Strategies to Achieve Alignment, Collaboration, and Synergy across Delivery and Financing Systems

Linking Medical Homes to Social Service Systems for Medicaid Populations

Research In Progress Webinar
Wednesday, February 21, 2018
12:00-1:00 pm ET/ 9:00 am-10:00 am PT

Funded by the Robert Wood Johnson Foundation
Welcome: CB Mamaril, PhD

Research Faculty, RWJF Systems for Action National Coordinating Center
University of Kentucky College of Public Health

Presenters: Sarah H. Scholle, DrPH, MPH
Vice President, Research & Analysis
Quality Measurement & Research Group
National Committee for Quality Assurance (NCQA)
scholle@ncqa.org

Keri Christensen, MS
Director, Research Innovation, Research & Analysis
National Committee for Quality Assurance (NCQA)
christensen@ncqa.org

Commentary: Cheryl Lulias, MPA
President and Executive Director
Medical Home Network
clulias@mhnchicago.org

Sara Standish, MBA
Principal, Analytic and Evaluation
Health Leads National
sstandish@healthleadsusa.org

Questions and Discussion: Moderated by Dr. Mamaril.
Dr. Scholle is an expert in health services and quality measurement in multiple settings. She has a demonstrated record of moving innovative measurement concepts into implementation, particularly through NCQA’s Healthcare Effectiveness Data and Information Set (HEDIS). Current measurement projects focus on cross-cutting areas where new health information technology is critical, including behavioral health care, patient reported outcomes, and goal setting and improvement.

Her experience also includes projects to test and assess the process of transformation to different models of care, including an initiative to test a patient-centered approach to oncology care. She leads NCQA’s efforts to expand measures for vulnerable populations; this includes leading health equity innovation efforts for the CMS Office of Minority Health. She led an AHRQ/CMS funded Center of Excellence in Pediatric Quality Measurement, which focused on developing and testing outcome measures for adolescent depression using electronic health records data, and currently leads a subsequent project to implement and demonstrate improvement on these measures.

She has also led activities in measurement related to patient-centered care and the patient-centered medical home (PCMH) and contributed to the development and implementation of surveys (such as the PCMH version of the CAHPS survey).
Keri Christensen has a BS in Industrial Engineering from the University of Iowa and an MS in Healthcare Quality and Patient Safety from Northwestern. She has spent over 20 years working in the Health Information Technology field.

Ms. Christensen has experience with the Illinois Medicaid managed care population and providers, including a previous role as CountyCare Project Manager at MHN.

Ms. Christensen is currently Director for Research Innovation at NCQA with a focus on measurement of social risk and digital health.
Cheryl Lulias has more than 20 years of experience working with complex health care systems and health plans in a broad range of areas including integrated delivery system development, population health management, value-based contracting, strategy and network management.

As the President & Executive Director of Medical Home Network (MHN), Cheryl leads a virtually integrated delivery system, which is a catalyst to drive delivery redesign and practice innovation in the safety net. She also serves as CEO of the MHN ACO, the 1st Medicaid ACO in Illinois.

Previously, Cheryl served as the Vice President of Network Management for WellCare Health Plans of IL, a provider of Medicaid and Medicare HMO products. Prior to that, Cheryl held leadership positions at several academic and community hospital systems in IL, IN and NY.
Sarah Standish has over a decade of experience as a senior leader in both the healthcare and non profit sectors. She is passionate about data-informed strategy and operations at the intersection of business and mission to spark sustainable, equitable community development.

She developed the Health Leads evaluation strategy, including direct evaluation of the organization’s operations at healthcare delivery systems across the county, dissemination of findings and best practices, and support for research and evaluation activities at other institutions / organizations.

