CCH National Learning Community

Network Expansion Participant Profiles

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CCH National Learning Community Participant Profile

Network: AgingCT/Network Connections
Community Care Hub: Southwestern Connecticut Agency on Aging, Inc.

Lead Contact: Marie Allen; mallen@swcaa.org
Co-Lead Contact: Melissa Lang; mlang@aoascc.org

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
State of Connecticut

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Case Management
- Assessment for Social Determinants of Health (SDOH),
- Housing Assistance
- Other: LTSS Provider Network

Network Partners:

- Department of Social Services
- VA CT Healthcare System
- MS Society

Public Health Partnership: Norwalk CT Public Health Department and New Haven Public Health Department

- Is part of a workgroup or coalition that includes public health department
- Provides programming or services
- Public health department serves as subject matter expert
- Serves as subject matter experts for public health department
- Cooperates on COVID responses

Housing Partnership:

- Coordination or referrals

Federally Qualified Health Center:

- Provides programming or services
- Serves as subject matter expert
- FQHC serves as subject matter experts

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Area Agency on Aging of Western Michigan
Community Care Hub: Area Agency on Aging of Western Michigan

Lead Contact: Kendrick Heinlein; Kendrick@aaawm.org
Co-Lead Contact: Suzanne Filby-Clark; Suzanne@aaawm.org

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
9 Counties of Michigan

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH),
- Housing Assistance

Network Partners:

- Area Agency on Aging of Western Michigan currently has over 56 network partners

Public Health Partnership: Michigan Department of Health and Human Services

- Is part of a workgroup or coalition that includes public health department
- Provides programming or services
- Public health department serves as subject matter expert
- Serves as subject matter experts for public health department
- Has representation from public health partner on their board
- Contracted to provide services

Housing Partnership:

- Contract or other financial arrangement in place
- Co-location of staff
- Coordination of referrals

Federally Qualified Health Center:

- Is part of a workgroup or coalition that includes FQHC
- Provides programming or services
- FQHC serves as subject matter expert
- Cooperates on COVID responses

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Adults (age 18 to 65) without a disability, impairment, or chronic illness Individuals with chronic illness
- Caregivers of any age

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Profile

Network: VAAACares®
Community Care Hub: Bay Aging – Area Agency on Aging

Lead Contact: Kathy Vesley; kvesley@bayaging.org
Co-Lead Contact: Fran Anderson; fanderson@bayaging.org

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Health Care Contracts

Network Expansion Track

Geographic Coverage:

State of Virginia and 6 additional states with VMC Veterans Directed Care

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g, meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Case Management
- Assessment for Social Determinants of Health (SDOH)

Network Partners:

- Health Plans
- Health Systems
- Veterans Administration Medical Centers
- Housing Agencies
- AAAs
- CILs

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age
- Children (up to age 18)

Public Health Partnership: Virginia Department of Health and Bay Rivers Telehealth Collaborative

- Is part of a workgroup or coalition with public health partner
- Provides programming or services
- Serves as subject matter experts
- Public health partner serves as subject matter experts
- Has representation from public health partner on their board

Housing Partnership:

- A Memorandum of Understanding (MOU)
- Contract or other financial arrangement in place
- Co-location of staff
- Cross training of staff
- Coordination of referrals

Federally Qualified Health Center:

- Is part of a workgroup or coalition with FQHC, provides programming or services
- Has representation from FQHC on their board

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Beacon Community Connections (VIA Network)
Community Care Hub: Beacon Community Connections – CBO

Lead Contact: Holly Howat; holly.howat@beaconconnections.org
Co-Lead Contact: Mark Evans; mark.evans@beaconconnections.org

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
Multiple Counties in Louisiana

Network Services:

- Non-clinical case management
- Care Transition Support
- Person-centered Planning
- Other: Resource connection and follow-up

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age
- Children (up to age 18)

Network Partners:

- Ochsner Lafayette General
- Lourdes Regional Health
- Lafayette Parish Sheriff's Office
- Acadiana Area Human Services District
- Hospice of Acadiana
- United Way of Acadiana
- 232-HELP/LA211
- Lafayette City Marshal's Office
- Lafayette Council on Aging
- Louisiana Department of Child and Family Services
- Rebuilding Together Acadiana
- Second Harvest
- Acadiana Regional Coalition on Homelessness
- Blue Cross and Blue Shield of Louisiana
- Governor's Office on Elderly Affairs
- Goodwill Industry of Acadiana

