Linking Medical Homes to Social Service Systems for Medicaid Populations

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

Research-in-Progress Webinar
January 27, 2021
12-1pm ET

Agenda

Welcome: Chris Lyttle, JD
S4A Deputy Director

Presenters: Keri Christensen, MS • Sarah Hudson Scholle, DrPH •
Phil Saynisch, PhD • Jeni Soucie
National Committee for Quality Assurance

Commentary: Caroline Fichtenberg, PhD
Social Interventions Research & Evaluation Network

Q&A: Chris Lyttle, JD

Presenter

Sarah Hudson Scholle, DrPH

Dr. Scholle is Vice President, Research and Analysis, at the National Committee for Quality Assurance. Dr. Scholle is an expert in health services and quality measurement in multiple settings and 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. She leads NCQA efforts work to expand measures for vulnerable populations; this includes leading health equity innovation efforts for the CMS Office of Minority Health. 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.

Keri Christensen, MS

Keri Christensen, MS is an innovation-driven strategist, program manager, and intrapreneurial leader with 15+ years of success at the intersection of health information technology, data, and healthcare with a focus on social risk and health equity. She serves as the Director of Strategy Implementation at the National Committee for Quality Assurance.

Presenter

Dr. Saynisch is the Phyllis Torda Health Care Quality Fellow at the National Committee for Quality Assurance. He is also 2019 graduate of the Health Policy (Management) PhD at the Harvard Business School and Graduate School of Arts and Sciences. His work aims to identify the drivers of performance for healthcare organizations and providers, and the mechanisms by which this performance can change over time.

Phil Saynisch, PhD

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Improving health care.

Caroline Fichtenberg, PhD

![siren - Social Interventions Research & Evaluation Network]

Caroline Fichtenberg, PhD is the Managing Director of the Social Interventions Research and Evaluation Network (SIREN) and Research Scientist in the Department of Family and Community Medicine at the University of California, San Francisco. In these roles, she leads efforts to conduct, catalyze, and disseminate high quality research on health sector strategies to reduce health inequities by addressing social determinants of health. She brings to these positions more than a decade of experience working to improve health and economic outcomes for America's most vulnerable families, including seven years working on national efforts in Washington, DC. While Director of Research at the Children's Defense Fund (CDF), she led the development of a report that identified nine federal policy changes that could reduce child poverty by 60 percent. As Director of Epidemiology and Planning at the Baltimore City Health Department, she oversaw the city's first analysis of neighborhood health inequities that uncovered a 20-year gap in life expectancy between the richest and poorest neighborhoods of the city. Caroline also served as director of the Center for Public Health Policy at the American Public Health Association (APHA).
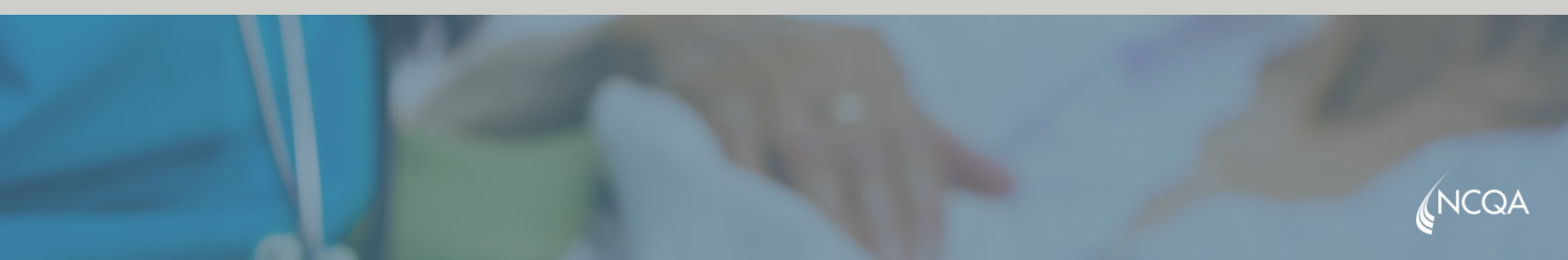
Agenda

