HEALTH EQUITY & QUALITY CARE SUBCOMMITTEE (HEQC) MEETING

March 28, 2023

VIRTUAL WebEx Meeting

10:30 AM – 12:00 PM

HFS
Illinois Department of
Healthcare and Family Services

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Healthcare and Family Services

OUR VISION FOR THE FUTURE

We improve lives.

- We address social and structural determinants of health.
- We empower customers to maximize their health and well being.
- We provide consistent, responive service to our colleagues and customers.
- We make equity the foundation of everything we do.

This is possible because:

We value our staff as our greatest asset.

We do this by:

Fully staffing a diverse workforce whose skills and experiences strengthen HFS.

Ensuring all staff and systems work together.

Maintaining a positive workplace where strong teams contribute, grow and stay.

Providing exceptional training programs that develop and support all employees.

We are always improving.

We do this by:

Having specific and measurable goals and using analytics to improve outcomes.

Using technology and interagency collaboration to maximize efficiency and impact.

Learning from successes and failures.

We inspire public confidence.

We do this by:

Using research and analytics to drive policy and shape legislative initiatives.

Clearly communicating the impacts of our work.

Being responsible stewards of public resources.

Staying focused on our goals.

Welcome To Health Equity & Quality Care Subcommittee

The Health Equity and Quality Care subcommittee is established to advise the Medicaid Advisory Committee concerning strategies to improve customer outcomes by ensuring that populations covered under Healthcare and Family Services' Medical Assistance program have efficient, cost effective, and timely access to quality care that meets their need without discrimination based on race/ethnicity, gender, primary language, disability, sexual orientation, or socio-economic status.

- ***This subcommittee shall:***
- Identify and Review evidence-based practices and programs that can improve patient care, population health outcomes by addressing strategies supporting the social determinants of health.
- Examine barriers that impact customer access to care and utilization of health care services and recommend strategies to mitigate these barriers.
- Recommend Improvements to quality metrics and indicators.
- Assess streamlined approaches to identifying gaps in the delivery of services to Medicaid Customers.
- Identify methods that can be modified or adapted to strengthen continuity of care.
- Develop data informed recommendations to improve program implementation and evaluation metrics.
- Recommend methods to improve provider participation and network adequacy.
- Review and provide recommendations on how the Department can mitigate health disparities and the impact on communities disproportionately affect by COVID-19.
- Consider and make recommendations on the definition of a "community" safety-net designation of certain hospitals
- Make recommendations on the establishment of a regional partnership to bring additional specialty services to communities.
- Review and make recommendations to address equity and healthcare transformation.

House Keeping

- **Meeting basics**
  - Please note, this meeting is being recorded.
  - To ensure accurate records, please type your name and organization, into the chat.
  - If possible, members are asked to attend meetings with their camera's turned on, however, if you called in, please note all meeting materials referenced today including this presentation deck will be made available to you on the MAC & Subcommittee website following this meeting. If you need assistance accessing this material, please email Melisha.Bansa@Illinois.gov & Kyle.Daniels@illinois.gov
  - If you have questions during the meeting, please contact the Host/Cohost. Patience please, a member of our team will get back to you between now and the next meeting.
  - Please Mute your audio throughout the duration of this WebEx meeting, except when speaking.
  - Please note that HFS staff may mute participants to minimize disruptive noise or feedback.
  - Patience, please – some committee members, staff, and participants are new to Health Equity and Quality Care Subcommittee proceedings.
  - If you are a presenter and whish to be granted presenter rights during your presentation, please use the chat function to contact the host.
- **HFS is committed to hosting meetings that are accessible and ADA compliant. Closed captioning will be provided. Please email Melisha.Bansa@Illinois.gov & Kyle.Daniels@illinois.gov in advance to report any requests or accommodations you may require or use the chat to alert us of challenges during a meeting.**
- **Minutes of the prior meeting will be circulated to subcommittee members in advance of each session. Once approved, they will be posted to the website.**

Agenda

I. Call to order

II. Roll call of Subcommittee Members

III. Introduction of HFS staff

IV. Review and Approval of Meeting Minutes

V. Telehealth Feedback

VI. MCOs Report Out: SSDOH Data Gathered and New Initiatives

VII. Public Comments

VIII. Additional Business: Old & New

IX. Adjournment

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II. Roll Call of Subcommittee Members

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IV. Review and Approval of Meeting Minutes

V. Telehealth Feedback

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Telehealth Feedback

Presenter: Kelly Cunningham, Medicaid Administrator

ANY QUESTIONS?