Public Health Partnership: Louisiana Office of Public Health, Region 4, Acadiana Area Human Services District, and Louisiana Bureau of Family Health

- Is a part of workgroups and coalitions that also includes their public health department
- Provides programming or services, serves as a subject matter expert, and
- Cooperates on COVID and disaster responses

Housing Partnership:

- Coordination of referrals

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Camden Coalition Regional Health Hub
Community Care Hub: Camden Coalition (other CBO)

Lead Contact: Natasha Dravid; ndravid@camdenhealth.org
Co-Lead Contact: Victor Murray; vmurray@camdenhealth.org

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
Camden, New Jersey

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness

Network Partners:

- Cooper University Health Care
- Jefferson Health NJ
- Virtua Health System
- Inspira Health Network
- CAMcare Health
- Project HOPE
- Oaks Integrated Care
- Ascenda Integrated Health
- Southern New Jersey Perinatal Cooperative
- Horizon NJ and
- Camden County Health Department

Public Health Partnership: Camden County Department of Health/Division of Senior and Disabled Citizens

- Provides programming and services and is contracted by public health department to provide services
- Cooperates on COVID responses

Housing Partnership:

- A Memorandum of Understanding (MOU)
- Contract of other financial arrangement in place

Federally Qualified Health Center:

- Is part of a workgroup or coalition that also includes FQHC
- Provides programming or services and is contract by FQHC to provide services
- Has representation from FQHC on their board
- Cooperates on COVID responses

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Community Care Hub of the Piedmont Triad
Community Care Hub: Piedmont Triad Regional Development Corp.

Lead Contact: Matthew Dolge; mdolge@ptrc.org
Co-Lead Contact: Adrienne Calhoun; acalhoun@ptrc.org

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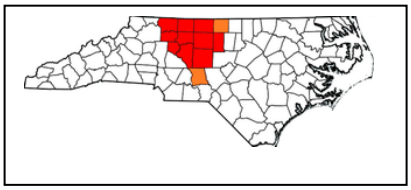
Health Care Contracts

Network Expansion Track



Geographic Coverage:
12 Counties of the Piedmont Triad Region of North Carolina

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Support
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Case Management/Care Coordination
- Assessment for Social Determinants of Health
- Housing Assistance/Home Modifications
- Adult Day Services
- Criminal Justice Services
- Workforce Development
- Other – Natural Supports

Network Partners:

- BC/BS Green and Healthy Homes
- Triad Healthcare Network
- United Way of Greater Greensboro
- UNC Cares for Money Follows the Person
- 56 Providers of CBS that include: for-profits, not-for-profits and county government agencies
- 75 Member Municipalities

Public Health Partnership: Forsyth, Guilford, and Rockingham County Health Departments

- Is part of a workgroup or coalition that also includes public health department
- Public health department serves as subject matter expert
- Has representation from public health department on their board
- Cooperates on COVID responses

Housing Partnership:

- A Memorandum of Understanding (MOU)
- Contract or other financial arrangement in place
- Cross training of staff
- Coordination of referrals
- Other: Forsyth County Planning grant to help design an inclusive housing community (I/DD)

Federally Qualified Health Center:

- Is part of a workgroup or coalition that also includes FQHC
- Provides programming or services
- FQHC serves as subject matter expert
- Serves as subject matter expert for FQHC

Populations Served:

- Older adults (age 60+)
- Individuals with disability or impairment (18+)
- Individuals with chronic illness (18+)
- Veterans
- Caregivers of any age

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Community Care Link (CCL): https://www.agingfundnyc.org/ccl
Community Care Hub: Dept. for the Aging/Aging in NY Fund – Area Agency on Aging

Lead Contact: Meghan Shineman; mshineman@aging.nyc.gov
Co-Lead Contact: Maritza Arroyo; marroyo@aging.nyc.gov

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
New York City, New York

Network Services:

- Assessment for Social Determinants of Health (SDOH)
- Navigation to preventive health services
- Person-centered Planning
- Case Assistance/Management
- Benefits & Entitlement assistance
- Care Transition Support
- Transportation
- Health Promotion: Self-management and Evidence-based Programs
- Caregiver Support
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Behavioral Health
- Housing Assistance
- Elder Abuse services

Network Partners:

- Healthfirst Medicare Advantage
- Bay Ridge Center
- Carter Burden Network
- Jewish Association Serving the Aging (JASA)
- Jewish Community Center of Staten Island
- Neighborhood Self Help by Older Persons Project, Inc. (NSHOPP)
- PSS
- SAGE
- Selfhelp Community Services
- Sunnyside Community Services

