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Care Transitions ECHO Series
Overview and Event Guide

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Care Transitions: Building Partnerships to Support Health Related Social Needs

Series Overview

In January 2024, HHS Administration for Community Living (ACL) invited hospitals, health systems, Accountable Care Organizations (ACOs) and community-based organizations (CBOs) to a special series of learning events and discussions around collaborative approaches to screening for health–related social needs (HRSN), connecting with community-based social services, and supporting transitions pre- and post-discharge.

The goal of the series was to provide tools and content to help organizations leverage community partnerships and assets to address patients' unmet health-related social needs. This learning opportunity used the Extension for Community Healthcare Outcomes (ECHO) Model®, an "all teach, all learn" approach to peer-based learning. Organizations and partnerships learned actionable strategies to implement in their own organizations from leaders with successful approaches to HRSN screening, referral, and care transition programs.

Using this Curriculum

This ECHO Series curriculum document includes a session overview and links to speaker presentations (available via YouTube). Additionally, supporting resources are provided to supplement speaker content.

This curriculum and the series topics themselves were ordered in a sequence meant to mirror the hospital transitions process, starting with HRSN screening, SDOH billing and coding, staff communication, building linkages to identified health-related social needs, streamlining CBO partnership, concurrent billing, and post-discharge patient engagement. While it is not necessary to follow the curriculum in sequence, each session builds upon previous session content and can be effective when viewed in order.

If you have questions about this curriculum or about care transitions in general, reach out to ACL at caretransitions@acl.hhs.gov.

Topic: Impact of Social Needs on Transitions from Hospital to Home

Overview:

This session focuses on current policies and requirements for addressing health-related social needs including:

- Joint Commission requirements
- Impact of FY2024 Inpatient Prospective Payment Systems (IPPS) Rule and mandatory reporting
- HRSN screening requirements
- Physician Fee Schedule rule and billing codes
- FY 2024 final rule classifying homelessness as Medicare Severity Diagnosis Related Groups (MS-DRGs)

Presentation Link & Description
Speaker: Tim McNeil, RN, MPH, Freedmen's Health **Link:** **Overview of HRSN Screening Requirements & Opportunities for Hospital and CBO Partnership - YouTube (15 mins)** **Description:** Tim McNeill, RN, MPH, and CEO of Freedmen's Health presents an overview and results from an AHRQ project focused on assessing, addressing, and aligning SDOH factors to improve patient outcomes during discharge. He also shares policies and opportunities related to Health-Related Social Needs (HRSNs) screening and care transitions, including Z codes, the Inpatient Prospective Payment System (IPPS) rule, Joint Commission Health Care Disparities requirements, reimbursement opportunities post-discharge, and Community Health Integration (CHI) services.

Supporting Resources:

- HEDIS MY 2023: See What's New, What's Changed and What's Retired - NCQA
- New Requirements to Reduce Health Care Disparities - Joint Commission
- FY 2027 IPPS Final Rule Home Page | CMS
- Improving and Promoting Social Determinants of Health at a System Level
- Enhancing Support for Patients' Social Needs to Reduce Hospital Readmissions and Improve Health Outcomes

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Topic: Screening for Health-Related Social Needs

Overview:

This session focuses on navigating the new screening requirements, what some of the roadblocks are to achieving success; how to document and identify trends in social needs, and when and how to connect with CBO partners.

Presentation Link & Description
Speaker: Caroline Fichtenberg, PhD, Social Interventions Research and Evaluation Network (SIREN) **Link:** **Promising Practices for HRSN Screening and Collaboration Between Hospitals and CBOs - YouTube (15 minutes)** **Description:** Caroline Fichtenberg, PhD, Co-Director Social Interventions Research and Evaluation Network (SIREN), University of California, San Francisco, provides background on the Social Interventions Research & Evaluation Network (SIREN). Her presentation includes an overview of the acceptability of HRSN screening by patients and caregivers; promising screening practices; suggestions for training staff on screening for social risks; and ways to build trust during the screening process.

