



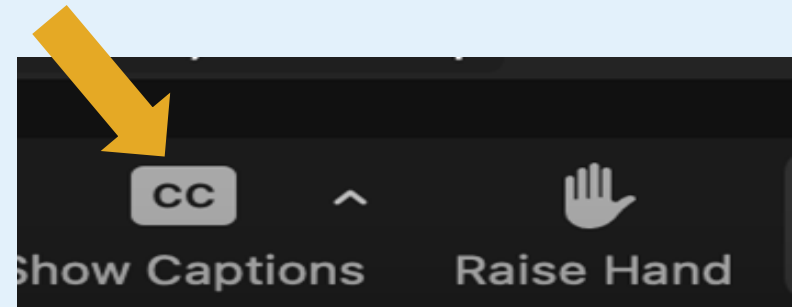
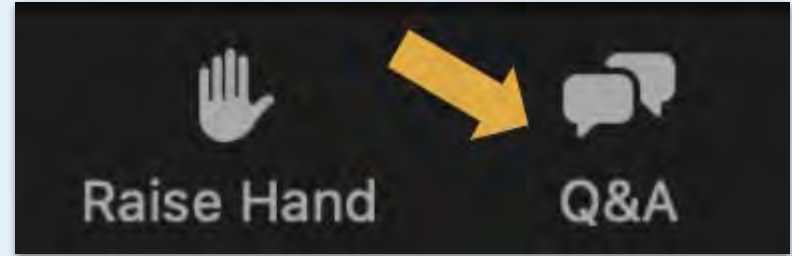
Implementing Medicare Reimbursement Pathways for Florida CHWs to Promote Whole Person Health

Tuesday, September 15, 2026 | 2:00-4:30 p.m. ET



Administrative Notes

- This webinar is being recorded. The recording and slides will be shared with all registrants
- Please use the Q&A tab at the bottom of your screen and we'll try address as many questions as possible during the discussion
- Closed captions are provided for this session, can also click "Show Captions" to display automated captions





Who is the Partnership to Align Community Care?

The *Partnership to Align Community Care* (Partnership) is a learning, sharing, and cross-sector change collaborative advancing and scaling sustainable community care delivery systems leveraging community care hubs (CCHs) to promote whole-person health.



Co-Designing Solutions Leveraging CCHs to Promote Whole-Person Health



Building Awareness

Engage cross-sector stakeholders to increase formal endorsement and promotion of the CCH model nationally.



Advancing CCH Maturity

Accelerating the adoption of core CCH functions, aligning service standards, and testing shared measures to strengthen cross-sector collaboration



Increasing CCH Network Readiness

Increasing the readiness of CBOs to become contracted CCH Network partners

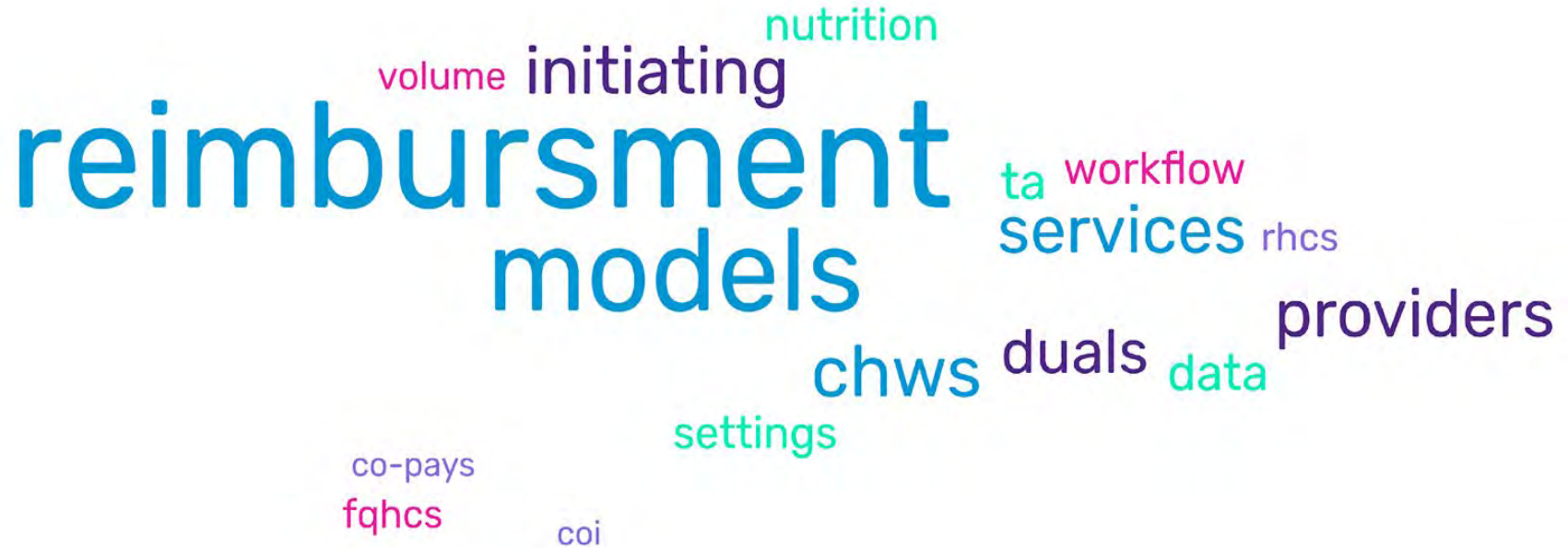


Expanding Clinical Integration

Addressing billing and coding pathways and advancing alternative payment arrangements to support CCH-delivered services



Implementing Medicare Reimbursement Pathways for Florida CHWs





Today's Agenda

1 Overview of Medicare Covered Services & Mechanics

- Basics of working with Medicare and applicable settings
- Overview of services and applicable billing codes for CHI, PIN, and PIN-PS
- Administrative details and billing requirements

2 Practical Implementation Strategies

- CHW workflows across settings and example sites
- referral workflows, documentation, coordination and reporting
- Coding practices, targeting, and co-pays

3 Supervision & Productivity

- Workforce options and supervision models

4 Common Misunderstandings & Pitfalls

- Key clarifications to address before Q&A

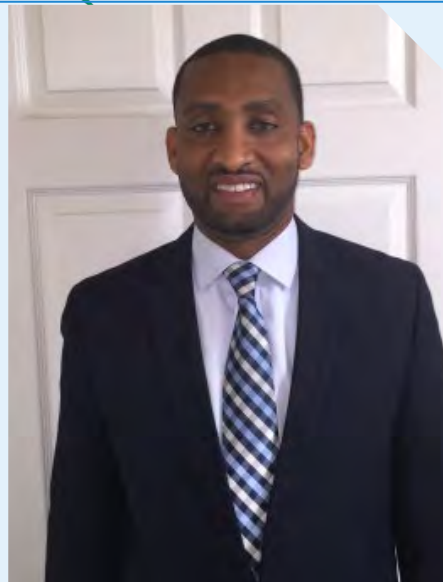


Today
we'll hear
from...



