Systems for Action
National Coordinating Center
Systems and Services Research to Build a Culture of Health

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

College of Public Health
Center for Public Health Systems and Services Research

Agenda

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.

Presenter

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).

Presenter

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.

Commentary Speaker

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.

Commentary Speaker

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

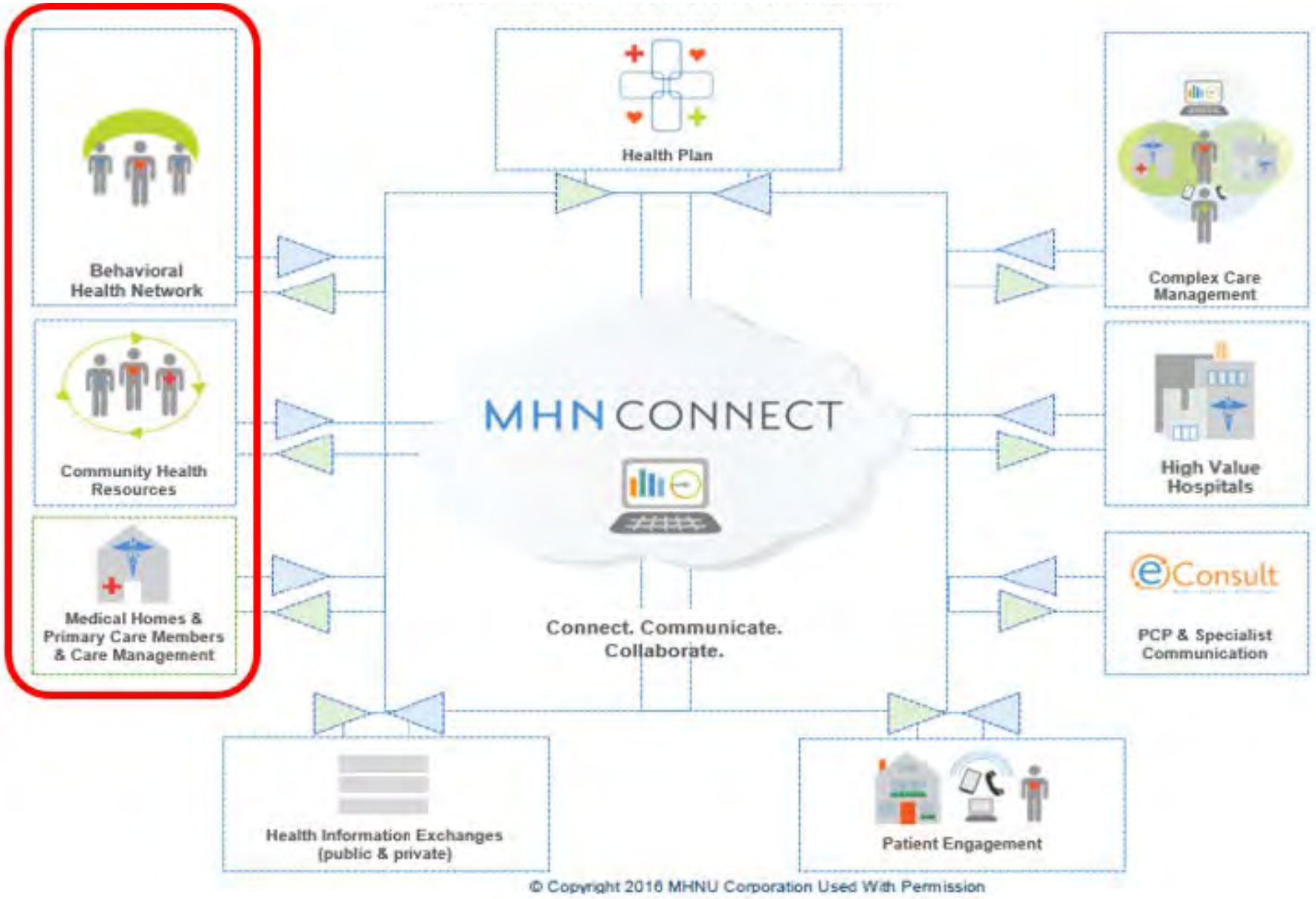
This project will assess the implementation and impact of connectivity and communication between medical homes and social service agencies.