VI. MCOs Report Out: SSDOH Data Gathered and New Initiatives

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Aetna

End to End Health Equity Model for Improvement

Utilizing Social & Structural Determinants of Health (SSDOH) Work Plan as Our Road Map

Aetna Better Health of Illinois is committed to achieving over 100 distinct results, tied to health outcomes, to address social and structural determinants of health by EoSFY 2023

1. SSDOH Data Inputs

ABHIL procures SSDOH data inputs from variety of data sources for analysis to identify areas of social need:

- IT Platforms & Dashboards (SociallyDetermined, HE Dashboard, Metopio, Pyx Health)
- Claims Data (Medical, Pharmacy, Z-codes)
- HRQ Log (Health Risk MiniScreener & Questionnaire)
- Member engagement vehicles (Member Services, Surveys, Texting-campaigns)
- Vendor utilization reports (ModivCare, MyOwnDoctor)
- Health Equity Assessments
- HE Surveillance Tool

2. How Data Informs Strategy

Data inputs are incorporated into analyses to identify areas of social need and inform go-forward strategy to address social gaps in care:

- Predictive modeling engine (CORE tool)
- Hyperlocal Analysis
- Geo-mapping and Hot-spotting
- Provider reporting tools
- HEDIS reporting

3. Leveraging Partnerships

ABHIL partners with organizations withing the community of care to deliver support and resources to communities marginalized by SSDOH factors.

- Health Transformation Collaboratives
- Community-based Organizations
- Value-based Provider partnerships
- FindHelp IT Platform

Health Equity: Community Involvement

Addressing social and structural inequities with ABHIL resources

Growing our footprint in the community to improve members overall wellbeing

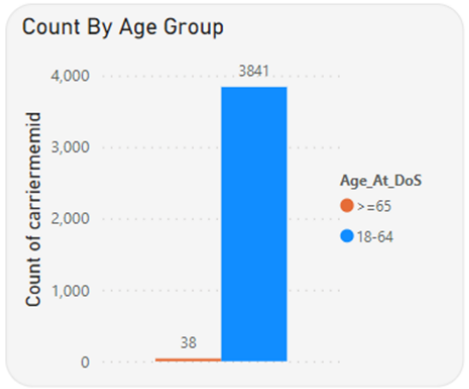
	Seeding the Partnerships	Expanding Our Reach	Leaving A Lasting Impact
Housing	*Lawndale Christian Legal Fund & Chicago Lights*	*East Lakeshore Community Development*	*Confidential Housing Solution Pilot*
Workforce	*Chicago Cook Workforce Partnership & Best Buddies*	*Community Job Fairs*	*Confidential Workforce Training Pilot*
Food Insecurity	*Community Gardens – Chicago Baptist Institute*	*Community Gardens – East Lakeshore Development*	*Farm on Ogden*

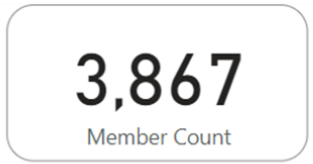
2022 Q3 - Q4 | **2023 Q1 – Q2** | **2023 Q3 – Q4**

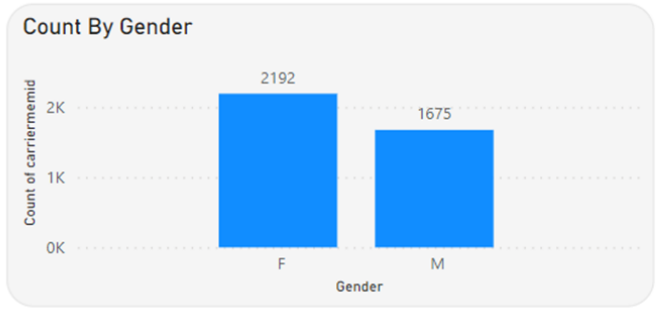
Health Equity Surveillance Tool

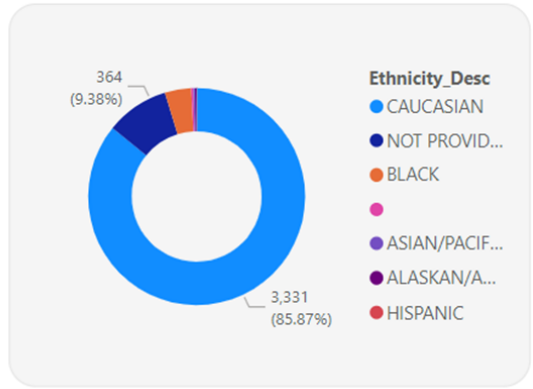
Illustrating Health Equity & Clinical Conditions for Select Populations