Lisa
Hamilton

Executive
Director, Florida
Community Health
Worker Coalition



Tim
McNeill

CEO, Freedmen's Health
Consulting
Co-Chair, Partnership to
Align Community Care



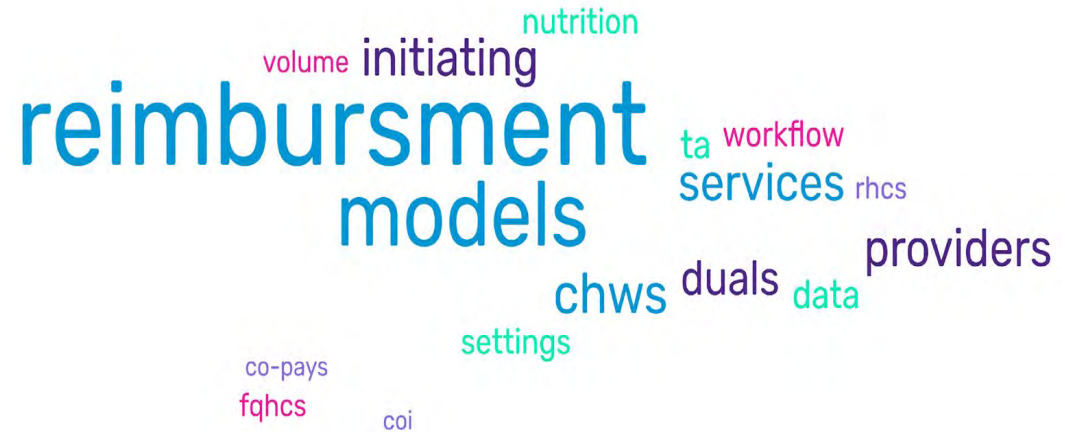
Bonnie
Ewald

Managing Director,
Center for Health and Social
Care Integration (CHaSCI)



Implementing Medicare Reimbursement Pathways for Florida CHWs

But First... We
Want to Hear
From You!





Working with Medicare



Medicare 101

Medicare eligibility

- US Citizen and permanent residents
- One of:
 - 65+ years old
 - Select people with disabilities
 - 2+ years of Social Security Disability Insurance coverage
 - Diagnosis of end-stage renal disease (ESRD) or ALS

Medicare coverage

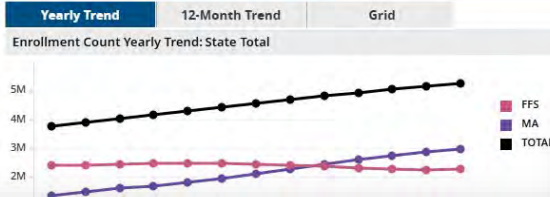
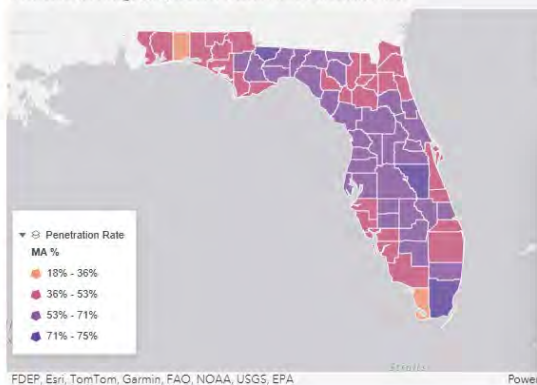
- Parts A, B, C, and D
- Part B covered services (*80% coverage, plus patient co-insurance 20%*)
 - Outpatient medical care and preventive services
 - Outpatient psychotherapy and substance use interventions
 - Care management services (*e.g., Chronic Care Management, Transitional Care Management, and Transitional Care Management*)
 - Expansion to additional codes (*e.g., crisis/risk focused services, Community Health Integration, Principal Illness Navigation*)



FLORIDA (68 counties) | TOTAL: 5,323,728 | FFS: 2,279,868 (43% of total) | MA: 3,043,860 (57% of total)

Florida

Medicare Advantage (MA) & Other Health Plans Penetration Rate



Population Health

2025 Scorecard

	Data year	State rate	U.S. average ^a	Best state rate	State rank
Adults age 65 and older who rated their health as fair or poor	2024	25.7%	25.0%	15.9%	37
Medicare beneficiaries diagnosed with three or more chronic conditions	2023	68%	62%	45%	48
Adults age 65 and older reporting 14 or more poor physical health days per month	2024	18.4%	17.5%	13.6%	35
Adults age 65 and older reporting 14 or more poor mental health days per month	2024	9.7%	8.7%	6.0%	42
Adults age 65 and older who reported difficulty with dressing, running errands alone, walking, or concentrating	2024	34.2%	32.6%	22.1%	37
Average number of years of additional life expectancy at age 65	2021	18.7%	18.4%	20.6%	18
Adults age 65 and older reporting loneliness or lack of emotional support	2022	31.7%	34.5%	28.7%	11
Adults age 60 and older who experienced food insecurity within the past year	2023	10.7%	9.2%	3.8%	43

Key concepts for billing Medicare Part B



- Centers for Medicare and Medicaid Services (CMS)
- Working with "Medicare Administrative Contractors" (MACs)
- Use of diagnostic codes (ICD 10) and "medical necessity"
- Use of procedural codes (CPT codes and HCPCS Level II codes)
- "National Coverage Determinations" and "Local Coverage Determinations"
- Annual "Medicare Physician Fee Schedule" update process

Settings for delivering care



- Common settings for delivering Part B health services
 - Medical office or community health clinic
 - Medical system (*outpatient, inpatient, integrated care team, etc.*)
 - Community-based service provider of any type (*e.g., aging network, non-profit service organization, behavioral health organizations*)
 - Private practice
- Use of Place of Service
 - A two-digit code that indicates the location the service was delivered
 - 11 (office) is common
 - "Facility" and "non-facility" settings and rates

Medicare Physician Fee Schedule



The Medicare Physician Fee Schedule (MPFS) is used by the to set payment rates for medical services and procedure, and to update and adjust covered services.