- Project Overview
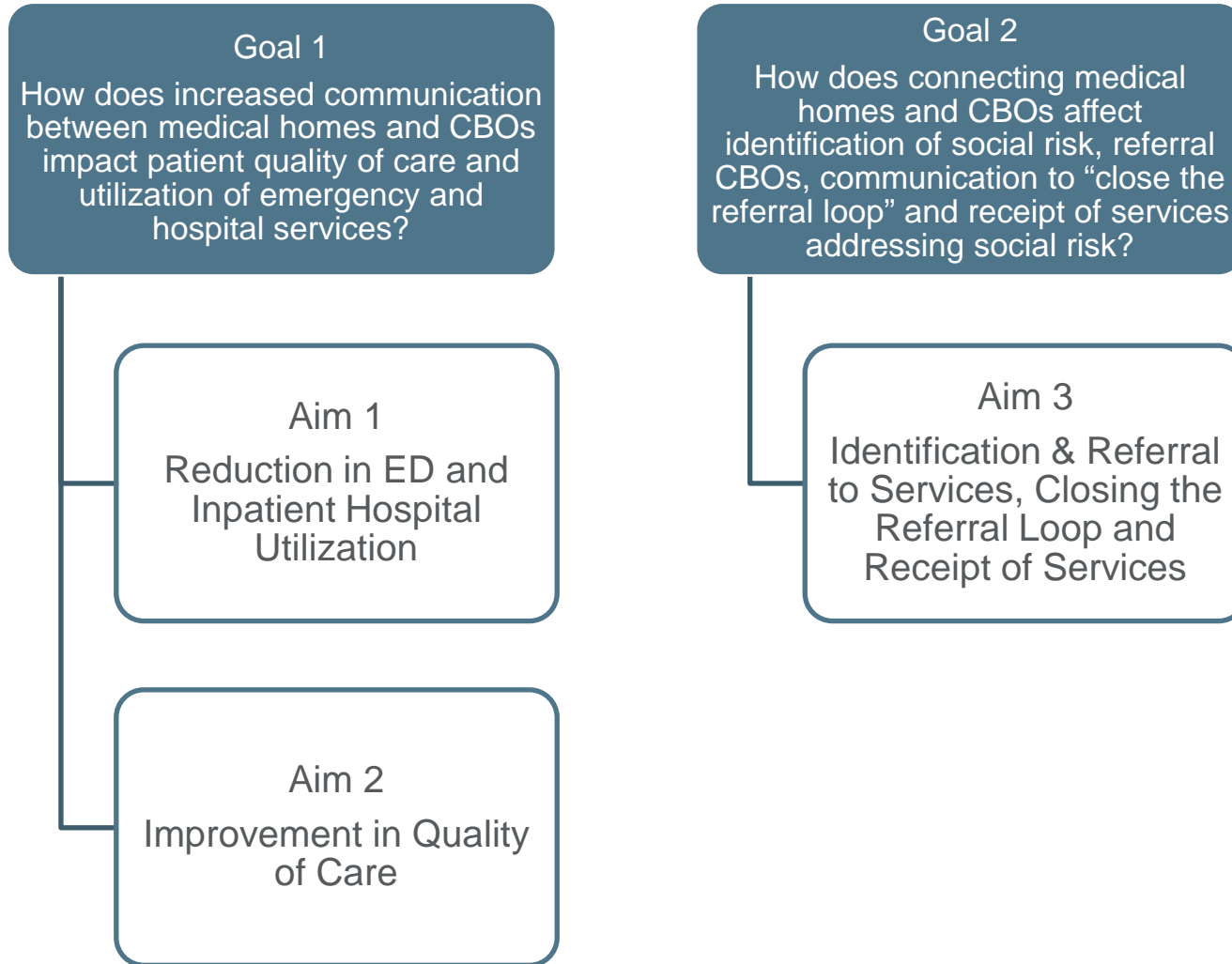
- Qualitative Findings