Health Equity Data Cuts

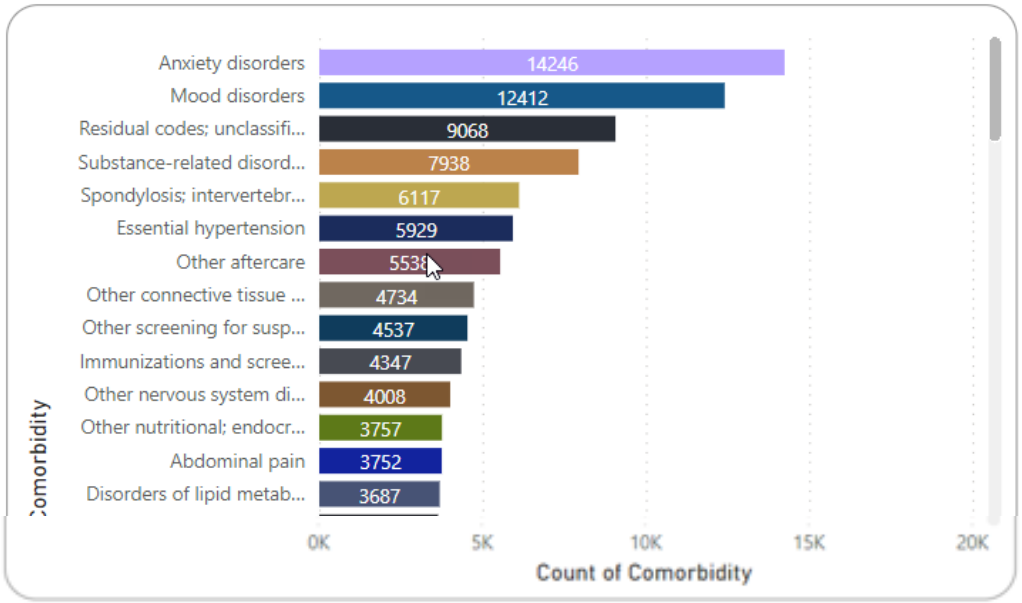








All Clinical Conditions

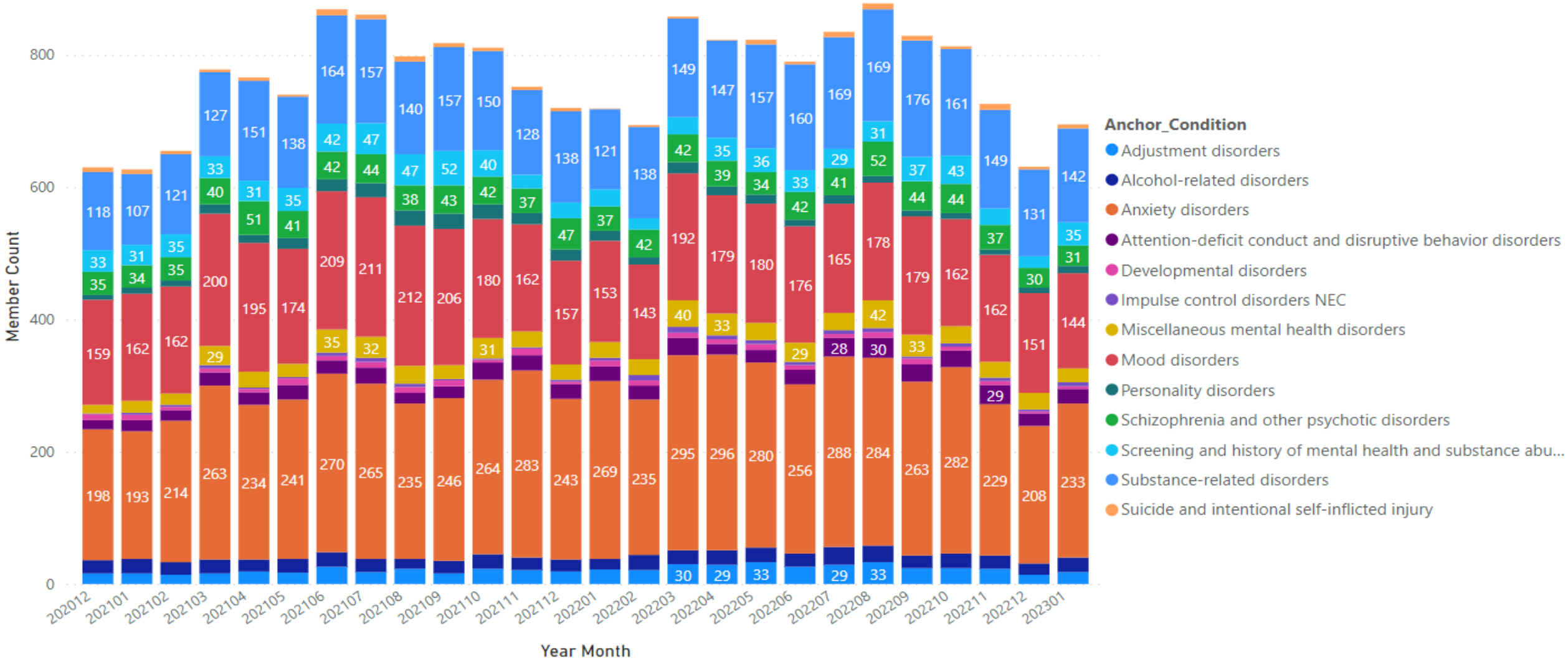


Comorbidity	%GT Cond_Desc Count
Anxiety disorders	6.55%
Mood disorders	5.70%
Residual codes; unclassified	4.17%
Substance-related disorders	3.65%
Spondylosis; intervertebral disc disorders; other back problems	2.81%
Essential hypertension	2.72%
Other aftercare	2.54%
Other connective tissue disease	2.18%
Other screening for suspected conditions (not mental disorders or infectious disease)	2.08%
Immunizations and screening for infectious disease	2.00%
Other nervous system disorders	1.84%
Other nutritional; endocrine; and metabolic disorders	1.73%
Abdominal pain	1.72%
Disorders of lipid metabolism	1.69%
Total	**100.00%**

Health Equity Surveillance Tool

Highlighting Monthly Member Count with Behavioral Health / Substance Use Disorder Conditions for Select Population

- *Utilizing CMS Clinical Classification Software (CCS)*



ANY QUESTIONS?

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Blue Cross
Blue Shield of Illinois

ANY QUESTIONS?

CountyCare

CountyCare

A MEDICAID HEALTH PLAN

Use of Social & Structural Determinants of Health Data for Health Equity & Performance Improvement

Health Equity & Quality Subcommittee

03/28/2023

SSDOH & Health Equity

- CountyCare has prioritized use of social and structural determinants of health data, segmented with other factors including race/ethnicity and other demographic data to better understand the needs of members.
- SSDOH data is analyzed by key stakeholders and used to inform performance improvement initiatives, changes in member benefits/rewards, and health plan programming.

