WEBINAR

Inclusive Alliance

Community Care Hub

Community Health Worker Pilot

Wednesday

January 22, 2025

TIME

12- 1 PM

inclusivealliance.org

Logistics & Learning Objectives

- Logistics:
  - Please send your questions in by using the Q&A box in Zoom
  - Slides & recording will be posted to the IA website

- By the end of this webinar you should know:
  - Expectation of pilot sites and process to express interest
  - Next steps to get involved

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Pilot Funding

How We Got Here

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- **Main challenge and goals:**
  - *Challenge 1: AAAs in NY are county-run Offices for the Aging (OFAs), creating cultural and legal barriers to involvement in CBO networks and a disconnect from the developing CCH*
  - *Challenge 2: Healthcare partners express support for CCH's planned offerings but neither healthcare partners nor CBOs can front start-up costs, stymieing development of contracts*
  - *Goal 1: Engage OFAs and healthcare partners in selection/codesign of CBO-delivered pilot interventions selected from a menu of successful CCH offerings aligned to HEDIS measures*
  - *Goal 2: Establish pilot contracts to test planned CCH offerings' feasibility & ROI (one pilot in each of our 8 counties) & scale successful pilots into broader CCH contracts*
- **Public Health and NWD access functions or goals:**
  - *Goal 1: Integrate CCH's screening & referral infrastructure with existing 211, ILC, & county NWD information & referral systems and emerging SDOH screening & referral platforms*
  - *Goal 2: Engage public health agencies as stakeholders in planning future CCH offerings aligned to community health indicators, filling gaps and/or bolstering existing services*

Overarching Goals

"[To] develop, expand, connect, and support sustainable, high-functioning aging and disability CCHs and their network of social care program and service providers (Hub Network) through infrastructure funding, technical assistance, and multi-level capacity building efforts that promote whole-person care through the alignment of health, public health, and social care systems."

A Community Health Worker by any other name....

Functional Definition of CHW Role

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NYS CHW Policy Manual

- Training Requirements
  - 20hr minimum training covering CDC-endorsed core competencies
  - OR 1400 hours of experience working as a CHW within the past 3 yrs
  - Basic HIPAA training
- Services
  - Health Advocacy: advocate for the client's direct needs, healthcare service needs, and connection with community-based resources
  - Health Navigation: referrals, screenings, accessing & coordinating resources, benefits enrollment, & attending visits
  - Health Education: educate to optimize health and to address barriers to accessing health care, health education, and/or community resources that incorporate the client's needs, goals, and life experience

https://www.emedny.org/ProviderManuals/CommunityHealth/PDFS/CHW_Policy_Manual.pdf

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Pathways Community Hub Model

