medical Encounter increase: TCM
  - Billed Medical Encounter increase: E/M & Preventive Services
- Clinical Outcomes
  - HEDIS Measures

Performance Metrics Analysis - AWV

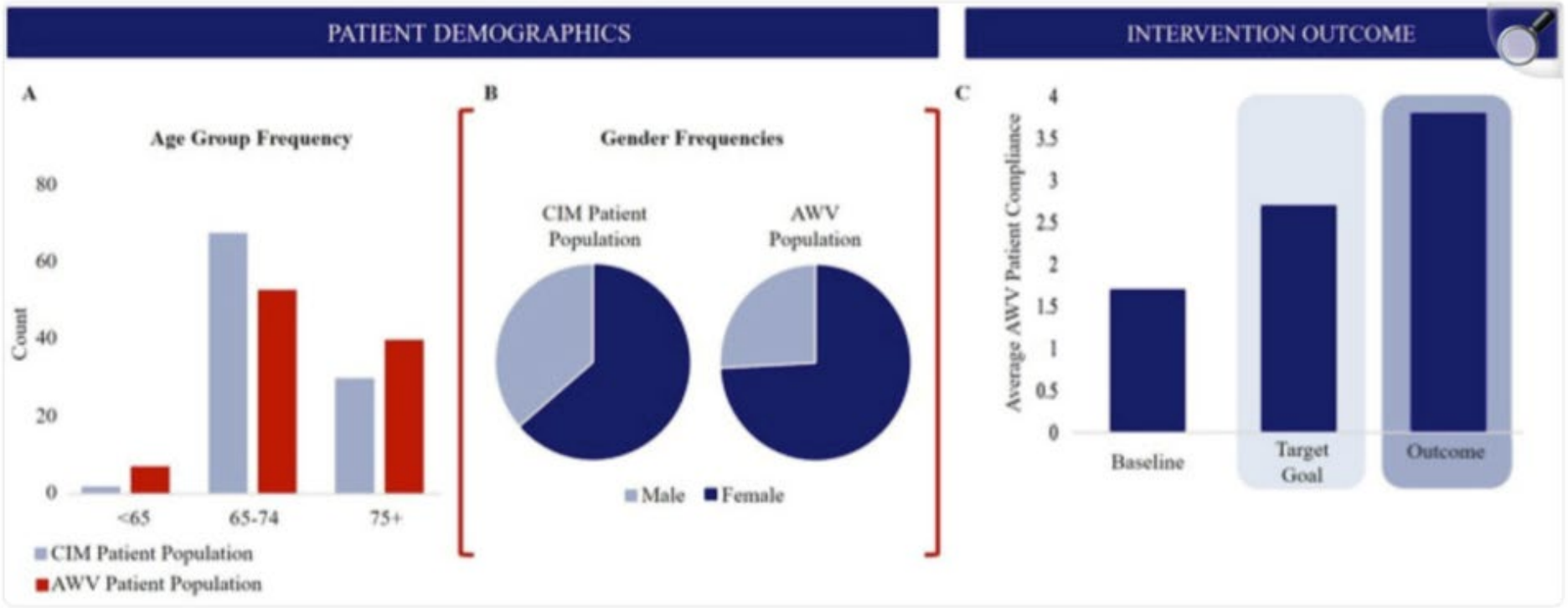
- Purpose of AWV:
  - An AWV, or Annual Wellness Visit, is a yearly appointment with a healthcare provider designed to assess a patient's current health status, identify potential risks, and develop a personalized prevention plan to proactively manage their health, rather than just treating existing conditions; it focuses on discussing health concerns, updating medical history, and recommending screenings based on individual risk factors, all with the goal of preventing future illnesses.
  - Important to support Provider and Health Plan Risk Adjustment
  - Proper risk adjustment can provide additional financial support to the provider and the Health Plan.
  - Risk Adjustment is very important in Value-Based Payment Models