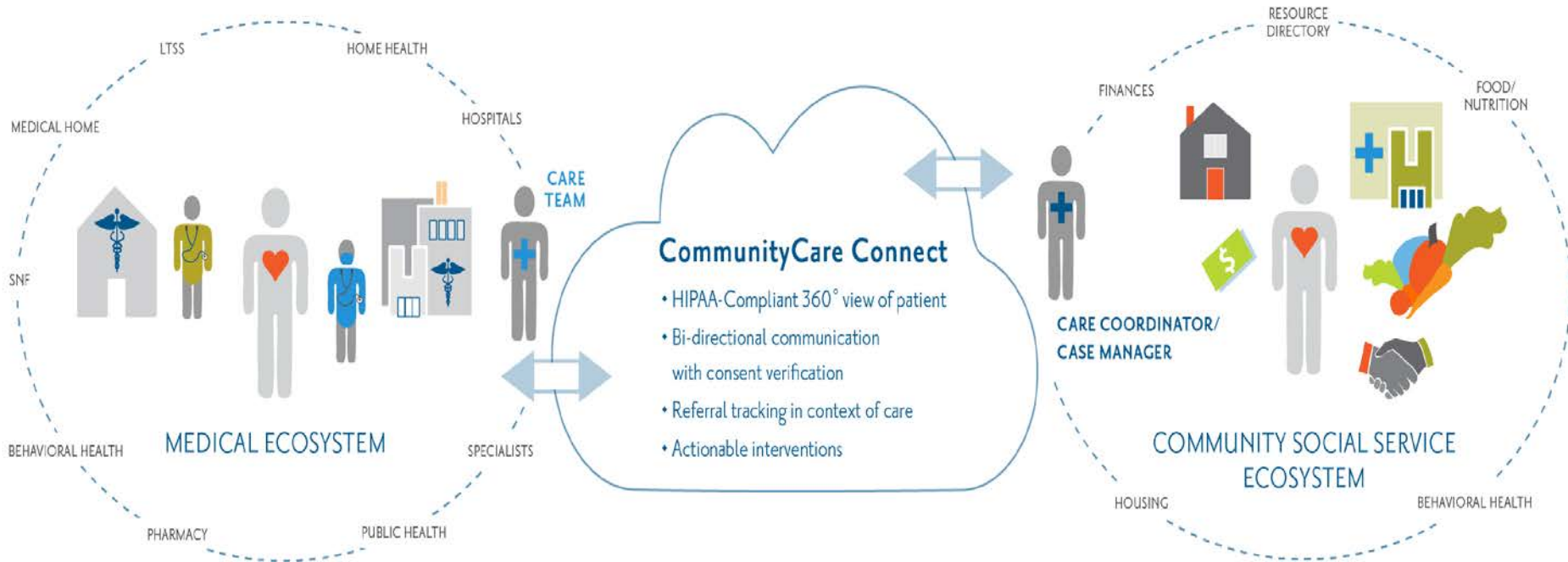- Quantitative Work

Project Overview

Project Background

Originally Proposed Work: Goals & Aims

Goal 1

How does increased communication between medical homes and CBOs impact patient quality of care and utilization of emergency and hospital services?

Goal 2

How does connecting medical homes and CBOs affect identification of social risk, referral CBOs, communication to "close the referral loop" and receipt of services addressing social risk?

Aim 1

Reduction in ED and Inpatient Hospital Utilization

Aim 2

Improvement in Quality of Care

Aim 3

Identification & Referral to Services, Closing the Referral Loop and Receipt of Services

