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**Medicaid Advisory Committee
Quality Care Subcommittee**

July 17, 2018
10:00 AM – 12:00 PM

James R Thompson Center
100 West Randolph
9th Floor, 9-040
Chicago, IL

And

201 South Grand Avenue East
1st Floor Video Conference Room
Springfield, Illinois

Agenda

- I. Welcome and Call to order
- II. Introductions
- III. New Committee Members
- IV. Review of April 3, 2018 Minutes
- V. Review Summary Population Health Disparities Presentation
 - a. Recommendations to HFS
- VI. LTSS Workgroup
- VII. Adjournment

Illinois Department of Healthcare and Family Services
Quality Care Subcommittee Meeting Minutes
April 3, 2018

Members Present

Ann Lundy, Chair, Access Community Health Network
Beverly Hamilton-Robinson, Human Services Consultant
Barrett Hatches, Chicago Family Health Center
Jenifer Cartland, Lurie Children's Hospital
Traci Powell, Harmony Health Plan
Andrea McGlynn, Cook County Health and Hospitals Systems
Jason Korkus, Sonrisa Family Dental
Catina Latham, University of Chicago

Members Absent

Krishna Das, Cook County Health and Hospitals System
Kathy Chan, Cook County Health and Hospitals System

HFS Staff Present

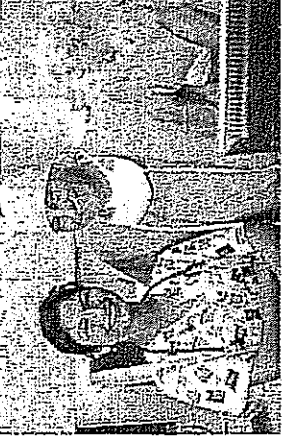
Arvind K. Goyal
Kyle Daniels
Sylvia Riperton-Lewis
Cheryl Easton

Interested Parties

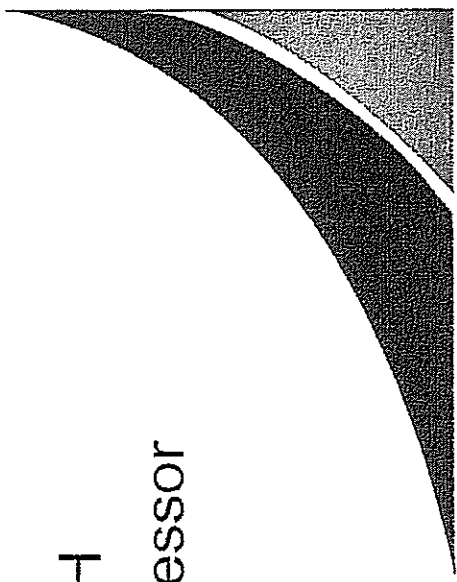
Katie Shaffer, UIC-DSCC
Sameena Aghi, IDHCA
Kate Maley, Shriver Center
Laurel Chadde, County Care
Anna Wojeik, UI Health
Nancy Kinsley, Harmony
Michael Lafond, Abbyie
Nadeen Israel, Everthrive Illinois
Martha Jarmuz, Choices, Inc.
Ralph Schubert, UIC-DSCC
Emily Chittajallu, La Rabida
Gaitlin Lueck, Meridian
Sunaina Menawat, IBM Watson Health
Marie Baker, Harmony
Carol Leonard, DentaQuest
Iveree Brown, Ounce of Prevention
Ann Cahill, Harmony
Sheon MacNeil, Next Level Health

- I. **Call to order:** The regular bi-monthly meeting of the Medicaid Advisory Committee Quality Care Subcommittee was called to order April 3, 2018 at 10:10am by chair Ann Lundy.
- II. **Introductions:** The Chair reviewed the meeting from January 2018.
- III. **New Committee Members:** Roll call of members was taken.
- IV. **Review of January 9, 2018 Minutes:** The minutes from January 2018 were approved.
- V. **LTSS Workgroup Report:** Quality Care Subcommittee member, Beverly Hamilton-Robinson reported on this subject. There are 11 members in this group. At this time, they have met twice. They will be meeting monthly for about an 8 to 12 month time period. The group is currently collecting information to address the mandated legislation.
- VI. **Population Health:** Dr. Marshall Chin gave a presentation on Solving Disparities through Payment and Delivery System Reform, Implications for Managed Care Contracts. The handouts are attached.
- VII. **Adjournment:** The meeting was adjourned at 11:50am.
- XI. **Next meeting:** July 17, 2018 at 10:00am.


Solving Disparities Through Payment and Delivery System Reform: Implications for Managed Care Contracts



Marshall Chin, MD, MPH
Richard Parrillo Family Professor
University of Chicago

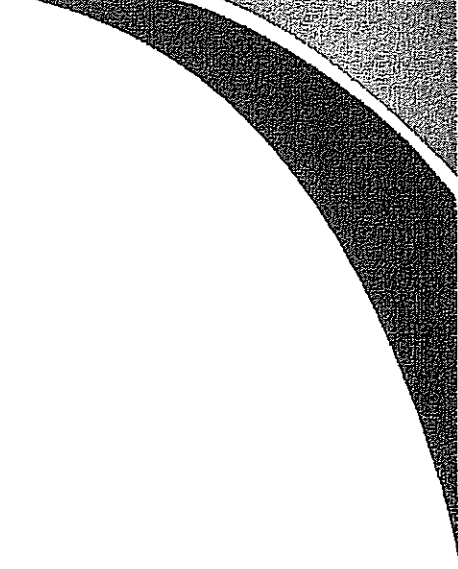


Disclosures / Funding


- NIDDK P30 DK092949
 - Merck Foundation
 - Robert Wood Johnson Foundation
 - AHRQ U18 HS023050
 - CDC Community Prev. Services Task Force
 - Co-Chair, NQF Disparities Standing Committee
 - PCORI – Disparities consultant
 - NIMHD National Advisory Council
 - National Advisory Board, Institute for Medicaid Innovation
 - Families USA – Equity and Value Task Force Advisory Council
- 