AWV Performance Improvement Strategy

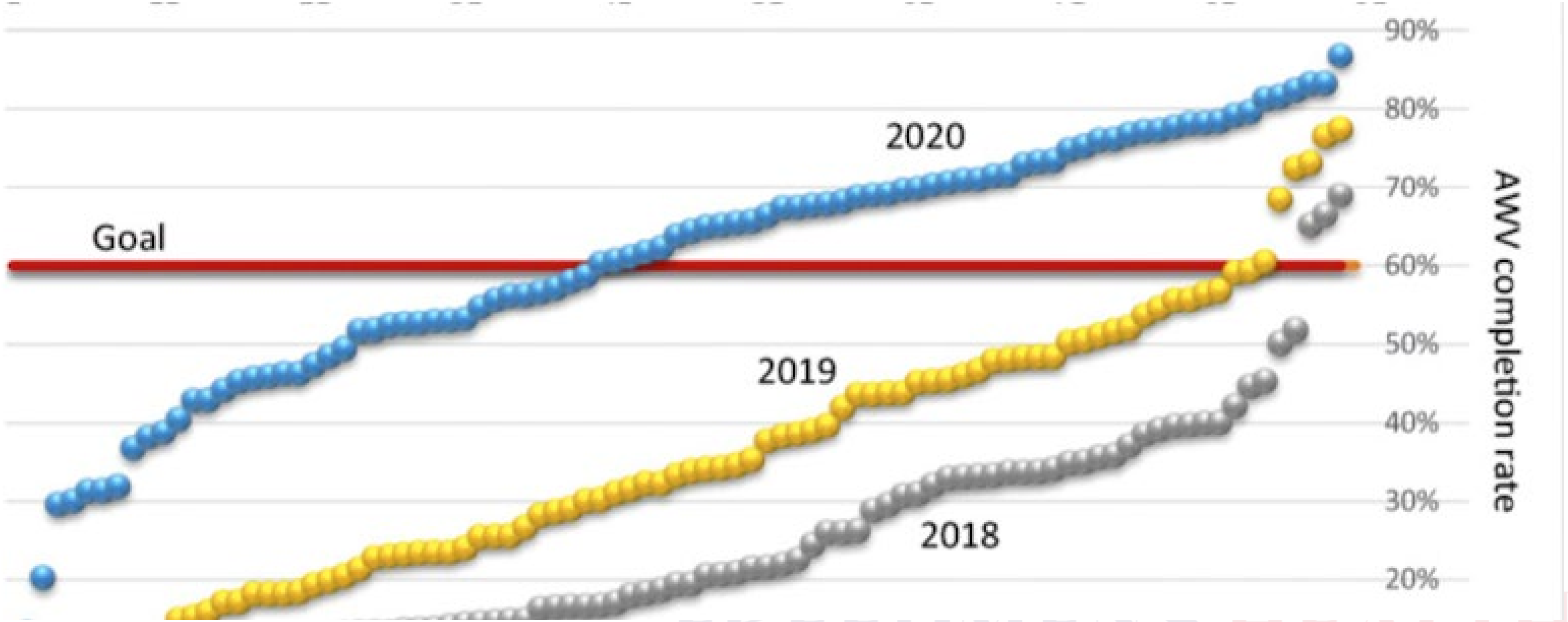
- Review current AWV campaign strategy:
- Assess the capture rate of AWV over a prior period (at least one year but 2 -3 years are preferred).
- Identify the population of persons that are not adherent to AWVs
- Establish a referral plan to the CBO
- Educate the population about the CBO collaboration
- Implement CBO interventions:
  - Assign Health Coach
  - Health Coach provides education on the importance of the AWV
  - Develop an individualized plan with the consumer
  - Address Transportation Insecurity
  - Assist with executing the plan
  - Provide follow-up with the consumer

Sample AWV Performance Improvement Model

Figure 1.