Connectivity Platform Workflow

Project Plan Revisions

Original project plan: evaluate the impact of connecting medical homes and CBOs

Barriers: Data sharing challenges, leadership transitions and CBO capacity for engagement
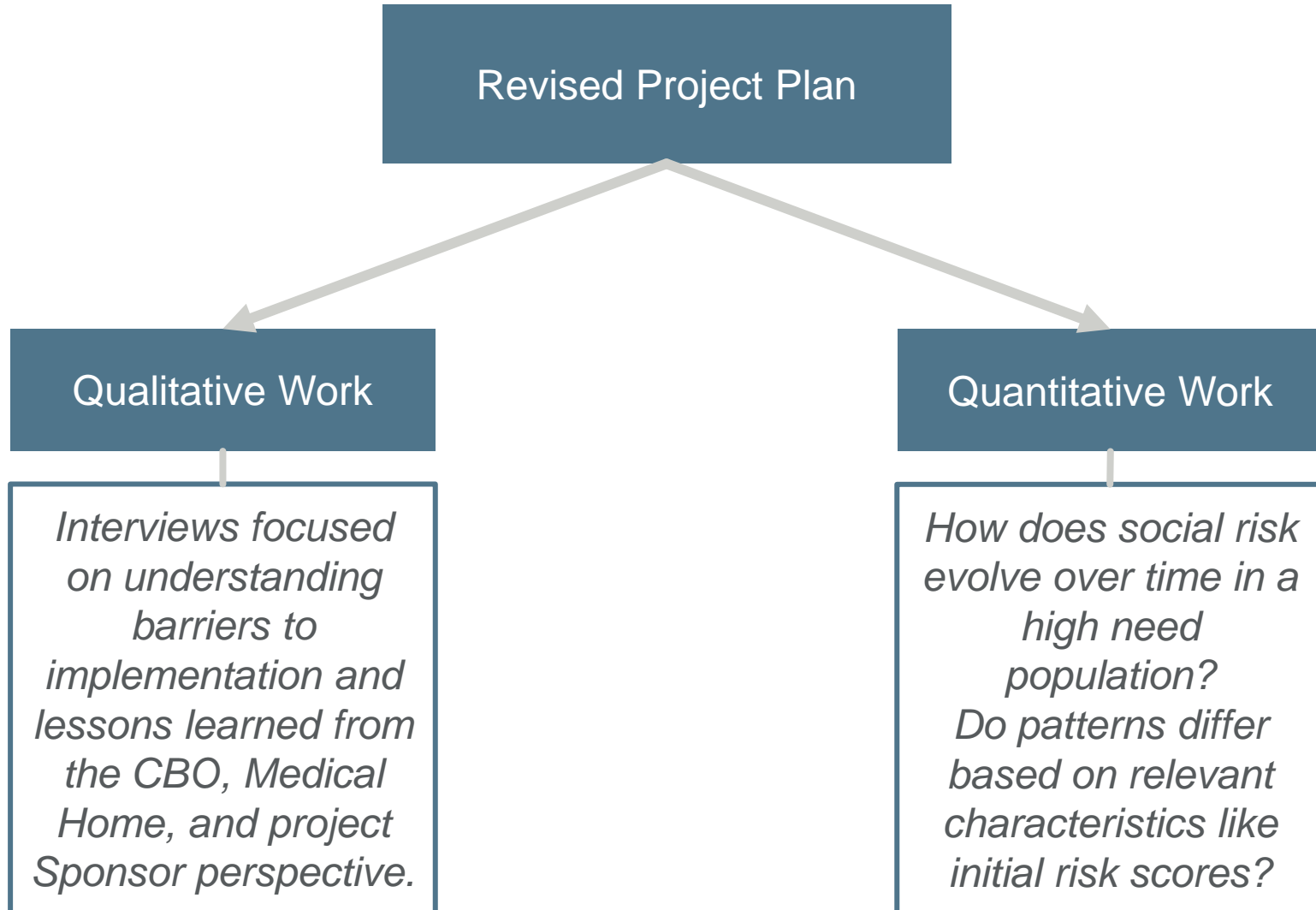
Delay in project implementation and evaluation
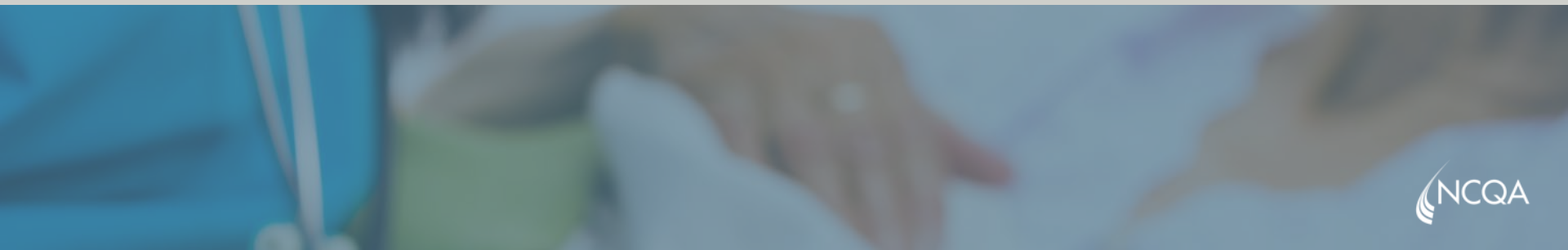
Revised project plan

Revised Project Plan

Qualitative and Quantitative Work

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│      Revised Project Plan       │
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Qualitative Work

Interviews focused on understanding barriers to implementation and lessons learned from the CBO, Medical Home, and project Sponsor perspective.

Quantitative Work

How does social risk evolve over time in a high need population?
Do patterns differ based on relevant characteristics like initial risk scores?

Qualitative Work

Revised Project Plan

Qualitative Work

Goal:
- Understand barriers to implementation and lessons learned from staff at CBOs, Medical Homes, and project sponsor.

Setting:
- Medical Homes and CBOs in Cook County, IL who were engaged to integrate the bidirectional communication features of the platform into their organization's workflow.

Methods:
- 23 half hour interviews were conducted either in person or by phone across 9 organizations.
- 4 leadership level staff, 8 project owners, and 11 end users were interviewed.

Findings:
- The team identified key themes which allowed us to develop a set of 10 issue types. The lessons learned and corresponding recommendations are tied to at least one issue type.

10 Issue Types Identified

HIPAA Concern includes whether sharing or receiving patient information from another provider or organization is compliant with HIPAA requirements.

Part 2 Concern looks at whether sharing or requesting information that may be related to substance use disorders and/or treatment is acceptable.

Patient Consent addresses whether a patient has given explicit consent for information to be shared with other providers and organizations.

Trust/Relationships includes concerns about the level of trust and working relationship needed between staff from different organizations for them to feel comfortable sharing information and that they will receive timely, accurate responses to questions, referrals, or requests.

Consistent Engagement include making sure that all the right people are at the table and stay at the table throughout the project as well as ensuring equitable participation by different types of stakeholders.

10 Issue Types Identified

Data Availability encompasses both ensuring that information on the appropriate patients or clients is found in the platform, as well as having the expected type and amount of information available with high levels of accuracy.

