ADVANCING ARTHRITIS PUBLIC HEALTH PRIORITIES
THROUGH NATIONAL ORGANIZATIONS (CDC-RFA-DP21-2106)

Arthritis Advisory Panel Design Session #4
Tuesday, June 27, 2023 – 10:00-11:30 A.M. ET

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Funding Attribution

This effort is part of the “Advancing Arthritis Public Health Priorities Through National Partners, Component 2” project supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $500,000 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, CDC/HHS or the U.S. Government.

Design Sessions

May 9 **Screening Arthritis Pt's for QoL**

May 23 **Brief Advice / Counseling**

June 13 **Referral**

June 27 **Care Coordination**

July 11 **Reimbursement and Beyond**

July 25 **Evaluation**

Agenda

- Welcome and Agenda Review
- Administration for Community Living Care Coordination
  - Chronic Disease Self Management Education Grantees
    - MAC Inc (MD)
    - Innovations for Aging / Trellis (MN)
    - Rush University Medical Center (IL)
  - Strategic Panel Discussion
- Bidirectional Services eReferral (BSeR)
- Strategic Discussion and Workflow
- Closing/Next Steps

Administration for Community Living

Lesha Spencer-Brown, MPH, CPH, PMP

Arthritis Advisory Panel Meeting: Community Care Hubs

Lesha Spencer-Brown, MPH, CPH, PMP
Administration for Community Living
Administration on Aging
Office of Nutrition and Health Promotion Programs

June 27, 2023

Community Care Hub (CCH)

A community-focused entity that organizes and supports a network of community-based organizations providing services to address health-related social needs.

A 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*

A CCH has trusted relationships with and understands the capacities of local community-based and healthcare organizations and fosters cross-sector collaborations that practice community governance with authentic local voices

ACL's Support of Hubs

- **CDSME & Falls Grant Programs:**
  - Hubs as sustainability strategy for evidence-based programs
  - Network Development Learning Collaborative

- **Advancing Partnerships to Align Healthcare and Human Services:**
  - 2021 No Wrong Door Community Infrastructure Grants: Scaling Network Lead Entities
  - National Learning Community
  - National Center of Excellence
    - Subawards to hubs

Community Care Hub Resources

- Health Affairs Blog: Improving Health and Well-Being Through Community Care Hubs
- Community Care Hub Primer: Background, Evolution, and Value Proposition of Working with a Local CBO Network Led by a Community Care Hub
- Working with Community Care Hubs to Address Social Drivers of Health: A Playbook for State Medicaid Agencies
- Other resources coming soon!

MAC Inc

Sue Lachenmayr, MPH, CHES, Living Well Center of Excellence

Leigh Ann Eagle, Director of the Health & Wellness Program

Maryland Living Well Center of Excellence (LWCE), a Division of MAC, Inc. AAA

- LWCE is one of the first fourteen organizations working to establish a statewide Community Care Hub to link AAAs and other Community-based organizations with primary care providers for referrals to ensure older adults and people with disabilities are able to age in place.
- LWCE works at the local and state level.
- The Goal is to connect older adults and people with disabilities to needed social services that impact overall health and quality of life. Referrals are received from primary care providers, care transitions organizations (CTOs) and hospitals.
  - Clients are linked to an array of services and programs as part of a Total Cost of Care model. Programs are tracked via Maryland's Health Information Exchange (HIE) to ensure bi-directional data-sharing with referring providers.
  - Currently, LWCE receives in excess of 400 referrals monthly for programs including Chronic Disease Self-Management, Chronic Pain Self-Management, PEARLS Depression Reduction Program, Falls-Prevention programs, and Exercise programs including EnhanceFitness, TaiJiQuan: Moving for Better Balance and Walk With Ease.
- The LWCE Care Team includes care transitions specialists and trained AAEBI leaders. The majority of AAEBIs are delivered through the statewide Hub to ensure statewide reach.
- Key Partners include members of Maryland Primary Care Program, thirteen hospitals, a number of CTOs, AAAs, and other community organizations.
- Currently, LWCE bills Medicare through the referring providers.

Maryland Living Well Center of Excellence (LWCE)

1. **What can the healthcare provider anticipate for the community hubs to do once a referral is received?**

The Hub and its partners are able to complete SDOH screenings, provided needed social services, match the client to the correct program (including physical activity and chronic disease self- management), track patient engagement and attendance, and communicate about the patient's progress via the HIE.

2. **What types of data do community hubs need in the referral?**

When the Hub receives a referral, it includes the patient's contact information/permission to contacted and provider's recommendation for programs. The Hub has access to patient health records vie the HIE and Epic.