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

Advisory Committee

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

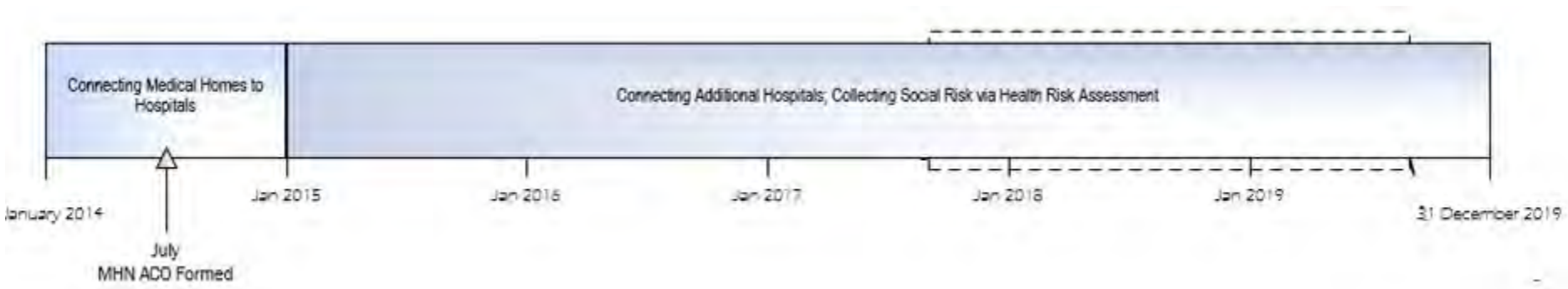
Population Served

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

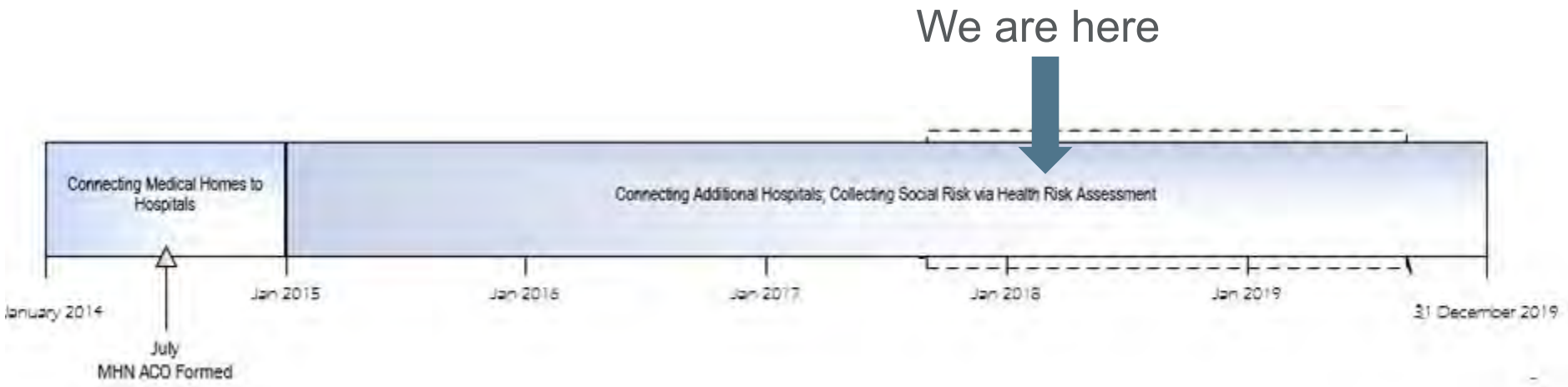
Setting: Medical Homes

	Total patients	Patient panel per medical home
Hospital Medical Groups: 3 groups, 127 physician medical homes	13,866	109 (1-866)
Federally Qualified Health Centers: 26 groups, 147 FQHC medical homes	125,494	854 (4-8614)

