Health Systems Transformation Research Coordinating Center (HSTRC)

Grantee Webinar

Avalere Health | An Inovalon Company
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Introduction of HSTRC Grantee Projects

Denver Health

HOPE: **H**ousing as an **O**pportunity to **P**romote health **E**quity: A Housing and Integrated Health Model of Care

Model of Care Components

- Persons experiencing homelessness (PEH)
- Housing and Integrated Health Model of Care
  - Supportive housing
  - Interdisciplinary care
  - Community advisory panel
  - Peer navigators
  - Integrated data systems
  - Program evaluation/quality improvement

Evaluation Description

- Feasibility and acceptability of a model of care that integrates existing data to align housing and services to PEH
- Established DH-CCH partnership Community Advisory Board will help direct the program, evaluation and interpretation
- Qualitative analyses among PEH, healthcare and service providers

Outcomes of Interest

- Program feasibility and acceptability
- Among PEH:
  - Housing stability
  - Program engagement and retention
  - Healthcare and service utilization
  - Health and social outcomes

Key Partners

- **Colorado Coalition for the Homeless (CCH)** – a local non-profit provider of housing, integrated health care, and supportive services
  - CCH provides care to an estimated 15,000 persons annually

PEH: Persons Experiencing Homelessness; DH: Denver Health; CCH: Colorado Coalition for the Homeless

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Denver Health

What do you think your grant will contribute to the HSTRC Research Agenda?

- PEH face disproportionate marginalization and stigmatization when accessing health care services, and frequently have sparse or fragmented social networks and high levels of social isolation, which have been linked to adverse mental and physical health outcomes
- By better aligning needs with housing prioritization and care, and incorporating community perspective at the core of our program, Project HOPE aims to:
  - Uplift and establish protocols and a replicable Model of Care for assessing and meaningfully addressing needs among PEH
  - Leverage and integrate existing data to establish Risk Tiering stratification and data to measure program processes and outcomes
  - Improve upon current methods for prioritizing patients for housing
  - Provide holistic care for persons with unmet housing, food and social needs

HSTRC: Health Systems Transformation Research Coordinating Center; PEH: Persons Experiencing Homelessness

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Heartland Health Centers

Building Relationships Into Care Delivery to Grow Equity (BRIDGE)

Model of Care Components

- "Relationship-Based Care Model" with care team coordinators (CTCs) who serve as patient liaison, guide, coordinator, & coach throughout the care experience
- Population Heartland serves low income (91% below federal poverty line) patients of all ages, including many immigrants & refugees that are best served in a language other than English

Evaluation Description

- We will compare and contrast 3 sites within Heartland Health Centers
- We will engage Medicaid beneficiaries through:
  - Surveys on their perceptions of care
  - Observations of their interactions with their care team
  - EHR and referral outcome data

Outcomes of Interest

- Referral use and outcomes, and patient-level use of indicators of quality (e.g., recommended cancer and mental health screenings, outcomes indicating chronic disease management, and avoidance of inappropriate medication prescriptions)
- Patients' perceptions of health knowledge, care team empathy, and their ability to follow a care plan

Key Partners

- **Heartland Health Centers** – federally-qualified health center network
- **UIC School of Public Health** – research leads
- **NowPow** – community referral platform that addresses SDoH
- **AllianceChicago** – health information technology and data experts

CTC: Care Team Coordinator; EHR: Electronic Health Record; UIC: University of Illinois at Chicago; SDOH: Social Determinants of Health

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Heartland Health Centers

What do you think your grant will contribute to the HSTRC Research Agenda?

- Describe implementation of an innovative two-caregiver (provider + CTC) model using a comprehensive, integrated approach in outpatient clinics that care predominantly for Medicaid patients
- Measure whether this relationship-based (focused on relationships rather than transactions) care model leads to improved preventive care, chronic disease management, and better linkage to social services
- Evaluate the impacts of this care model on patient knowledge, patient satisfaction, and whether patients wholistic social needs are addressed
- Examine how a two-caregiver model can enhance learning, problem-solving, and understanding among providers, CTCs, and patients

HSTRC: Health Systems Transformation Research Coordinating Center; CTC: Care Team Coordinator

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Johns Hopkins University School of Medicine

The Impact of Telehealth Access on Health Equity for Patients, Families, and Community Members in Two Medicaid-Focused Pediatric Primary Care Models