Populations Served:

- Older adults (age 60+)
- Caregivers of any age
- Historically disinvested and underserved communities

Public Health Partnership: NYC Department of Health and Mental Hygiene (DOHMH)

- Is part of a workgroup or coalition that includes public health department
- Public health department serves as subject matter expert
- Serves as subject matter experts for public health department
- Cooperates on COVID responses
- Other: ANYF/Community Care Link often applies to grants that partners with NYC DOHMH

Housing Partnership:

- Cross training of staff of NYC governmental agencies
- Coordination of referrals
- Other: Some of Community Care Link's network CBOs offer housing assistance services internally

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Community Care Solutions
Community Care Hub: SARCOA – Area Agency on Aging

Lead Contact: Dave Crocker; david.crocker@sarcoa.org
Co-Lead Contact: Joel Bass; joel.bass@sarcoa.org

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
18 Counties of Alabama

Network Partners:

- Blue Cross Blue Shield of Alabama
- Central Alabama Aging Consortium
- Southern Clinic

Populations Served:

- Older adults (age 60+ or 65+, as defined by the
- program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age

Public Health Partnership: Southeastern District Public Health Department

- Provides programming or services

Network Services:

- Care Transition Support
- Transportation
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers,
- SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- Other: Preventative Gaps in Care Education/Closure

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Connecticut Healthy Living Collective
Community Care Hub: Connecticut Community Care, Inc. - CBO

Lead Contact: Sherry Ostrout; sherry.ostrout@ctcommunitycare.org
Co-Lead Contact: Karen Green; karen.green@ctcommunitycare.org

Geographic Coverage:
State of Connecticut

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Health Care Contracts

Network Expansion Track

Network Services:

- Care Transition Support
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Assessment for Social Determinants of Health (SDOH),
- Housing Assistance

Network Partners:

- Senior Centers
- YMCA's
- Local Public Health Departments and Districts
- Community Centers
- Faith Organizations
- LGBTQ+ Serving Organizations
- Network Development Partners - New England Collaborative for Evidence Based Programs (Agespan)

Public Health Partnership: State of CT Department of Public Health; Local Public Health Departments and Districts

- Is part of a workgroup or coalition that includes public health department
- Provides programming or services
- Public health department serves as subject matter expert
- Serves as subject matter experts for public health department
- Has representation from public health partner on their board

Housing Partnership:

- A Memorandum of Understanding (MOU)
- Contract or other financial arrangement in place
- Co-location of staff

Federally Qualified Health Center:

- Part of a workgroup or coalition that includes FQHC

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Council on Aging of Southwestern Ohio
Community Care Hub: Council on Aging of Southwestern Ohio - AAA

Lead Contact: Judy Eschmann; jeschmann@help4seniors.org
Co-Lead Contact: Kim Clark; kclark@help4seniors.org

Geographic Coverage:
Southwestern and Central Ohio; Northern Kentucky

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Health Care Contracts

Network Expansion Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH),
- Housing Assistance

Network Partners:

- Aetna
- Molina
- Humana
- Med Mutual
- Passport
- Butler, Clinton, Hamilton and Warren Board of County Commissioners
- Other: Is part of a contracted network of over 340 community partners

Public Health Partnership: Hamilton, Cincinnati, Clermont, Butler, Clinton, and Warren County Health Departments

- Is part of a workgroup or coalition that includes public health department
- Provides programming or services
- Public health department serves as subject matter expert
- Serves as subject matter experts for public health department
- Cooperates on COVID responses

Housing Partnership:

- Coordination of referrals

Federally Qualified Health Center:

- Is part of a workgroup or coalition that includes FQHC
- FQHC serves as subject matter expert
- Serves as subject matter expert for FQHC
- Has representation from FQHC on their board
- Cooperates on COVID responses

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Caregivers of any age

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Direction Home Ohio
Community Care Hub: Direction Home LLC (other CBO)

Lead Contact: Larke Recchie; recchie@ohioaging.org
Co-Lead Contact: Beth Kowalczyk; kowalczyk@ohioaging.org

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Health Care Contract

Network Expansion Track

Geographic Coverage:
State of Ohio

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Support
- Caregiver support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- Other: Development of Natural Supports

Network Partners:

- Council on Aging of Southwestern Ohio
- Area Agency on Aging 2
- Area Agency on Aging 3
- Area Office on Aging of Northwestern Ohio
- Ohio District 5 Area Agency on Aging
- Central Ohio Area Agency on Aging
- Area Agency on Aging 7
- Buckeye Hills Regional Council
- Area Agency on Aging 9
- Western Reserve Area Agency on Aging
- Direction Home Akron Canton
- Direction Home of Eastern Ohio

Public Health Partnership: Ohio Health Department

- Is part of a workgroup or coalition that also includes public health department
- Provides programming or services
- Public health department serves as subject matter expert
- Cooperates on COVID responses

Housing Partnership:

- Memoranda of Understanding (MOU) with housing developers
- Contract of other financial arrangement in place
- Co-location of staff for service coordination
- Coordination of referrals

Federally Qualified Health Center:

- Is part of a workgroup or coalition that also includes FQHC
- FQHC serves as subject matter expert
- Serves as subject matter expert for FQHC
- Cooperates on COVID responses

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Healthy Alliance
Community Care Hub: Healthy Alliance (other CBO)

Lead Contact: Kristen Scholl; kristen.scholl@healthyalliance.us
Co-Lead Contact: Erica Coletti; erica.coletti@healthyalliance.us

Geographic Coverage:
25 Counties of New York

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Health Care Contracts

Network Expansion Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Support
- Caregiver support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- Coordination of referrals

Network Partners:

- Healthy Alliance has over 160 partner organizations representing: city and county social service agencies, health care providers, multi-cultural groups, faith-based organizations and many others. For a complete list please contact the CCH lead.

Public Health Partnership: Schenectady County Public Health Department and Rensselaer County Mental Health Department

- Is part of a workgroup or coalition that also includes public health department
- Public health department serves as subject matter expert
- Has representation from public health department on their board
- Other: public health partner is a contracted Healthy Alliance affiliate

Housing Partnership:

- Contract or other financial arrangement in place
- Coordination of referrals

Federally Qualified Health Center:

- Is part of a workgroup or coalition that also includes FQHC
- FQHC serves as subject matter expert
- Serves as subject matter expert for FQHC
- Has representation from FQHC on their board

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age
- Children (up to age 18)

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Profile

Network: Healthy Living for ME (HL4ME)
Community Care Hub: Healthy Living for ME – Area Agency on Aging

Lead Contact: Gerard Queally; gqueally@healthylivingforme.org
Co-Lead Contact: Maija Dyke; mdyke@healthylivingforme.org

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
State of Maine

Network Services:

- Care Transition Support
- Person-centered Planning
- Case Management
- Resource connection and follow-up
- Evidence-based programs

Network Partners:

- Aetna DSNP
- All the Difference
- Anthem Blue Cross Blue Shield (via Ground Game Health)
- Aroostook Area Agency on Aging
- Boothbay Regional YMCA
- Bridges Home Services
- Cary Medical Center
- Catholic Charities Maine
- CLC YMCA
- CMMC Trauma Program
- Eastport Healthcare Inc.
- Franklin Adult Education
- HealthReach Community Health Centers (FQHC)
- Healthy Acadia
- Kennebec Valley YMCA
- MaineGeneral Health
- Northern Light AR Gould Hospital
- Northern Light Sebasticook Hospital
- Region 9 Adult Education
- SeniorsPlus (Western Maine Area Agency on Aging)
- Spectrum Generations (Central Maine Area Agency on Aging)

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age

Public Health Partnership: Maine Center for Disease Control and Prevention (CDC)

- Is a part of a workgroup or coalition
- Provides programming or services
- Serves as subject matter experts for a public health department
- Contracted to provide services

Federally Qualified Health Center: HealthReach Community Health Centers

- Provides programming or services
- Serves as subject matter experts
- Contracted to provided services
- Cooperates on COVID responses

ACL Administration for Community Living
CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: AgeOptions/Coordinated Care Alliance

Lead Contacts: Robert Mapes; Robert.mapes@ageoptions.org
Bailey Huffman; bhuffman@coordinatedcarealliance.org

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
State of Illinois

Network Services:

- Care Transition Support
- Health Promotion Evidence-based Programs
- Caregiver support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Case Management
- Social Isolation Interventions
- Assessment for LTSS
- Care Management
- Assessment for Social Determinants of Health (SDOH)
- Information and Assistance/Referral

Network Partners:

- AgeOptions/Coordinated Care Alliance has over 50 partner organizations representing: city and county social service agencies, health care providers, multi-cultural groups, faith-based organizations, and many others. For a complete list please contact the CCH lead.

