Community Care Hub 101
Learning Series

Introduction to Community Care Hubs

November 16, 2023
Center of Excellence to Align Health and Social Care
Welcome

Webinar hosted by the Center of Excellence to Align Health and Social Care, powered by USAging’s Aging and Disability Business Institute

In partnership with:

• The Administration for Community Living

Presenters

• Lauren Solkowski, Administration for Community Living
• Nikki Kmicinski, Executive Director, Western New York Integrated Care Collaborative

Facilitator

• Maya Op de Beke, Senior Program Manager, USAging’s Aging and Disability Business Institute
Community Care Hub 101 Learning Series Overview

1. **Introduction to Community Care Hubs**: November 16, 2023, from 2:00-3:30 PM ET
2. **Community Care Hubs Core Functions**: November 30, 2023, from 2:00-3:30 PM ET
3. **Contracting Opportunities to Address Health-Related Social Needs**: December 7, 2023, from 2:00-3:30 PM ET
4. **Building the Community Care Hub Business Case**: December 14, 2023, from 2:00-3:30 PM ET

Register today!
Poll Question

Which of the following options best describes your current level of awareness regarding what community care hubs are and their emergence as conveners of CBO-networks:

• I am not aware
• I am somewhat aware
• I am aware
• I am very aware
Webinar Instructions for Zoom

Audio Options

• Use your computer speakers, OR dial in using the phone number in your registration email.
• All participants are muted.

Questions and Answers (Q&A)

• You can submit questions for the panelists at any time during this presentation. On the Zoom module on the bottom of your screen, click the Q&A icon, type your question in the box and submit.

Chat Feature

• The Chat feature allows webinar attendees to make comments during the webinar question and answer period.
Landscape Overview

Drivers for better coordinated care
Opportunities to Align Health and Social Care

• Increased attention on social drivers of health (SDOH)/health-related social needs (HRSNs)
  – HHS SDOH Action Plan and ongoing inter-agency coordination
  – Medicaid 1115 Waivers supporting state investments to address health-related social needs (HRSNs)
    ▪ CMS “In Lieu of” Services Guidance to address HRSNs in Medicaid Managed Care
    Advanced Payment Incentives for Medicare ACOs, Physician Fee Schedule Final Rule

• Multi-sector collaboration through Alternate Payment Models that advance health equity and integrate clinical care
  with community health and social services.
  – CBOs are well-poised to make meaningful contributions in the continuum of value-based care (VBC), CBOs
    are highly effective in addressing socioeconomic barriers, care coordination, and combatting health inequities
    (Guidance for Health Care Entities Partnering with Community-Based Organizations Addressing Health-
    Related Social Needs in Alternative Payment Models (hcp-lan.org)).

• Need to ensure capacity exists within communities to effectively partner with health care to address HRSNs,
  respond to increase in referral volume.
Calendar Year 2024 Medicare Physician Fee Schedule
Final Rule

• Services Addressing Health-Related Social Needs
  – **Community Health Integration Services**
    ▪ Intended to address unmet SDOH needs that affect the diagnosis and treatment of the patient’s medical problems
    ▪ Separate coding and payment for CHI services (two new G codes)
  – Social Determinants of Health Risk Assessment
    ▪ Furnished by the practitioner on the same date they furnish an evaluation/management (E/M) visit
    ▪ Also proposing to add SDOH risk assessment to the annual wellness visit as an optional, additional element
  – Principal Illness Navigation Services
    ▪ Help people with Medicare who are diagnosed with high-risk conditions (for example, dementia, substance use disorder) identify and connect with appropriate clinical and support resources.
Contracting Between CBOs and Health Care

- Community-based organizations (CBOs) are increasingly contracting with health care organizations to address health-related social needs (Aging and Disability Business Institute 2021 Request for Information)
  - Leverages CBO core competencies and services
  - Proportion of CBOs contracting with health care has increased from 38% in 2017 to 44% in 2021
  - Percentage of CBOs contracting as part of a network doubled between 2017 and 2021, from 20% to 40%
Learning System to Align Health and Social Care