Graphic: https://www.cdc.gov/about/sdoh/index.html

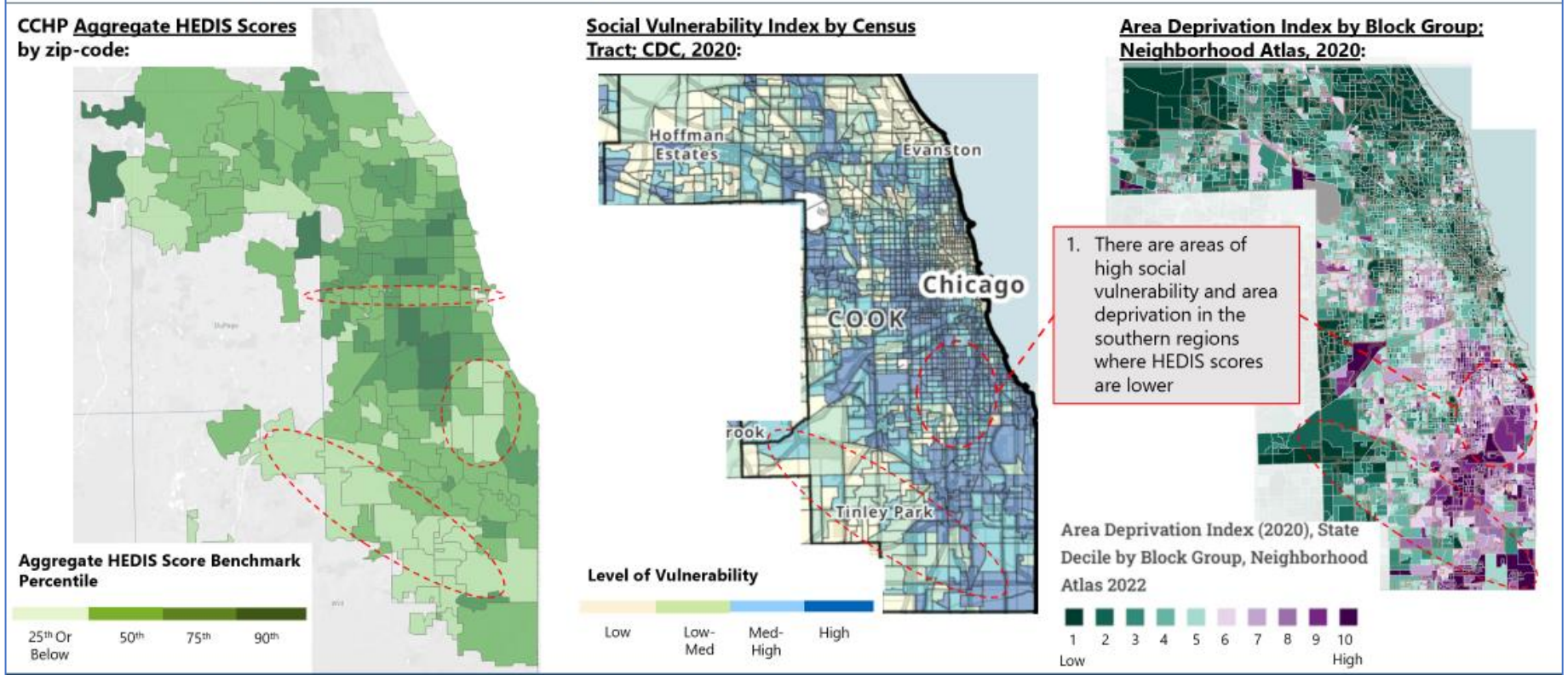
Assessing SSDOH

CountyCare assesses SSDOH in multiple ways.

Member Surveys & Tools	Program & Benefit Evaluation	Patient Engagement
• Health Risk Screening • Health Risk Assessment • CAHPS Member Survey • Care Management Survey	• Brighter Beginning Utilization Data • Self-Management Program Outcomes & Member Survey • Rewards Utilization	• Marketing & Communications • Analysis of text campaigns to determine patient needs and opportunities for engagement

SSDOH Assessment Example

Social risk scoring such as the SVI or Area Deprivation Index can help inform factors impacting low HEDIS performance



Sources: CCHP HEDIS Data Report CY2022; CCHP Provider Network Data Nov-2022; Chartis analysis 2023; CDC/ATSDR Social Vulnerability Index 2020