Sample AWV Performance Improvement Model

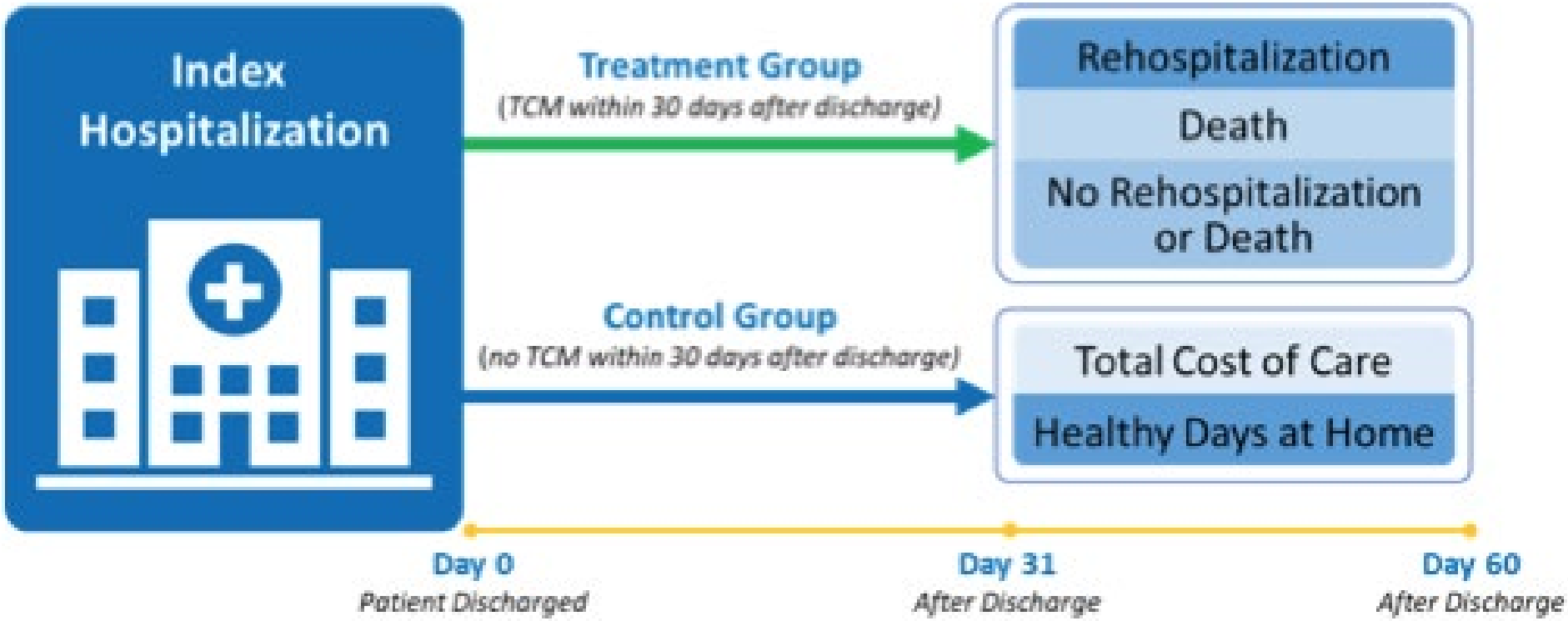


Process Measure - TCM

- ASPE Study
- https://aspe.hhs.gov/sites/default/files/documents/7efe5a4755b8c3aee4774393bab0c2dc/PTAC-Jun-12-TCM-Findings.pdf
- University of Chicago
- June 6, 2023
- "Impact of Transitional Care Management Services on Utilization, Health Outcomes, and Spending Among Medicare Beneficiaries, 2018-2019"

Study Design

Figure 1. Schematic Diagram for Study Design



TCM Study Outcoms

Table 2. Difference between Treatment and Comparison Groups Risk-Adjusted Rehospitalization Rate, Mortality, Rehospitalization or Mortality, Total Cost of Care, and Healthy Days at Home