Model of Care Components

- 2 Pediatric Primary Care Medical Homes
  - Harriet Lane Clinic
  - Children's Medical Practice
- Multidisciplinary models
- Both sites launched telehealth March 2020
- Both sites have CAB/FAB
- > 90% of patients insured by one MCO

Evaluation Description

- Qualitative interviews to understand patient/family and stakeholder insights regarding telehealth experience and opportunities/challenges for future (English & Spanish)
- Quantitative comparison of cost and quality (HEDIS) data for in person versus telehealth visits 3/15/20-12/15/20

Outcomes of Interest

- Qualitative themes from patients/parents/stakeholders
- HEDIS - Well child visits, immunizations, weight/nutrition counseling, ADHD fu
- Cost – visit charges, payment, travel/time saved
- Recommendations from Pediatric Medicaid Telehealth Equity Summit

Key Partners

- HLC Community Advisory Board
- CMP Latino Family Advisory Board
- Centro SOL (Salud/Health and Opportunity for Latinos)
- Johns Hopkins Center for Health Equity
- Johns Hopkins Healthcare LLC/Priority Partners MCO

CAB: Community Advisory Board; FAB: Family Advisory Board; MCO: Managed Care Organization; HLC: Harriet Lane Clinic; CMP: Children's Medical Practice

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Johns Hopkins University School of Medicine

What do you think your grant will contribute to the HSTRC Research Agenda?

- Telehealth was understudied in pediatrics prior to COVID-19, particularly among Medicaid-insured children who had little access (payment/policy).
- Community, patient/family, and stakeholder input from two Medicaid-insured populations with ability to compare and contrast.
- Quantitative analysis of cost and quality data may facilitate longer term policy and payment reform.
- Engagement of local stakeholders through Pediatric Medicaid Telehealth Equity Summit from health system and payor could lead to refining of models of care.

HSTRC: Health Systems Transformation Research Coordinating Center

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NORC at the University of Chicago

Advancing Equitable Models of Care for Medicaid-Eligible Children Served by Head Start Programs: Implementation and Evaluation of Telehealth Services

Model of Care Components

- The study will evaluate a telehealth service delivery model for rural Head Start (HS) programs serving culturally & linguistically diverse children.
- One goal is to improve access & reduce disparities for Medicaid-eligible populations within rural communities.
- Another goal is to develop a sustainable Medicaid finance model.

Evaluation Description

- A mixed-methods, randomized control trial design will address the primary study research questions.
- The study team will partner with two HS programs across two states, where 4 centers from each HS program will be randomly assigned to either a telehealth intervention or control condition).

Outcomes of Interest

- Effectiveness of a telehealth model of care in HS on improved health care access, patient experience, and reduced costs.
- Key child health improvements compared to the previous year, and to control sites.
- Staff and parents' experience of health care access and services for their children.
- Issues and opportunities for providers

Key Partners

- National Migrant & Seasonal Head Start Association
- National Indian Head Start Director's Association
- Community Action Partnership of San Luis Obispo
- San Luis Obispo Community Health Center
- Other HS programs & health providers.

HS: Head Start

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NORC at the University of Chicago

What do you think your grant will contribute to the HSTRC Research Agenda?

- *Strengthen evidence examining health system models of care that address the goals and needs of Medicaid-eligible individuals.*
  - NORC is partnering with HS centers that serve culturally & linguistically diverse Medicaid-eligible children, often from rural and underserved communities.
  - NORC is conducting a randomized control intervention to understand the effects of telehealth services on improved health care access and important health outcomes.
- *Identify and evaluate resources that can help to ensure health system model of care sustainability*
  - NORC seeks to understand the sustainability of telehealth payment models with Medicaid-eligible populations for the continued access to health care.
  - NORC plans to develop a comprehensive toolkit to provide step by step costs, procedures, and implementation strategies for broader adoption of telehealth services for Medicaid-eligible populations served by HS programs.