Additionally, Ms. Standish currently supervises a team she organized at Health Leads that delivers regular performance management reporting to healthcare delivery partners and co-designs evaluations.
Addressing Social Risk Through Medical Home and Social Services Connectivity and Communication

Research-In-Progress Webinar. 02.21.2018

Project Team Members: National Committee for Quality Assurance (NCQA), Medical Home Network (MHN), Cook County Health & Hospitals System (CCHHS)
Principal Investigator: Sarah Hudson Scholle, NCQA
Project Director: Keri Christensen, NCQA
Project Team

National Committee For Quality Assurance (NCQA)
Sarah Hudson Scholle, MPH, DrPH
Keri Christensen, MS
Manasi Tirodkar, PhD
David Bardach, PhD
Mimi Asafo-Adjei, MPH

Partners
Medical Home Network (MHN)
Cheryl Lulias, MPA
Sana Syal, MPH
Beth McDowell, MA
Monica Vuppalapati, MS
Jack Patlovich, BA

Cook County Health & Hospitals System (CCHHS)
James Kiamos, MBA
Andrea McGlynn, MSN
LaMorris Perry, MD
Caryn Stancik, MPA
Project Overview

This project will assess the implementation and impact of connectivity and communication between medical homes and social service agencies.

Aims

1) To examine how connecting medical homes and CBOs affects the identification of social risk, referrals to social service agencies, communication to "close the referral loop" and receipt of services addressing social risk.

2) To evaluate the impact of increased communication between medical homes and CBOs on patients’ quality of care and utilization of emergency and hospital services.
Connecting Social Services to Medical Care in Cook County
Project Aims

Research Objectives

Q1
What is the impact of connectivity between medical homes and CBOs on the quality of care and use of emergency and hospital services?

Q2
How does connectivity between medical homes and CBOs affect the identification and provision of services to address social risks?

Methodology

We will use a quasi-experimental design to understand the impact of connectivity on
1) identification and provision of services to address social risks,
2) quality of care, and
3) emergency and hospital utilization
Project Team

NCQA
- Leads quantitative and qualitative research activities
- Manages all aspects of project

Medical Home Network
- Recruits patients and providers
- Extracts quantitative data for analyses

Cook County
- Provides chart review data
- Provides permission for patient and provider interviews
<table>
<thead>
<tr>
<th>Advisor</th>
<th>Organization</th>
<th>Area of Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donald Dew</td>
<td>Habilitative Systems, Inc.</td>
<td>Social and community services: Building healthy communities through social support</td>
</tr>
<tr>
<td>Joshi Kiran</td>
<td>Cook County Dept. of Public Health</td>
<td>Public Health: Serves approximately 2.5 million residents in 125 municipality</td>
</tr>
<tr>
<td>Suresh Kumar</td>
<td>TextureHealth</td>
<td>Technical expertise in the Care Management space</td>
</tr>
<tr>
<td>Jacqueline McClendon</td>
<td>Patient perspective</td>
<td>Patient perspective from Lawndale Christian Health Center, an FQHC in the MHN ACO</td>
</tr>
<tr>
<td>Leena Sharma</td>
<td>Community Catalyst</td>
<td>Consumer perspective</td>
</tr>
<tr>
<td>Marc Rivo</td>
<td>Population Health Innovations, LLC</td>
<td>Population health and patient experience</td>
</tr>
<tr>
<td>Sara Standish</td>
<td>Health Leads</td>
<td>Connecting patients to the community-based resources they need to be healthy</td>
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</table>
### Population Served

<table>
<thead>
<tr>
<th>Total members/ patients ~150K</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Under 65 years of age</td>
<td>100%</td>
</tr>
<tr>
<td>Age 18 years of age and older</td>
<td>65%</td>
</tr>
<tr>
<td>Gender Female</td>
<td>50%</td>
</tr>
<tr>
<td>Race Black</td>
<td>44%</td>
</tr>
<tr>
<td>Race Caucasian</td>
<td>17%</td>
</tr>
<tr>
<td>Language Spanish as Primary</td>
<td>20%</td>
</tr>
<tr>
<td>Medical Conditions 6 or more</td>
<td>21%</td>
</tr>
<tr>
<td>Medical Conditions 4-5</td>
<td>15%</td>
</tr>
<tr>
<td>Medical Conditions 2-3</td>
<td>19%</td>
</tr>
<tr>
<td>Utilization At least 1 ED visit in a year</td>
<td>30%</td>
</tr>
<tr>
<td>Utilization At least 1 IP visit in a year</td>
<td>10%</td>
</tr>
<tr>
<td>Coverage ACA (Medicaid Expansion)</td>
<td>41%</td>
</tr>
<tr>
<td>Coverage FHP (Traditional Family Health Plan)</td>
<td>59%</td>
</tr>
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</table>
## Setting: Medical Homes