3. **What type of data should be shared back with the healthcare provider through bi-directional referral or other type of reporting?**

Utilizing the HIE for tracking and documentation, we are able to report class registration, class completion, services provided, and pre/post outcomes (quality of life, improved/maintained health status.

LWCE submits pre-/post- data via the HIE to see hospital and emergency department utilization/ length of stay. The HIE also tracks Medicare expenditures, and we hope to link information back to the provider that demonstrates improved patient status, which will align with Maryland's Total Cost of Care initiative.

MARYLAND Living Well CENTER of EXCELLENCE
A Division of MAC Incorporated

Ensuring Access to Better Health and Quality of Life Services for Older Adults and Adults with Disabilities

To enable all of us to stay connected to our communities as we age, it's important that we have access to health care and quality of life services that meet our changing needs – in the ways we need them, no matter where we live or what insurance we have.

WHAT IS THE MARYLAND LIVING WELL CENTER OF EXCELLENCE?

The Maryland Living Well Center of Excellence (LWCE) is a statewide Community Care Hub that connects older adults (age 60+) and adults with disabilities who are Maryland residents to the health care, support, and resources they need for health, wellbeing, and community connection. LWCE works with the Maryland Department of Aging, the Maryland Department of Health, and the Maryland Primary Care Program to increase equity in health care and community services across Maryland.

WHY DO MARYLAND RESIDENTS NEED THE LIVING WELL CENTER OF EXCELLENCE?

LWCE and partner agencies provide an array of programs and services to help older residents and adults with disabilities manage challenges like chronic health issues, living alone, transition care after hospital stays, and limited mobility. Unfortunately, many people who qualify for these services and programs don't always know about them or have trouble accessing them. LWCE serves as an important partner to clinics and hospitals by helping residents who are Medicaid and Medicare members find the services they need, understand what's required to participate, and manage paperwork or other issues.

HOW DOES MARYLAND LIVING WELL CENTER OF EXCELLENCE WORK?

- **Forming strong partnerships:** LWCE has strong partnerships with multicultural non-profits, clinics and hospitals, and government agencies, as well as the Statewide Aging Network to help connect older adults and adults with disabilities to a wide range of services and programs.
- **Connecting residents to services:** When health care providers use the Chesapeake Regional Information System for Patients (CRISP), Maryland's Health Information Exchange, to make referrals for residents throughout the state, LWCE helps link individuals to the non-clinical services they need and track what services and programs they are provided with.
- **Providing health education:** LWCE provides evidence-based workshops to equip older adults to manage health issues like diabetes, chronic pain, arthritis, and loneliness or depression. The workshops promote lifestyle changes including healthy eating, exercise, stress management, and counseling.
- **Training providers:** To increase access to workshops, LWCE provides training to clinics and other organizations throughout the state so they can offer workshops in their communities.

HOW IS MARYLAND LIVING WELL CENTER OF EXCELLENCE MAKING A DIFFERENCE?

Connecting older Maryland residents (age 60+) and adults with disabilities to services and evidence-based programs has produced some remarkable outcomes:

- **Better controlled chronic health conditions.** LWCE's evidence-based workshops have helped residents achieve healthier weight, improved blood pressure readings, and lower blood sugar readings.
- **Fewer emergency room visits and lower costs.** When clinics and hospitals partnered with LWCE, fewer patients visited the emergency room or needed to be hospitalized for chronic conditions.
- **Healthier behaviors.** When health care partners connected their patients to LWCE, their patients reported increases in socializing, exercising, and making healthy food choices.

MARYLAND LIVING WELL CENTER OF EXCELLENCE IMPROVES COMMUNITY HEALTH

21,000
older adults and adults with disabilities have participated in our evidence-based programs to self-manage ongoing health issues

$500K
in savings reported by local health systems due to fewer hospital stays and emergency room visits

800
participants took part in 91 workshops.

96%
of workshop participants reported they were better able to manage their symptoms

HOW CAN I GET INVOLVED?

Our network of hospitals and clinic partners is growing! Learn more about how to partner with the Maryland Living Well Center of Excellence. https://mdlivingwell.org/providers/

We're helping the State of Maryland fulfill its ongoing commitment to better access to health care and quality of life services for older adults and adults with disabilities. Join us in our journey to healthy opportunities for all. https://mdlivingwell.org/

Using Innovation to Reduce Food Insecurity and Social Isolation and Increase Physical Activity

To address the needs of older adults living in rural areas of the Eastern Shore, LWCE developed 'Healthier You', an innovative program that couples weekly fresh vegetables, evidence-based programming and opportunities for social interaction.