Evidence Based Care Coordination

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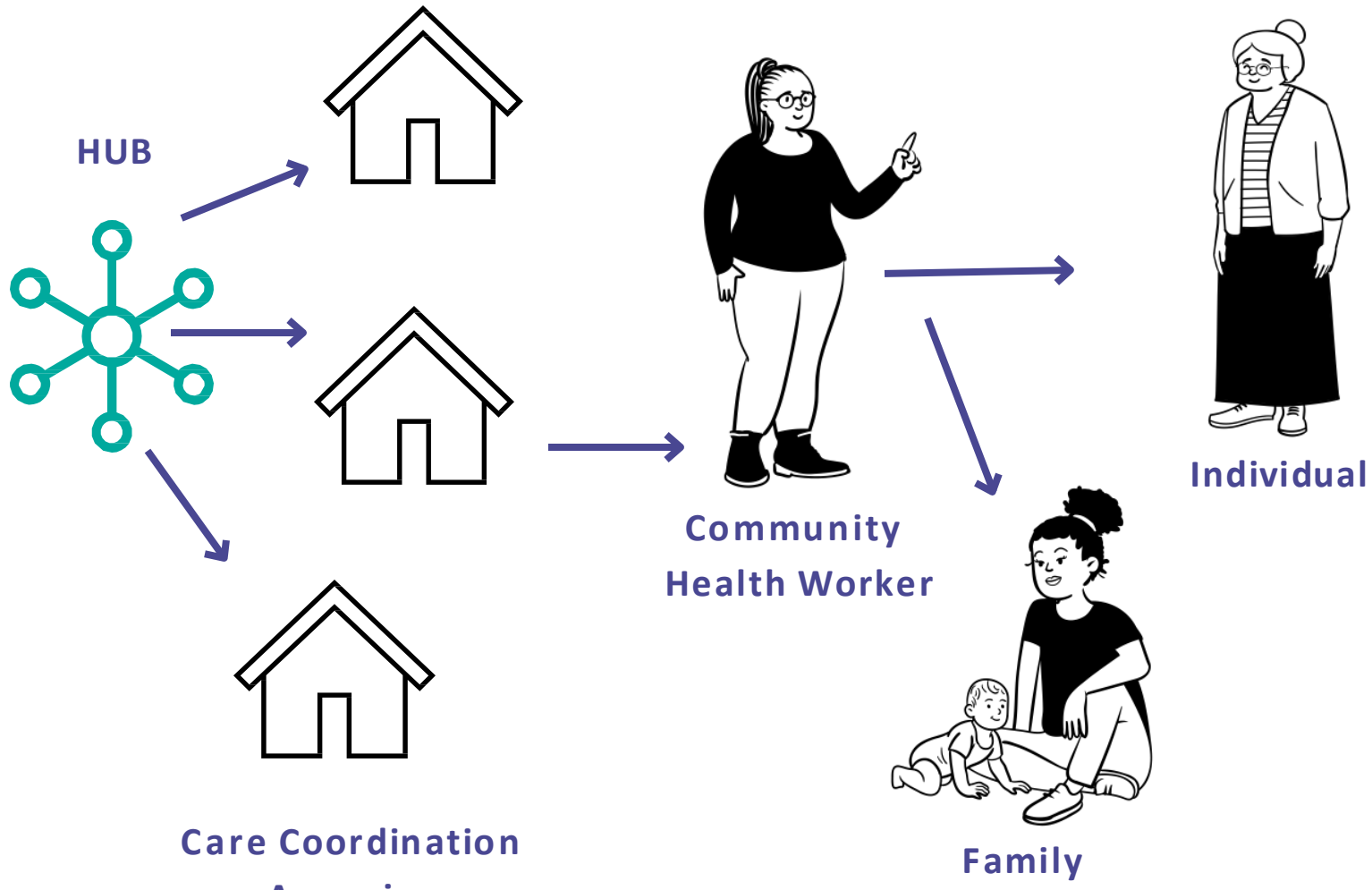
What Is a Pathways Community HUB (PCH)?

Both a standardized, evidence-based approach to community health work AND the central administrative infrastructure that supports CHWs to ensure services have measurable impact, are financially sustainable, & respond to community need



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PCH Approach to Care Coordination

1

Engage client and use standardized assessment to identify modifiable individual, family, and household risk factors:

- Lack of a Medical Home
- Lack of Stable Housing
- Lack of Access to Food
- Lack of Prenatal Care
- Lack of Stable Employment
- Lack of Consistent Transportation
- Lack of Mental Health Care
- Lack of Substance Use Treatment
- + many more

2

Mitigate identified risk factors by assigning & working with client to complete standardized "Pathways" (set of action & completion steps):

- Medical Home Pathway
- Housing Pathway
- Food Security Pathway
- Pregnancy Pathway
- Employment Pathway
- Transportation Pathway
- Mental Health Pathway
- Substance Use Pathway
- +13 more

3

Track/measure outcomes

- Medical Home Established
- Housing Established
- Food Security Achieved
- Normal Birth Weight Infant
- Employment Achieved
- Transportation Established
- Mental Health Care Received
- Substance Use Treatment Received
- +13 more

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Community Health Workers

Community health workers (CHWs) are KEY to the PCH model

- Job titles include but are not limited to: promotores/promotoras, navigators, care coordinators, care connectors, referral coordinators, peers, health coaches, etc.
- Provide care coordination services and are employed by care coordination agencies throughout the community
- Practice Whole Person, Whole Family Care
- Coordinates, partners, coaches and advocates
- Trained & supervised to deliver the PCH model to fidelity
- Represented on the Community Advisory Council