Vision/Goal Alignment includes ensuring all participants have a shared understanding as to why the project is happening and that all participants feel that they will benefit significantly from the work and resources they put into the project.

System Integration addresses how to best integrate the new platform and data into an organizations current system.

Workflow Alignment addresses whether a new platform is compatible with the user's current workflow and provides a benefit, or if the platform creates a burden for the user.

Education encompasses project participants' knowledge level about why the project is happening and its significance, along with how to use the platform. Additionally, education issues include understanding HIPAA and Part 2 compliance, and what an organization needs to meet those requirements.

Recommendations

By Staff and Organization Type

	LEADERSHIP	PROJECT MANAGEMENT
FUNDER/ HEALTH PLAN	Recommendation 13.2: Provide funding or other benefits to organizations, such as CBOs, that will likely not receive financial benefit from the platform.	
IMPLEMENTER	Recommendation 13.1: Provide access to the platform, workflow consultation, implementation support and ongoing support at no cost to CBOs.	Recommendation 13.3: Ensure the team works to gain a clear understanding of CBOs' goals and needs. Recommendation 13.4: Work with CBOs to identify reasons that will motivate them to participate.

Lesson Learned 13

There were few clear benefits to CBOs for adding new workflows. Simply providing CBOs access to more information about their clients for free wasn't enough to drive adoption of a separate technology system.

Issue, Staff and Organization Types

Staff Type
Leadership
Project Owner
End User

Organization Type
Health Plan
Implementer
Community-Based Organization
Medical Home

Issue Type
HIPAA Concern
Part 2 Concern
Patient Consent
Trust/Relationships
Consistent Engagement
Data Availability
Vision/ Goal Alignment
System Integration
Workflow Alignment
Education

End-Product

Qualitative Work

- **End-Product:** A white paper including context of our work, lessons learned and recommendations.

Opportunities for Dissemination
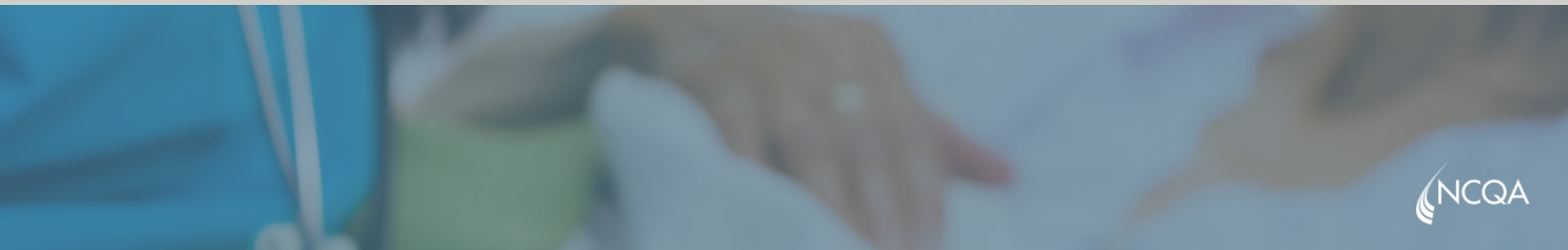
Messaging
- Website
- Blog
- Newsletter

Social
- Twitter
- Inside Healthcare Podcast

Panels
- Consumers
- Public Policy

Quantitative Work

Documenting Social Needs Over Time

Problem: Understanding the evolution of social needs is important to managing population health and evaluating the usefulness of health risk assessment (HRA) tools

- However, frequent patient churn due to changing eligibility status, empanelment and other factors complicates following a population
- Long time series and large sample from our setting allows us to follow patients over time and document trends

Research Question: How do social needs change over time in a Medicaid population? Do patterns differ based on relevant characteristics like initial risk scores? Which social needs change over time?

Revised Project Overview*

Recent Efforts

Setting:

- Medical Home Network (MHN) is an accountable care organization (ACO) providing care management to patients in a Medicaid Managed Care arrangement with CountyCare, in Cook County, IL
- Through MHN ACO's decentralized model, care managers are hired by medical homes. Patients required to complete HRA once per eligibility spell at minimum, though many complete multiple HRAs, collected by medical home staff by phone or in-person

Data:

- 100,153 unique patients 18-64, up to 5 years of HRAs (2015-2019)
- HRA includes factors like difficulty paying for medications, lack of social support, transport/housing barriers, and difficulty getting essentials
- Supplemental data on ED, IP and PCP utilization

Methods:

- Descriptive analyses

HRA Data Description*

- Of 100,153 patients, 10.7% have at least one HRA in three or more consecutive years - this is subsample we focused on

- Patients are stratified into four risk levels for care management based on social risk factors, plus utilization and comorbidities: High, Medium, Low, and Low with Social Risk.