G S, a male participant married for 51 years, noted: **'It is one of the best things I've done since I retired. The longer you stay active, the better off you are.**

60 participants enrolled in the 6-month program. Participants lost an average of 11.5 pounds. The participants formed their own new network of friends and many are now 'regulars' at the senior center and other local events.

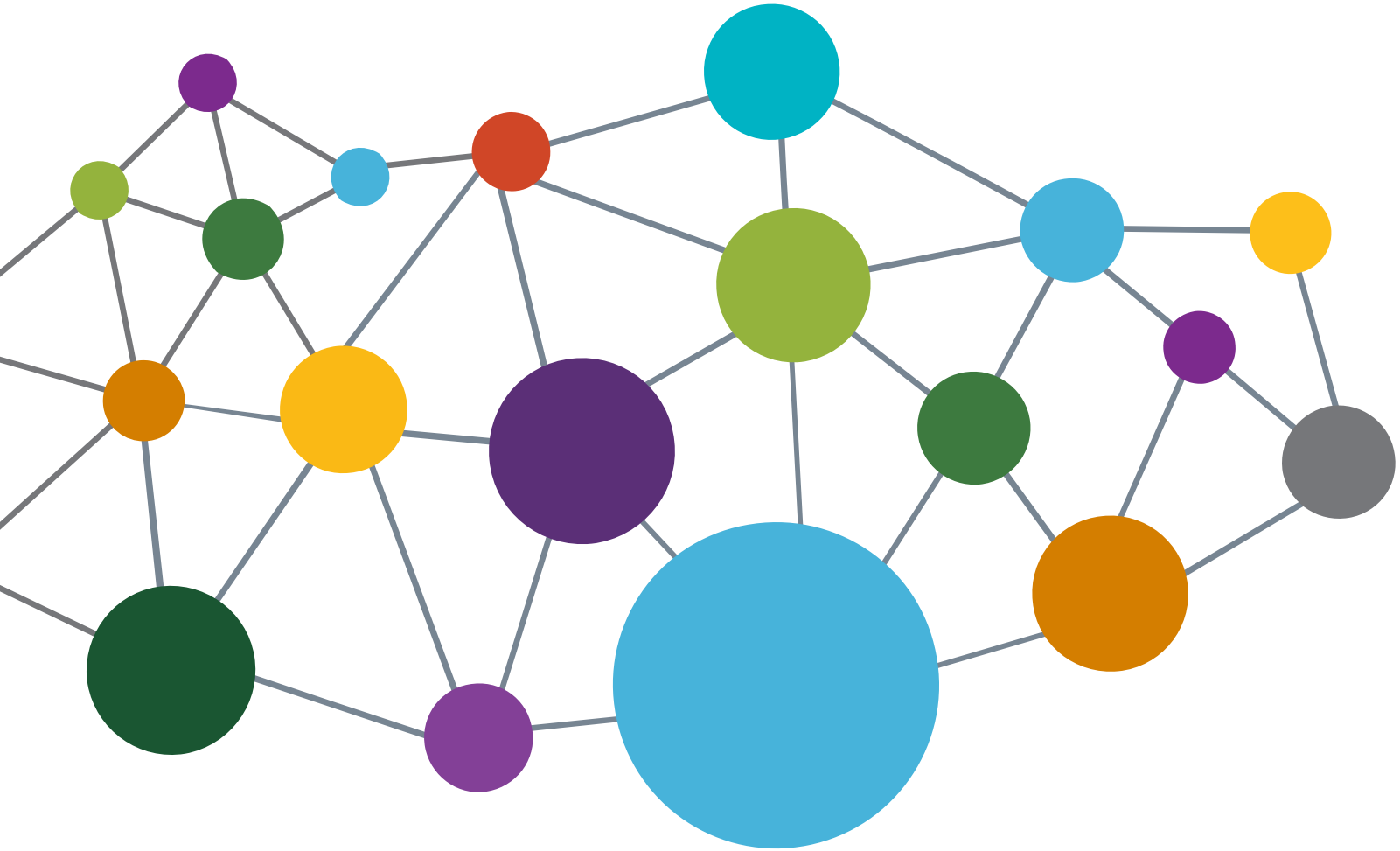
Juniper Network and Trellis

Mark Cullen, Vice President of Strategy and Business Development

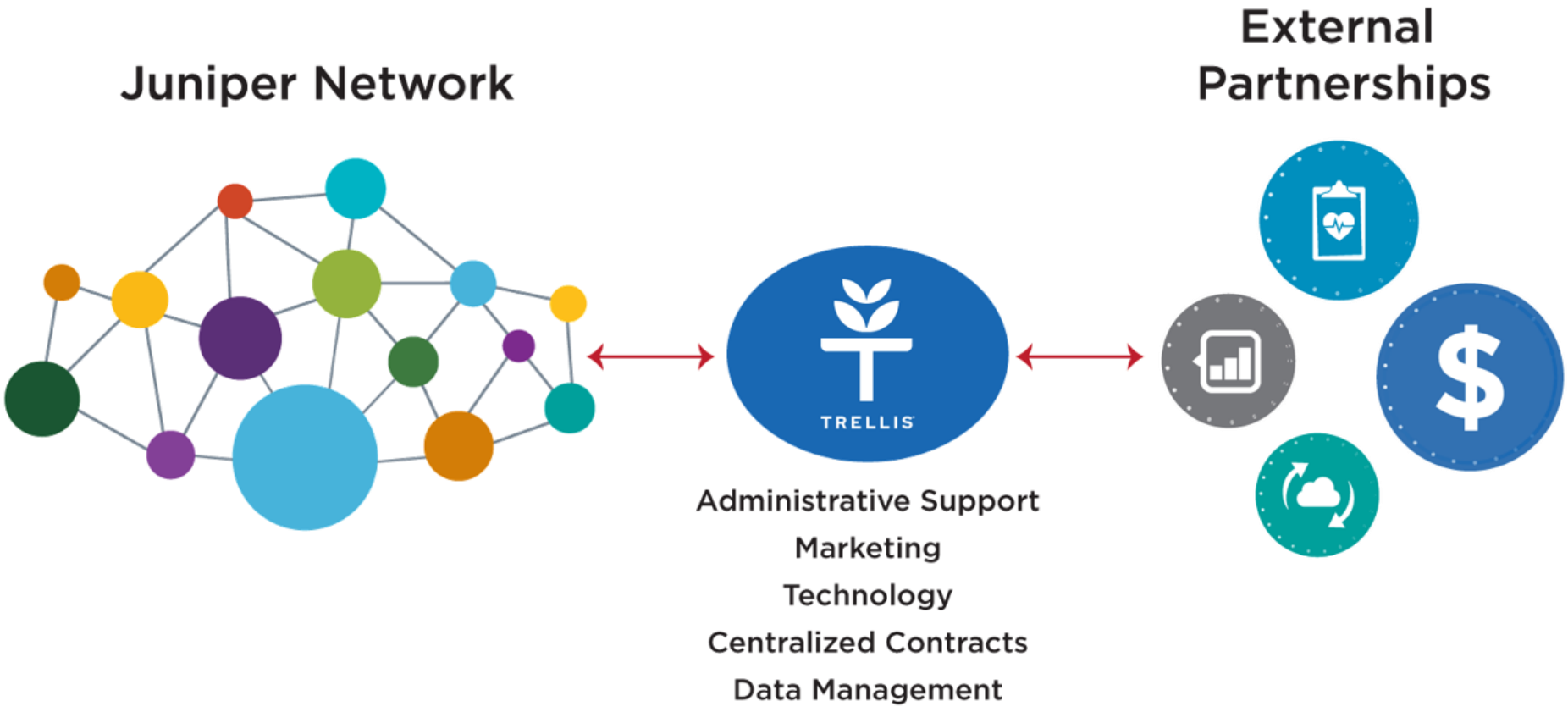
Juniper

- Juniper evidence-based health promotion classes engage individuals with chronic conditions or at risk for falls in classes that build their capacity to manage their health and motivate them to take actions to improve their health. Offered through a network of community-based organizations and healthcare providers, the classes are available to people across Minnesota with in-person, online and phone options.
- Project Goals –
  - Aiming to serve 10,000 people in health promotion programming and SDoH screening
  - Focus on BIPOC participants to ensure representation at least twice their proportion of the population
  - Focus on Medicaid-eligible program participants (including duals) to ensure we help people with highest barrier to access

Juniper is a Network



Umbrella Hub / Community Care Hub



Juniper

1. **What can the healthcare provider anticipate for the community hubs to do once a referral is received?**
    - We receive referrals and follow-up with patients. We can also conduct social needs screening and (with the right data sharing arrangements) feed information back to the provider confirming social need gap closure using SDoH z codes
2. **What types of data do community hubs need in the referral?**
    - In the referral, we need name, phone number / contact info, and some direction on programming (e.g., need for diabetes focused programming vs. fall prevention programming
    - We would love to build a partnership that will help us understand the impact of programs on healthcare quality measures or cost of care (e.g., reduction in ED usage, lower readmissions, improved medication adherence)
3. **What type of data should be shared back with the healthcare provider through bi-directional referral or other type of reporting?**
    - Class enrollment, participant (e.g., number of sessions attended and/or completion)
    - Social needs with z-codes