HSTRC: Health Systems Transformation Research Coordinating Center; HS: Head Start

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San Francisco Department of Public Health

Impact of a New Street Crisis Response Team on Service Use Among San Francisco's Homeless Population with Mental and Substance Use Disorders

Model of Care Components

- **SF Street Crisis Response Team (SCRT)**: Dispatched by 911, real-time response in public spaces
- **Co-responder model**: paramedic, behavioral health clinician, peer
- **Target population**: Medicaid-eligible adults experiencing homelessness in mental health and/or substance use crisis

Evaluation Description

- **Interrupted Time Series design** to measure impact on key outcomes pre/post-implementation (Dec 2020)
- **Equity analysis** by stratifying outcomes by race/ethnicity
- **Qualitative semi-structured interviews** with target population re: facilitators and barriers to achieving positive outcomes

Outcomes of Interest

- **7/30-day post-crisis episode:**
  - **Linkage to outpatient mental health or substance use treatment**
  - **Acute service reutilization** (return to SCRT, ED, psych emergency, etc.)
  - **Assessment for supportive housing or long-term placement**

Key Partners

- **SCRT partners** – Fire, Police, Emergency Management, Mayor's office, etc.
- **University of California, San Francisco** – Program in Research for Implementation Science for Equity; Clinical Translational Science Institute
- **Heluna Health** – fiscal sponsor

SCRT: SF Street Crisis Response Team; ED: Emergency Department

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San Francisco Department of Public Health

What do you think your grant will contribute to the HSTRC Research Agenda?

- Provide new insights into the overall effectiveness of an increasingly popular mental health crisis services model (CAHOOTS) in a field that lacks rigorous research
- Focus on the impact of a new program aimed at serving San Francisco's highly vulnerable Medicaid-eligible homeless population in reducing disparities and advancing equity
- Critically examine the impact of a prominent publicly financed social services initiative designed to decrease the role of law enforcement in non-criminal mental health crisis response
- Demonstrate the power of data integration by utilizing San Francisco's Care Coordination Management System that links public EHRs (behavioral health and medical) to housing, jail, and public assistance data

HSTRC: Health Systems Transformation Research Coordinating Center; EHR: Electronic Health Record

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Sinai Urban Health Institute

Equitably Assessing the Impact of a Coordinated, Multidisciplinary Diabetes Care Model using Implementation Science and Participatory Approaches

Model of Care Components

- Clinical team (clinical care, education and support), Pharmacy team (medication decisions, adherence), Social Workers, CHWs, Navigators (address social and emotional needs), Data Analytics team (risk stratification and patient technology)
- Target Population: Low income, Medicaid-eligible individuals with prediabetes, diabetes, and other endocrine disorders

Evaluation Description

- Community Based Participatory Research Methods guided by Implementation Science Framework
- Community Health Workers will conduct patient interviews
- Patient Advisory Council will assist in conducting qualitative analysis

Outcomes of Interest

- Healthcare utilization (i.e., Emergency Department visits related to diabetes)
- Adherence (i.e., Ambulatory visits 3-6 months after entering Center)
- Satisfaction (Perception of knowledgeable/approachable clinical team)
- Health (i.e., A1c levels, weight)

Key Partners

- Patient Advisory Council
- Sinai Chicago's Information Systems Department
- Sinai Medical Group
- SUHI's Community Health Workers
- Community leaders

CHW: Community Health Worker

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Sinai Urban Health Institute

What do you think your grant will contribute to the HSTRC Research Agenda?

- Add to the evidence base on successful health system models aimed to address chronic disease burden in Medicaid-eligible populations in innovative and coordinated ways
- Explore the extent to which the Center integrates the RWJF-HSTRC Research Agenda's seven priority components, and determine how this approach leads to increase healthcare effectiveness and improvement in patient outcomes
- Explore how equitable participatory methods in evaluation can improve and/or sustain patient satisfaction, patient engagement and sustainability of a healthcare model

HSTRC: Health Systems Transformation Research Coordinating Center

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Trustees of Boston University

Advancing an Equitable Telehealth Delivery Model for Medicaid-Eligible Populations with Chronic Conditions at Federally Qualified Health Centers

Model of Care Components

- Equity-focused and primary care-based telehealth delivery model within a large Medicaid ACO comprised of FQHCs
- Committed to addressing full range of medical, behavioral, and social needs
- Model invests in telehealth capacity, training, and infrastructure at FQHCs across MA

Evaluation Description

- Aim 1: Evaluate the effects of telehealth on quality of care and patient experience among FQHC patients with chronic conditions
- Aim 2: Heterogeneity in effects across racial/ethnic and linguistic subpopulations
- Aim 3: Identify best practices for optimizing the quality and equity of telehealth in Medicaid-enrolled patients

Outcomes of Interest

- Inform playbook of best practices for local and national dissemination
- Inform how telehealth may optimize measured quality and equity within ACO contract
- Optimally integrate telehealth into the Integrated Primary Care Home Model via 1115 waiver (2023)

Key Partners

- Ariadne Labs: co-lead
- C3: health system partner, Medicaid ACO
- MA FQHC Telehealth Consortium
- Mass League of Community Health Centers

ACO: Accountable Care Organization; FQHC: Federally Qualified Health Center

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Trustees of Boston University

What do you think your grant will contribute to the HSTRC Research Agenda?