Outcome Variables	Unadjusted Average		Regression Adjusted Means (95% Confidence Interval [CI])		
	Treatment	Comparison Group	Treatment	Comparison Group	Difference
Rehospitalization (31 to 60 days) %	10.05	10.13	10.09 (9.72-10.46)	10.69 (10.38-11.00)	(0.60)**
Mortality (31 to 60 days) %	1.61	1.39	1.63 (1.48-1.79)	1.53 (1.41-1.65)	0.10
Rehospitalization or Mortality (31 to 60 days) %	10.98	10.94	11.22 (10.84-11.62)	11.81 (11.49-12.15)	(0.59)**
Total Cost of Care (31 to 60 days) $	2933.67	3278.86	2803.15 (2749.59-2857.75)	3039.26 (2994.43-3084.76)	(236.11)**
Total Cost of Care (1 to 60 days) $	6520.80	7702.13	6303.53 (6206.73-6401.85)	7300.63 (7214.19-7388.10)	(997.10)**
Healthy Days at Home (31 to 60 days)	26.65	26.59	25.88 (25.81-25.95)	25.56 (25.52-25.61)	0.32**

Notes:The treatment group included qualifying episodes where the beneficiary received TCM services within 30 days following a short-term acute care hospital stay.
Total cost of care is defined as Medicare Parts A and B spending between the 31st and 60th day following index hospitalization. It does not include Medicare spending for Part D services.
Healthy days at home was calculated by subtracting the following days from the total observation period of 31 to 60 days: mortality days; the total number of days spent in inpatient, observation, skilled nursing facilities (SNF), inpatient psychiatry, inpatient rehabilitation, and long-term hospital settings; and days with outpatient emergency department and home health visits.
Source: Analysis of 5% sample of Medicare Part A and Part B claims for 2018 and 2019.
Statistical significance is shown at the 1% (**) level.

TCM Utilization Data

- ASPE Study. March 2022
- https://aspe.hhs.gov/sites/default/files/documents/31b7d0eeb7decf52f95d569ada0733b4/CCM-TCM-Descriptive-Analysis.pdf
- Analysis of 2019 Medicare Fee-for-Service (FFS) Claims for Chronic Care Management (CCM) and Transitional Care Management (TCM) Services

TCM Utilization Data

Exhibit 2: Medicare FFS Beneficiaries Receiving CCM or TCM Services in 2019

Category	CCM	TCM
Total Medicare FFS beneficiaries with Part B coverage	35,598,051	35,598,051
Number of FFS beneficiaries potentially eligible for CCM or TCM	22,570,404	6,282,242
Percent of FFS beneficiaries potentially eligible for CCM or TCM	63.4%	17.7%
Beneficiaries with one or more CCM or TCM claims	882,728	1,078,580
Percent of potentially eligible beneficiaries with CCM or TCM claims	4.0%	17.9%

TCM Performance Improvement Strategy

- Review current TCM capture strategy:
- Assess the capture rate of TCM visits over a prior period (at least one year but 2 -3 years are preferred).
- Identify the population of persons that are not adherent to TCMs
- Establish a referral plan to the CBO
- Educate the population about the CBO collaboration
- Implement CBO interventions:
  - Assign Transitions Coaches
  - Transition Coach provides education on the importance of the TCM visit
  - Develop an individualized plan with the consumer prior to discharge
  - Address Transportation Insecurity
  - Assist with executing the plan
  - Provide follow-up with the consumer

Preventive Health Visits

- Persons with chronic disease are recommended to have a preventive health visit once per quarter.
- The visit frequency may increase if there are complications.
- The preventive health visit does not include sick visits or TCM visits.
- Key Activities:
  - Labs (HgbA1c each quarter, Chronic Kidney Disease screening, disease specific labs)
  - Screening (depression PHQ-9, cognitive, substance use, functional status, other)
  - Medication adherence

Financial Outcome Measures

- Billed Medical Encounter increase: AWVs
- Billed Medical Encounter increase: TCM
- Billed Medical Encounter increase: E/M & Preventive Services

Service	Code	National Rate
AWV Initial	G0438	$160.44
AWV Subsequent	G0439	$126.47
TCM (7 days)	99496	$272.68
TCM (14 days)	99495	$201.20
E/M Visit, Moderate decision making	99214	$125.18