• Multi-pronged approach to learning a collaborative and holistic model of care that builds upon existing community capacity to address HRSNs

• Intended to meet CBOs, CCHs, and their health care partners where they are in journey to screen, refer, coordinate, deliver, and finance services

• Coordinate across various organizations providing relevant TA to implement a comprehensive approach that reaches a broad group of aging and disability CBOs, CCHs, and health care organizations
Technical Assistance Opportunities in 2024

• Community Care Hub 101 Learning Series
  – All CBOs interested in or early in their hub development

• Community Care Hub National Learning Community
  – For CBOs- existing and emerging hubs with existing health care contracting capacity

• Center of Excellence to Align Health and Social Care
  – Funding opportunity for community care hubs to support and enhance hub infrastructure

• Health Equity Learning Collaborative (Partnership to Align Social Care)
  – For more advanced hubs and their health care partners to collaborate on team based learning and multi-payer alignment

• ECHO learning series on care transitions with CBOs and hospital partners
  – All CBOs serving older adults/people with disabilities with hospital partners learn how to collaborate on HRSN screening, referral, transition support, and service activation/coordination

• Housing and Services Partnership Accelerator
  – Support state teams coordinating across organizations that provide services and resources that help people find – and keep – stable housing in the community

• Multi-state IT learning collaborative on interoperable referral systems
Learning System Timeline

November 23’
- Accepting applications for ACL’s 2023/2024 Community Care Hub (CCH) National Learning Community
- CCH 101 Learning Series hosted by Center of Excellence to Align Health and Social Care
  - Timeline: 2 months
  - Audience: New and emerging CCHs, and other organizations interested in the CCH model

December 23’
- Announce funding opportunity for CCHs through Center of Excellence
- Launch of HHS-HUD Housing and Services Partnership Accelerator
  - Timeline: 12 months
  - Audience: Up to 4 states with Medicaid 1115 demonstrations or section 1915(j) state plan benefit to address housing stability

January 24’
- Launch of Community Driven, Multi-Payer Health Equity Solutions: An ECHO Collaborative
  - Timeline: 9 months
  - Audience: Up to 20 community/clinical teams
- Launch of ACL’s Care Transitions ECHO Series
  - Timeline: 6 months
  - Audience: Aging and disability network organizations and their hospital partners
- Launch of ACL’s 2023/2024 CCH National Learning Community
  - Timeline: 10 months
  - Audience: Up to 30 CCHs serving aging and/or disability populations

February 24’
- Launch of Multi-State Learning IT Collaborative Series
  - Timeline: 6 months
  - Audience: State agency leadership (e.g., SUAs, CIOs, Medicaid)

March 24’
- Award grants for up to 20 CCHs through Center of Excellence
- Ongoing participant engagement in various Learning System activities
Community Care Hub
National Learning Community (NLC)

• Bring together organizations serving as community care hubs to take part in shared learning, information and resource sharing, and coordinated TA with the goal of building the strength and preparedness of the hub to address health-related social needs through contracts with health care entities

• 2022/2023 NLC cohort included 58 participants representing 32 states
NLC Interactive Map

- **Map** of NLC Participants
  - Search by: State, County, or CCH
  - Information Available: Organization Type, Key Contact information, Geographic Coverage
## 2023-2024 CCH National Learning Community

### CCH 101 Learning Series
**Nov – Dec 2023**
- 4 week intensive offering an introduction to CCHs and health care contracting for new and emerging CCHs
- 1 curriculum session per week
- Open to aging/disability CBOs serving as CCH or interested in learning about CCH model through open webinar registration

### NLC Learning Modules
**Dec 2023 – Aug 2024**
- Monthly ECHO sessions / Small group coaching calls
- ~30 participants selected through application process
- Topics:
  - Medicare Healthcare Common Procedure Coding System (HCPCS) codes
  - Contracting with health care
  - CCH value propositions

### Additional TA Opportunities
- Individual technical assistance with subject matter experts
- Action Plan development and related technical assistance
- CCH Capacity Assessment completion support
Defining Community Care Hubs

What are CCHs, why are they needed
CCH Definitions

**Community Care Hub:** A community-centered entity that organizes and supports a network of community-based organizations providing services to address health-related social needs.