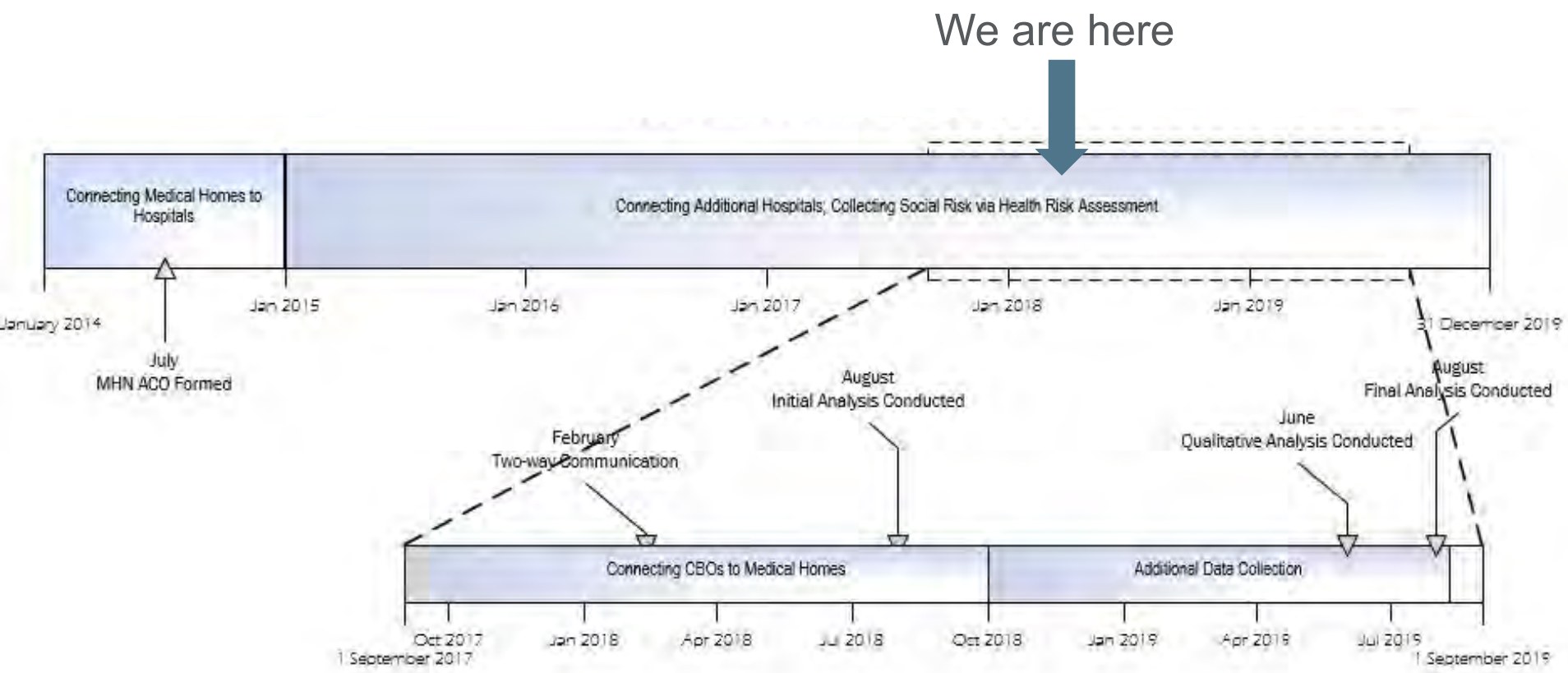
Project Overview



Project Overview

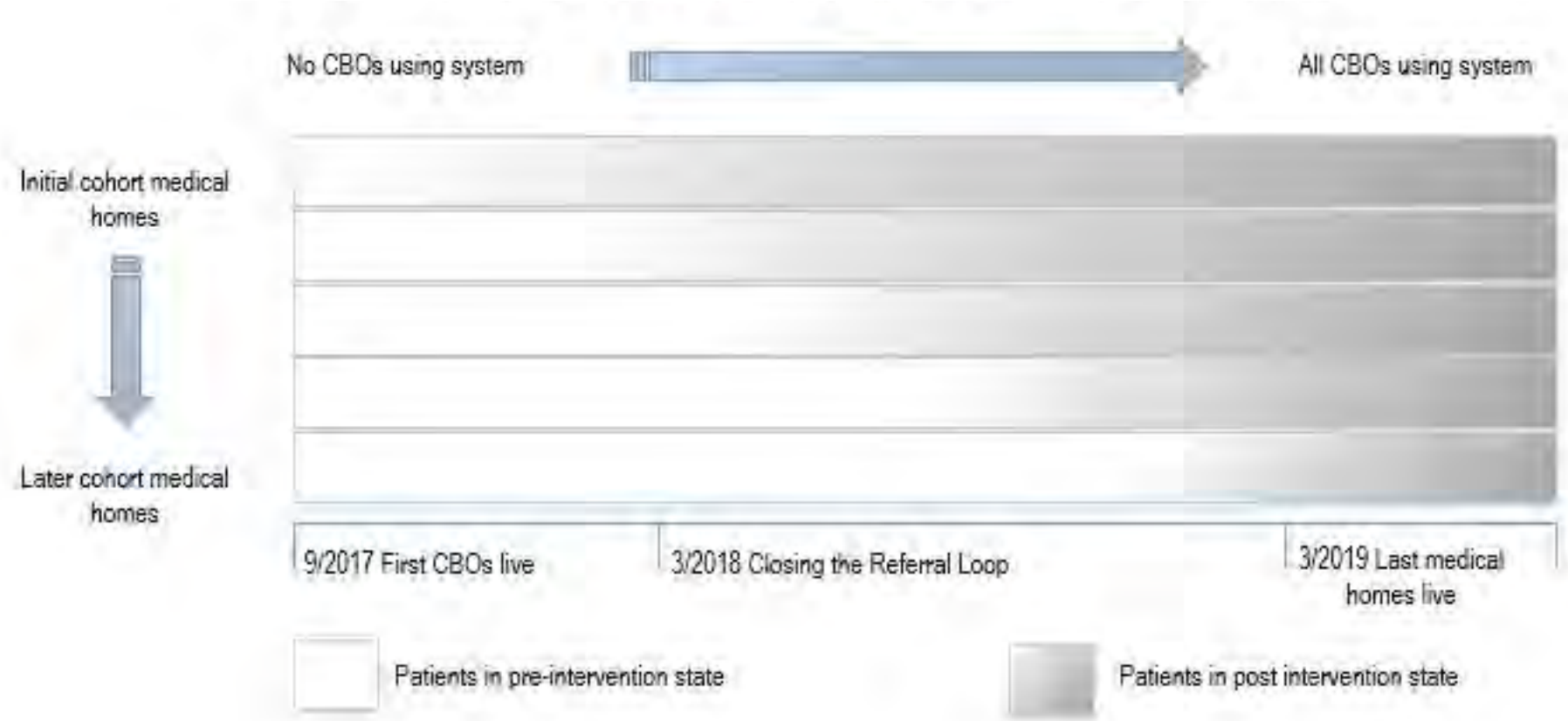


Project Overview

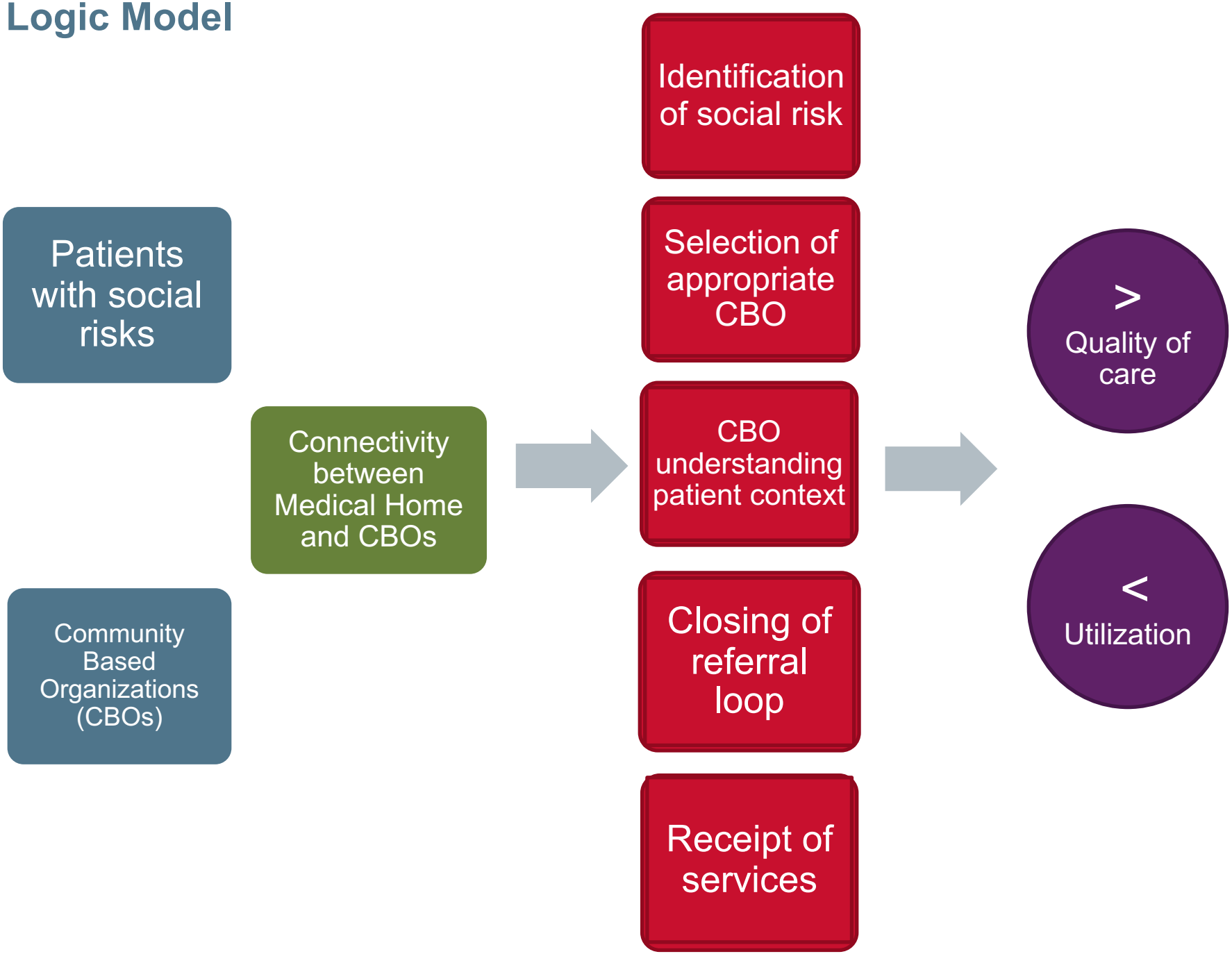


Study Design