Rush University Medical Center

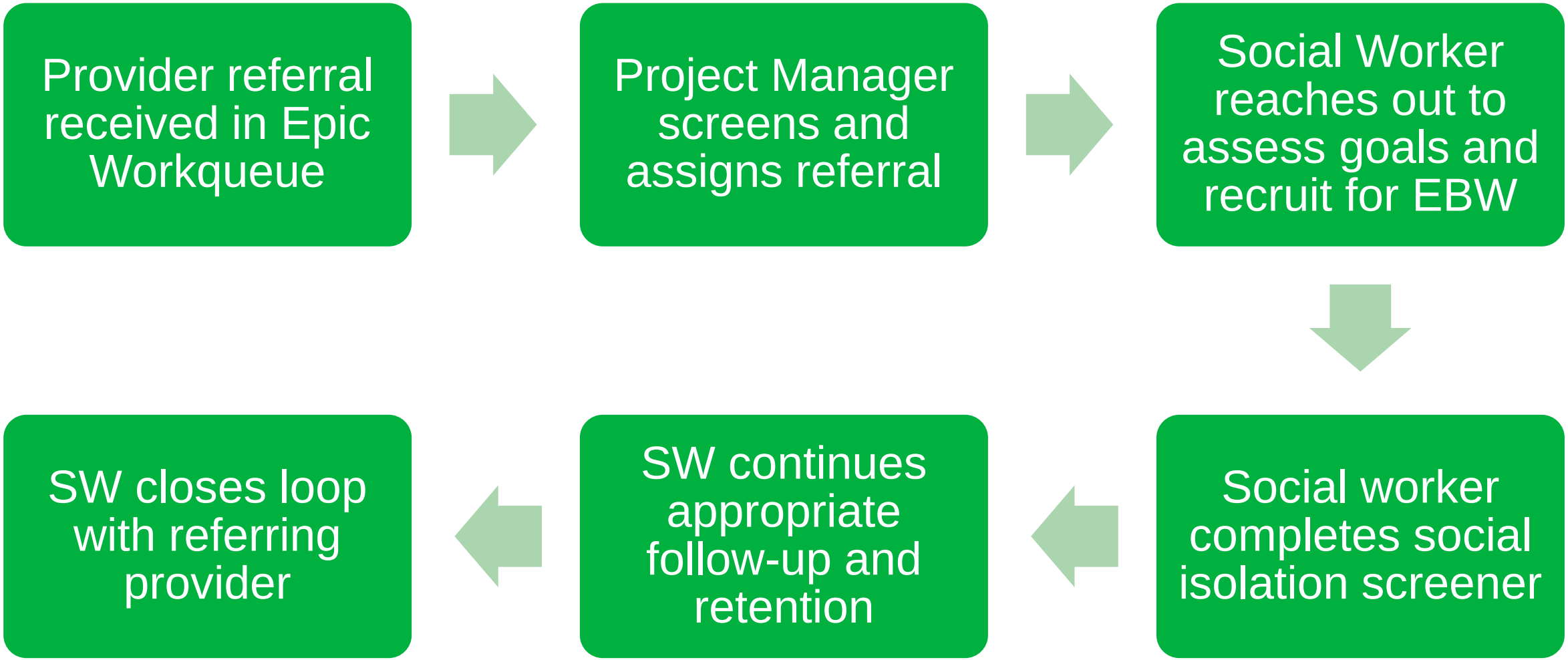
Padraic Stanley, MSW, LCSW, Program Manager of Community Integration, Health Promotion & Disease Prevention

Grisel Rodríguez-Morales, MSW, LCSW, Manager of Health Promotion Programs

Rush University Medical Center

- Connecting patients with chronic pain to our social worker, who screens and intervenes for social isolation, and recruits for CPSMP.
- We serve the West Side of Chicago, predominantly low-income Black and Latinx older adults
- Project Goals –
  - 100 CPSMP participants
  - 265/200 referrals received
- Team includes our project manager and social worker (LCSW)
- Our team and programs are integrated into Social Work department of a nonprofit hospital

Rush University Medical Center



Rush University Medical Center

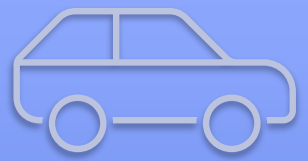
- Staff receive training in motivational interviewing and are granted the time to appropriately follow-up and engage with referrals/participants
- This has led to us having a 64% turnover rate from referral to participant, which was <5% before utilizing MI
- By understanding that the EBWs are a group, and social engagement is a key factor, we are able to address the co-occurrence of social isolation/loneliness and chronic pain

Facilitated Discussion

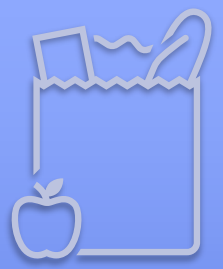
Care Coordination and AAEBIs

Uses Motivational Interviewing and Brief Action Planning to set **Personal Goals**

Help to find a **local program** that meets their needs



Assistance to arrange transportation and/or childcare



Find resources to follow personal plan

(ie. healthy food resources, exercise equipment, etc.)