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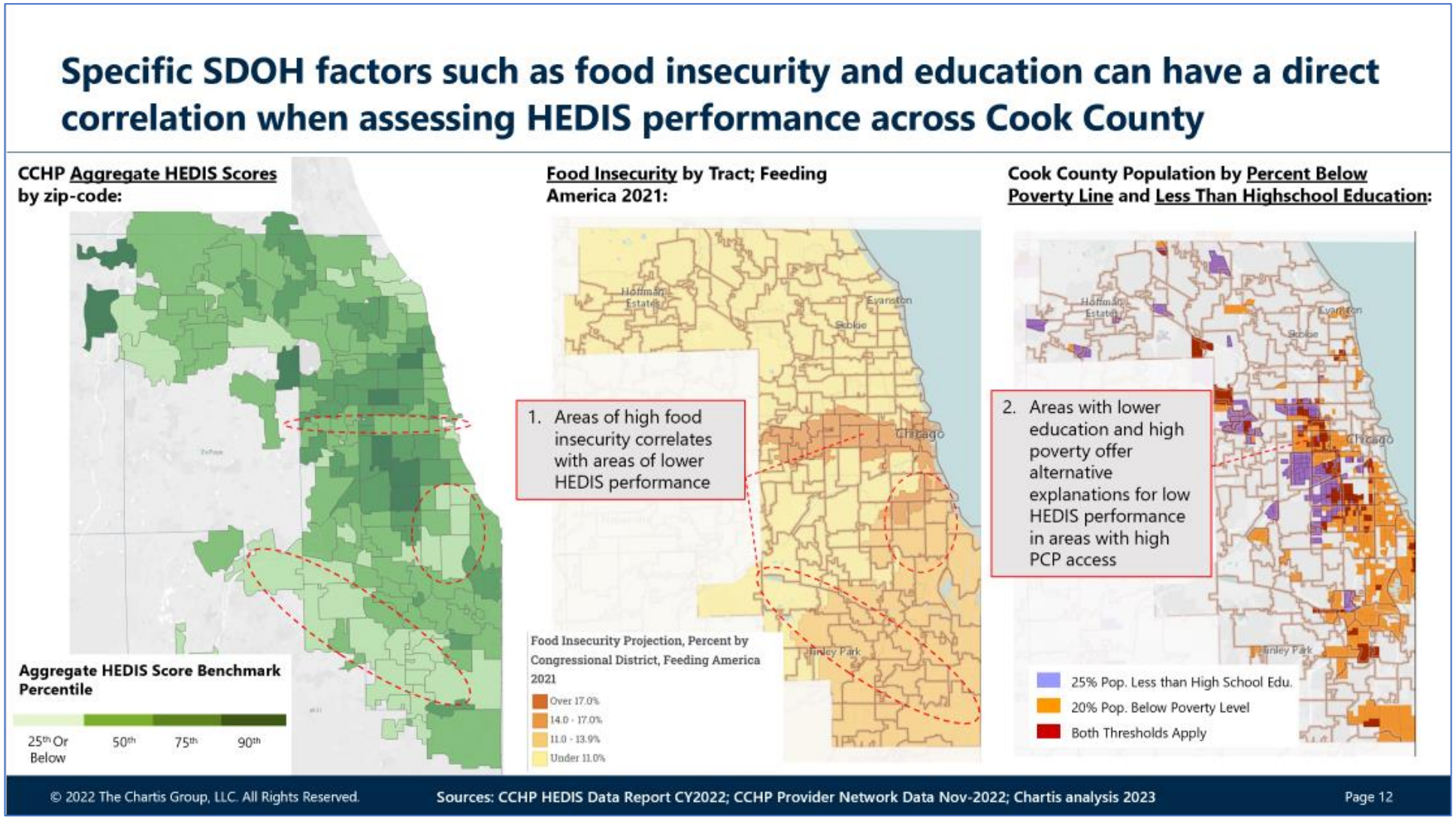
SSDOH Assessment Example



SSDOH Initiatives

- Modification of Rewards Card Program
  - Can be used for a wider range of items or services including:
    - Utilities – electric, gas, water, phone bills and more
    - Transportation
    - Childcare services
    - Clothing
    - Gas
    - Grocery stores, supermarkets
    - Automotive parts and repairs
    - Drug stores and pharmacies

SSDOH Initiatives

- Text Message Campaigns
  - New Member Outreach
  - Closure of Care Gaps & Targeted Groups
    - Assess barriers to completing services
    - Send engaging educational materials
    - Fostering member engagement

Hi from CountyCare, your health plan! Need help setting up transportation to health visits? Contact Member Services at 312-864-8200 to schedule a ride 72 business hours before your appointment or request CTA or PACE cards two weeks before your appointment.

Hi from CountyCare, your health plan! Our Brighter Beginnings program offers rewards for pregnant women and families. You can get money added to your rewards card for well-child visits, free car seats, coupons for free diapers and more. See all rewards here. [https://countycare.com/members/benefits-rewards/]

Thank you for choosing CountyCare, your health plan! There are lots of benefits to being our member! Please reply with the number of the benefit you are most

1 Transportation
2 Having a baby
3 Book club for kids
4 Pharmacy
5 Dental
6 Vision
7 Car seats
8 Mental health support
9 Community resources (like food or housing)

SSDOH Initiatives

- Exploring expansion of existing programming to address social needs of members.

Flexible Housing Pool – currently connects individuals who have been homeless and persistent users of crisis systems to supportive housing

Exploring additional expansion of housing programming and resources

Emergency Meals – currently have resources to provide emergency meals to members in need.

Implementing an additional partner to support nutrition needs

CountyCare

A MEDICAID HEALTH PLAN

Questions?

Meridian

meridian

Medicaid Advisory Committee (MAC): Health Equity and Quality Subcommittee

MCOs Report Out – SSDOH data gathered and new initiatives

Tuesday, March 28, 2023
10:30 AM – 12:00 PM

What Is Collected?

- Member Name
- Member Address
- Member Date of Birth (DOB)
- Medicaid Number

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When Is It Collected?