<table>
<thead>
<tr>
<th></th>
<th>Total patients</th>
<th>Patient panel per medical home</th>
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<tbody>
<tr>
<td><strong>Hospital Medical Groups:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 groups, 127 physician medical homes</td>
<td>13,866</td>
<td>109 (1-866)</td>
</tr>
<tr>
<td><strong>Federally Qualified Health Centers:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 groups, 147 FQHC medical homes</td>
<td>125,494</td>
<td>854 (4-8614)</td>
</tr>
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</table>
Project Overview
Project Overview

We are here
Project Overview

We are here
Study Design

Illustration of Stepped Wedge Approach: Data Availability and Timeframes
 Logic Model

Patients with social risks

Connectivity between Medical Home and CBOs

Identification of social risk

Selection of appropriate CBO

CBO understanding patient context

Closing of referral loop

Receipt of services

> Quality of care

< Utilization

Community Based Organizations (CBOs)
## Data Sources and Variables

<table>
<thead>
<tr>
<th>Topic / Data Source</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical home and intervention group</td>
<td>Medical home practice and start date on care management platform</td>
</tr>
<tr>
<td>Demographics (from MHNConnect)</td>
<td>Age, gender, race, ethnicity, language preference</td>
</tr>
<tr>
<td>Social risk (from MHNConnect)</td>
<td>• Need help getting food/clothing/housing</td>
</tr>
<tr>
<td></td>
<td>• Friend/relative/neighbor who could care for you for a few days</td>
</tr>
<tr>
<td></td>
<td>• Housing type (shelter, halfway house, homeless)</td>
</tr>
<tr>
<td></td>
<td>• Physically / emotionally safe</td>
</tr>
<tr>
<td></td>
<td>• Transportation issues</td>
</tr>
<tr>
<td>Information on how social risks are</td>
<td>• Referral(s) to CBOs</td>
</tr>
<tr>
<td>addressed (from MHN Connect)</td>
<td>• Whether CBO viewed patient in system</td>
</tr>
<tr>
<td></td>
<td>• Whether CBO provided service</td>
</tr>
<tr>
<td></td>
<td>• Whether social risk factor was addressed</td>
</tr>
<tr>
<td></td>
<td>• Whether response was provided to medical home</td>
</tr>
<tr>
<td>Quality measures (claims-based)</td>
<td>• 7/30 day follow up visit after hospitalization</td>
</tr>
<tr>
<td></td>
<td>• Breast Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>• Colorectal Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>• Transition of Care-Continuity and Coordination of Care</td>
</tr>
<tr>
<td>Utilization measures</td>
<td>• Inpatient Hospital Utilization</td>
</tr>
<tr>
<td></td>
<td>• Emergency Department Utilization</td>
</tr>
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</table>
Qualitative Interviews

How did the process work? How well did it meet your needs? What could be improved?
Project Timeline

Advisory Panel Meetings
- First Meeting (2018)
- Second Meeting (2019)
- Third Meeting (2019)

IRB Protocol
- IRB Submission (2018)
- Obtain Approval (2019)

Qualitative Research
- Develop Interview Protocol
- Recruit Participants
- Conduct Interviews
- Conduct Analyses & Write Report

Quantitative Research
- Extract Data
- Conduct Analyses
- Conduct Analyses & Write Report
Impact

• Our work will inform public policy efforts to encourage assessing and addressing of social risk factors by medical homes and payors.
• This is particularly salient to value based payment and health outcomes.
• This project will also provide actionable information to health systems and communities on how to implement connectivity between medical homes and community-based social services providers.
Commentary Speakers
Cheryl Lulias
Medical Home Network

Commentary Speaker 1
Communication, Collaboration & Connectivity Across the Continuum
CommunityCare: Virtual Connections to Support Comprehensive Care

Standardized workflows & actionable interventions
Changing What Counts as Health Care

Addressing Patients’ Social Needs at Scale

Sara, Principal, Evaluation
February 21, 2018
We envision a healthcare system that addresses all patients’ *basic resource needs* as a *standard* part of quality care.