- **Centralizes administrative functions and operational infrastructure**
- Has **trusted relationships** with both local community-based and healthcare organizations
- **Fosters cross-sector collaborations** that practice community governance with authentic local voices.

Source: [Partnership to Align Social Care](#)
Types of CCH Operating Models

How are CCHs structured? Common models include:

• Central Authority
• Lead Agency
• Federated Model (hybrid)

Source: Aging and Disability Business Institute
Central Authority Operating Model

Typically, a stand-alone or other organization that is NOT participating as a CBO service provider in the CCH’s network

• Primary purpose is to perform the CCH functions and lead CBO-network contracting and execution efforts

Characteristics:

• Distinct legal entity
• Appropriate for single contracting approach
• High start up costs if standalone
• High contracting oversight responsibilities
Lead Agency Operating Model

Typically, a single community-based organization that is also a service provider in the CCH network

• Takes it upon itself to build the CCH functions in house or through a subsidiary.
• Performs or contracts all CCH functions and forms the CBO-network.

Characteristics:
• Can use single contracting entity approach
• Moderate start up costs
• Contracting oversight responsibilities vary
Federated Operating Model

CCH may be formed by a consortium of the participating CBOs

- Hybrid between Central Authority and Lead Agency
- Most, if not all CCH functions are contracted to one or more of the network-participating CBOs or through other vendors

Characteristics:

- Most flexible approach
- Can use single contracting entity approach
- Lowest start up costs
- Decentralized contracting oversight responsibilities
Diversity in Types of Organizations Serving as CCHs

- Aging and Disability Resource Centers (ADRC)
- Area Agencies on Aging (AAAs)
- Centers for Independent Living (CILs)
- Multi-sector collaboratives including HHS, Education and Government entities housed at United Way entity
- Nonprofit health improvement organization
- Private nonprofit 501(c)(3)
- Public nonprofit
- Rural health network
- State Associations
Core Functions

Managed internally by CCHs or Contracted Out

• Leadership and governance
• Network CBOs recruitment, retention, reflective of the community
• Operations
• Contract administration and compliance
• Quality and fidelity
• IT systems and security and data management
• Strategy and business development
Western New York Integrated Care Collaborative (WNYICC)

CCH field example
Western New York Integrated Care Collaborative, Inc.

Community Care Hubs: 101

Nikki Kmicinski, Executive Director
November 16, 2023
nkmicinski@wnyicc.org
Community Integrated Health Network: since 2016
- WNYICC is the Community Care Hub of the Network

56 Network Members
- 2 Departments of Health
- 1 Independent Living Agency
- 8 Area Agencies on Aging (AAA)
- 45 Social Care Agencies (non-profits)

www.wnyicc.org
WNYICC Network Membership
Mission: Our service-provider network produces better health outcomes and quality of life by providing comprehensive, cost-effective, community-based integrated care.

Vision: To represent community-based organizations from Western New York as we seek to provide sustainable, high-quality integrated business models for community-based programs and services proven to address Social Determinants of Health.
Community Care Hub Business Model
https://wnyicc.org

Patients / Community Members
❖ Better Quality of Life
❖ Improved Outcomes
❖ Reduced Healthcare Costs

Delivery of Services Addressing Health-Related Social Needs
- Food / Meals
- Case Management
- Community Health Coaching
- Falls Prevention
- Chronic Disease Self-Management Programs
- Caregiver Support, Training, & Respite
- Health / SDoH Screening
- Diabetes Prevention Program (DPP)
- Transportation
- Housing Supports
- Nutrition Counseling
- Care Transitions
- Social Isolation Supports
- Care Coordination
- Community Health Integration services
- Child and Family services
- Legal services
- Benefit Navigation and more

Clinical Care Delivery
Contracts, Referrals, Reimbursement, Claims data
Delivery + outcome data, Billing

CBO
CBO
CBO
CBO
CBO
CBO
CBO
CBO

NETWORK MEMBERS

Better Quality of Life
Improved Outcomes
Reduced Healthcare Costs

Contracts, Training Academy, referrals, reimbursements, QA, compliance,
Health plans and providers need to address the health-related social needs of their members/patients.