Illustration of Stepped Wedge Approach: Data Availability and Timeframes



Logic Model

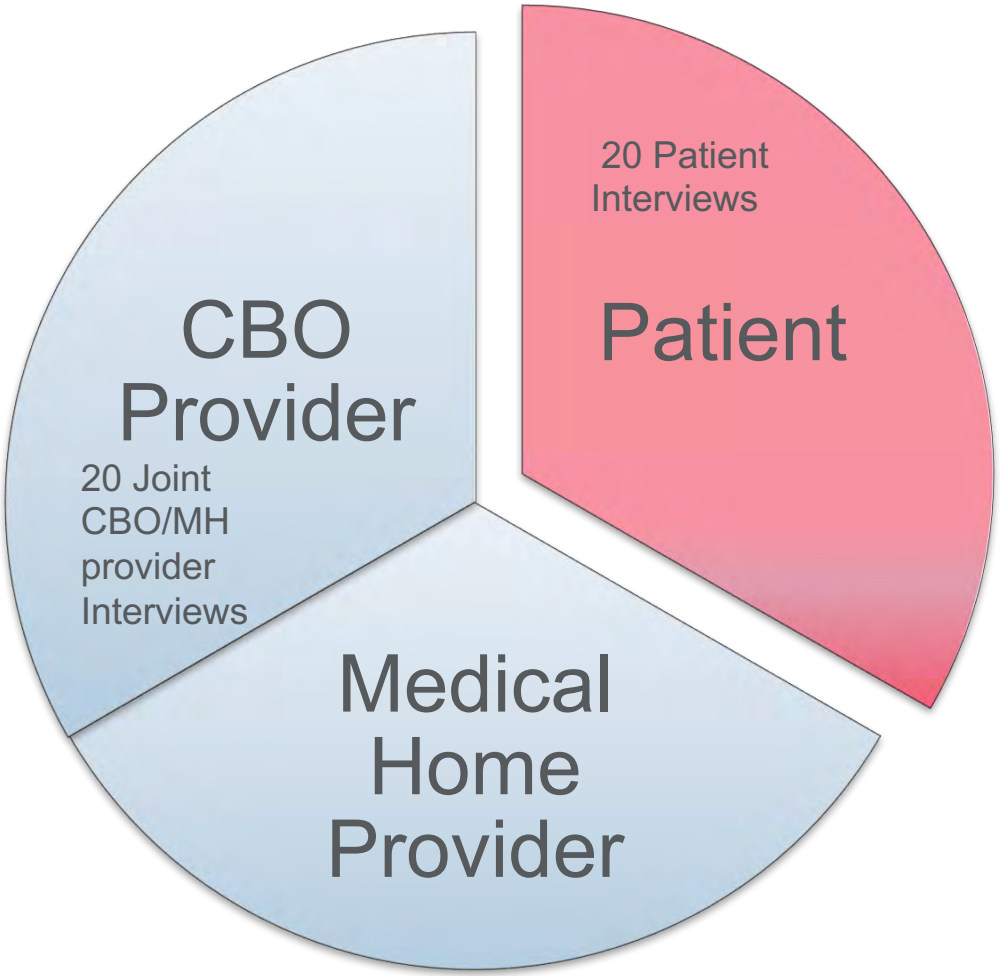

Patients with social risks
Community Based Organizations (CBOs)
Connectivity between Medical Home and CBOs
Identification of social risk
Selection of appropriate CBO
CBO understanding patient context
Closing of referral loop
Receipt of services
> Quality of care
< Utilization