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*Our Vision*
Our Solutions

20+ years of empowering healthcare organizations to integrate social needs into care delivery with learning, consulting and technology solutions:

**Design**
Create your social needs strategy through our interactive workshops or hands-on coaching

**Implement**
Integrate social needs into care delivery and improve over time with our Implementation Services

**Enable**
Manage patients and track success using our Reach social needs technology
Our Clinical Partners

- Kaiser Permanente
- University Hospitals
- Dayton Children’s
- Boston Medical Center
- Johns Hopkins Medicine
- The Dimock Center
- Codman Square Health Center
- Contra Costa Regional Medical Center & Health Centers
- Baylor Scott & White Health
- NYC Health + Hospitals
- Yale New Haven Health
- Children’s Hospital of Wisconsin
- Massachusetts General Hospital

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A patient perspective

Additional barriers:
- Legal support for unsafe housing
- Applications for food and other essential needs (SNAP, WIC)
- Utilities support (LIHEAP)
- Coordination of transportation (in multiple languages)
- Applications for insurance and or prescription benefits
Hospital-based screen & refer intervention

Patient presents for care

Screening and triage

Intake

Follow-up

Clinical communication

Resource referral and Action Plan

Increased connectivity could:

- Increase likelihood and speed of contact
- More consistently close the referral loop
- Improve successful referrals
- Identify gaps in the resource landscape
- Improve partnerships / care coordination
Questions?

www.systemsforaction.org
Upcoming Webinars

http://systemsforaction.org/research-progress-webinars

Upcoming

Wednesday, March 28, 2018 12-1pm ET/ 9-10am PT  
**UNCOMPENSATED CARE PROVISION AND THE IMPLEMENTATION OF POPULATION HEALTH IMPROVEMENT STRATEGIES**  
Systems for Action National Program Office  
Principal Investigators: CB Mamaril, PhD, and Glen Mays, PhD, MPH

Wednesday, April 11, 2018 12-1pm ET/ 9-10am PT  
**TESTING AN INTEGRATED DELIVERY AND FINANCING SYSTEM FOR OLDER ADULTS WITH HEALTH AND SOCIAL NEEDS**  
New York Academy of Medicine, New York University  
Principal Investigators: Jose Pagan, PhD, and Elisa Fisher, MPH, MSW

Wednesday, April 25, 2018 12-1pm ET/ 9-10am PT  
**TESTING A SHARED DECISION-MAKING MODEL FOR HEALTH AND SOCIAL SERVICE DELIVERY IN EAST HARLEM**  
New York City Department of Health and Mental Hygiene  
Principal Investigators: Carl Letamendi, PhD, MBA, and Jennifer Pierre
Acknowledgements

*Systems for Action* is a National Program Office of the Robert Wood Johnson Foundation and a collaborative effort of the Center for Public Health Systems and Services Research in the College of Public Health, and the Center for Poverty Research in the Gatton College of Business and Economics, administered by the University of Kentucky, Lexington, Ky.
Social risk factors such as low socioeconomic status are linked to poor health outcomes, increased emergency department (ED) visits and impact health care quality, cost, and use. Assessing and addressing these social risk factors can lead to improved patient outcomes.

However, making connections between organizations who provide social services addressing these risk factors and those who provide medical services is very challenging due in part to systems which do not “talk” to each other. In this study researchers will evaluate the linking of information technology systems between patient-centered medical homes and social service providers as a means of improving the health and well-being of Medicaid patients.

The research team will investigate if the use of a web-based communication and care management platform that digitally connects medical homes and social service providers improves the identification and delivery of services to address social risks, quality of care, and unnecessary ED utilization.

Findings from this study will identify best practices and guidance for other communities.