- The low-risk category is split into two groups because one has significant social risk factors that would benefit from additional care management.

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Defining Social Risk*

- Wide range of social needs explored in the HRA
- Because of close relationships between factors collected, collapsed to five major need categories

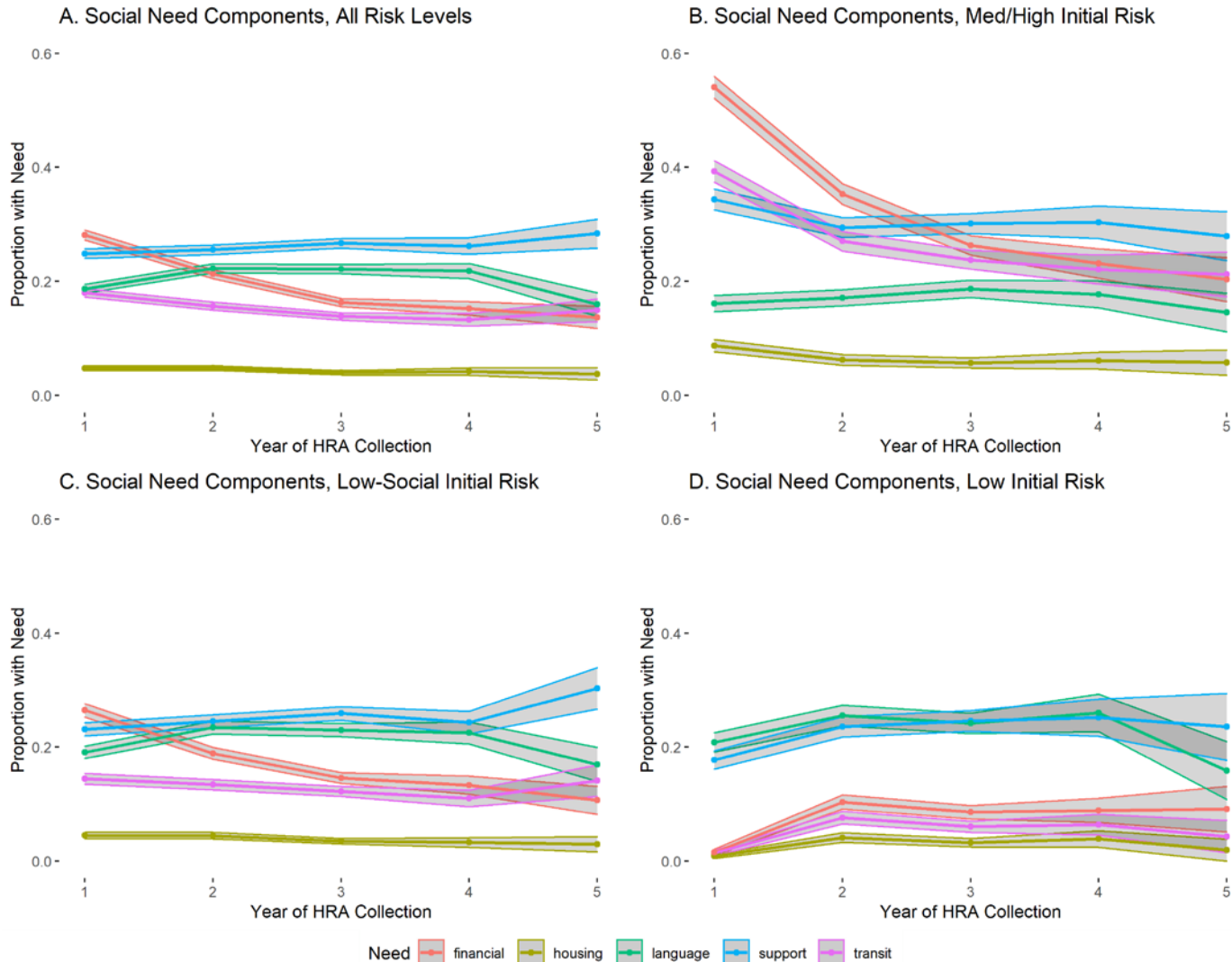| Risk Factor	Components
Support	• Patient lives alone • There is no responsible adult who can take care of them for a few days • Member needs assistance making appointments
Transit	• Need help with transportation to medical appointments
Housing	• Member lives in shelter or is homeless • In temporary housing • Feels safe at home
Financial	• Have essentials such as food and housing • Have difficulty paying for medication
Language	• Primary language isn't English