Public Health Partnership: Kankakee, Effingham, DuPage Henry, LaSalle, McDonough, Rock Island, McHenry, Cook, and Knox County Health Departments

- Is part of a workgroup or coalition that also includes public health department
- Public health department serves as subject matter experts
- Provides programming or services and is contracted to provide services
- Cooperates on COVID responses
- Are in the same department with public health

Housing Partnership:

- Contract of other financial arrangement in place

Federally Qualified Health Center:

- Provides programming or services
- Cooperates on COVID responses

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Caregivers of any age

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Indiana Community Care Hub
Community Care Hub: Aging & In Home Services of NE Indiana - AAA

Lead Contact: Chris Forcucci; cforcucci@agingihs.org
Co-Lead Contact: Beth Evans; bevans@agingihs.org

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
Indiana Statewide

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH),
- Housing Assistance
- Other: Information and referral

Network Partners:

- Parkview Health System
- Allen County Board of Health
- Ford Wayne Senior Health Commission
- TRIAD
- GroundGame.Health

Public Health Partnership: Allen County Department of Health

- Is part of a workgroup or coalition that includes public health department
- Provides programming or services
- Public health department serves as subject matter expert
- Serves as subject matter experts for public health department
- Has representation from public health partner on their board
- Cooperates on COVID responses

Housing Partnership:

- Co-location of staff
- Coordination of referrals

Federally Qualified Health Center:

- Is part of a workgroup or coalition that includes FQHC
- FQHC serves as subject matter expert
- Serves as subject matter expert for FQHC

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Caregivers of any age

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Profile

Network: Juniper
Community Care Hub: Trellis – Area Agency on Aging

Lead Contact: Mark Cullen; mcullen@trellisconnects.org
Co-Lead Contact: Sarah Blonigan; sblonigan@trellisconnects.org

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
State of Minnesota

Network Services:

- Evidence-based Health Promotion Programs
- Diabetes Prevention Program
- Social Care Screening and Care Navigation

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age

Public Health Partnership: Minnesota Department of Public Health

- Is part of a workgroup or coalition with public health partner
- Provides programming or services
- Serves as subject matter experts
- Contracted to provide services

Housing Partnership:

- A Memorandum of Understanding (MOU) and Business Associate Agreement (BAA)
- Co-location of staff
- Coordination of referrals

Federally Qualified Health Center:

- Currently coordinating a relationship with an ACO comprised of FQHCs

Acute Care System:

- Memorandums of Understandings, Data Use Agreements, and Business Associate Agreements

Network Partners:

- Juniper has approximately 100 network partners who deliver services. Several other organizations offer various types of support, including cash and in-kind contributions. Juniper holds 6 D-SNP contracts with 4 health plans and is a Medicare Supplier and a Minnesota Managed Health Care Programs Provider.

ACL Administration for Community Living
CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Maryland Living Well Center of Excellence-Mac Inc.
Community Care Hub: Maryland Living Well Center of Excellence-Mac Inc. - CBO

Lead Contact: Leigh Ann Eagle; laeagle@macinc.org
Co-Lead Contact: Sue Lachenmayr; bslach@earthlink.net

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
State of Maryland

Network Services:

- Care Transition Support
- Evidence-based Programs
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Assessment for SDOH

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age

Public Health Partnership: Maryland State Health Department, along with 10 county health departments, Maryland Primary Care, Health Information Exchange, ASTHO and NACCHO

- Provides programming or services, contracted to provide services
- Has public health partner representation on their board, and
- Cooperates on COVID responses

Federally Qualified Health Center:

- Is part of a workgroup or coalition with FQHC and provides programming or services

Network Partners:

- Tidal Health, Frederick Hospital, MedStar, University of Maryland Medical Services
- ASTHO/NACCO
- Maryland Department of Aging, Area Agencies on Aging
- Chesapeake Regional Information System for Patients (CRISP) -Maryland Health Information Exchange
- John's Hopkins Geriatric Workforce Enhancement Program (GWEP)

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Profile

Network: Aging Service Access Point/AAA of Massachusetts
Community Care Hub: Mass Home Care Association – AAA

Lead Contact: Michael Banville; mbanville.mhced@gmail.com
Co-Lead Contact: Sean Rogers; srogers@carecoordinate.com;
Kelly Magee Wright; k.mageewright@minutemansenior.org