Topic: Communication Pathways

Overview:

This session focuses on the importance of communication as the connective tissue that bridges each step of the process that supports the development of a patient's person-centered discharge plan back to the community. The TEAMS STEPPs evidence-based framework and tools are presented including a case study that describes how a hospital and CBO network implemented communication workflows to expedite referrals and communications necessary to ensure service delivery and documentation post-discharge.

Presentation Link & Description
Speaker: Tim McNeill, RN, MPH, Freedmen's Health **Link:** **An Overview of HRSN Screening Measure and Requirements and Clinical-CBO Handoffs and Application - YouTube (15 minutes)** **Description:** Tim McNeill, RN, MPH, and CEO of Freedmen's Health provides an overview of Health Related Social Needs (HRSN) screening measure requirements and goals. He also presents on clinical and Community Based Organization (CBO) handoffs and application, pathways to success and sustainability, Community Health Integration (CHI) and Principal Illness Navigation (PIN) codes, and CHI application of transitions of care to address HRSNs identified during an inpatient admission.

Supporting Resources:

- TeamSTEPPS Homepage - AHRQ
- Cross-Sector Data Sharing to Address Health-Related Social Needs: Lessons Learned from the Accountable Health Communities Model (cms.gov)
- Medicare Physician Fee Schedule Final Rule Summary CY 2026 (cms.gov)

Topic: Methods of CBO Engagement for People in Transition

Overview:

This session focuses on how to navigate the discharge and transition process to ensure people receive the supports needed when back in the community, how use of z-codes supports referrals, documentation, and billing; how Part B codes can support post-transition CBO activities.

Presentation Link& Description
Speaker: Dr. Julia Skapik, National Association of Community Health Centers **Link:** **Understanding SDOH, Challenges in Health Equity Data Collection, and Opportunities to Advance Equity - YouTube (15 minutes)** **Description:** Dr. Julia Skapik presents on the social determinants of health as it relates to coding frameworks and interventions. Her presentation includes a historical overview of Community Health Centers, challenges to supporting data standardization and documentation of SDOH in electronic health records (EHRs), health equity data collection and quality, and opportunities to advance equity in primary care.

Supporting Resources:

- CHI Implementation Resources – Freedman's Health
- National Association of Community Health Centers - About

Topic: Short and Long-Term Supports – The Role of the CBOs and Post-Discharge Providers

Overview:

This session focuses on the importance of communication in sending as well as receiving referrals, follow up post-discharge, collaborative problem-solving, and understanding billing requirements in order to apply properly post discharge.

Presentation Link & Description
Speaker: Rebecca Holik, MSW, Partners in Care Foundation **Link:** **Recommendations for Creating Partnerships with Payors, Growing Contracts, and Building a Program - YouTube (15 minutes)** **Description:** Rebecca Holik, MSW, provides strategies to build partnerships with payors including recommendations on creating and implementing partnerships and growing contracts to bring a program to scale.

Supporting Resources:

- ICD-10-CM Coding for Social Determinants of Health
- CMS Infographic: Improving Collection of SDOH data with ICD-10-CM Z Codes
- CMS Infographic: Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes

Topic: Concurrent Billing

Overview:

Payment pathways for HRSN screening and responding to unmet needs is top of mind for healthcare providers and CBOs. This session addresses billing for care transition activities, strategies to support CBO payment, and the connection to Medicare Part B providers.

Presentation Link & Description
Speaker: Tim McNeill, RN, MPH, Freedmen's Health **Link: Overview of Concurrent Billing to Support Whole Person Care Transition Models + HRSN Interventions - YouTube (15 minutes)** **Description**: Tim McNeill, RN, MPH, and CEO of Freedmen's Health provides an overview of concurrent billing regulations, evidence supporting implementation of Community Health Integration (CHI) concurrent billing model, Transitional Care Management (TCM) as the post-discharge initiating visit, concurrent billing financial model, and shares a case study example.