The MPFS is updated each calendar year.

- A proposed rule is released in July and followed by a public comment period through September.
- CMS reviews these comments in the autumn and releases a final rule in November that will go into effect on January 1 of the new year.

The last several MPFS updates have included many significant developments for community health providers.

Where do I learn more about Medicare?



Medicare Learning Network

- Articles, weekly newsletter
- <https://www.cms.gov/training-education/medicare-learning-network/resources-training>

Your Medicare Administrative Contractor

- Find your state's at <https://www.cms.gov/MAC-info>
- Search your MAC website for local fee schedule information, Local Coverage Determinations, educational events, news

Medicare Coverage Database

- Searchable repository that has information related to what's covered and not covered by Original Medicare
- Including National and Local Coverage Determinations
- <https://www.cms.gov/medicare-coverage-database/search.aspx>

The Partnership to Align Community Care (PACC)

- Resources to support healthcare-community partnerships and financing
- <https://www.partnership2acc.org/resources>

CHI/PIN/PIN-PS Implementation Support Session

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Impact on Total Cost of Care and Clinical Outcomes



AHC Second Evaluation Report: May 2023

- Accountable Health Communities (AHC) Model Evaluation
- A CMMI 5-year model that tested whether identifying and addressing the HRSNs of Medicare and Medicaid beneficiaries impacts total health care costs and utilization.



Accountable Health Communities (AHC) Model Evaluation

Second Evaluation Report

May 2023

Submitted To:
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
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Baltimore, MD 21244-1850
Contract # HHSM-500-2014-000371
TRN # 7456789101112

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Accountable Health Communities Model (2017 – 2022)

Model Overview

- The Accountable Health Community (AHC) Model tests whether connecting beneficiaries to community resources can improve health outcomes and reduce costs by screening and addressing health-related social needs (HRSNs).
- **1+ Million Medicare/Medicaid Beneficiaries** successfully screened using an evidence-based HRSN screening tool.

Key Components

The AHC Model focuses on five core HRSNs:

Housing
instability



Food
insecurity



5



Transportation
problems



Utility
difficulties



Interpersonal
violence

Prevalence of HRSNs in the AHC Population (N=1+ Million)

67%



Food Insecurity: Sometimes or often worried that food would run out before money was available to buy more, or food bought did not last and money was unavailable to buy more

53%



Housing: Worried about losing housing or having no steady place to live or problems with pests, mold, lead, heat, ovens, smoke detectors, or water

44%



Transportation: Lack of reliable transportation for medical appointments, meetings, work, or getting things for daily living

36%



Utilities: Electric, gas, oil, or water company threatened to shut off services or already shut off services

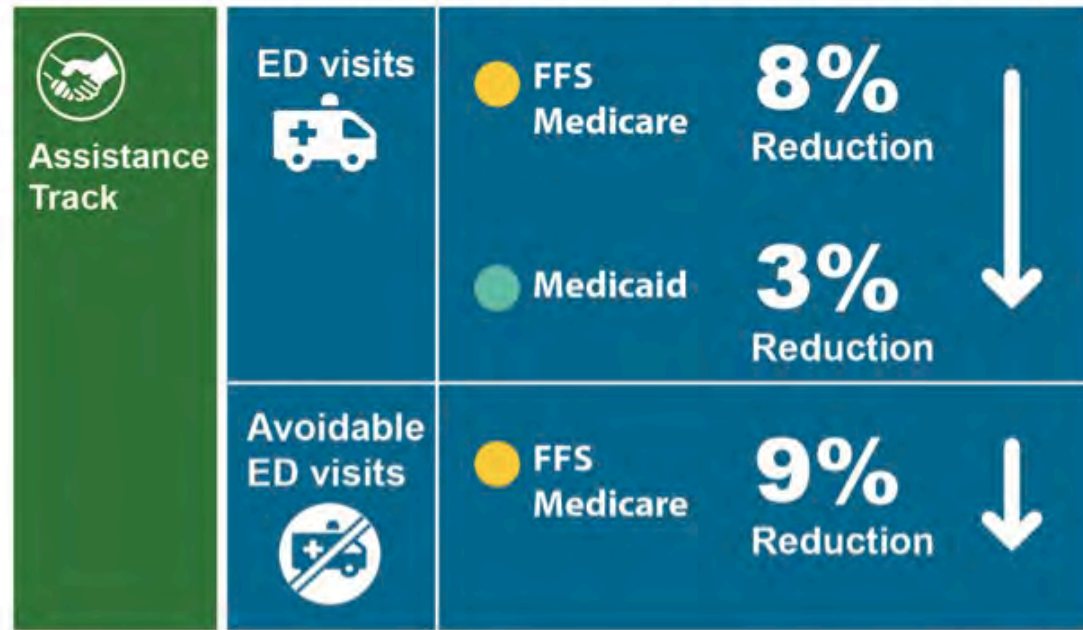
5%



Interpersonal Violence: Regular occurrence of being physically hurt, insulted, threatened with harm, or screamed or cursed at by another person, including a family member

Statistically Significant Outcome (N = 1+ Million)

Exhibit ES-5. Assistance Track Impacts on Emergency Department Visits



Some Populations Had Greater Reductions in Total Cost of Care

Exhibit ES-4. Assistance Track Impacts on Expenditures and Use for Selected FFS Medicare Subpopulations