Identify an **accountability partner**

Bidirectional Services eReferral (BSeR)

Heather Hodge, M.Ed., Senior Director, Equity, Access, Engagement and Health Approaches Network Experience

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

EXPLORING THE POSSIBILITIES OF BI-DIRECTIONAL COMMUNICATION BETWEEN HEALTH CARE AND COMMUNITY-BASED ORGANIZATIONS

JUNE 2023

THE CHALLENGE

Community-based organizations deliver high quality, evidence-based lifestyle programs resulting in health improvements

+

Health care providers are not aware of the programs to support their patients, have no easy way to refer to non-health care entities, and want to know how their patients do if they seek community services

=

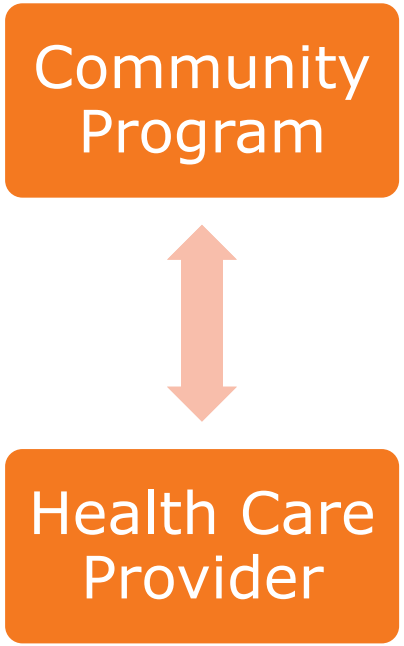
NEED:

A solution to ease the burden between health care and non-health care entities to facilitate bi-directional communication within each organization's work flows.