Geographic Coverage:
State of Massachusetts

X
Health Care Contracts

Network Expansion Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g, meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance

Public Health Partnership: Will need to poll each individual ASAP for this information

- Is part of a workgroup or coalition with public health partner
- Provides programming or services
- Public health partner serves as subject matter experts
- Cooperates on COVID responses

Housing Partnership:

- Cross training of staff
- Coordination of referrals

Network Partners:

- AgeSpan
- Aging Services of North Central Massachusetts
- BayPath Elder Services, Inc.
- Boston Senior Home Care
- Bristol Elder Services, Inc.
- Central Boston Elder Services, Inc.
- Coastline Elderly Services, Inc.
- Elder Services of Berkshire County, Inc.
- Elder Services of Cape Cod and the Islands, Inc.
- Elder Services of Worcester Area, Inc.
- Ethos
- Greater Springfield Senior Services Inc.
- HESSCO
- Highland Valley Elder Services, Inc.
- LifePath, Inc.
- Mass Home Care
- Minuteman Senior Services, Inc.
- Mystic Valley Elder Services, Inc.
- Old Colony Elder Services, Inc.
- SeniorCare, Inc.
- Somerville/Cambridge Elder Services, Inc.
- South Shore Elder Services, Inc.
- Springwell
- Tri-Valley, Inc.
- WestMass ElderCare, Inc.

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Caregivers of any age

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Community Care Hub: Detroit Area Agency on Aging

Lead Contact: Tyruse Walls; wallst@daaa1a.org
Co-Lead Contact: Wanda Bowman; Bowmanw@daaa1a.org

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
Southeast Michigan

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
  - Diabetes Self-Management
  - Dementia Care
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Case Management
- CMS Certified Professionals
- CMS Credentialed Biller

Network Partners:

- DAAA Partners with over 100 providers which include: Michigan Department of Health and Human Services, Administration for Community Living (ACL), MiHealth Link, Amerihealth, Meridian, and HAP, Veterans Administration

Public Health Partnership:

City of Detroit Health Department, Detroit/Wayne Integrated Health Network

- Has representation from accountable care organization on their board

Housing Partnership:

- Housing partnership with senior housing facilities and Detroit Housing Commission
- Co-location of staff
- Coordination of referrals

Federally Qualified Health Center:

- Provides programming or services
- FQHC serves as subject matter expert
- Has representation from FQHC on their board
- Cooperates on COVID responses

Populations Served:

- Older adults (age 60+, as defined by the program)
- Individuals with disability or impairment 18yrs and older
- Individuals with chronic illness (including behavioral health)
- Veterans of any age
- Adults aged 18+ with a disability
- Caregivers aged 18+

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Mid-America Community Support Network
Community Care Hub: Mid-America Regional Council – Area Agency on Aging

Lead Contact: Melody Elston; melston@marc.org
Co-Lead Contact: Tane Lewis; tlewis@marc.org

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
5 Counties of Missouri and 4 Counties of Kansas

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Assessment for LTSS
- Case Management
- Assessment for Social Determinants of Health (SDOH)

Network Partners:

- Missouri Department of Health and Senior Services, Adult Protective Services
- US Department of Veterans Affairs
- Home State Health
- Blue Cross and Blue Shield of Kansas City (commercial and Medicare Advantage)
- University of Missouri - Kansas City, Healthcare Institute for Innovations in Quality

Public Health Partnership: City of Kansas City, Missouri Health Department; Unified Government Health Department

- Is part of a workgroup or coalition that includes public health department
- Cooperates on COVID responses

Housing Partnership:

- Coordination of referrals

Federally Qualified Health Center:

- Provides programming or services
- Other: An FQHC is one of Mid-America Support Network's network members, who we pay to provide services for our partners' referrals.

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age
- Children (up to age 18)

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Profile

Network: Oklahoma Healthy Aging Initiative
Community Care Hub: Oklahoma Healthy Aging Initiative – other CBO

Lead Contact: Keith Kleszynski; keith-kleszynski@ouhsc.edu
Co-Lead Contact: Lee Jennings; lee-jennings@ouhsc.edu

Geographic Coverage:
State of Oklahoma

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Health Care Contracts

Network Expansion Track

Network Services:

- Evidence-based Programs
- Caregiver Support

Network Partners:

- Oklahoma State Department of Health/Oklahoma Healthy Brain Initiative
- Oklahoma Department of Libraries
- Kiamichi Economic Development District Oklahoma
- Development District Oklahoma
- Long Term Care Authority
- Eastern Oklahoma Development District
- AVEM Health Partners