Subpopulation		\$ Total Expenditures	 ED Visits	 Avoidable ED Visits	 Inpatient Admissions
Overall Impact for Assistance Track		↓	↓	↓	NS
	Non-White and/or Hispanic beneficiaries	↓	↓	↓	↓
	Non-Hispanic White beneficiaries	NS	↑	NS	NS
Is there a significant difference between subpopulations?		Yes	Yes	Yes	Yes
	Beneficiaries with pulmonary disease	↓	↓	↓	NS
	Beneficiaries without pulmonary disease	NS	↑	NS	NS
Is there a significant difference between subpopulations?		Yes	Yes	Yes	No
	Beneficiaries with diabetes	↓	↓	↓	↓
	Beneficiaries without diabetes	NS	↑	NS	↑
Is there a significant difference between subpopulations?		Yes	Yes	Yes	Yes



Beneficiaries in the Assistance Track group had lower expenditures or fewer visits or stays in the first 3 years after screening for HRSNs



Beneficiaries in the Assistance Track group had higher expenditures or more visits or stays in the first 3 years after screening for HRSNs

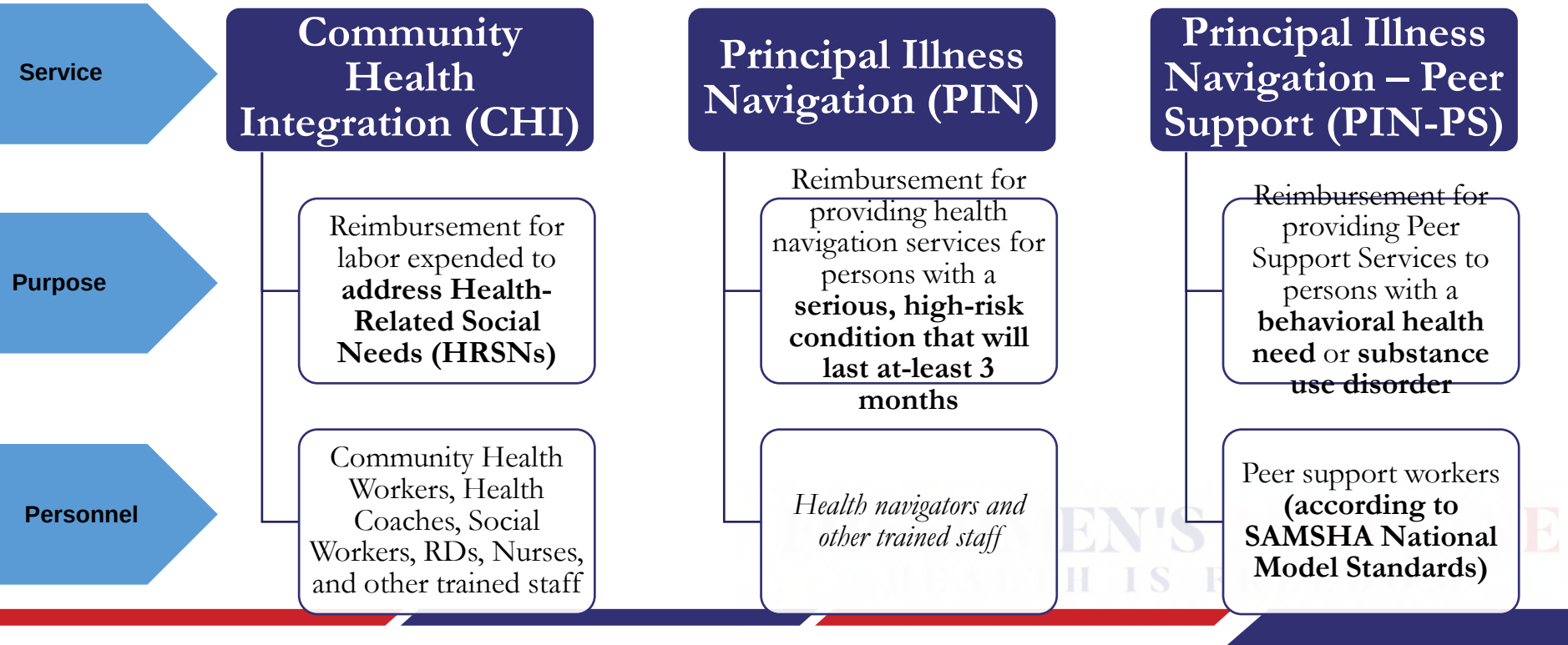
Resolution of HRSN in AHC Population (N = 1+ Million)

- The majority of persons, positive for HRSNs, did not have all of their HRSNs resolved – **within one year** of receiving social care navigation.
 - 38% with one or more HRSNs had at least one (1) HRSN resolved.
 - 20% had all of their HRSNs resolved.
 - **80% did not have all HRSNs resolved after 1-year of receiving supports.**
- **National Data on Impact of HRSNs on Medicare Population**
 - **Duals: 80% of Duals report at least one HRSN**
 - **Non-Duals: 48% of non-duals report at least one HRSN**

CY2026 Update Overview



Overview of the New Benefit



CHI HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0019	Community Health Integration Services (CHI) SDOH 60 min	\$86.17	\$44.09
G0022	Community Health Integration Services (CHI); add ea. 30 min	\$54.11	\$30.73

PIN HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0023	PIN Service, 60 minutes per month	\$86.17	\$44.09
G0024	PIN Service, add ea. 30 min	\$54.11	\$30.73

PIN-PS HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0140	PIN-Peer Support, 60 minute	\$86.17	\$44.09
G0146	PIN-PS, Peer Support, add ea. 30 min	\$54.11	\$30.73

***CY2026 Rate Schedule. Rates listed are the National Rate, effective January 1, 2026**

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Changes to HCPCS G0019: Community Health Integration

- New Definition of G0019.
 - Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities **to address upstream driver(s)** that are significantly limiting ability to **diagnose or treat problem(s)** addressed in an **initiating visit**.
- **Key Action:** Replace the term “social determinants of health (SDOH)” with the term “upstream driver(s)”

Upstream Drivers Defined

- Upstream Drivers are factors, such as housing, food insecurity, transportation, and financial constraints, which are common in the Medicare population.

Community Health Integration Services

CHI Services List		
Person-Centered Assessment	Facilitating patient-driven goal setting	Providing tailored support
Practitioner, HCBS Coordination	Coordinating receipt of needed services	Communication with practitioners, HCBS providers, hospitals, SNFs
Coordination of care transitions	Facilitating access to community-based social services	Health education
Building patient self-advocacy skills	Health care access / health system navigation	Facilitating behavioral change
Facilitating and providing social and emotional support	Leveraging lived experience when applicable	

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PIN Services

List of PIN Services		
Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition.	Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.	Health Education
Practitioner, Home, and Community-Based Care Coordination	Coordination of care transitions	Facilitating access to social services
Building patient self-advocacy skills	Health care access/system navigation	Facilitating behavioral change
Facilitating and providing social and emotional support	Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.	