Data Sources and Variables

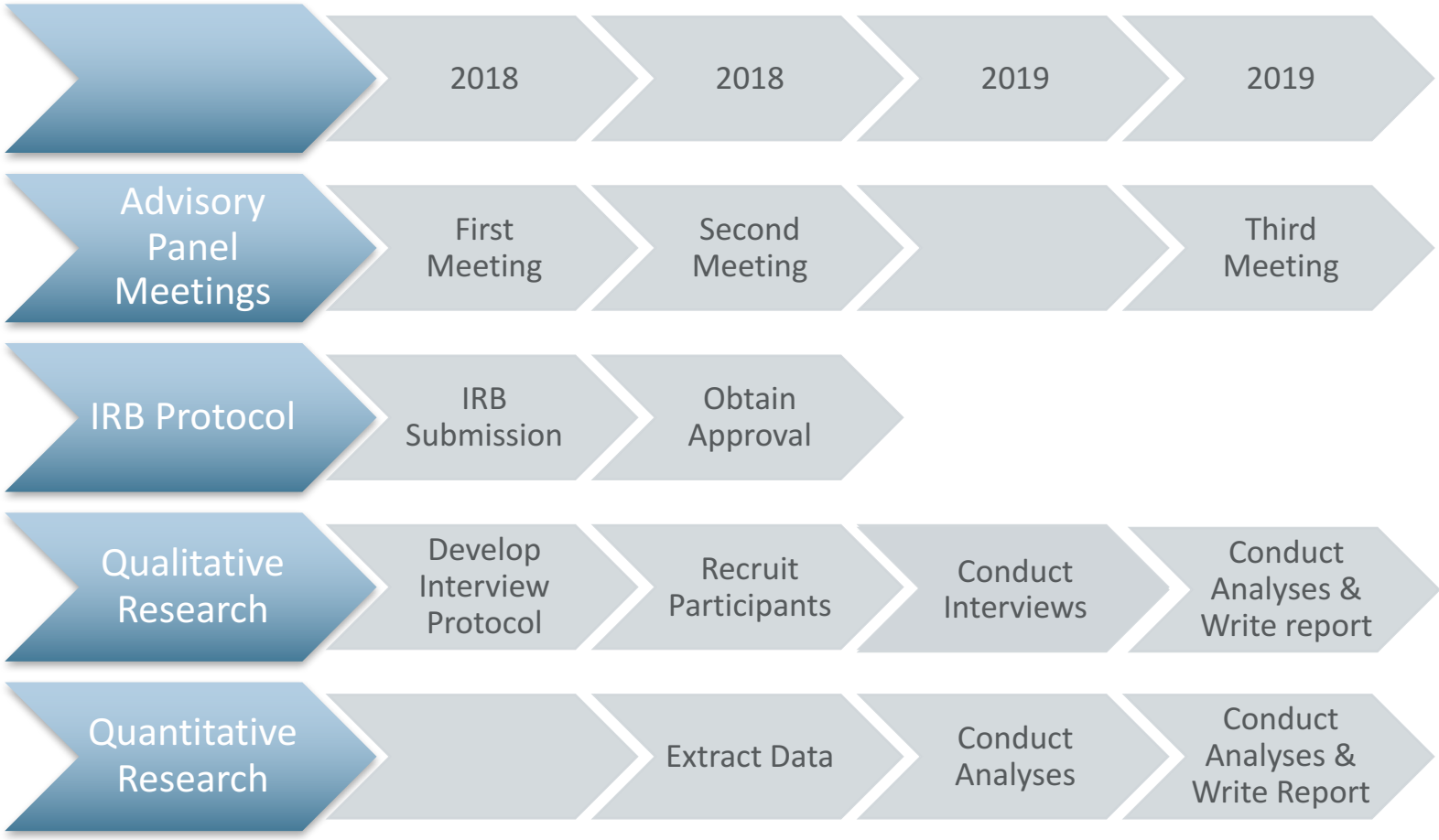
Topic / Data Source	Variables
Medical home and intervention group	Medical home practice and start date on care management platform
Demographics (from MHNConnect)	Age, gender, race, ethnicity, language preference
Social risk (from MHNConnect)	• Need help getting food/clothing/housing • Friend/relative/neighbor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

Qualitative Interviews

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



Project Timeline



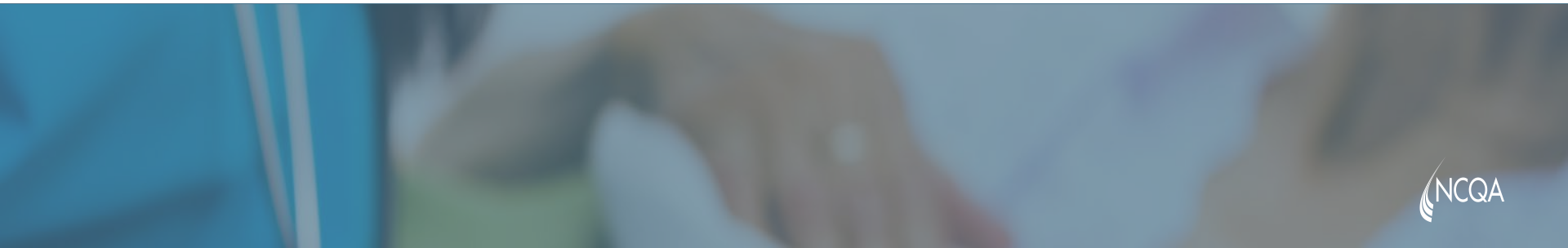
Impact

- 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.

