Partnership to Align Social Care

A National Learning & Action Network

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

CAPSTONE

March 20, 2025 | 2:00-3:30 p.m. ET

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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.”

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Agenda

1. Welcome and Introductions
2. Capstone
   - ❖Piedmont Triad Regional Council Area Agency on Aging
   - ❖Beacon Community Connections, Inc.
   - ❖Denver Regional Council of Governments (DRCOG)
   - ❖Health and Welfare Council of Long Island
   - ❖Pathways Community HUB Institute PCHI
3. Next Steps

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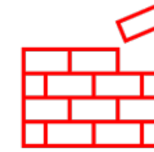
Status	Definition
In Development	Building Partnerships Readiness to file a claim is greater than 6 months
In Progress	Readiness to claim is less than 6 months
In Implementation	Have filed at least one claim



Development — Convener Name Here — Convener Logo Here

Our Team	Accomplishments	Challenges and Barriers	Next Steps
• Enter who is on your team	Insert accomplishments here	• Insert challenges and barriers here	• Enter next steps here
	Lessons Learned Insert lessons learned here		

In Progress — Convener Name Here — Convener Logo Here

Our Team	Geographic Area	Accomplishments	Next Steps
• Enter who is on your team	Insert geographic area here	• Enter any accomplishments here	• Enter next steps here
	Target Populations Insert target populations here		
	Services Insert services here	**Lessons Learned** • Enter any lessons learned here	

Implementation — Convener Name Here — Convener Logo Here

Our Team	Geographic Area	Accomplishments	Next Steps
• Enter who is on your team	Insert geographic area here	• Enter any accomplishments here	• Enter next steps here
	Target Populations Insert target populations here		
	Services Insert services here	**Lessons Learned** • Enter any lessons learned here	

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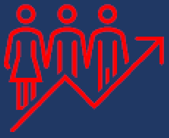
Piedmont Triad Regional Council Area Agency on Aging



In Progress

Piedmont Triad Regional Council
Area Agency on Aging

Our Team

Adrienne Calhoun, PTRC AAA Director

Eboni Lewis, PTRC Assistant AAA Director

Bob Cleveland, Aging Program Planner

Luna Williams, Aging Program Planner

William Crumpton, CEO Compassion Healthcare

Tim Gallagher, person with lived experience

Geographic Area

Caswell and Rockingham Counties in NC

Target Populations

Medicare beneficiaries with diabetes and other complex chronic conditions

Services

CHI/ PIN

- Screening for HRSN
- Navigation Services
- Person Centered Planning
- Care Coordination
- Caregiver Support
- Chronic Condition Education

Accomplishments

Cultivated partnership with healthcare through numerous conversations and meetings

Signed: Third Party Provider Agreement with Compassion Healthcare 10/30/24

Signed: Compassion Healthcare IT Access Form 11/14/24 (Access to EHR)

Provided secured fax number to Compassion Healthcare to send referral 1/31/25

Lessons Learned

- Have the right people at the table
- Be patient
- Getting healthcare to allow access to the EMR is difficult
- Challenges with shared cost
- We have to educate healthcare on social supports
- Building relationships is key

Next Steps

Followed up on 2/19/25

– on status of first referral to be sent.