Any services must be available to all beneficiaries/patients.

Plans/Providers need an efficient option to partnering with multiple community-based organizations for multiple programs.

CBOs need strategic partner to lead in contracting, form network, and provide administrative functions of contracting.
Position regional CBOs to be ready for contracting opportunities with health care payers.

Strength in numbers

Provide administrative services to allow CBOs of all sizes to participate in contracting: legal, compliance, QA, contracting, billing, training

Allow for regional service provision

Allow for culturally diverse service provision

Allow for ease in contracting for payers

Advocacy for CBOs

Keep network of CBOs informed on policy, trends, legal, compliance
<table>
<thead>
<tr>
<th>Current Contracted Programs</th>
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<tbody>
<tr>
<td><strong>Health Coaching + evidence-based workshop</strong></td>
</tr>
<tr>
<td>• SDoH Assessment + Care coordination</td>
</tr>
<tr>
<td>• Enrollment in evidence-based workshops</td>
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<tr>
<td>• Community Health Coaching, Falls Prevention, Caregiver Support, Benefit Navigation</td>
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<tr>
<td><strong>Healthy IDEAS</strong></td>
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<tr>
<td>• Evidence-based community depression/social isolation program</td>
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<tr>
<td><strong>Diabetes Programs</strong></td>
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<tr>
<td>• Pre-diabetes (DPP), Diabetes Self-Management</td>
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<tr>
<td><strong>Meal Delivery Program</strong></td>
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<tr>
<td>• Provided by local meal delivery providers</td>
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<tr>
<td><strong>Medical Nutrition Therapy</strong></td>
</tr>
<tr>
<td>• Provided by Registered Dietitians</td>
</tr>
<tr>
<td><strong>Shared Services</strong></td>
</tr>
<tr>
<td>• Billing, Nutrition services, Trainings</td>
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### WNYICC Contracts with Health Care Payers

<table>
<thead>
<tr>
<th>Contract Types</th>
<th>No. of Contracts</th>
<th>No. of Lives in plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage</td>
<td>15+</td>
<td>96,373+</td>
</tr>
<tr>
<td>Medicare FFS in NY</td>
<td>Provider &amp; Supplier</td>
<td>180,000+</td>
</tr>
<tr>
<td>Managed Medicaid (MCOs) WNY</td>
<td>5+</td>
<td>320,000+</td>
</tr>
<tr>
<td>Medicaid FFS in WNY</td>
<td>Supplier</td>
<td>300,000+</td>
</tr>
<tr>
<td>Commercial Plans</td>
<td>5</td>
<td>200,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>1,096,373+</strong></td>
</tr>
</tbody>
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Addressing Health Disparities

Social Determinants of Health Assessments completed in Programs

- Community Health Coaching
- Falls Prevention Program
- Caregiver Support Program
- Medical Nutrition Therapy
- Diabetes Self-Management Education and Support
- Healthy IDEAS

Clients are linked to services based on needs and aided in enrollment.
Notable Accomplishments

- **Infrastructure**
  - Centralized health information technology platform
  - Compliance Program
  - Quality Assurance & Improvement Program
  - Centralized referral system
  - Centralized billing system
  - Training Academy
  - Data & Reporting Systems

- **Contracting**
  - 25 contracts with health payers
    - Strong partnership with largest health plan in WNY: Independent Health
  - Sub-contracts with 32 community-based organizations
Notable Accomplishments

- **Reimbursements to CBOs:**
  
  As of Aug 2023:
  
  $423,241 paid out in reimbursements to 32 CBOs
  
  93.9% increase in 2022

- **Award Winner**
Program Impact

**Healthy IDEAS Outcomes: 2023**
- 85% of participants - PHQ9 or UCLA Loneliness improve score by 15%
- 76% of participants increased their physical and/or social activity through the program.
- 57 referrals made to clinical providers: PCP, Mental Health providers or Registered Dietitians.