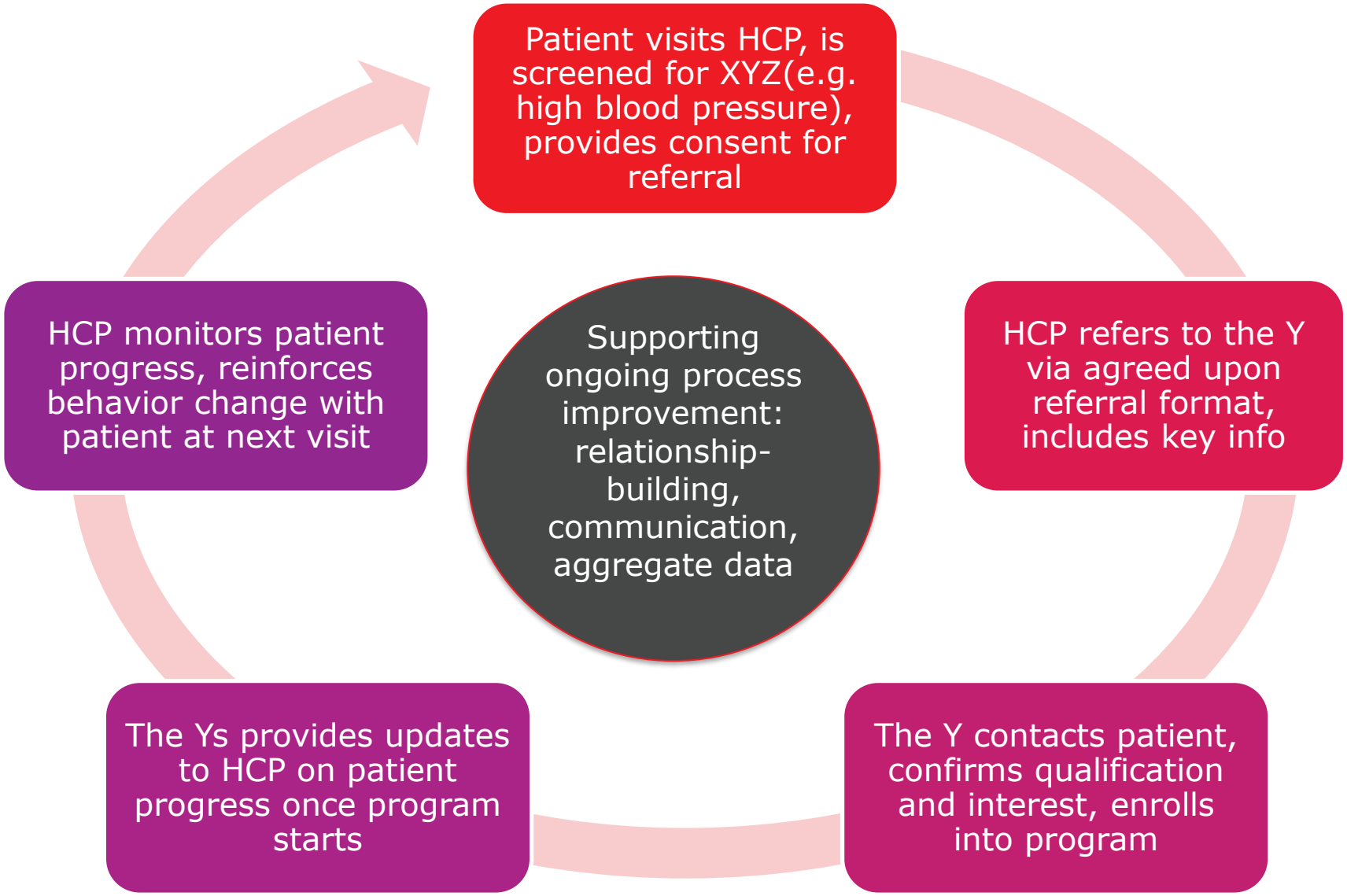
THE GOAL – INCREASE CLINIC TO COMMUNITY LINKAGES

Bi-directional e-referrals:

- Identify pathways for e-referral that reduce time and burden for health care providers making the referral to community resources easier and within their normal workflow; and
- Identify pathways for sharing participant program progress back with the health care provider and integrating participant outcomes into the patient's electronic health record.



THE BI-DIRECTIONAL PATHWAY



HL7 FHIR CONNECTATHON – SEPTEMBER 2018

FHIR – Fast Healthcare Interoperability Resources

A standard for exchanging healthcare information electronically

- Provided feedback on HL7 FHIR standards for BSeR – bidirectional services e-referral – helped to identify relevant data needed for referral across multiple public health services, including diabetes prevention
- This specification defines two transaction types, a **Referral Request** and a **Referral Feedback**.
- Began to explore opportunities for connecting FHIR to REDCap for BSeR

More detail on the FHIR BSeR standards can be found at: http://build.fhir.org/ig/HL7/bser/

INFORMING BSeR STANDARDS

One of the ongoing challenges with bi-directional referrals was facilitating the exchange of only the relevant patient data from the clinical to the community

Initial domains include:

- Diabetes prevention
- Hypertension
- Arthritis
- Obesity
- Early childhood nutrition
- Tobacco cessation