PIN-PS Services

List of PIN-PS Services		
Person-centered interview, performed to better understand the individual context of the serious, high-risk condition.	Practitioner, Home, and Community-Based Care Communication	Health Education
Building patient self-advocacy skills	Developing and proposing strategies to help meet person-centered treatment goals	Facilitating and providing social and emotional support
Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.		

CHI/PIN Practitioner Types



Eligible Healthcare Practitioners

- Physician (MD/DO)
- Nurse Practitioner
- Physician Assistant
- Clinical Nurse Specialist
- Clinical Social Worker (CSW), MFT, MHC

CSWs, MFTs, & MHCs as the billing practitioner

- CSWs, MFTs, & MHCs can serve as the billing practitioner for CHI and PIN as long as the following factors are met:
- The CSW, MFT, or MHC personally completed a qualifying initiating visit.
- CSWs, MFTs and MHCs bills Medicare directly for CHI and PIN services they **personally perform** for the diagnosis or treatment of mental illness.

Additional Clarification on the Role of CSWs, MFTs, & MHCs as the Billing Practitioner



- Time spent by auxiliary personnel cannot be included in a direct claim submitted by a CSW, MFT, or MHC because this practitioner type is not authorized to provide incident to services, under general supervision.
- Individuals who personally furnish or serve as auxiliary personnel for CHI and PIN services must meet all other service requirements associated with these codes.

CHI/PIN Process & Requirements



Provider Steps for Implementation

- Determine that there is a Health–Related Social Need.
- Document the need and the impact on the health condition.
- Obtain consent (verbal or written)
- Refer to auxiliary personnel to address all identified HRSNs.
- Develop a person-centered plan to address identified needs.
 - Auxiliary personnel can help develop the plan.
- Ensure proper clinical integration to exchange the plan of care and provide feedback to the clinician.

Clinical Integration Requirement

- An eligible healthcare practitioner must provide general supervision.
- General supervision definition:
 - Must be an established plan of care.
 - Provider and auxiliary personnel have access to the plan of care.
 - Interventions are deployed to address identified needs.
 - Interventions are evaluated to determine their impact on addressing HRSNs.
 - There is regular communication between the healthcare provider and the auxiliary personnel to provide updates on interventions deployed to address HRSNs.

Person-Centered Plan

- A person-centered plan should be developed based on identified needs.
- There should be targeted interventions to address each identified need.
- Often, HRSNs reported to a healthcare practitioner are less than the reporting to a trusted CBO.
- If new HRSNs are identified by a CBO, the list of HRSNs should be updated.

Interaction between HRSN and Health Condition

- HRSNs must have an impact on the ability of the healthcare practitioner to treat or diagnose a health condition.
- The impact of the health condition must be documented in the medical record.
- If new HRSNs are identified, the record must be updated to record the impact of the HRSN(s) on the health condition(s)
- If new HRSNs are identified, the person-centered plan should be updated.

Consent

- The beneficiary must provide consent to obtain CHI/PIN services.
- Consent can be verbal or written.
- Consent can be obtained by any member of the care team – to include auxiliary personnel.
- Consent must be documented in the health record.
- Consent process must include an explanation of the cost sharing requirement.

Cost Sharing Requirement

- All Medicare Part B benefits have a co-insurance requirement.
- Co-insurance is different from a co-pay.
- Co-pay requires the beneficiary to pay a fixed amount for a health service, regardless of the total cost of the service.
- Co-insurance, requires the beneficiary to pay a percentage of the total cost of the service. With co-insurance, the out-of-pocket expense for the beneficiary increases as the cost of the services increase.
- According to KFF 90% of all FFS Medicare Beneficiaries have a secondary policy that covers the co-insurance expense.

Cost-Sharing (cont.)

- Medigap plans are an insurance product that covers the cost of deductibles and co-insurance a beneficiary incurs when receiving healthcare services.
- Often referred to as a secondary policy.
- If a person has a Medigap or secondary policy, there may be no out-of-pocket expense.

Types of Secondary Policies

- 90% of the Medicare Population has a secondary policy.
 - Medicare Supplement Insurance (Medigap)
 - Employer or Retired coverage
 - Medicaid (Low-Income, Dual Eligible, aka Medi-Medi)
 - Military (Tricare for Life)

Can you Waive the Co-Insurance Requirement?

- NO: You must attempt to collect all applicable co-insurance fees.
- If the person has a Medigap or Secondary policy, the attempt to collect is to bill the Medigap policy.
- If the person does not have a Medigap or Secondary policy, you must charge the beneficiary.
- If the beneficiary cannot pay, you must document the attempt to collect.
- It is at the discretion of the program to render services after it is documented that a person cannot pay.
- Must keep a ledger documenting outstanding balances owed.

Billing Tips



Actual Payment Rates

- Medicare Reimbursement Rate application to Co-Insurance concept:
- 2 hours of CHI services reimburses in the following manner:

Aggregate of Time per calendar month	Allowable Reimbursement Amount
Hour 1	\$86.17
+30 minutes	\$54.11
+30 minutes	\$54.11
Total Time – 2 hours	$\$86.17 + \$54.11 + \$54.11 = \194.39

Provider Type Adjustments

Provider Type	Allowable Amount	Provider Adjustment	Amount prior to co-insurance (80%)
MD/DO	\$194.39	\$194.39	\$155.51
NP/PA (85%)	\$194.39	\$165.23	\$132.18
CSW/MFT/MHC (75%)	\$194.39	\$145.79	\$116.63

Claim Filing Details

- **Diagnosis Code:** Should be the diagnosis code of the health condition that is adversely impacted by the Upstream Drivers.
- **Concurrent Billing:** Concurrent billing is allowed for other care management services during the same calendar month.
- **TCM:** Care management services can be rendered during the same episode as a transitional care management visit and both will be reimbursed.
- **Home Health episode:** Services cannot be rendered during a Medicare home health episode of care.