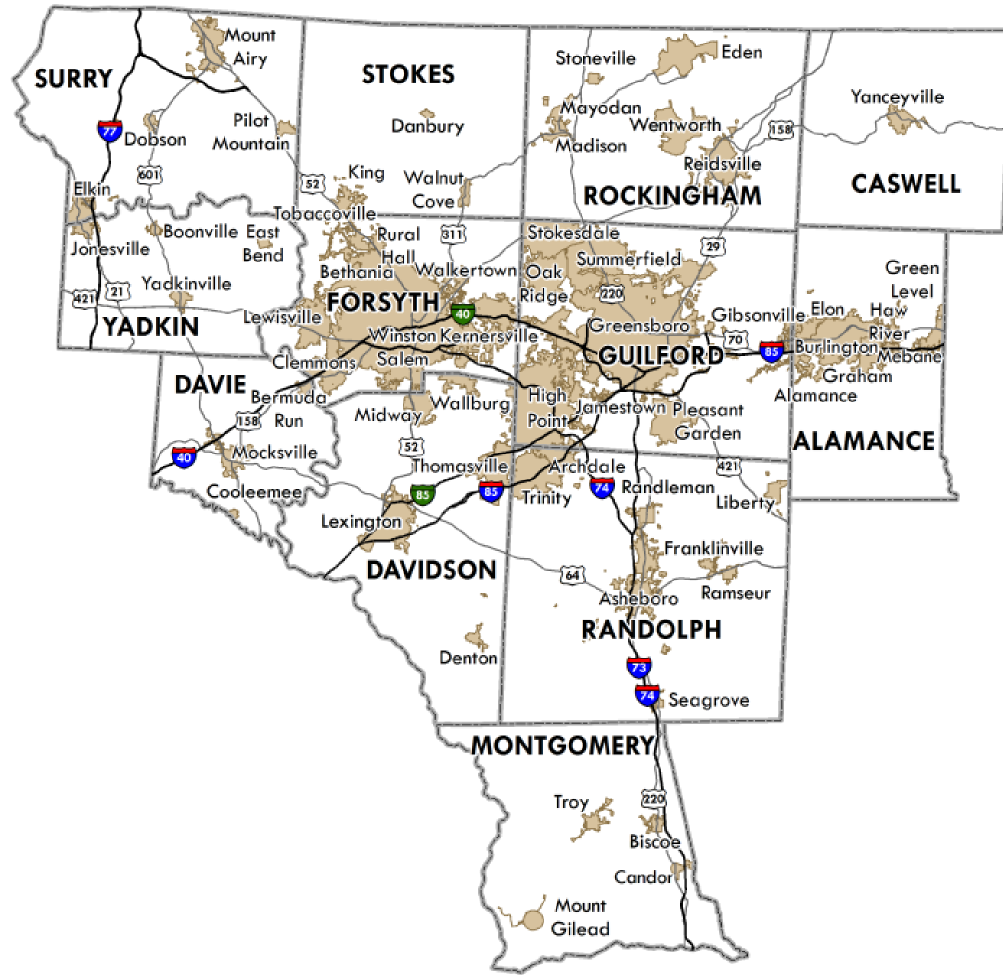
As soon as it is received Eboni Lewis will respond and begin the work.

Piedmont Triad Regional Council Area Agency on Aging

CONNECTING WITH HEALTHCARE

(ALSO KNOWN AS…) WE ARE ALMOST THERE!

Who is PTRC AAA?



- Area Agency on Aging serving a 12 county region in the north central area of NC
- We receive approximately $13 M annually in OAA and NC GRF funding for aging services
- There are approximately 544,000 people age 55+ living in the region
- We have been working to connect with healthcare
  - Embedded a staff member 1 day/week in the ER to help with connections to CBS (2016)
  - Hired 2 CHWs for home visits for CHESS (ACO) who referred their patients. (2021) *no payment
  - Contracted with BC/BS for home mods for their members due to falls (2022)
  - Working to operationalize CHI/PIN with a healthcare partner (2024---)
  - Partnership w/AWFBH to address HRSN for stroke patients, using our CHW (2025)

Working to implement CHI/PIN

- Invited CHESS, Atrium Wake Forest Baptist Health, BC/BS NC, to be partners in the learning collaborative
    - Tepid participation by the HC team with promise of collaboration that never materialized
    - CHESS courted us for about 6 months, told us they would find providers for us to work with, then told us they could not help us (right about the time we told them the (free) CHW services would end and they would have to pay for them (we told them at the beginning [over a year and a half earlier] that there was a funding cliff)

Working to implement CHI/PIN

Shifting focus

- We switched our focus to Compassion Healthcare, a rural FQHC that has a high percentage of Medicare clients and serves two rural counties, both with high incidences of diabetes in their population
- Over the years we developed a relationship with the FQHC and their Director.
- We approached him about the opportunity to implement CHI/PIN services for their patients. What we didn't know is the FQHC learned about CHI/PIN early on in 2024 and hired their own CHWs. The FQHC has successfully billed for these services. We didnt give up…..