Financial Outcome Measures

- Financial Performance given the following:
  - 1 TCM Visit (7 days)
  - 1 AWV (subsequent)
  - 4 Moderate E/M Visits

Service	Code	Rate	Total
TCM	99496	$272.68	$272.68
AWV	G0439	$126.47	$126.47
E/M moderate X 4	99214	$125.18	4 x $125.18 = $500.72
Grand Total			$899.87

Sample Clinical Outcomes

- Acute Hospital Utilization (AHU)
- Emergency Department Utilization (EDU)
- Plan All-Cause Readmissions (PCR)
- Care of Older Adults (COA)
- Follow up after hospitalization for mental illness (FUH)
- Follow-up after Emergency Department ED visits
- Diabetes Screening / Monitoring
- Transitions of Care (TOC)

Clinical Outcomes – HEDIS

- Acute Hospital Utilization (AHU)
  - Assesses acute inpatient and observation stay discharges among adult commercial and Medicare health plan members.
  - Health plans report observed and expected rates of hospital use that consider a member's health history.
- Role of the CBO
  - Support transitions of care
  - Coordination of HCBS
  - Address transportation for follow-up visits
  - Support Medication adherence
  - Review medication

Clinical Outcomes – HEDIS

- Emergency Department Utilization (EDU)
  - Assesses emergency department (ED) utilization among commercial (18 and older) and Medicare (18 and older) health plan members. Plans report observed rates of ED use and a predicted rate of ED use based on the health of the member population.
- Role of the CBO
  - Notification of ED Visit – ENS System
  - Support post ED follow-up visit
  - Coordination of HCBS
  - Address transportation for follow-up visits
  - Review any medication changes post ED visit
  - Review medication
  - Support Medication adherence

Clinical Outcomes – HEDIS

- Emergency Department Utilization (EDU)
  - Assesses emergency department (ED) utilization among commercial (18 and older) and Medicare (18 and older) health plan members. Plans report observed rates of ED use and a predicted rate of ED use based on the health of the member population.
- Role of the CBO
  - Notification of ED Visit – ENS System
  - Support post ED follow-up visit
  - Coordination of HCBS
  - Address transportation for follow-up visits
  - Review any medication changes post ED visit
  - Review medication
  - Support Medication adherence

Clinical Outcomes – HEDIS

- Plan All-Cause Readmissions (PCR)
  - Assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge among commercial (18 to 64), Medicaid (18 to 64) and Medicare (18 and older) health plan members.
- Role of the CBO
  - Notification of admission Visit – ENS System
  - Support post discharge follow-up visit
  - Coordination of HCBS
  - Address transportation for follow-up visits
  - Post-Discharge Medication review
  - Flag medication discrepancies and review with medical group
  - Support Medication adherence (transportation, copays, adverse effects, patient dislike, etc.)

Clinical Outcomes – HEDIS

- Care of Older Adults (COA) Pain Assessment (New)
  - The COA pain assessment indicator, specified for individuals 65 years of age and older who are enrolled in a Special Needs Plan (SNP) or a Medicare-Medicaid Plan (MMP), requires at least one pain assessment be conducted during the measurement year.
- Role of the CBO
  - Health coach asks about pain
  - Reports pain status to medical group
  - Address transportation for follow-up visits to address reports of pain
  - Assist with obtaining medication post medical visit for pain
  - Support Medication adherence (transportation, copays, adverse effects, patient dislike, etc.)

Clinical Outcomes – HEDIS

- Hemoglobin A1c Control for Patients with Diabetes (HBD)
  - Assesses the percentage of members 18–75 years of age with diabetes (type 1 or type 2) whose HbA1c was at the following levels:
  - HbA1c control (<8.0%).
  - HbA1c poor control (>9.0%).Role of the CBO
- CBO Activities
  - Address Food Insecurity
  - Assist with Behavior Change
  - Provide ongoing support to facilitate long-term behavior change
  - Provide health education (label reading, diet modifications, coordinate DSMES/MNT access)
  - Reinforce DSMES/MNT recommendations
  - Assist and provide ongoing support to increase physical activity
  - Address transportation for follow-up visits and quarterly HgbA1C testing
  - Assist with obtaining diabetes medication
  - Support Medication adherence (transportation, copays, adverse effects, patient dislike, etc.)