Clarification of Auxiliary Personnel and Training Requirements



Do Auxiliary Personnel Include CHWs only

- Clarification:
- As we stated previously in the CY 2024 PFS final rule (88 FR 78926), the codes **do not limit the types of other health care professionals**, such as registered nurses and social workers, that can perform CHI services (and PIN services, as we discuss in the next section) incident to the billing practitioner's professional services, **so long as they meet the requirements to provide all elements of the service included in the code**, consistent with the definition of auxiliary personnel at § 410.26(a)(1).

Reminder of the CHI Training Requirement

- Source: CMS FAQ CHI/PIN 2024
- What kind of certification or training is needed for auxiliary personnel providing CHI services under the general supervision of the billing physician or other practitioner?
- a. Auxiliary personnel, including community health workers, must meet applicable State requirements, including certification or licensure.
- In States with no applicable requirements, auxiliary personnel providing CHI services must be trained or certified in
- the competencies of:
 - i. Patient and family communication
 - ii. Interpersonal and relationship-building
 - iii. Patient and family capacity-building
 - iv. Service coordination and system navigation
 - v. Patient advocacy, facilitation, individual and community assessment
 - vi. Professionalism and ethical conduct
 - vii. Development of an appropriate knowledge base, including of local community-based resources.

Reminder of the PIN Training Requirement

- Source: CMS FAQ CHI/PIN 2024
- What kind of certification or training is needed for auxiliary personnel providing PIN services under the general supervision of the billing physician or other practitioner?
- a. Auxiliary personnel must meet applicable State requirements, including certification or licensure.
- In States with no applicable requirements, auxiliary personnel providing PIN services must be trained or certified in the competencies of:
 - i. Patient and family communication
 - ii. Interpersonal and relationship-building
 - iii. Patient and family capacity building
 - iv. Service coordination and systems navigation
 - v. Patient advocacy, facilitation, individual and community assessment
 - vi. Professionalism and ethical conduct
 - vii. Development of an appropriate knowledge base, including specific certification
 - or training on the serious, high-risk condition, illness, or disease being addressed.

Provider Agreements with CBOs

Federal Register / Vol. 88, No. 220 / Thursday, November 16, 2023 / Rules and Regulations 78931

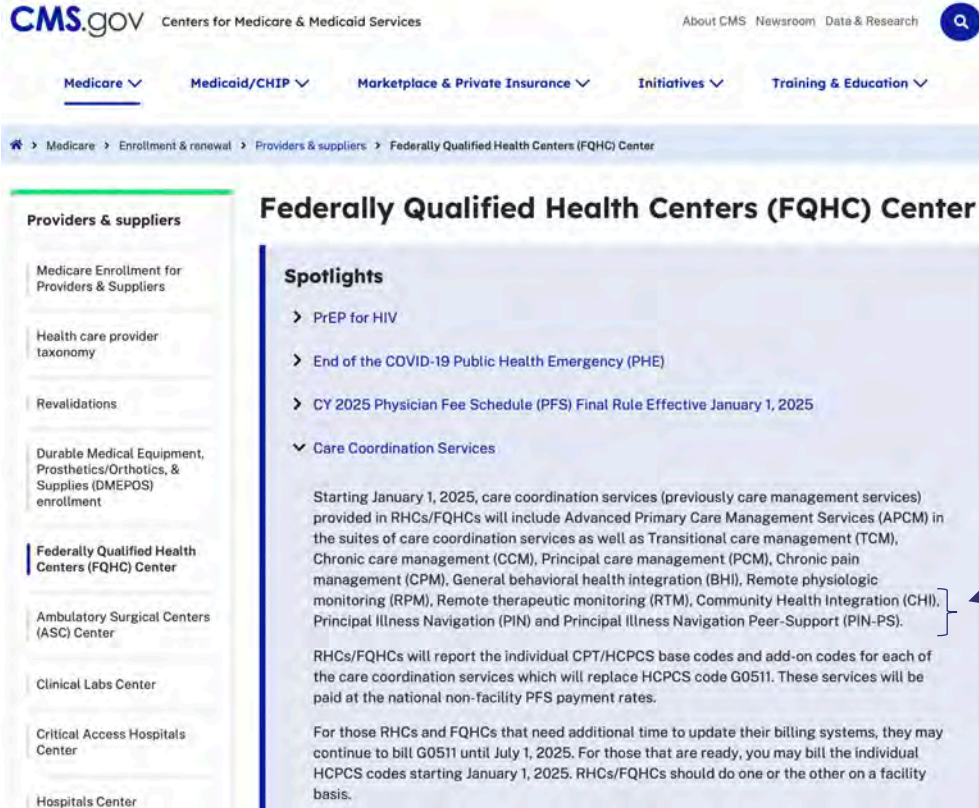
After consideration of public comments, we are finalizing as proposed that a billing practitioner may arrange to have CHI services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs, if all of the “incident to” and other requirements and conditions for payment of CHI services are met, and that there must be sufficient clinical integration between the third party and the billing practitioner in order for the services to be fully provided. We are also finalizing as proposed that CHI

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FQHC/RHC Care
Management Billing Rule
Changes Effective
CY2025



FQHC/RHC Billing Updates Posted on CMS Website



The screenshot shows the CMS.gov website. The top navigation bar includes 'About CMS', 'Newsroom', and 'Data & Research'. The main navigation menu has 'Medicare', 'Medicaid/CHIP', 'Marketplace & Private Insurance', 'Initiatives', and 'Training & Education'. The breadcrumb trail reads: 'Medicare > Enrollment & renewal > Providers & suppliers > Federally Qualified Health Centers (FQHC) Center'. The left sidebar lists various categories, with 'Federally Qualified Health Centers (FQHC) Center' selected. The main content area is titled 'Federally Qualified Health Centers (FQHC) Center' and features a 'Spotlights' section with a list of updates. An arrow points from the URL on the right to the 'Care Coordination Services' spotlight item.