- Will generate quasi-experimental, mixed methods evidence on a promising telehealth delivery model for Medicaid enrollees served by FQHCs
  - Which clinical, racial/ethnic, and linguistic populations benefit? Which do not? How might the model mitigate or exacerbate inequities in quality of care and patient experience?
  - Equity-focused best practices and scalable solutions that can be disseminated to FQHCs, Medicaid-serving providers, and/or ACOs across the US
  - Identify challenges and gaps to be addressed
  - How to best integrate telehealth model into 1115 waiver to ensure health system sustainability

HSTRC: Health Systems Transformation Research Coordinating Center; FQHC: Federally Qualified Health Center; ACO: Accountable Care Organization

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University Hospitals of Cleveland

The Dose of the Web of Well-Being with Integrated Clinical Case Management to Reduce Inequities in Value in a Medicaid Population

Model of Care Components

- Intensive Clinical Case Management
  - Individuals with high complexity health conditions and any mental health disorder
  - Relational and longitudinal
  - Caseloads of 30:1 maximum
  - System-level integration, including primary care

Evaluation Description

- Medicaid beneficiaries consent to treatment and co-develop treatment plans
- Community Advisory Group
- Survey vs. Focus Group

Outcomes of Interest

- Primary Outcomes
  - Unplanned care (ED, inpatient admissions)
  - Total cost of all care
- Secondary Outcomes
  - Adherence to treatment (planned appointments, medications)
  - Variation between case managers
  - Impact of total time

Key Partners

- Medicaid Managed Care Organizations
- Community Partnerships (Unite Us)
  - MetroHealth
  - Cleveland Clinic

ED: Emergency Department

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University Hospitals of Cleveland

What do you think your grant will contribute to the HSTRC Research Agenda?

- Full integration of equity interventions into large health systems
- Integration of behavioral and behavioral health engagement traditionally confined to community mental health settings into large health systems
- Refinement of data gathering mechanisms that can be applied across larger population
- Improve equity through enhanced relationship through evidence-based model
- Correlate relationship, self-efficacy, mental illness, substance use disorders and overall health outcomes related to effectiveness of reducing disparities

HSTRC: Health Systems Transformation Research Coordinating Center

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University of Tennessee Health Science Center

Social Determinants of Health Treatment as an Essential Structural Change in Primary Care

Model of Care Components

- The model integrates siloed systems of care, promoting a culture of understanding poverty as an environmentally based condition
- An evidenced-based treatment of social determinants of health (poverty treatment) integrated into a system that traditionally focuses on treatment of physical and behavioral health

Evaluation Description

- Input on program design obtained via focus groups of key informants and stakeholders
- Focus group with health system providers and evaluation of training to obtain feedback on implementation challenges
- UTHSC researchers perform statistical analysis of program outcomes in collaboration with health system data team

Outcomes of Interest

- Improvements in the social determinant exposures and economic self sufficiency
- Reductions in health care utilization
- Improved physical and behavioral health conditions
- Reductions in the overall cost of care for low-income Medicaid-eligible Black and Hispanic patients

Key Partners

- University of Tennessee Health Science Center (UTHSC)
- Transition to Success (TTS)
- Cherokee Health Systems/FQHC
- TTS CARE (Coordinating All Resources Effectively) Network

UTHSC: University of Tennessee Health Science Center; TTS: Transition to Success; FQHC: Federally Qualified Health Center; CARE: Coordinating All Resources Effectively

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University of Tennessee Health Science Center

What do you think your grant will contribute to the HSTRC Research Agenda?

- The model is a structural and cultural change in the delivery of health care for persons who live in poverty
- The model addresses well established and sustained disparities in physical and economic health experienced by low-income, Medicaid-eligible minority populations
- The model points directly to the need for a defined approach (standard of care) based on science and data to understand and treat poverty as an environmentally-based condition caused by exposures to social determinants of health (SDOH)
- We provide empirical evidence of whether health outcomes can be further enhanced and sustained by the integration of an evidenced-based treatment of SDOH into a setting that traditionally focuses on treatment of physical and behavioral health

HSTRC: Health Systems Transformation Research Coordinating Center; SDOH: Social Determinants of Health

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