Bonus Measure – Cardiovascular Disease

- Controlling High Blood Pressure
  - Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg)
- List the CBO activities to address this measure:

Bonus Measure – Cardiovascular Disease

- Statin therapy for patients with cardiovascular disease
  - Statin Therapy for Patients with Cardiovascular Disease: Assesses males 21–75 years of age and females 40–75 years of age who have clinical atherosclerotic cardiovascular disease (ASCVD) and who received and adhered to statin therapy.
- List the CBO activities to address this measure:

Bonus Measure – Cardiovascular Disease

- Beta Blocker Therapy after a Heart Attack
  - The percentage of members who received persistent beta-blocker treatment for six months after being discharged from the hospital for a myocardial infarction (AMI)
- List the CBO activities to address this measure:

Bonus Measure – Cardiovascular Disease

- Cholesterol Management for Patients with a Cardiovascular Condition
  - The percentage of members who had a cholesterol screening after being discharged from the hospital for an AMI
- List the CBO activities to address this measure:

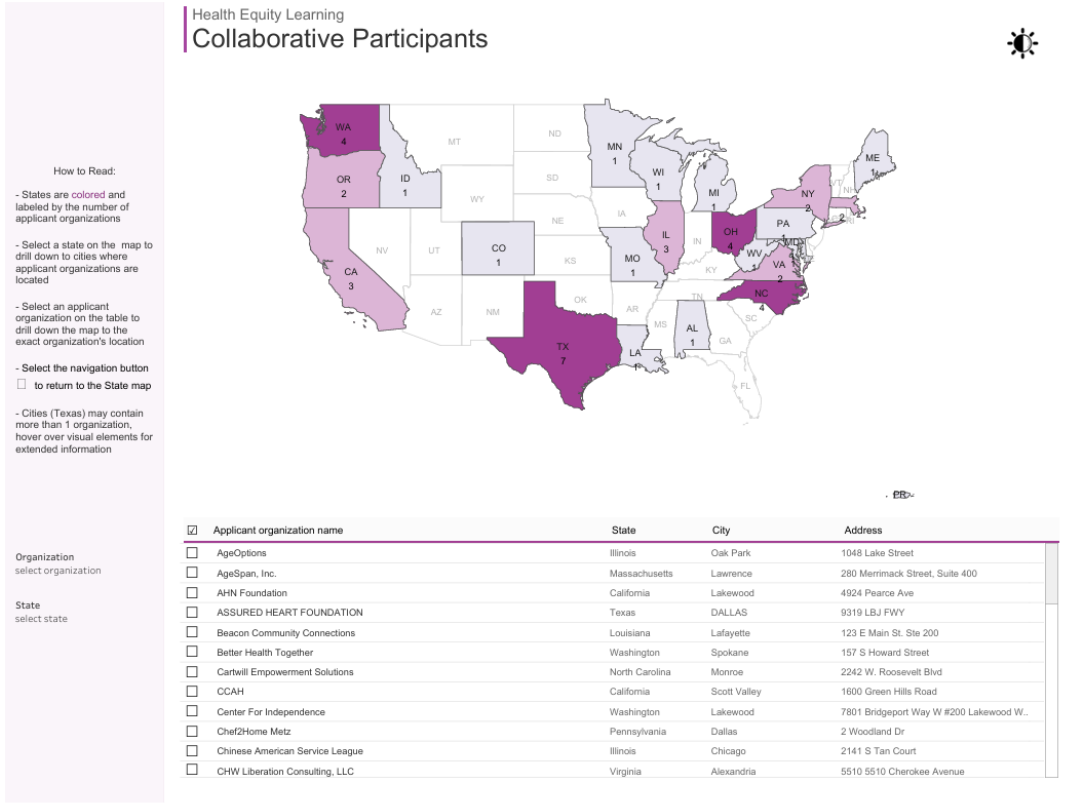
Health Equity Capstone Event

Purpose

- Highlight accomplishments, lessons learned and next steps
- Celebrate progress made since the inception of the Health Equity Learning Collaborative
- Provide content for marketing those accomplishments beyond the conclusion of the Health Equity Learning Collaborative