- New Members Intake Process
- Established Members (updates as needed)
- Over the Phone
- Face to Face (F2F)

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Key Areas of Social Determinants of Health (SDoH)

Economic Stability

- Poverty, Resources available, Food insecurity, Housing instability, Access to job training opportunities

Education

- Language and literacy, Early childhood education and development, High school graduation rates, Enrollment in higher education

Social and Community

- Culture, Technology Access, Discrimination, Incarceration, Health and Health Care

Access to health care

- Health literacy, Quality of care, Provider's linguistic and cultural competency,

Neighborhood environment

- Residential segregation, Access to healthy food, Crime, Violence

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Pillars of Engagement w/ Members

Health Disparities affect groups of people who have systemically experienced greater obstacles

Screenings & Referrals

- We provide screenings & referrals and social care plans for members (Ex. Housing, food, transportation, utilities, medical, etc.)

Trainings

- We offer and provide staff culturally competent trainings and resource supports
- Integrate cultural beliefs, interests, and/or needs into action plan

Partner and Advocate

- We engage with local community agencies to support members with SDOH needs

Person-Centered Communication

- We discuss how SDoH impacts each individual's health and quality of life

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Our Interventions: SDoH

Economic Stability

- Fund GCFD Workforce Program
- Housing Partnership Initiatives: FHP, homeless and (expanding to pregnant moms) w/ BEP vendors
- Fund Chicago Northwest Homeless Outreach Volunteers

Education

- Provider 26 CHWs in the community, who provide education to members and support health literacy
- Project Success: GED Support (starting with HTCs)

Social and Community

- Safer Foundation, support members re-entering society as citizens
- Chicago Police Department: Hip Hop Tuesday Program

Access to Healthcare

- Assist members w/ connecting to providers in network and assisting with scheduling appointments
- Offer Start Smart for Baby Program

Neighborhood environment

- Housing partnerships w/ outcomes focused on neighborhood safety and affordability
- Fund Community Gardens
- Support and fund Chicago Police Department funding Hip Hop Tuesday Program
- We use NEST SDoH Risk Scores (individual and community) associated with neighborhood conditions

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Thank you!

ANY QUESTIONS?

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Molina Healthcare of Illinois

Molina Healthcare of Illinois

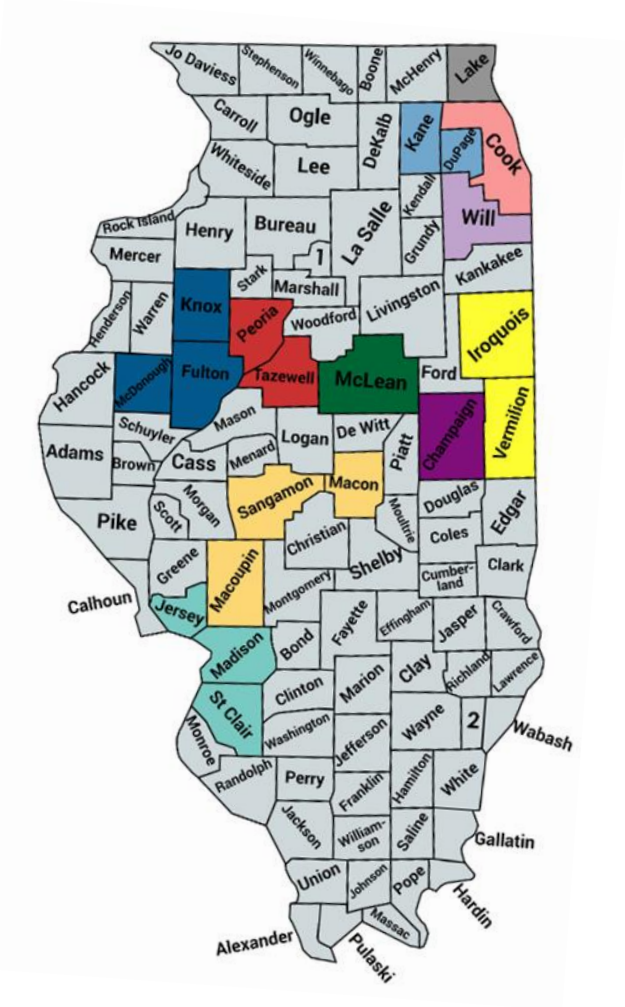
MAC Health Equity and Quality Subcommittee 03.28.2023

