

USAging

**Making Sense of Health and
Social Care Systems
Integration**

USAging | Answers
on Aging

Tampa

JULY 8-11 2024

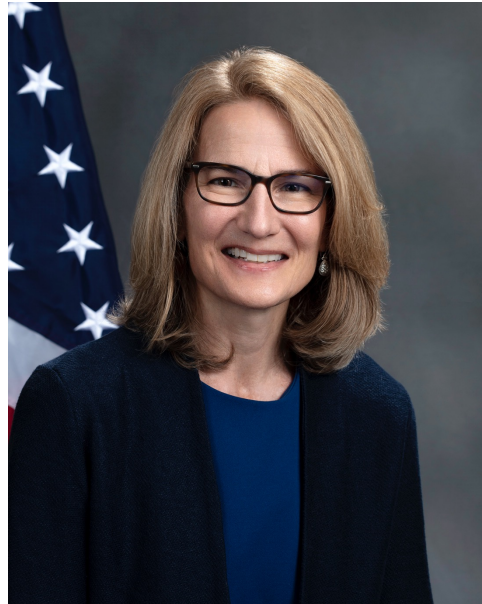
49TH ANNUAL CONFERENCE & TRADESHOW

usagingconference.org

Speakers



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USAging Healthcare Integration Panel

- Kelly Cronin
- Deputy Administrator, Innovation and Partnership
- Administration for Community Living






Opportunities to Align Health and Social Care

- Increased attention on social determinants of health (SDOH)/health-related social needs (HRSNs)
 - White House SDOH Playbook, HHS Call to Action, and ongoing inter-agency coordination
 - Medicaid 1115 Waivers supporting state investments to address HRSNs
 - In Lieu of Services guidance to address HRSNs in Medicaid managed care
 - CMS rules: New screening measures for SDOH for hospitals, physicians, and Special Needs Plans, Advanced Payment Incentives for Medicare ACOs, Physician Fee Schedule Final Rule
- Need to ensure capacity exists within communities to effectively partner with health care to address HRSNs, respond to increase in referral volume
- Federal and state funding is important starting point, but need to braid other sources of funding to deliver comprehensive services to meet increasing need

U.S. Playbook to Address Social Determinants of Health

Purpose: Highlight a set of exemplary actions under three main pillars that federal agencies are undertaking to support health by improving the social circumstances of individuals and communities.

- **Pillar 1: Expand Data Gathering and Sharing.**  The Administration is advancing data collection and interoperability among health care, public health, social care services, and other data systems to better address SDOH with federal, state, local, tribal, and territorial support.
- **Pillar 2: Support Flexible Funding to Address Social Needs.**  The Administration has been working to identify how flexible use of funds could align investments across sectors to finance community infrastructure, offer grants to empower communities to address HRSNs, and encourage coordinated use of resources to improve health outcomes.
- **Pillar 3: Support Community Backbone Organizations.**  The Administration is supporting the development of community backbone organizations and other infrastructure to link health care systems to community-based organizations. The Administration will distribute new grants to enhance emerging and existing backbone organizations and continue ongoing programs that bolster entities providing housing assistance, food access, free or low-cost legal resources, environmental justice resources, and more.

HHS Call to Action – Addressing HRSNs in Communities Across the Nation

- **Motivation**

- Given research showing SDOH accounts for about half of variation in health outcomes, HHS is moving with urgency to advance a series of new policies, as well as funding and training opportunities, to address SDOH and HRSNs.

- **Vision**

- We envision a future in which everyone, regardless of their social circumstances, has access to aligned health and social care systems that achieve equitable outcomes through high-quality, affordable, person-centered care.

- **Purpose**

- Call to Action intended to catalyze cross-sector partnerships to facilitate enhanced coordination between health and social care providers through shared decision making and by leveraging community resources.

HHS Call to Action – Addressing HRSNs in Communities Across the Nation

Example Actions

- **Community-Based Organizations:** Develop and/or expand capacity to serve as a Community Care Hub and/or participate as a partner organization in a CBO network led by a Hub organization.
- **Health Systems and Clinicians:** Engage community partners on needs assessments and in shared decision making, enlist the expertise of backbone organizations such as Community Care Hubs, and consistently identify patients with HRSNs and connect them with community resources.
- **Payers:** Consider covering and paying for allowable services, incentivize health care providers to screen and refer patients for HRSNs, and establish partnerships with backbone organizations.
- **Public Health Departments:** Leverage community health assessments and multi-sector partnerships, forge relationships with backbone organizations, and support the health care sector's work on SDOH and HRSNs through public health's population health expertise.
- **Health Information Technology:** Partner with other sectors in planning and implementing interoperable, community- and person-centric approaches to electronic social care referrals and care coordination, and adopt and advance the use of open data standards.