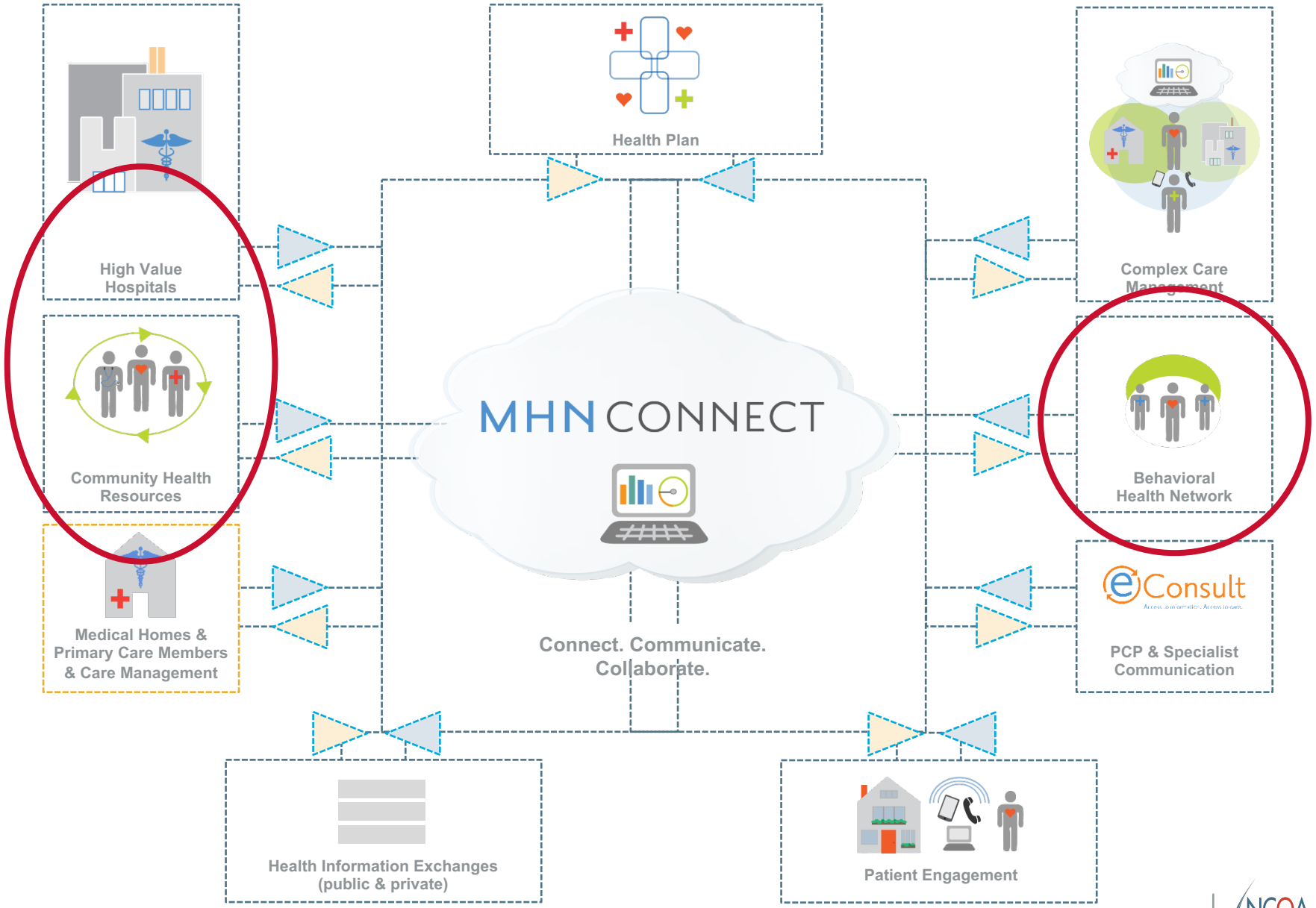
Commentary Speakers

Commentary Speaker 1

Cheryl Lulias
Medical Home Network

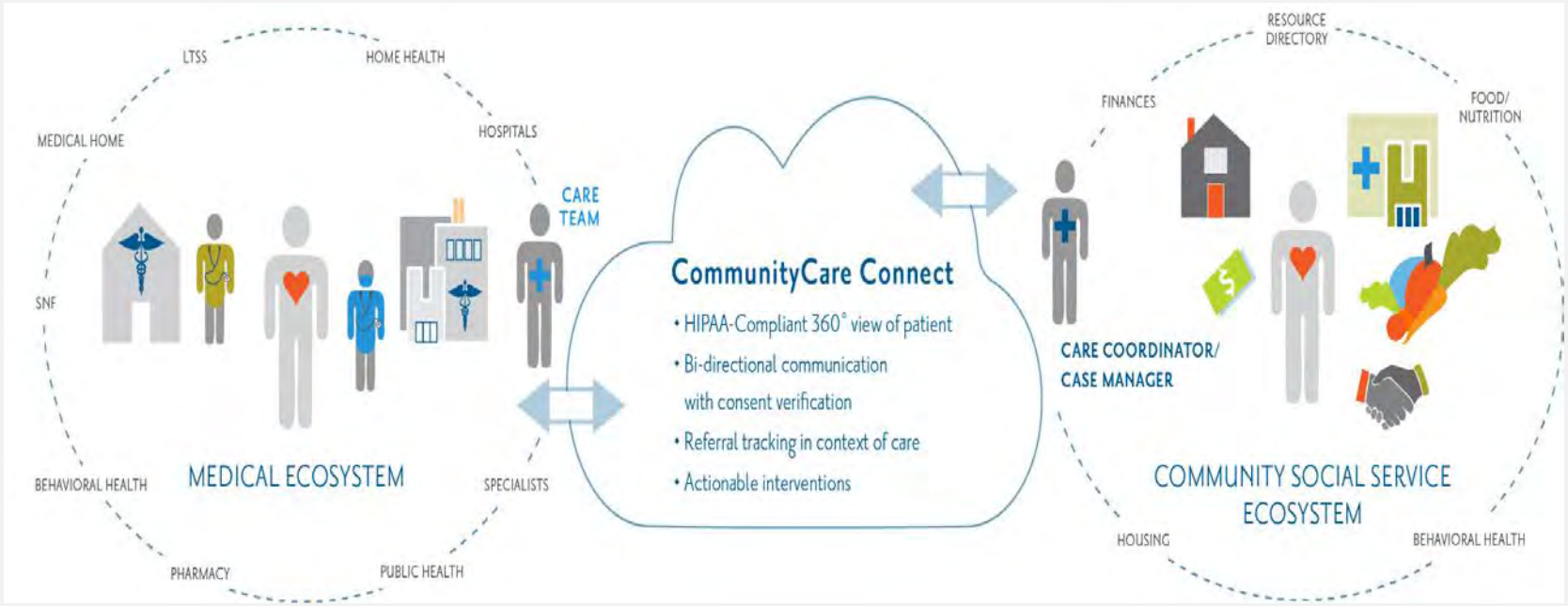


Communication, Collaboration & Connectivity Across the Continuum



NCQA

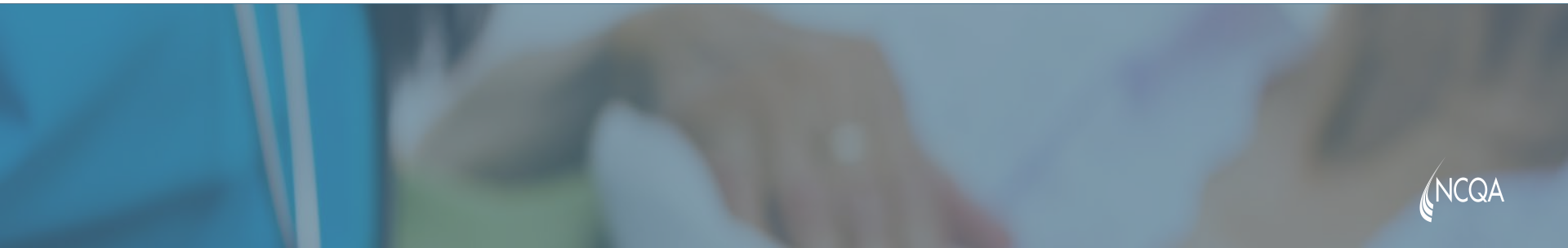
CommunityCare: *Virtual Connections to Support Comprehensive Care*



Standardized workflows & actionable interventions

Commentary Speaker 1

Sara Standish
Health Leads



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.