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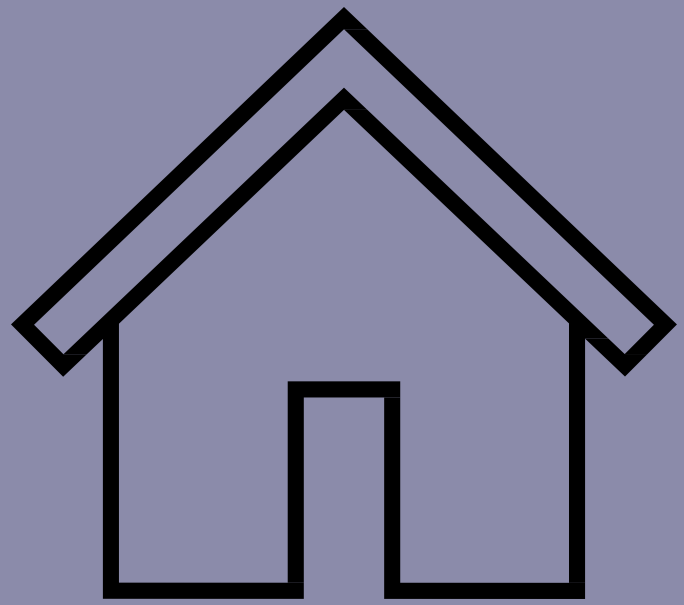
Care Coordination Agencies

Community-based organizations, clinics, & other entities

- Employs CHWs to:
  - Find community members at greatest risk
  - Visit enrolled participants in their homes
  - Identify individually modifiable risks
  - Use standardized Pathways to track risk mitigation
  - Provide “whole-person” care and “whole family” care
- Contracts with the HUB on an outcome-basis to be reimbursed for risks that were successfully mitigated (earned revenue – unrestricted)
- Represented on the Community Advisory Council



Attribution: Pathways Community HUB Institute®

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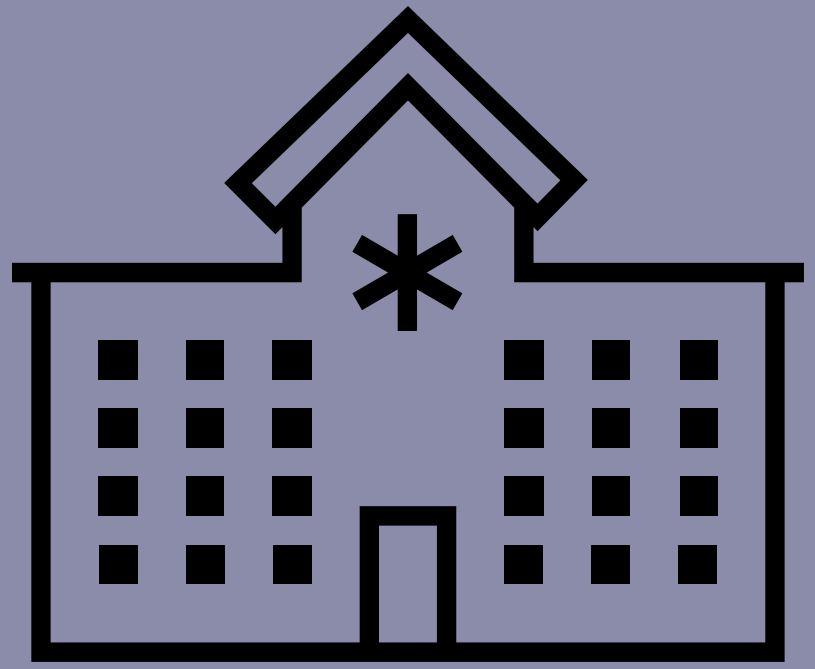
Referral Partners

Other CBOs, Providers & Community Stakeholders

- Refer their patients/clients to the HUB for services
- Accept referrals from CHWs working to connect participants to services:
  - Medical Care
  - Mental Health
  - Substance use treatment
  - Housing
  - Food
  - Transportation
  - Etc.
- Benefit from HUB data about needs & improved social service safety net
- Represented on the Community Advisory Council



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The Inclusive Alliance Community Care Hub

Phase 1 Pilots

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USAging Grant Overview

- Timeline: June 1, 2024 – May 31, 2026
- Population: Older adults & adults with disabilities enrolled in Medicare
- Geography: 8 HFWCNY counties (Cayuga, Cortland, Herkimer, Madison, Oneida, Onondaga, Oswego, & Tompkins counties)
- Primary participants
  - Inclusive Alliance member CBOs serving older adults & adults with disabilities
  - Healthcare entities identified by member CBOs as ideal partners
  - The Office for the Aging (OFA) in each county
- Key partners: HealtheConnections & OCIDN, Omnes, ICAN, & NYAging IPAs