CMS.gov Centers for Medicare & Medicaid Services

About CMS Newsroom Data & Research

Medicare ▼ Medicaid/CHIP ▼ Marketplace & Private Insurance ▼ Initiatives ▼ Training & Education ▼

Medicare > Enrollment & renewal > Providers & suppliers > Federally Qualified Health Centers (FQHC) Center

Providers & suppliers

- Medicare Enrollment for Providers & Suppliers
- Health care provider taxonomy
- Revalidations
- Durable Medical Equipment, Prosthetics/Orthotics, & Supplies (DMEPOS) enrollment
- Federally Qualified Health Centers (FQHC) Center**
- Ambulatory Surgical Centers (ASC) Center
- Clinical Labs Center
- Critical Access Hospitals Center
- Hospitals Center

Federally Qualified Health Centers (FQHC) Center

Spotlights

- > PrEP for HIV
- > End of the COVID-19 Public Health Emergency (PHE)
- > CY 2025 Physician Fee Schedule (PFS) Final Rule Effective January 1, 2025
- ▼ **Care Coordination Services**

Starting January 1, 2025, care coordination services (previously care management services) provided in RHCs/FQHCs will include Advanced Primary Care Management Services (APCM) in the suites of care coordination services as well as Transitional care management (TCM), Chronic care management (CCM), Principal care management (PCM), Chronic pain management (CPM), General behavioral health integration (BHI), Remote physiologic monitoring (RPM), Remote therapeutic monitoring (RTM), Community Health Integration (CHI), Principal Illness Navigation (PIN) and Principal Illness Navigation Peer-Support (PIN-PS).

RHCs/FQHCs will report the individual CPT/HCPCS base codes and add-on codes for each of the care coordination services which will replace HCPCS code G0511. These services will be paid at the national non-facility PFS payment rates.

For those RHCs and FQHCs that need additional time to update their billing systems, they may continue to bill G0511 until July 1, 2025. For those that are ready, you may bill the individual HCPCS codes starting January 1, 2025. RHCs/FQHCs should do one or the other on a facility basis.

<https://www.cms.gov/medicare/payment/prospective-payment-systems/federally-qualified-health-centers-fqhc-center>

FQHC/RHC Billing for CHI/PIN/PIN-PS

- FQHCs/RHCs will bill for CHI/PIN/PIN-PS using the physician fee schedule HCPCS codes.
- FQHCs/RHCs will utilize the HCPCS codes including the add-on codes for additional time spent once the minimum threshold of time was met to account to complete the encounter.
- CHI/PIN/PIN-PS is reimbursed as a separate payment from PPS for direct healthcare services.
- All FQHCS/RHCs are reimbursed at the National Rate, regardless of their location.

Productivity



Establishing Productivity goals

- It is common practice for medical clinics and outpatient practices to establish a productivity goal and manage the schedule of all billing providers:
 - Physicians
 - Nurse Practitioners
 - Physician Assistants
 - Clinical Social Workers
- When CHW labor moves from grant-based to claims-based, the same level of productivity management is required.

Sample CHW Workday Plan

Time	Activity	Billable vs Non-Billable
8:30 – 9:00am	Morning Huddle, call list prep	Non-Billable
9:00 – 12:00pm	3 hours of member engagement and service delivery	3 Billable hours
12:00 – 12:30pm	Lunch	Non-Billable
12:30 – 3:30pm	Member encounters and service delivery to address identified needs.	3 Billable hours
3:30 – 4:30pm	Member encounter follow-up	1 Billable hour
4:30 – 5:00pm	Daily wrap-up and planning for the next day/week	Non-Billable
Total Billable Time per Day		7 Billable Hours Total

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Note: admin meetings and other duties not included in this sample* **HEALTH IS FREEDOM

Sample CHW Productivity Report Card & Grading Rubric



Daily Productivity	Daily Productivity Grade	Average Weekly Productivity (Hrs)	Weekly Grade
7+ Hours per day	A	7+ Average for the week	A
6.0 – 6.9 Hours per day	B	6.0 – 6.9 Average for the week	B
5.0 – 5.9 Hours per day	C	5.0 – 5.9 Average for the week	C
4 hours or less for the day	F	4 hours or less, average for the week	F

FREEDMEN'S MEDICINE

**Note: admin meetings and other duties not included in this sample* HEALTH IS FREEDOM

CHI Financial Analysis – Demonstrating Scale

- One Community Health Worker supporting a caseload of 50 patients
- CHW spends an **average of 60% of their time** providing billable services
 - 1.0 FTE CHW works 160 hours per month (40 hours per week)
 - **96 hours per month billable (60%) with 64 hours/mo. non-billable admin time**
- Reimbursement
 - G0019 = \$86.17 / 60 min. (average reimbursement per hour of CWH labor).
 - 96 hours CHI/mo. X \$86.17 (avg rate) = \$8,272.32

Salary (1.0 FTE CHW)	Fringe (35%)	Labor Expense	Gross Revenue	Net/CHW (assuming all revenue goes toward CHW)	Net for 10 CHW Team
\$25/hr. X 160 hrs./mo. = \$4,000.00/month	\$1,400/mo.	\$5,400/month	\$8,272.76 / month	+\$2,872.32	+\$28,723.20/ <u>mo.</u> +\$280,051.20/ <u>yr.</u>

Case Study and Business Model





Case Study

- John suffered a spinal cord injury after a major car accident.
- John was initially admitted to a trauma center and subsequently completed an extended post-acute rehab stay.
- John developed diabetes and is now having difficulty managing his diabetes.
- HRSNs impacting the ability of John to manage his diabetes diagnosis:
 - Food Insecurity
 - Housing Insecurity (needs accessible housing)
 - Transportation Insecurity (accessible trans.)



CHI Interventions Deployed

- CHW contacts the the local HUD funded Continuum of Care (CoC) program for emergency housing voucher.
 - <https://www.hudexchange.info/programs/coc/>
 - Secured a HUD 811 Voucher to move John to an accessible housing unit.
- CHW helps apply for USDA Emergency Food Assistance and SNAP Benefits.
 - https://www.fns.usda.gov/fns-contacts?f%5B0%5D=fns_contact_related_programs%3A27
- CHW sets up FCC Lifeline Cell Phone with medication text reminders.
 - <https://cnm.universalservice.org>
- Enrollment in an accessible transportation program for medication and appointment adherence.