Social Determinants of Health

MOLINA® HEALTHCARE

Molina Healthcare of Illinois Community Connectors

- Assigned to Specific Geographic Areas
- Establish Relationships with Local Resources and Organizations
- Implement Social Determinants of Health (SDOH) interventions
  - Completion of Community Needs Assessment (CNA) and Health Risk Assessment (HRA)
- Integrate with local PCPs and Clinics when requested by the provider
- Outreach assigned members
  - Engage and outreach members in various ways including via telephone, face to face and delivering door hangers
- Receive referrals from Molina Health Educators who identify a SDOH need when scheduling members into needed services such as annual wellness exams and preventive screenings



Molina Healthcare of Illinois Community Connectors

Outreach assigned members

- Community Connectors engage and outreach members in various ways including via telephone, face to face and delivering door hangers

Conduct a community needs assessment (CNA) and health risk assessment (HRA), if applicable.

- An intervention is created that includes an SDOH care plan if the CNA or other information received indicate a SDOH need
- Support is provided for the member to succeed in the plan
- If the member declines, the Community Connector provides education to the member
- Follow up with members is scheduled no later than 7 days from the date of assessment to continue to meet the short-term community resource needs
- Support for members may include finding resources, helping to secure the resources, accompanying members to resource locations to ensure that they can navigate properly, following up with members, and working with community agencies or providers to link them to the member.

Molina Healthcare of Illinois Housing Specialist

In conjunction with the Community Connectors there is also a Housing Support Specialist who is responsible for:

- Building relationships in the community
- Linking members with community resources to help stabilize homelessness and social determinants impacting the member's ability to be housed
- Having a strong presence in the community and works with members through the housing support program

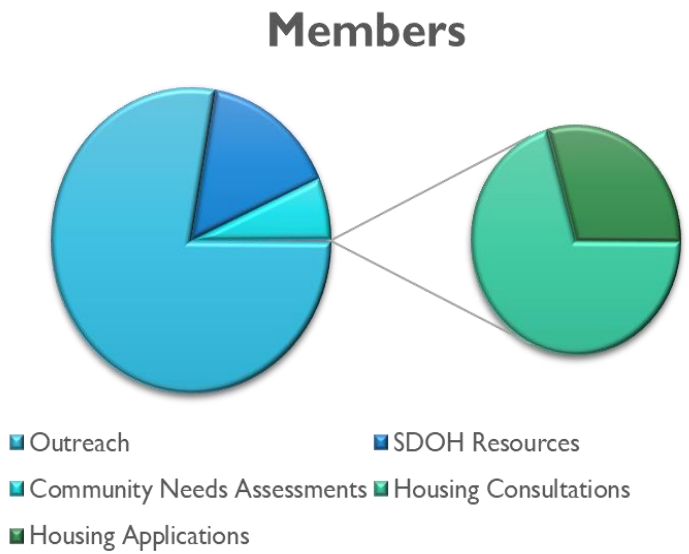
The Housing Support Specialist role includes:

- Identifying partnership opportunities with community providers for homelessness support and placement options
- Coordinating internal case consultations to establish interventions to members' long-term success
- Assisting with housing application and voucher assistance to secure permanent housing

Measurable Results: SDOH Interventions

Social determinant of health outreach/intervention results:

- Completed 4,741 Community Needs Assessments
- Over 41,000 outreaches
- Completed 41 housing applications
- Completed 83 housing consultations to review member needs and provide recommendations



Molina has a multi-channel member outreach strategy which facilitates SDOH in the community

- **Community Engagement Team**
  - Scholarship program awarding 10 low Income college students a $10,000 scholarship.
  - Scholarship program awarding returning citizens the opportunity to attend barber college, technical school, etc.

- **Community Events**
  - Multiple food drive events focusing on food disparities within Illinois.
  - Partnerships with community-based organizations to provide coats, shoes, gloves/hats.
  - Fresh for Learning Laundry Program-Provides laundry services for school districts to have access to clean clothes
  - Molina Healthcare Micro-Pantries-neighborhood micro pantries that provides nonperishable food items to the community.

- **Articles** (various print media accessible to members)
  - Molina Member Quarterly Newsletter
    - Lawndale Christian Health Center, Streetwise, CHA, Springfield Housing authority

ANY QUESTIONS?

VII. Public Comments

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Public Comments

Update:

A. None

VIII. Additional Business: Old & New

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A. Items For Future Discussion

ANY QUESTIONS?

IX. Adjournment

THANK YOU

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