Benefits to Your Organization

- Placement on the Health Equity map which will support overall marketing of your health equity efforts



[HELC Participants | Partnership to Align Social Care]

Instructions

- Step 1. Prepare your Capstone
- Step 2. Send your Capstone to HealthEquity@partnership2asc.org **by the end of February**
  - If you choose not to present a Capstone, your organization will be removed from the Health Equity map
- Step 3. Be ready to share a 5-minute presentation of your Capstone during assigned date
  - If the date assigned does not work for you, please reach out to HealthEquity@partnership2asc.org

Assigned Dates for Your Capstone

March 6, 2025

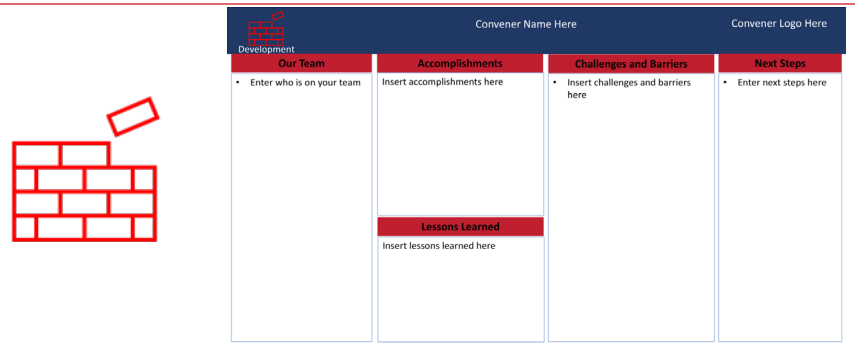
- SARCOA, Dothan, AL
- AHN Foundation, Lakewood, CA
- CCAH, Scott Valley, CA
- LifeSpring Homenutrition, Lake Forest, CA
- Denver Regional Council of Governments - Area Agency on Aging, Denver, CO
- Health Empowerment Network of DC, Washington, DC
- AgeOptions, Oak Park, IL
- Chinese American Service League, Chicago, IL
- Beacon Community Connections, Lafayette, LA
- AgeSpan, Inc., Lawrence, MA
- Somerville-Cambridge Elder Services, Somerville, MA
- Maryland Living Well Center of Excellence, a Division of MAC, Inc. AAA, Salisbury, MD
- Healthy Living for ME, Augusta, ME
- Detroit Area Agency on Aging, Detroit, MI
- Winona Health Foundation (Winona Community HUB), Winona, MN
- Mid-America Regional Council, Kansas City, MO
- Impact Health, Asheville, NC
- Piedmont Triad Regional Council, Kernersville, NC
- Quality Comprehensive Health Center, Charlotte, NC
- Cartwill Empowerment Solutions, Monroe, NC
- Health and Welfare Council of Long Island, Huntington Station, NY
- Western New York Integrated Care Collaborative, Inc., Buffalo, NY