Social Need Count Results*

Mean health risk assessment score, by initial risk
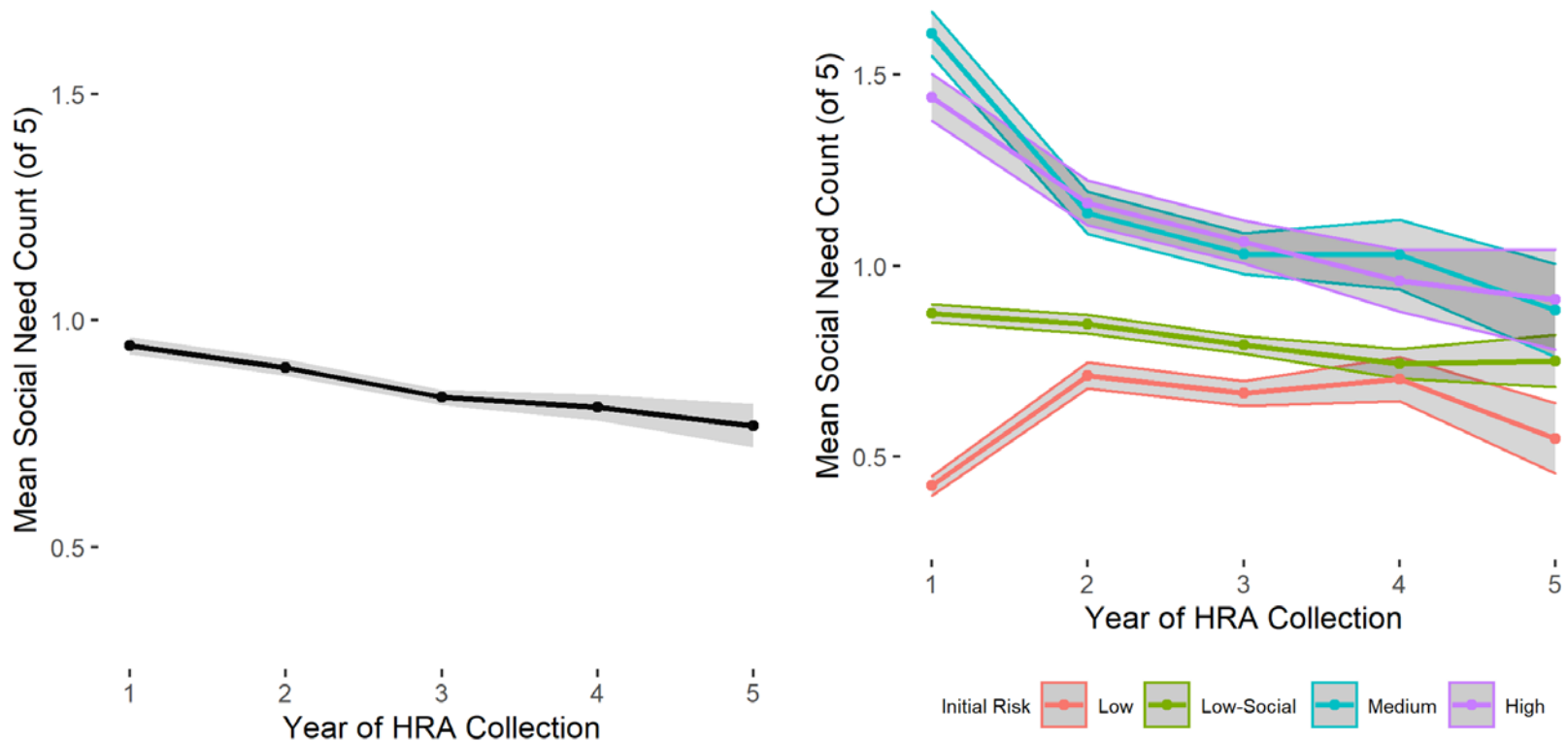
- Downward trend in measured social risk over time
- Trend driven by medium- and high-risk individuals (~16% of sample)
- Flatter trajectory for lower-risk subgroup, increased count among lowest-risk

Changes by Social Need Results*

Changing needs over time

A. Social Need Components, All Risk Levels

B. Social Need Components, Med/High Initial Risk

C. Social Need Components, Low-Social Initial Risk

D. Social Need Components, Low Initial Risk

Need — financial — housing — language — support — transit

Changes by Social Need Results*

Changing needs over time

- Overall:
  - Largest decline in stated financial barriers over time
  - Slight increase in language needs from first to second year of HRA data

- Medium- and High-Risk Enrollees
  - Larger declines in unmet financial and transit needs

- Lowest-Risk Enrollees
  - Increases across all measured categories

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Discussion

- Key limitation - selected sample
  - Only required to collect *one* HRA. Low risk group may represent subset who had unreported risks emerge over time
- Decline in unmet needs driven by medium- and high-risk subgroups consistent with care management working (though not definitive)
- Financial needs and transit needs most likely to be met
- Increase in self-reported language needs – potentially result of financial barriers being lowered?
- Stresses importance of standard assessment repeated over time – at least for a large subset of patients, unmet social needs change over time