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Caregivers of any age

Public Health Partnership: Oklahoma State Department of Health, Oklahoma City-County Health Department

- Is a part of a workgroup or coalition
- Provides programming or services
- Serves as subject matter experts for a public health department

Federally Qualified Health Center:

- Provides programming or services

Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Oregon Wellness Network (OWN)
Community Care Hub: Oregon Wellness Network (OWN) - AAA

Lead Contact: Lavinia Goto; Lavinia.goto@nwsds.org
Co-Lead Contact: Katrina Seipp-Lewington; KSeipp@comagine.org

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
State of Oregon

Network Services:

- Care Transition Support
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH),
- Other: Fall Prevention Services

Network Partners:

- Clackamas County Social Services
- Comagine Health
- Community Action Team
- Community Connection of Northeast Oregon
- Douglas County Senior Services
- Klamath & Lake Counties Council on Aging
- Lane County Council of Governments
- Lifestyle Medicine Multnomah County Aging, Disability & Veteran Services
- Northwest Senior & Disability Services
- Rogue Valley Council of Governments
- South Coast Business Employment Corporation
- Virginia Garcia Clinics (Beaverton, McMinnville, Newberg, Cornelius, Hillsboro -5)
- Washington County Disability, Aging, and Veteran Services

Public Health Partnership: Oregon Health Authority/ Health Promotion and Chronic Disease Prevention

- Is part of a workgroup or coalition that includes public health department
- Public health department serves as subject matter expert
- Serves as subject matter experts for public health department
- Other: Oregon Health Authority is a key partner in Oregon Health Network's Community Integrated Network of Oregon (CINO) collaborative

Federally Qualified Health Center:

- Some FQHC staff are provider of E-B services offered by their network

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Veterans of any age
- Caregivers of any age

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Partners at Home
Community Care Hub: Partners in Care Foundation

Lead Contact: June Simmons; jsimmons@picf.org
Co-Lead Contact: Ester Sefilyan; esefilyan@picf.org

Geographic Coverage:
State of California

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Health Care Contracts

Network Expansion Track

Network Services:

- Care Transition Support
- Evidence-Based Programs
- Assessment for LTSS
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Nursing Home Diversion
- Other: Non-Medical Homecare Services (i.e., personal care/respite)

Network Partners:

- 1st Meridian, Acasa/SMR Healthcare, AccentCare, Access TLC, Aveanna dba Berger/Accredited, Alegre Home Care, AmeriCare SF, Arosa, At Home Caregivers, California Caregivers, Camarillo Health District, Cambrian Home Care, Care Partners, Comfort Paradise Home Care, Easy Care Management, El Sol, Firstlight , FSA Santa Barbara, Greentree Home Care, Health Projects Center, Helping Hands Groups, Homewatch Caregivers, J&M Homecare, LIFE ElderCare, Maxim Healthcare Services, Meals on Wheels OC (MOWOC), My Care Management, My Home Care Partners, Resilient Home Care, Rose Agency Home Care, Special Service for Groups (SSG), Visiting Angels SLO

Public Health Partnership: Los Angeles County Department of Public Health

- Is part of a workgroup or coalition that also includes public health department
- Cooperates on COVID responses
- Other: Partners in Care Foundation has an extensive relationship with the LA County Department of Public Health through their evidence-based programs. They have collaborated to form the Los Angeles Alliance for Community Health and Aging (LAAACHA) and now has moved over to a strong focus on racial justice and equity across the region

Housing Partnership:

- A Memorandum of Understanding (MOU)
- Other: Partners in Care Foundation has worked with many housing sites through its Community Wellness evidence-based programs

Federally Qualified Health Center:

- Other: Partners at Home is working with the FQHC association for LA County to create a community care hub for CalAIM's ECM and Community Supports

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness

CCH National Learning Community Participant Profile

Network: SC Thrive
Community Care Hub: SC Thrive – other CBO

Lead Contact: Beth Franklin; bfranklin@scthrive.org
Co-Lead Contact: Allie Boykin; aboykin@scthrive.org

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
State of South Carolina

Network Services:

- Care Transition Support
- Evidence-based Programs
- Caregiver support
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- Other: SC Thrive provide an array of support services, ranging from Medicaid application assistance to mental health first aid training

Network Partners:

- SC Thrive has over 145 partner organizations representing: city and county social service agencies, health care providers, multi-cultural groups, faith-based organizations and many other. For a complete list please contact the CCH lead.