**Post-Discharge Meals Program - 2023**
- 935 Participants received meals
- 25,000+ meals delivered
- 73% report that receiving the meals helped prevent a re-admission.

**Medical Nutrition Therapy - 2023**
- 93 Participants
- 86% of completers increased vegetable intake.
- 90% made changes in eating habits
- 69% increased amount of physical activity
- 70% of those “At risk for malnutrition” improved to “Normal nutrition status”.
Community Health Coaching

➢ Average 8 Goals/Interventions per participant
➢ 128 High or Medium Priority HRSN Concerns with Goals to resolve Areas of Concern
➢ 92% Resolved or In-Progress
➢ 8% Incomplete

Falls Prevention Program

- 47 participants Jan- Aug 2023
- 32 developed MYMobility Plan
- 29 registered for free PERS from plan
- 40 goals set to address HRSN
- 38 goals to address falls hazards in home
**Diabetes Programs Impact**

**Diabetes Prevention Program:**
- Full-Plus+ Recognition from CDC
- Results of Most Recent DPRP Evaluation Report from CDC
  - % of completers: 62%
  - Achieved at least 5% weight loss: 63%
  - Achieved at least 4% weight loss + average 150 minutes per week of physical activity: 88%

**Diabetes Self-Management Education & Support Program**
- Accredited through American Diabetes Care and Education Specialists (ADCES)
- Ave. reduction in A1c: 3.8%
- 73% lost weight
- 100% received foot and eye exams
WNYICC Leadership & Advocacy in National Forums

Partnership to Align Social Care
- Contracting Workgroup
- Billing and Coding Workgroup
- Featured in article
- https://www.partnership2asc.org

U.S. Administration for Community Living Community Care Hub Learning Coalition
- Network Expansion Track
- Technical Assistance provider to CA, ME, Adirondack–region in NY
- Found on national Map of CCH

National Council on Aging
- Webinar presentation
  DEI Equity Network Learning Collaborative

Aging Society for America
- Presentations at conference

AHI/LTQA/SCAN Foundation
- Co-Presented on CBO Network Contracting with MA Plans
  Featured in LTQA article

Association of Diabetes Care and Education Specialists - Member

Academy of Dietetics and Nutrition - Member

Coming Soon:
Robert Woods Johnson Foundation
WNY Health Equity Project

Let’s Go CBO!
NYS Food As Medicine Coalition
Steering Committee
Funding Workgroup

Social Care Network Coalition of NY
Recommendations to State on Medicaid Waiver

New York State DOH Small Wellness Mini-Grant
Expand Evidence-Based Programs to more populations in WNY

NYS Office For the Aging
CDSMES Grant ended May 2023

Association on Aging NY
Aging Concerns Unite Us Conference

NY Master Plan on Aging
Workgroup/Sub-Committee

Greater NY Hospital Association Foundation
Advising on SDoH Curriculum for Medical Students

NYS Dietetic Association

Let’s Go CBO!
WNYICCC Leadership & Advocacy Local Forums

**Medicaid 1115 Waiver workgroup**
Nov 2022 – Apr 2023
Speaker on panel – Dec.
4 public convening meetings

**WNY Social Care Data Coalition**

**Live Well Erie/WNY**

**WNY Food As Medicine Coalition**

**WNY Dietetic Association**

**African-American Health Equity Taskforce**

**Erie County Hub Workgroup**

**Maternal Child Coalition**
Doula Project

**Fellows Action Network**

**Exhale Projects – Caregiver Respite Programs**

*Let’s Go CBO!*
WNYICCC Network is Featured in National Publications

- Administration for Community Living
  ACL Community Care Hub Spotlight August 2023

  Western New York Integrated Care Collaborative Addressing Social Determinants of Health: Nutrition and Food Insecurity: A Community Care Hub Innovation Brief

  Sustainability Spotlight: Western New York Integrated Care Collaborative Contracting for Health and Well-Being Coaching

- Health Affairs
  Improving Health And Well-Being Through Community Care Hubs

- Manatt Health
  Working With Community Care Hubs to Address Social Drivers of Health: A Playbook for State Medicaid Agencies

- Partnership to Align Social Care
  Background, Evolution, and Value Proposition of Working with a Local CBO Network Led by a Community Care Hub

WNYICCC can be found on a National Registry of Community Care Hubs! ACL National Registry of Community Care Hubs
Contact Us to Join the Network!