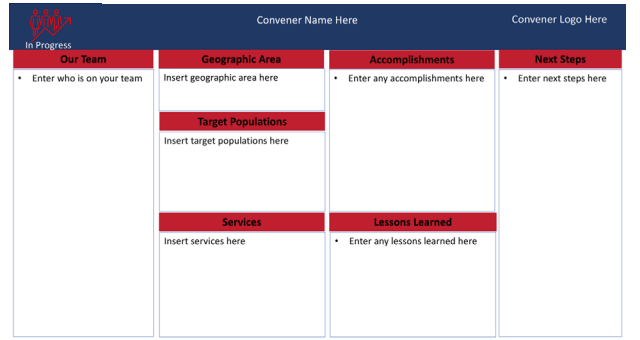
March 20, 2025

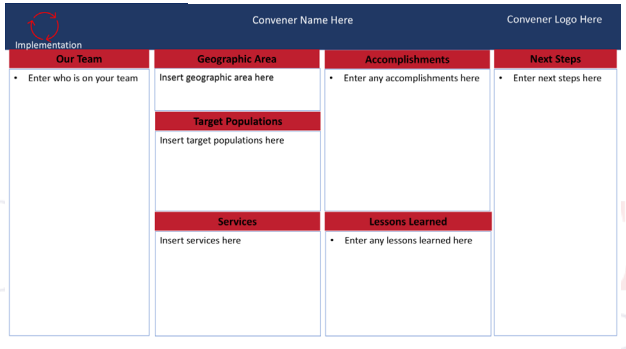
- Partners for Advancing Community Health, Columbus, OH
- The Foodbank, Inc., Dayton, OH
- Timothy Freeman, MD, Center for Intellectual and Developmental Disabilities, Cincinnati, OH
- Western Reserve Area Agency on Aging, Cleveland, OH
- Oregon Wellness Network, Salem, OR
- Project Access NOW (PANOW), Portland, OR
- Chef2Home Metz, Dallas, PA
- REMA, LLC (dba Sociants), San Juan, PR
- Assured Heart Foundation, Dallas, TX
- Houston Health Department / Harris County Area Agency on Aging, Houston, TX
- The Health Collaborative, San Antonio , TX
- Community Council of Greater Dallas, Dallas, TX
- Community Health Worker Training Institute, Arlington, TX
- The Network of Behavioral Health Providers, Houston, TX
- YWCA San Antonio, San Antonio, TX
- Virginia Community Health Worker Association, Richmond, VA
- Better Health Together, Spokane, WA
- Center For Independence, Lakewood, WA
- Lucid Living (SafetyNet), Tacoma, WA
- Washington State Department of Social and Health Services (WA DSHS), Olympia, WA
- YMCA of Metropolitan Milwaukee, WI
- The Arc of the Mid-Ohio Valley, Parkersburg, WV

Preparation

Status	Definition
In Development	Building Partnerships Readiness to file a claim is greater than 6 months
In Progress	Readiness to claim is less than 6 months
In Implementation	Have filed at least one claim







Implementation

Convener Name Here

Convener Logo Here

Our Team

- Enter who is on your team

Geographic Area

Insert geographic area here

Target Populations

Insert target populations here

Services

Insert services here

Accomplishments

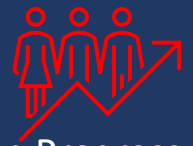
- Enter any accomplishments here

Lessons Learned

- Enter any lessons learned here

Next Steps

- Enter next steps here



In Progress

Convener Name Here

Convener Logo Here

Our Team

- Enter who is on your team

Geographic Area

Insert geographic area here

Target Populations

Insert target populations here

Services

Insert services here

Accomplishments

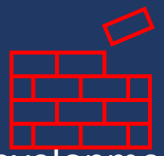
- Enter any accomplishments here

Lessons Learned

- Enter any lessons learned here

Next Steps

- Enter next steps here



Development

Convener Name Here

Convener Logo Here

Our Team

- Enter who is on your team

Accomplishments

Insert accomplishments here

Lessons Learned

Insert lessons learned here

Challenges and Barriers

- Insert challenges and barriers here

Next Steps

- Enter next steps here

Review

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Questions?

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Next Steps

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Reminder

- **January HELC Sessions**
  - **January 16** @ 2:00-3:30 p.m. ET, ECHO Session Office Hours with a Presentation by Christine Vanlandingham, CEO of Region IV Area Agency on Aging in Southwest Michigan

- **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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FREEDMEN'S HEALTH I

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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