Lessons Learned & Recommendations

Lesson Learned
End users wanted to know that the partner organization receiving the message will be checking the platform regularly and will provide a timely response.
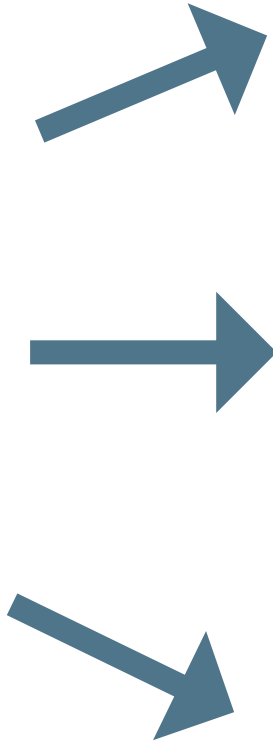
Recommendation #1
Design the platform to ensure messages are responded to quickly even if a specific user is out of the office or otherwise unavailable.

Recommendation #2
Publish transparent statistics showing average response times overall and by organization for different types of messages.

Recommendation #3
Identify a platform champion at each individual organization. Users with concerns or resistance to the platform can talk with a colleague rather than having to go to leadership or the project management team.

Lessons Learned and Recommendations

Lesson Learned

The sponsoring health plan, as well as the already connected medical homes saw the new platform as a way for medical homes to make referrals and connect patients to CBOs and get information back from CBOs. However, CBOs didn't see medical homes as their primary way of being connected to new clients, and therefore this new communication method wasn't seen as critical to their workflows.

Recommendation

Consider what need(s) CBOs have and how their platform can address those needs and market the platform accordingly. Consider messages such as, "this is a resource you can use to help get your patients reconnected with their medical home".

Lessons Learned and Recommendations

Recommendation #1
Create a memorandum of understanding (MOU) document which will create a plan for the project team in the event a specific leader or project manager leaves the organization. This helps ensure that the success of the project isn't dependent on individual relationships.

Recommendation #2
Work across participating organizations to build a professional pipeline for staff in key roles. Developing a clear career ladder can help mitigate some of the staff turnover and developing a professional pipeline can help strengthen the CBOs.

Recommendation #3
Frequently educate staff about the purpose of the project and how it will benefit their patients and clients.

Lesson Learned
Staff and leadership turnover affected CBOs' participation, project decision making, and implementation speed.

Recommendation #4
Fund additional training and development programs to increase the pipeline of trained individuals with the skill sets to do care management and care coordination work at CBOs.

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Lessons Learned & Recommendations

Lesson Learned
Unintentional inequities can arise when you have a multiorganizational governance structure. Some participants on the advisory committees or governance council will be able to do so during their working hours, and be paid for their work, while other organizations or community members may not be able to be compensated for that time.

Recommendation
Define processes that are equitable to allow everyone to participate. Consider how to equitably compensate people and organizations who want and need to be represented on these shared governing bodies but don't have a budget or funding source to be paid for their time.
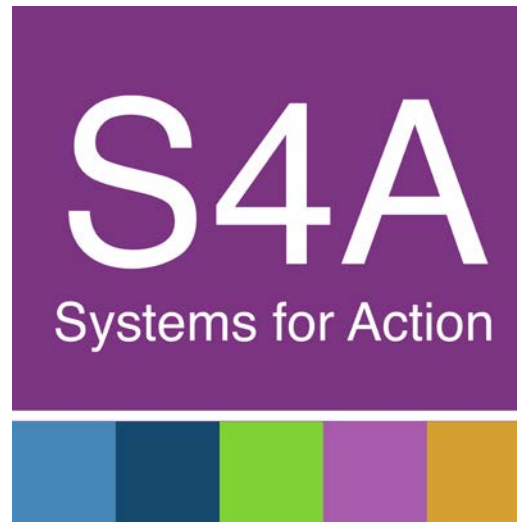
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Questions?

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Feb. 10 Effectiveness of Early Childhood Development Partnerships in Addressing Pediatric Health and Social Needs during the COVID-19 Pandemic

Feb. 24 Changes in Capacity to Absorb Clinical-to-Community Referrals during the COVID-19 Pandemic

Mar. 10 Using Whole Person Care to Coordinate Health and Social Services for Medicaid Populations during the COVID-19 Pandemic

Apr. 7 Effectiveness of Homeless Service Networks in Coordinating Services during COVID-19

April 21 Multi-Dimensional COVID-19 Control in US: Identifying Counties with High and Low Levels of Success

Acknowledgements

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