Public Health Partnership: SC Department of Health and Environmental Control

- Is part of a workgroup or coalition that also includes public health department
- Provides programming or services
- Cooperates on COVID responses

Housing Partnership:

- Contract of other financial arrangement in place
- Cross training of staff
- Coordination of referrals

Federally Qualified Health Center: CareSouth Carolina, Little River Medical Center, Fetter Health Center

- Is part of a workgroup or coalition that also includes FQHC
- Provides programming or services
- FQHC serves as subject matter expert
- Serves as subject matter expert for FQHC
- Has representation from FQHC on their board

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age
- Children (up to age 18)

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: To Be Determined
Community Care Hub: Houston Health Department – Local Public Health Department

Lead Contact: Stephen L. Williams; stephen.williams@houstontx.gov
Co-Lead Contact: Linda Highfield, PhD; Linda.D.Highfield@uth.tmc.edu

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Health Care Contracts

Network Expansion Track

Geographic Coverage:
13 Counties of Texas and Houston, Texas

Network Services:

- Care Transition Support
- Evidence-based Programs
- Caregiver support
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- Other: SC Thrive provide an array of support services, ranging from Medicaid application assistance to mental health first aid training

Network Partners:

- TBD has over 145 partner organizations representing: city and county social service agencies, health care providers, multi-cultural groups, faith-based organizations and many other. For a complete list please contact the CCH lead.

Public Health Partnership: Houston Health Department

- Serves as subject matter experts
- Contracted to provide services
- Has representation from public health partner on their board
- Cooperates on COVID responses
- Other: The City of Housing Public Health Department is their parent organization

Housing Partnership:

- A Memorandum of Understanding (MOU)
- Cross training of staff
- Coordination of referrals
- Other: The Houston Health Department has a relationship with the Houston Homeless Coalition, and the ADRC has established a partnership with the Houston Housing Authority to support qualifying individuals with housing assistance

Federally Qualified Health Center:

- Provides programming or services
- FQHC serves as subject matter expert
- Serves as subject matter expert for FQHC
- Cooperates on COVID responses

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age
- Children (up to age 18)

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Western New York Integrated Care Collaborative
Community Care Hub: Western New York Integrated Care Collaborative - other CBO/non-profit agency

Lead Contact: Nikki Kmicinski; nkmicinski@wnyicc.org
Co-Lead Contact: Jordan Breckon; jbreckon@wnyicc.org

Geographic Coverage:
15 Counties of Western New York

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Health Care Contracts

Network Expansion Track

Network Services:

- Evidence-based Programs
- Participant-directed Care
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Assessment for Social Determinants of Health (SDOH)

Network Partners:

- WNYICC has over 40 partner organizations representing: city and county social service agencies, multi-cultural groups, faith-based organizations and many others. For a complete list please contact the CCH lead.

Public Health Partnership: Erie County Health Department and Niagara County Health Department (other county health departments as well)

- Provides programming or services
- Other: Both listed health departments are WNYICC network members
- Cooperates on COVID responses

Housing Partnership:

- Other: WNYICC has housing partners in their network

Federally Qualified Health Center:

- Other: WNYICC is meeting with FQHCs to submit referrals to their programs and work jointly on programs/services

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Wisconsin Aging and Disabilities Network
Community Care Hub: The Greater Wisconsin Agency of Aging Resources, Inc. - AAA

Lead Contact: Sky Van Rossum; sky.vanrossum@gwaar.org
Co-Lead Contact: Angela Sullivan; angela.sullivan@gwaar.org

Geographic Coverage:
70 Counties and 11 Sovereign Tribal Nations of Wisconsin

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Health Care Contracts

Network Expansion Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Support
- Caregiver support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH)

Public Health Partnership: Wisconsin Department of Health Services

- Provides programming or services and is contracted to provide services
- Public health department serves as subject matter expert
- Serves as subject matter experts
- Cooperates on COVID responses

Federally Qualified Health Center:

- FQHC serves as subject matter expert
- Serves as subject matter expert for FQHC
- Cooperates on COVID responses

Network Partners:

- Ground Game Health
- Inclusa Managed Care/Family Care
- University of Wisconsin Madison Extension Office
- Great Rivers United Way
- Wisconsin Department of Health Services Chronic Disease Prevention Program
- 11 Tribal Nations and 80 Offices on Aging and Aging Disability Resource Centers in 70 of Wisconsin Counties

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

December 2022