Working to implement CHI/PIN

PTRC AAA and Compassion Healthcare (FQHC)

- We had numerous conversations with the FQHC Director about working with them to implement CHI/PIN . Once we found out that they already had billed for CHI/PIN, we asked for a pilot of 10 Medicare clients. He agreed. Only because of our history.
- It took several months, but he finally sent a BAA. We were surprised he split the reimbursement 50/50 versus 90/10, but he explained it was a partnership and he wanted to see how we performed first. After lawyers reviewed we signed the BAA.
- We asked for our Asst Director to have access to the EHR. After months of asking and prodding, they sent paperwork for her to sign which would provide limited access to the EHR.

Current Status

- We provided the FQHC a secure fax line to send referrals, at their request
- The FQHC has identified a provider that will send us CHI/PIN clients
- Waiting for training on their EHR system
- Waiting on connecting with FQHC clinical and admin staff on documentation, billing, etc.

Lessons Learned

- Building relationships is key
- Have the right people at the table
- Be patient and persistent
- Getting healthcare to allow access to the EMR is a challenge
- Challenges with negotiating reimbursement
- Educating healthcare is a challenge/physicians don’t have time

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Questions?

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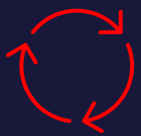
Beacons Community Connections, Inc.



Implementation

Beacon Community Connections, Inc.

BEACON COMMUNITY CONNECTIONS

Our Team

- Dr. Holly Howat, Beacon
- Mark Evans, Beacon
- Rachel Martin, Beacon
- Dr. Antoine Keller, Ochsner
- Dr. Karen Wyble, Ochsner
- Pauline Breaux, FMOLHS
- Brice Mohundro, LA Blue
- Cian Robinson, Robinson Ventures

Geographic Area

Louisiana

Target Populations

Medicare population
Medicaid population
People with chronic conditions
People with substance use
Perinatal women

Services

Social care services by Community Health Workers and Peer Support Specialists to connect people to community resources

Accomplishments

- Completed pilot in 2024 to successful provide services, submit claims to Medicare, and receive reimbursement
- Awarded an AARP grant to continue building out the Community Care Model
- Presented information on Beacon's social care services to multiple state and national groups

Lessons Learned

- Encourage healthcare providers to use Principal Care Management and Chronic Care Management services to complement social care services provided by CHWs and PSSs. This involves lots of technical assistance.

Next Steps

- Expand CHI/PIN service model to multiple healthcare providers
- Complete pilot project with an ACO
- Engage with Medicaid MCOs
- Refine and expand Silver Services Community Care Hub
- Launch Nurture Community Care Hub for perinatal women
- Keep learning and growing

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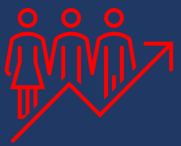
Denver Regional Council of Governments (DRCOG)



In Progress

Denver Regional Council of Governments (DRCOG)

Our Team

- Denver Regional Council of Governments - Community Care Hub (DRCOG-CCH) staff including Manager, facilitation expert, and Community Resource Navigators.
- Denver Health staff including director and staff including social workers, EHR network analysts, and financial/billing specialists.

Geographic Area

City and County of Denver, Colorado and surrounding counties

Target Populations

Medicare and Medicaid dual eligible patients

Services

- Health-related social needs screening
- Care/Action planning
- Community resource navigation
- Referral to network CBOs to address clients Health-Related Social Needs.