Community Care Hub

- Effective, sustainable partnerships between CBOs and health care can be facilitated through a community care hub (CCH)
 - Community-focused entity that organizes and supports a network of community-based organizations providing services to address health-related social needs
 - CCH centralizes administrative functions and operational infrastructure, including but not limited to:
 - Contracting with health care organizations
 - Payment operations
 - Management of referrals
 - Service delivery fidelity and compliance
 - Technology, information security, data collection, and reporting



ACL Support for CCHs

■ National Learning Community

- Currently operating second cohort, 32 organizations across 23 states
- Existing and emerging CCHs with health care contracting capacity
- Curriculum focused on new Physician Fee Schedule billing codes, contracting, and value propositions

■ Community Care Hub 101 Learning Series

- All CBOs interested in or early in their hub development (recordings available)

■ Center of Excellence to Align Health and Social Care (COE)

- Cooperative agreement awarded to USAging in September 2023 (three-year project period)
- Providing funding for 20 CCHs to support infrastructure costs
 - ~\$468K over two years



Health Equity Services in the 2024 Physician Fee Schedule (PFS) Final Rule

- Services Addressing Health-Related Social Needs
 - Community Health Integration (CHI) Services
 - Intended to address unmet SDOH needs that affect the diagnosis and treatment of the patient's medical problems
 - Principal Illness Navigation Services
 - Help people with Medicare who are diagnosed with high-risk conditions (for example, dementia, mental health conditions, substance use disorder, and cancer) identify and connect with appropriate clinical and support resources.
 - 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

Role of Aging and Disability Networks (PFS Final Rule)

- Billing practitioner may arrange to have CHI services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs, if all of the “incident to” and other requirements and conditions for payment of CHI services are met
 - CBOs include community-action agencies, housing agencies, **area agencies on aging, centers for independent living, aging and disability resource centers** or other non-profits that apply for grants or contract with healthcare entities to perform social services
 - May receive grants from other agencies in the U.S. Department of Health and Human Services, including Federal grants administered by the Administration for Children and Families (ACF), **Administration for Community Living (ACL)**, the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), or State-funded grants to provide social services



Importance of Investing in Community Capacity

- Population demographics + policy drivers will continue to increase demand on aging and disability CBOs to address social needs
- This work closely aligns with the core competencies of aging and disability networks
 - If our networks can't effectively respond, others will (likely for-profit, less connected to community)
- Strengthening community capacity to provide services is vital (need to avoid “bridge to nowhere” scenario)
- Challenge and opportunity to expand community care hubs to create fair and sustainable partnerships between CBOs and health care

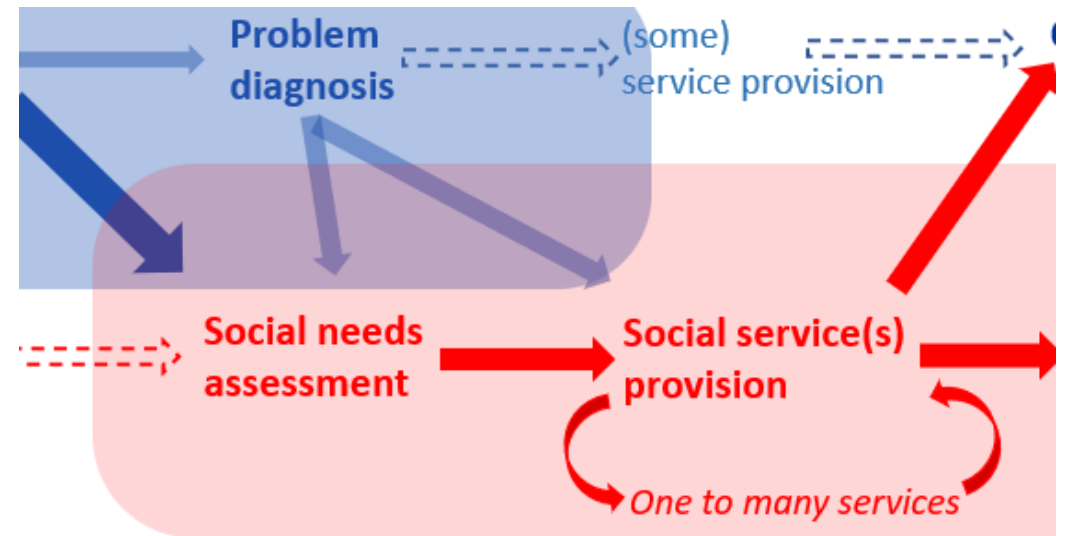
**Who should you be talking
to?
Who should you be
partnering with?**

Mike Klinkman



For contracting, will need to develop 'medical-to-social' data exchange capacity

- Receive and accept referrals from medical care (the blue part)
- Assess social care needs
- Receive authorization for service
- Participate in 'closing the loop'
- Document the care provided
 - *following funders' requirements**
- Bill for services provided
 - *using funders' codes**
- **PLUS - Connect to your own network of social service providers ('social-to-social' connections)**