Accessible Housing as a HRSN





Case Study CHI for Diabetes Complications

- Gertrude is a 62 y/o female with a history of bipolar disease, history of homelessness, and food insecurity.
- Utilization History: Frequent ED visits for uncontrolled diabetes and one ICU admission for DKA.
- Poor adherence to her insulin regimen with HgbA1C 13.4
- Intersection of depressive symptoms, food insecurity, poor medication adherence, and lack of dietary changes lead to increasing HgbA1Cs.
 - Issues
 - Food Insecurity
 - Inability to obtain medications
 - Transportation Insecurity



CHI Interventions Deployed

- CHW contacts the the local HUD funded Continuum of Care (CoC) program for emergency housing voucher.
 - <https://www.hudexchange.info/programs/coc/>
- CHW helps apply for USDA Emergency Food Assistance and SNAP Benefits.
 - https://www.fns.usda.gov/fns-contacts?f%5B0%5D=fns_contact_related_programs%3A27
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- Enrollment in an accessible transportation program for medication and appointment adherence.

Reflecting: Other relevant interventions for these examples



CHI Services List		
Person-Centered Assessment	Facilitating patient-driven goal setting	Providing tailored support
Practitioner, HCBS Coordination	Coordinating receipt of needed services	Communication with practitioners, HCBS providers, hospitals, SNFs
Coordination of care transitions	Facilitating access to community-based social services	Health education
Building patient self-advocacy skills	Health care access / health system navigation	Facilitating behavioral change
Facilitating and providing social and emotional support	Leveraging lived experience when applicable	



- Questions,
- (hopefully) Answers,
- and Discussion

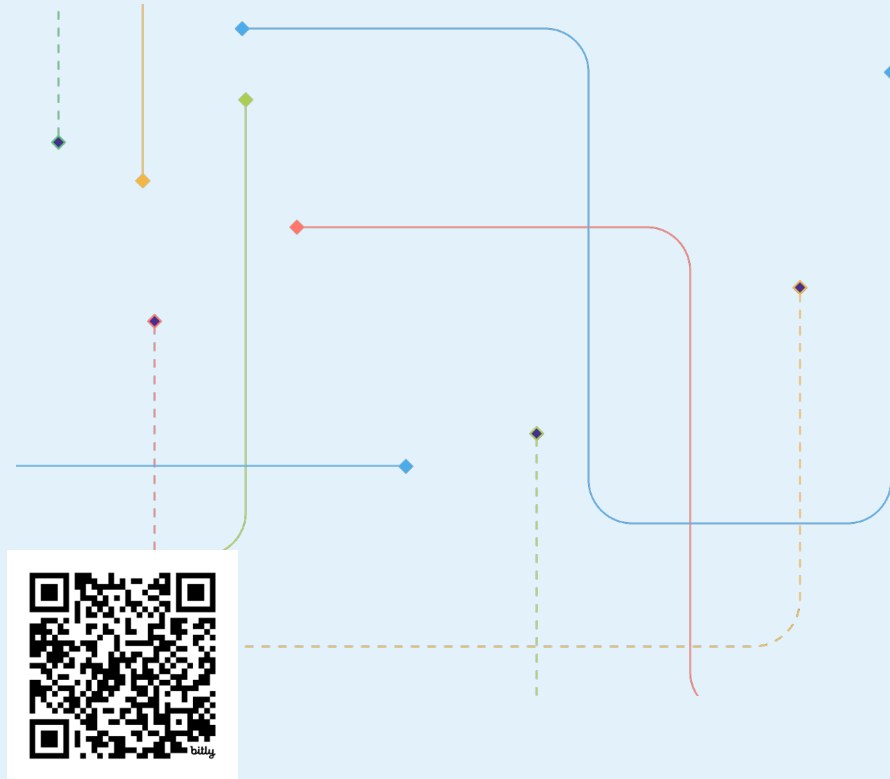


More Resources Available

- ✓ Partnership Billing/Coding Implementation Toolkit: Navigating Medicare Reimbursement for Whole-Person Care
- ✓ Exploring Reimbursement Pathways for Whole Person Health (webinar with NACHC)
- ✓ Ask Us Anything! Open Discussion re: Exploring Reimbursement Pathways for Services to Promote Whole Person Health (webinar)

And Much More at:

<https://www.partnership2acc.org/resources>





Additional CHW Training Resources

The image shows the top portion of the Partners in Care Foundation website. The header includes the organization's name, a navigation menu with links for About, Programs, Tribute Dinner, Ways to Give, Success Stories, and Contact Us, and a blue "Donate" button. Below the header, the "WORKFORCE DEVELOPMENT" section is highlighted in blue. The main heading for this section is "Workforce Development Training Center" in large, bold black letters. Below this, a subheading reads "Strengthening the Workforce Delivering Community-Based Care". A paragraph of text describes the online training for various roles including CHWs, Promotoras, CHRs, Care Navigators, and supervisors. To the right of the text is a photograph of two people, a woman and a man, sitting at a table and looking at documents together.

Partners in Care Foundation

About Programs Tribute Dinner Ways to Give Success Stories Contact Us Donate

WORKFORCE DEVELOPMENT

Workforce Development Training Center

Strengthening the Workforce Delivering Community-Based Care

Online training for Community Health Workers (CHWs), Promotoras, Community Health Representatives (CHRs), Care Navigators, supervisors, and other frontline professionals working across healthcare and community-based care.

Partners in Care Foundation:
<https://www.picf.org/workforce-development/>

Camden Coalition Courses:
<https://courses.camdenhealth.org/>

The image shows the top portion of the Camden Coalition website. The header includes the organization's name and a "Sign In" button. Below the header, the main heading is "BUILT FROM REAL-WORLD EXPERIENCES" in large, white, serif letters. Below this, a subheading reads "Training designed for the realities of complex care". A large photograph shows a woman and a man, a woman and a man, looking at a document together. Below the photograph is a yellow button that says "View our trainings". At the bottom of the section, a text box reads "EXPLORE OUR ENTIRE CATALOG OF TRAININGS DEVELOPED TO MEET YOUR NEEDS IN THE COMPLEX CARE FIELD." Below this is a search bar with the placeholder text "Search for content" and a "Q. SEARCH" button.

Camden Coalition

BUILT FROM REAL-WORLD EXPERIENCES

Training designed for the realities of complex care

View our trainings

EXPLORE OUR ENTIRE CATALOG OF TRAININGS DEVELOPED TO MEET YOUR NEEDS IN THE COMPLEX CARE FIELD.

Search for content Q. SEARCH



THANK YOU!

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