Accomplishments

- Completed Journey Mapping process to design the process flow between clinical, CCH and its network of community-based providers to integrate the patients' perspectives and impacts in the process flow.

Lessons Learned

- Include leadership staff, service level staff, and provide internal data, compliance and financial/billing support to ensure comprehensive approach .
- Use structure of CHI reimbursement to enhance partnership. The cumulative nature of time-based billing can lead to better coordination.

Next Steps

- Finalize billing and reimbursement procedures.
- Finalize policies and procedures for the exchange of data between Denver Health and CCH.
- Design and deliver training on screening and documentation requirements with clinical and Hub staff.

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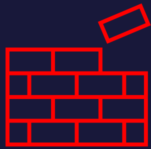
Health and Welfare Council of Long Island



Development

Health and Welfare Council of Long Island

HWCLI
Health & Welfare Council of Long Island

heali
Led by HWCLI

Our Team

- Lori Andrade, Executive Vice President

- Sam Klein, Program Manager

Accomplishments

- Selected as Lead Entity of Long Island's Social Care Network through NYHER 1115 Waiver
- Long Island allocated $43M through March 2027
- 43 Contracted CBOs, FQHCs, health systems
- 15 Contracted MCOs
- Expanding to Primary Care PCMH

Lessons Learned

- Trust and relationship building are highest priorities
- Share information through monthly meetings
- Meet with partners one-on-one (MCO, health system, FQHC, CBO)

Challenges and Barriers

- Workflow Integration Challenges
- IT Interoperability Challenges
- Time Limitation while developing Social Care Network through Medicaid

Next Steps

- Build capacity of CBO partners to screen and navigate clients to services through grants and training
- Strengthen partnerships with primary care
- Participate in 2025 Community Care Hub National Learning Community hosted by the Center of Excellence to Align Health and Social Care, USAging

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Pathways Community HUB Institute PCHI

Implementation

Pathways Community HUB Institute PCHI

Our Team

- Dr. Sarah Redding, MD. Founder of PCHI
- Jan Ruma, Senior Advisor
- Mary Martell, Director of Education and Training
- Isaac Baez, Assistant Director of Education and Training
- Brenda Leath, Director of Certification
- Ellie Kaufman, Manager of Operations and Certification
- Amy Vreeland, Chief Quality Officer

Geographic Area

There are over 40 Pathways Community HUBs (PCHs) and Pathways Agencies in 19 states.

Target Populations

Maternal and child health, at risk children. Individuals with chronic conditions, Seniors, and Any under-resourced population

Services

- an evidence-based model for community-based care coordination.
- Icertification to ensure PCHI Model fidelity for PCHs. PAs, vendors
- Technical Assitance to support communities creating HUBs.
- Traing: CHW. CLAS, other.

Accomplishments

Research has shown that PCHs can achieve ROI, reduce costs, and improve outcomes for pregnant people and their babies

A recent article in Health Affairs Scholar on MCD billing for CHW services identified the PCHI Model as a contributing factor to Ohio's unique success having significantly more MCD CHW beneficiaries than any other state. See next slide for detail

Lessons Learned

Payment for outcomes CHWs help their participants achieve is a key element of success.
CHW home visiting, and relationships they develop is a key to success.

Next Steps

Hosting a Braided Funding task force across the PCHI Network to develop a strategy and approach, and vendor requirements regarding how to leverage new CHW reimbursement opportunities for existing CBOs and PCHs.

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Questions?

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Cross-Cutting Themes

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After listening to your peers, what themes did you hear?

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As the Learning Collaborative comes to an end, what technical assistance is still needed?

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Next Steps

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Reminder

- **Survey Request for Information re: CHI, PIN, PIN-PS Implementation Activity**
  - https://www.surveymonkey.com/r/K7VCYVV

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Learning Collaborative Resources

- 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

- 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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