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

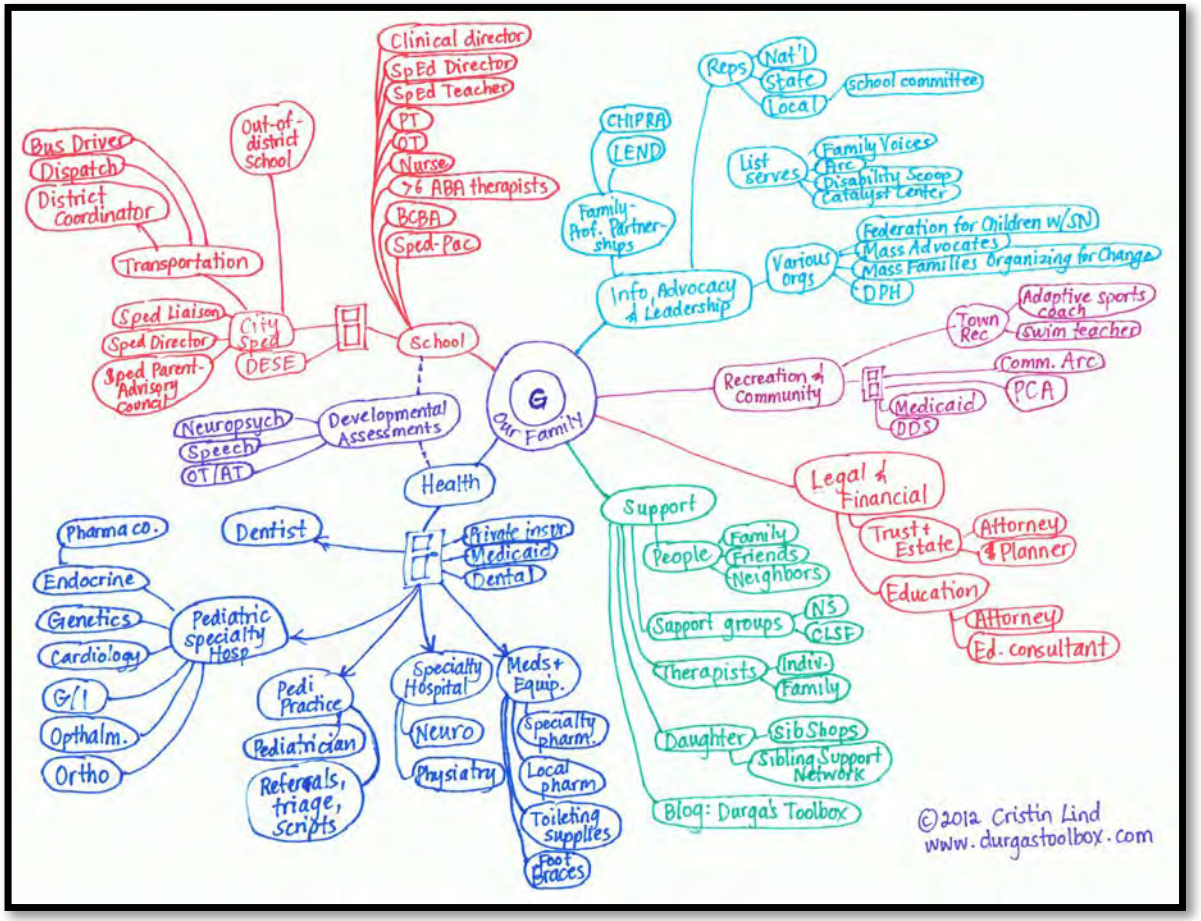
Integrate social needs into care delivery and improve over time with our Implementation Services

Enable

Manage patients and track success using our Reach social needs technology

Our Clinical Partners

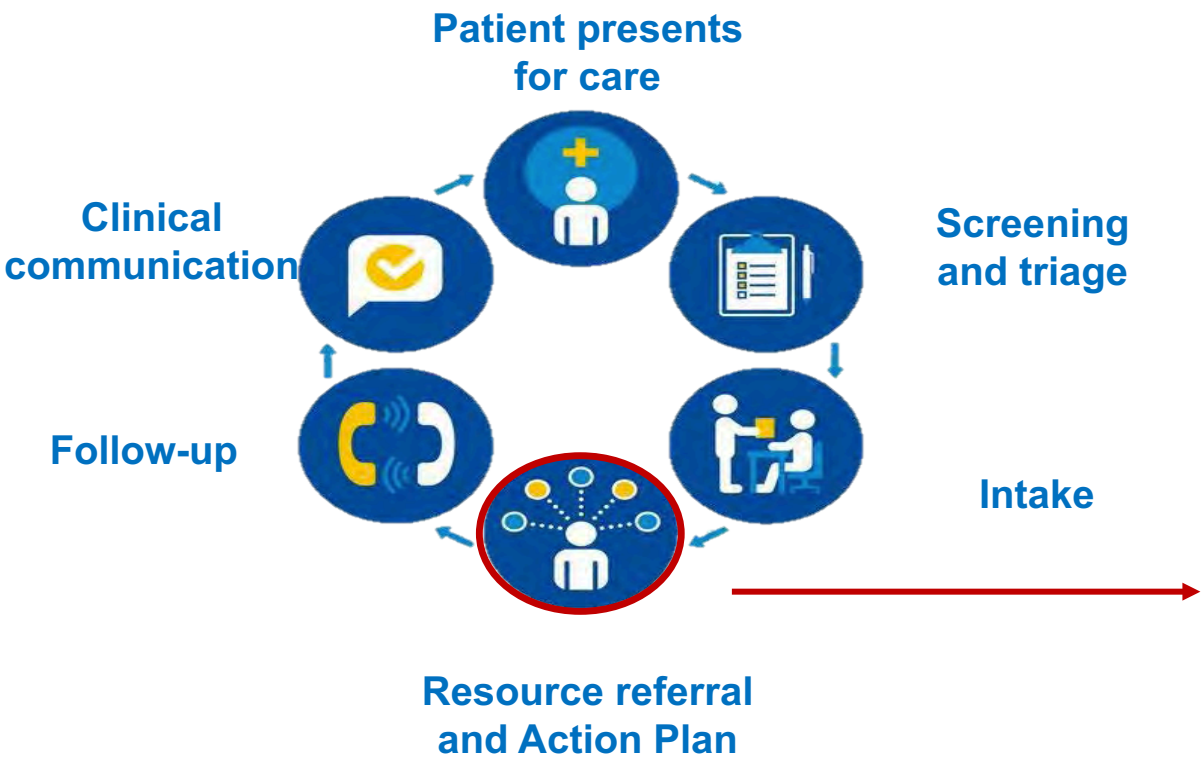
A patient perspective



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



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


NCQA


MEDICAL HOME NETWORK


COOK COUNTY HEALTH
& HOSPITALS SYSTEM
CCHHS

Questions?

Questions?

www.systemsforaction.org

Upcoming Webinars

Archives

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.

College of Public Health
Center for Public Health Systems and Services Research

and

Gatton College of Business and Economics

Topic Summary

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.