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Grant Phases

Phase 1 – Primary Launching Focus

- 2 member CBOs pilot Pathways care coordination with a local healthcare partner using Medicare community health integration (CHI) codes
- Implement Pathways Community hub incl. data analysis & contracts for older adults and adults with disabilities

Phase 2 – Anticipated Future Funding Focus

- Expand existing pilot organization operations or establish new pilot CBOs to implement Pathways care coordination for perinatal & Medicaid populations

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Implementation Plan

- 2 CBOs pilot Pathways Community Hub care coordination model with local hospital or physician group leveraging CHI codes
- Priorities
  - One rural & one urban site
  - Healthcare partner serving large number of Medicare eligible adults & CBO with particular expertise serving older adults
  - Healthcare partner serving large number of Medicare eligible adults with disabilities & CBO with particular expertise serving adults with disabilities
- Seed funding available for:
  - Backfill & travel for pilot staff training
  - Technology (e.g., EHR enhancement, tablets, etc.)
  - Payment for pilot services prior to Medicare billing reimbursement

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Roles & Responsibilities

(subject to revision)

Inclusive Alliance	CBO	Healthcare Partner
• Training • Platforms for documenting services & automating text & phone outreach • Contracting • Coding, billing & payment • Technical assistance • Project management • Data analysis & QA • Seed funding	• Engages OFA and healthcare partner regarding pilot proposal • Reviews, refines, & approves proposed service workflow • Provides staff time of existing care coordinator/navigator/CHW, supervision & general worksite overhead • Provides company vehicle OR policy regarding staff use of personal vehicles for service delivery • Accepts referrals & delivers service, documenting in IA's platform	• Reviews, refines & approves proposed service workflow • Identifies eligible clients • Provides referrals using preferred platform/referral process • As part of approved workflow, identifies information required to close the information loop and desired reporting mechanism

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Pilot Participation

How To Get Involved

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Pilot Opportunity Overview

1. Up to $50,000 per pilot available to subsidize CHW personnel costs, backfill & travel to attend training, cell phone & laptop/tablet, mileage, printing, etc.
2. Deliver Pathways Community HUB-style community health worker (CHW) services to Medicare members (older adults and adults with disabilities)
3. Adopt IPA-provided, Pathways Community Hub Institute (PCHI) certified IT platform to document assessments & services
4. Partner with IPA, local Office for the Aging, and at least one healthcare partner to establish & deploy inbound referral processes
5. Refine outbound referral processes with primary referral partners
6. Attend quarterly Community Advisory Council and check in meetings
7. Inform and participate in ongoing IPA-led CHW in-service training and quality improvement programs

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Member Requirements

1. Maintain IPA membership in 2025
   - Selected pilot organizations must execute service agreement with IPA
2. Already employ staff member with capacity to devote up to 50% of time to delivering Pathways CHW services
   - Employee must have access to either a company-owned vehicle for client home visits OR personal vehicle available for use under existing organizational policy
3. Existing supervisory capacity
4. Both CHW and supervisor MUST attend required training (to be scheduled)
5. Complete the (short) Request for Information

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Request for Information

2 Options:

- Serve as a pilot site under **THIS** funding opportunity focused on older adults and adults with disabilities

AND/OR

- Serve as a pilot site under *anticipated future funding* opportunity focused on perinatal & Medicaid populations

Request for Information Includes:

1. Organizational Information
2. Indication of Interest (now and/or later)
3. Experience Delivering CHW like services
4. Ability to Reach Priority Population
5. Partnerships incl. OFA & Healthcare Entity
6. Optional: Ability to Reach Special Sub-populations Experiencing Disparities
7. Budget Request

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Timeline & Next Steps

- Webinar 1/22
- RFI released 1/28
- FAQ released 2/4
- CHW workflow small group discussion with HealtheConnections 2/19
- RFI Responses due 2/21
- Selected pilots notified 2/28
- Required Training & pre-launch activities: March/April
- Pilots launch: April/May
- Pilot conclusion: March/April 2026

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QUESTIONS

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Stay Involved & Get in Touch!

Lauren Wetterhahn, Executive Director
- Lauren.Wetterhahn@inclusivealliance.org
- 315-899-1043

Nicole Hall, Director of Programs
- Nicole.Hall@inclusivealliance.org
- 315-971-0398

Salina Fasulo, Manager of Operations
- Salina.Fasulo@inclusivealliance.org
- 315-887-8233

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- Sign up for our Network Scoop newsletter
- Visit our website: inclusivealliance.org