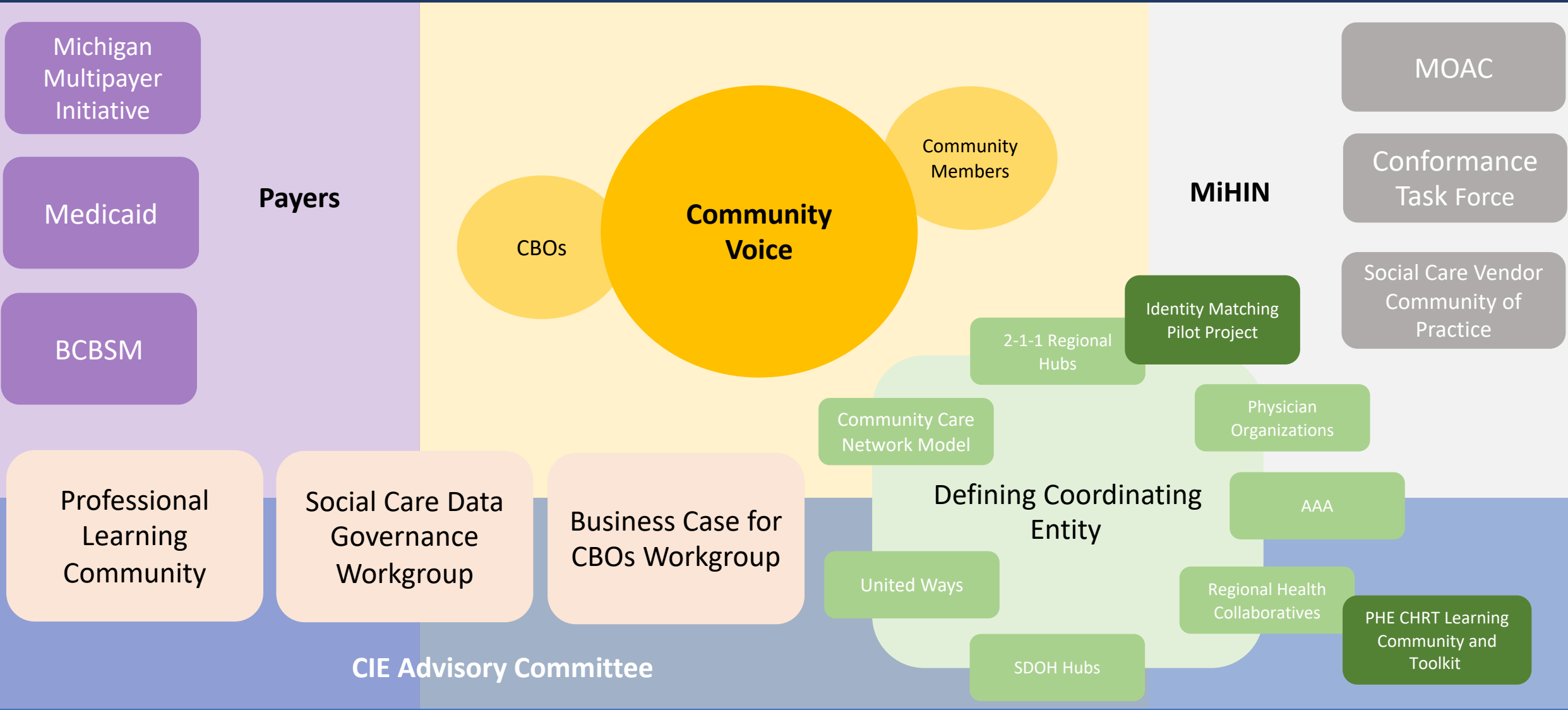


Who do you talk to?

Depends on where you are.

- Other CBOs – peers and downstream providers *[compete or collaborate?]*
- Your IT vendor(s)
- Local health / public health departments
- Local FQHCs, CHCs
- Local – regional health care organizations
- Local and regional governments
- Health plans/payors (Medicaid, Medicare Advantage at top of list)
- State government agencies – DHHS, Medicaid, Senior Services, OPP, HIT, LARA
- Regional or state HIE/HINs, CIE/CINs (to prepare for data exchange)

Federal Guidance: CMS, ONC



An AAA's Perspective

What to Worry About and what to focus on

What to Worry About

- Data Privacy and Security
 - Find ways to work with partners to ensure HIPAA compliance
- Interoperability
 - Establish standards to the greatest extent possible; helps promote a seamless process
- Funding and Resources

What to focus on

- All the things that we also worry about
 - HIPAA
 - Interoperability
 - Resources and funding
- Developing a culture of change and innovation
- Regulatory Compliance
- Quality and continuity of Care
- Customer experience
- Partnerships

Thank you to our sponsor!

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