Supporting Resources:

- Accountable Health Communities (AHC) Model Evaluation, 2nd Report, May 2023
- JAMA: Medicare Transitional Care Management Program and Changes in Timely Postdischarge Follow-Up
- Medicare Physician Fee Schedule Final Rule Summary CY 2026 (cms.gov)
- CHRONIC CARE MANAGEMENT TOOLKIT (cms.gov)
- Transitional Care Management Services (cms.gov)
- MLN909188 – Chronic Care Management (cms.gov)

Topic: Closing the Loop with Medicare Part B Providers

Overview:

This session focuses on closing the loop for a transition, emphasizing the important connections that must be made with Part B providers, and how CBOs can serve as the important connection with Part B providers and their patients.

Presentation Link & Description
Speaker: Nikki Kmicinski, Western New York Integrated Care Collaborative (WNYICC) **Link: Community Based Organizations Closing the Loop with Medicare Part B Providers - YouTube (15 minutes)** **Description:** Nikki Kmicinski, Executive Director, Western New York Integrated Care Collaborative (WNYICC), provides background on the organization. Her presentation includes an overview of the role of a Community Care Hub (CCH), WNYICC's programs and funding mechanisms, and the WNY Community Health Integration/Principal Illness Navigation Services.

Supporting Resources:

- USAging's Aging and Disability Business Institute Honors Western New York Integrated Care Collaborative, Inc. with The John A. Hartford Foundation 2023 Business Innovation Award - Aging and Disability Business Institute
- USAging's Aging and Disability Business Institute Honors Southern Alabama Regional Council on Aging with The John A. Hartford Foundation 2024 Business Innovation Award - Aging and Disability Business Institute
- Aging Innovations Awards_2023 (usaging.org)

Topic: Wrap Up and Celebrations

Overview:

This session provides an overview of any new national policies and relevance to this work and ongoing opportunities to further develop community partnerships. There is a didactic segment focusing on opportunities using Medicaid to support transition activities. This final series session concludes with a celebration of participants' efforts and offer participants and partnerships an opportunity to share their successes, growth, most important learnings, and plans for the future.

Presentation Link & Description
Speaker: Tim McNeill, RN, MPH, Freedmen's Health **Link: Overview of CMS FY2023 IPPS Rule & CY 2024 Physician Fee Schedule Services to Address Health Equity - YouTube (20 minutes)** **Description:** Tim McNeill, RN, MPH, and CEO of Freedmen's Health provides an overview of the Centers for Medicare and Medicaid Services (CMS) FY2023 Inpatient Prospective Payment System (IPPS) Rule Highlights and CY 2024 Physician Fee Schedule services to address health equity. He also presents on other Medicaid sustainability innovations to address homelessness, HRSNs, and more.
Speaker: Christina Neill Bowen, MSW, LICSW **Link: Opportunities to Leverage Medicaid Administrative Claiming to Sustain Care Transition Activities - YouTube (15 minutes)** **Description:** Christina Neill Bowen, MSW, LICSW, Lewin TA Team, provides an overview of Medicaid Administrative Claiming (MAC), No Wrong Door (NWD) Functions Supporting Care Transitions that are eligible for claiming, and how organizations can get started.

Supporting CMS Resources:

- Fact Sheet: Calendar Year (CY) 2025 Medicare Physician Fee Schedule Proposed Rule (CMS-1807-P)-Medicare Shared Savings Program Proposals
- FY 2027 IPPS Final Rule Home Page | CMS
- Medicare Physician Fee Schedule Final Rule Summary CY 2026 (cms.gov)
- Cross-Sector Data Sharing to Address Health-Related Social Needs: Lessons Learned from the Accountable Health Communities Model
- CMS Infographic: Improving Collection of SDOH data with ICD-10-CM Z Codes

- CMS Infographic: Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes
- Transitional Care Management Services
- Chronic Care Management

Supporting Medicaid Claiming Resources:

- ACL: Leveraging Medicaid Administrative Claiming for No Wrong Door Systems
- Iowa Uses Medicaid Administrative Claiming to Help Fund Care Transitions
- Medicaid Administrative Claiming – time tracking
- Looking to strengthen the Medicaid role in your NWD System????
- Care Transitions in Oregon's Aging and Disability Resource Centers