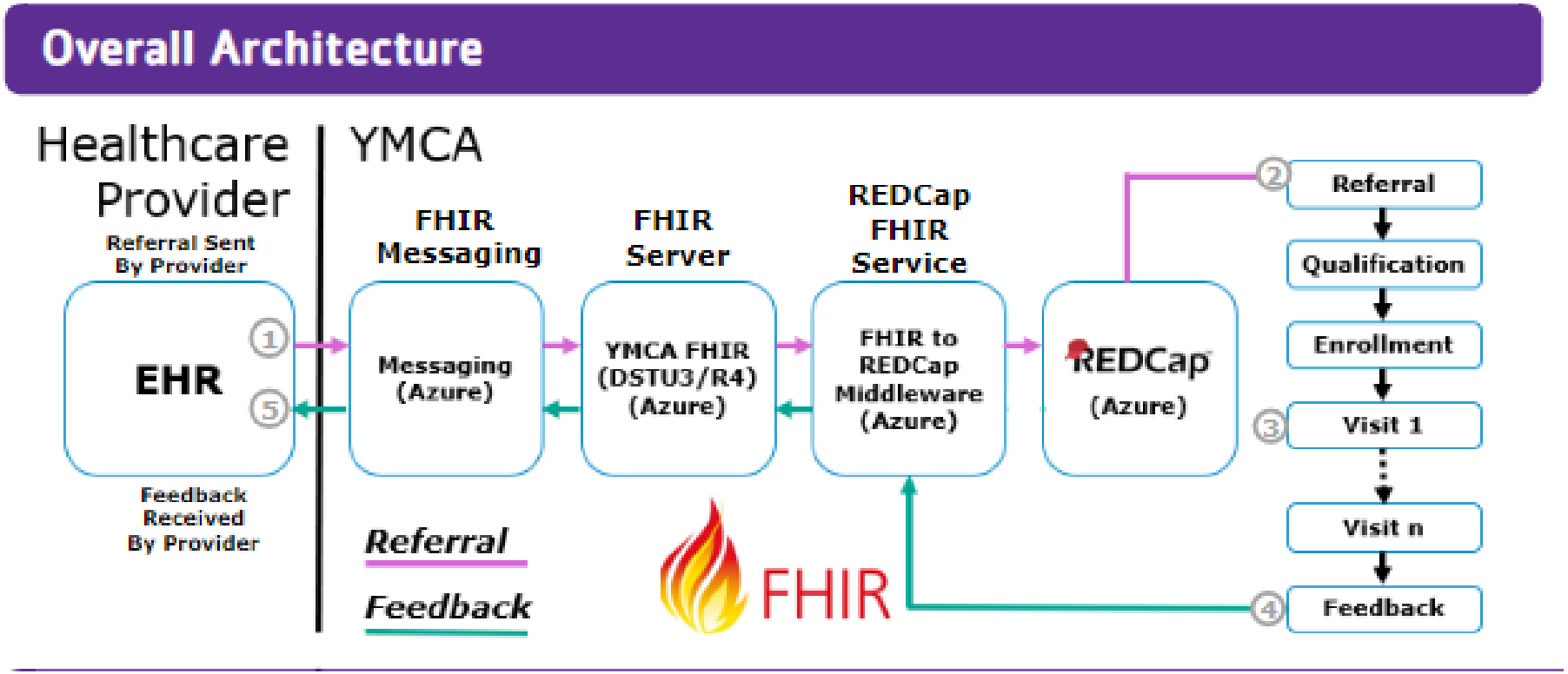
COMMON REFERRAL DATA

Common Data			
Referring Provider	**Service Provider**	**Patient**	**Transaction**
Referring Provider	**Program Organization**	**Patient**	**Referral**
providerAddress	parentOrganizationName	birthDate	identifier
providerEmailAddress	primaryContactEmailAddress	ethnicGroup	referralDateTime
providerName	primaryContactEmailTelephone	patientEmailAddress	referralNote
providerTelephone	primaryContactName	patientName	referralType
providerType	programAddress	patientPostalAddress	
	programName	patientTelephone	
Referring Provider Organization		preferredLanguage	**Feedback**
parentOrganizationName	**Program Provider**	race	activityStatus
primaryContactEmailAddress	providerEmailAddress	sex	activityStatusReason
primaryContactName	providerName		feedbackReportDate
primaryContactTelephone	providerTelephone	**Patient Consent**	feedbackReportNote
providerOrganizationAddress	providerType	consentText	referralIdentifier
providerOrganizationName			referralStatus
	Program Site	**Patient Contact Person**	referralType
	primaryContactEmailAddress	contactEmailAddress	sessionsAttendedQuantity
	primaryContactEmailTelephone	contactName	
	primaryContactName	contactTelephone	
	programSiteAddress		
	programSiteName	**Patient Insurance**	
		carrierName	
		insuranceType	

DOMAIN SPECIFIC DATA ELEMENTS

Arthritis	
Transaction	
Referral	
	Height (inches)
	Weight (lbs.)
	BMI (cm/KG)
	Last taken BP systolic/diastolic
	Medication name
	Medication dose
	Medication frequency
	Allergies (Y/N)
Feedback	
	Pain Management
	pain, fatigue, frustration and isolation
	improving strength, flexibility, and endurance
	Appropriate use of medications
	Healthy eating

WORKFLOW SCHEMATIC



THANK YOU

Strategic Discussion and Workflow

Theresa Kreiser, Comagine

Shalu Garcha, NACDD

Proposed pathway

For patients age ≥18…

Screening → **Brief Advice/ Counseling** → **Referral to PA / EBI** → **Care Coordination** → **Bi-directional Feedback**

All patients (Universal Prevention for Patient Vital Signs)

No, OA Diagnosis

- Every Visit
- PAVS* +(intensity) Muscle strengthening
- Assess Readiness for Change, Risks, & Provides Brief Advice
- Prescribe PA & Refer to Community Programs

>Annual Physical & Medicare Annual Wellness

- 1. Annual Physical
  2. Medicare AWV
- Health Risk Assessment
- Risk Identification, Care Plan, Counseling
- Refer to Community Programs (e.g., PA, fall prevention, nutrition)

Coaching to support patient

Update on Patient Progress

Patients w/ Diagnosis of OA Knee /Hip

Yes, OA Diagnosis

- 1. Annual Physical
  2. Medicare AWV
  3. Knee/hip joint pain visit
- +PROMIS
- + Modifications for OA
- +Triage based on OA severity

Chief Complaint of Knees/Hips Pain & Function Limitation (no diagnosis)

- Knee/hip joint pain visit
- +PROMIS +Clinical Diagnosis

* Ensure alignment with SDOH Screeners

Jamboard

Thank you!