Nikki Kmicinski
Executive Director
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Resourses for Developing a Community Care Hub

Community Care Hubs (CCHs) or hubs are emerging as lead organizations that perform contracting and administrative functions on behalf of a network of community-based social service providers to enable the development of cross-sector partnerships to align health and social care. CCHs create a focal point in communities to assimilate the social care delivery system and strategically partner with health care organizations, to implement scalable, sustainable, and sustainable and scalable interventions for quality care.

The existing resources collected on the Aging and Disability Business Institute (ADBI) at U.S. Aging are designed to support social care hubs in expanding their capacity to address health-related social needs, as well as social determinants of health. This catalog serves as a compendium of resources to support existing and emerging hubs expand their capacity.

Building the Case—Addressing Health Related Social Needs Through CCHs
One of the first steps in becoming a CCH is understanding the reasoning for the development of such entities, what their roles and responsibilities entail, and how they support ongoing creation of cross-sector partnerships. The following resources explore and articulate this need, a key component for building run, which can inform a CCH’s mission and voice.

Improving Health and Wellbeing Through Community Care Hubs: This Health Affairs brief by the ADBI at U.S Aging provides examples of these organizations, and explores policy opportunities to maximize their role.

Addressing Social Determinants: Scaling Up Partnerships With Community-Based Organizations: This Health Affairs brief describes the role of a CCH in driving health care’s increasing interest in addressing both medical and social drivers of health (SDOH).

Community Care Hubs: Making Social Care Happen: This primer from the ADBI at U.S Aging provides information on the emergence of CCHs, their evolution, and value proposition for working with a social network of social care organizations (SCOs) led by a Community Care Hub. It also highlights examples of Community Care Hubs.

Catalog of existing resources to support existing and emerging hubs in expanding their capacity.

Core CCH Functions
Once you understand the why behind CCHs, the next step is building an understanding of critical functions related to how a CCH operates and delivers its administrative and contracting services to its network of providers and payers. Identifying core roles held by a CCH will inform your team’s understanding of the expertise and infrastructure needed to stand up and operate a CCH. The following resources highlight core CCH functions:

- Functions of a Mature Community Care Hub: This brief by the ADBI at U.S Aging provides an overview of the functions described in this resource, and examples of the roles that CCHs have in place to support their operation.
- Launching a CBO Network: Options for Function and Form: This resource from the ADBI at U.S Aging explores the options for launching a CBO network, and provides guidance on how to structure these networks.
- Building a CBO Network for Health Care Contracting: Choosing the Right Model: This resource from the ADBI at U.S Aging provides an overview of the functions of a CBO network, and guidance on how to choose the right model for your organization.

Key Elements for Infrastructure Development
Infrastructure is the foundation of any organization—without it, processes, technology, partners, and finances cannot function. This section highlights the key elements of infrastructure development, and provides guidance on how to build a strong, sustainable community care hub.

- Lifting the Veil: How Networks Form, Operate, Succeed: This report from the ADBI at U.S Aging explores the key elements of infrastructure development for CBO networks, and provides guidance on how to build a strong, sustainable community care hub.

The roadmap for Community-Integrated Health Care: This roadmap from the National Council on Aging explores resources for building strong relationships with the health care sector.
Questions?

Please enter your question into the designated Q&A box on your Zoom panel bar.
Join Us Next Time!

November 30th, 2023
2pm ET

Webinar focus: CCH core functions, roles and responsibilities