Goals


- Review what is known about how to reduce health disparities and achieve equity through payment and delivery system reform
- Discuss implications of these health equity lessons for managed care contracts



Agenda

- Define equity
 - Conceptual framework
 - Health care and social determinants within context of history, culture, and values
 - Multiple levels of intervention
 - Place
 - Implementation science
 - Economic drivers and motivation
 - National Quality Forum – Performance measurement and payment
 - Early findings: 3 RWJF grantees
 - Implications for IL HFS
- 

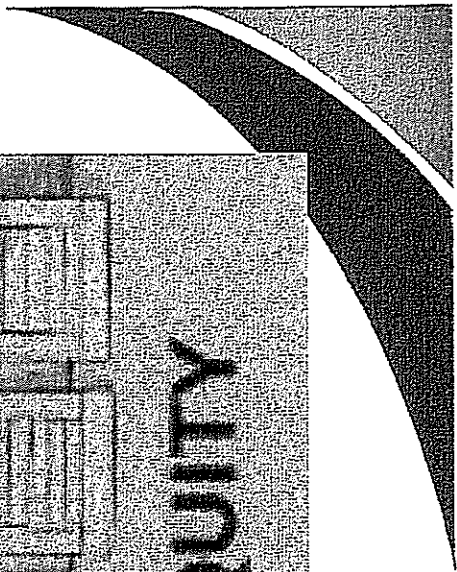
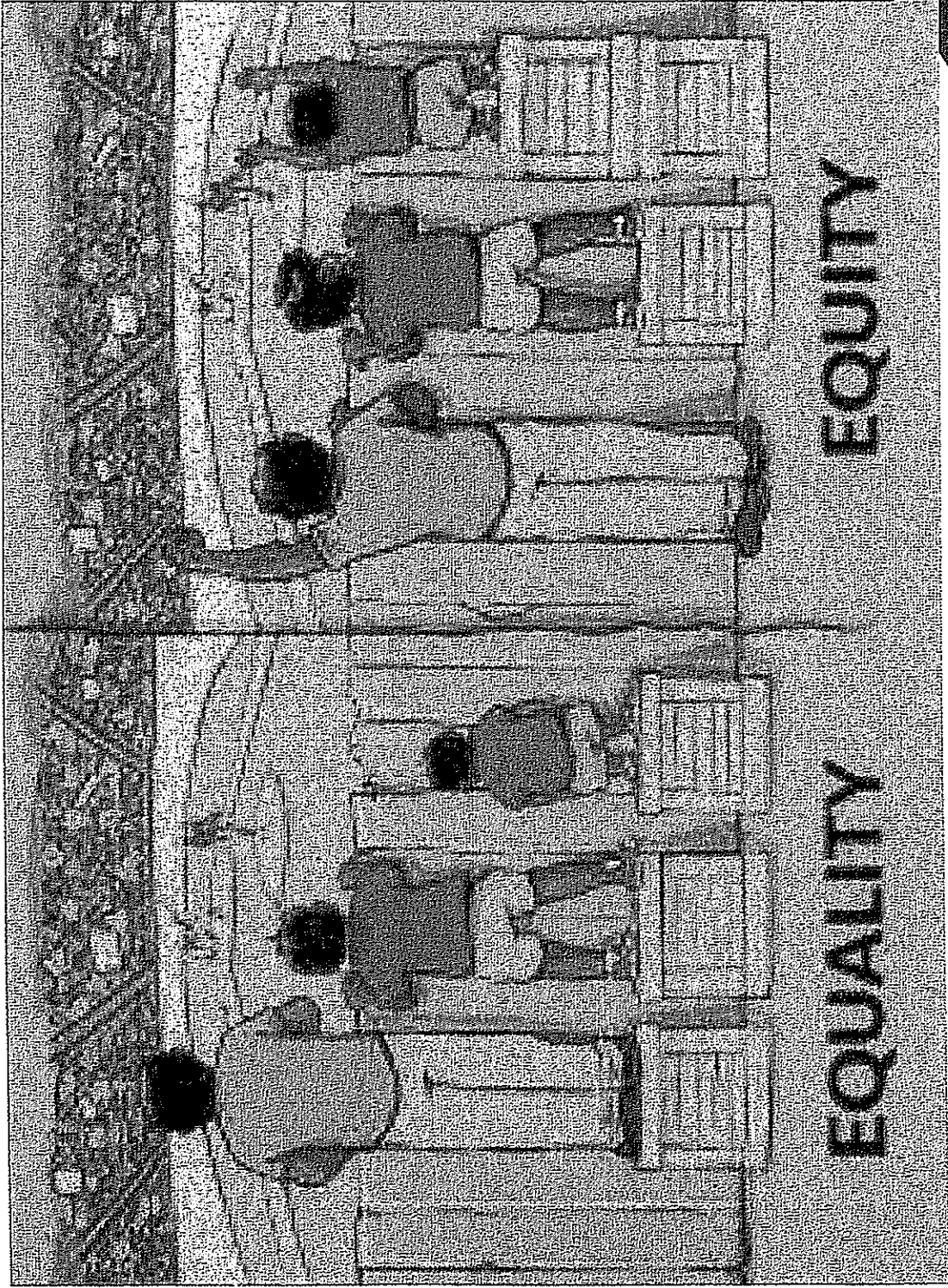
My Perspectives

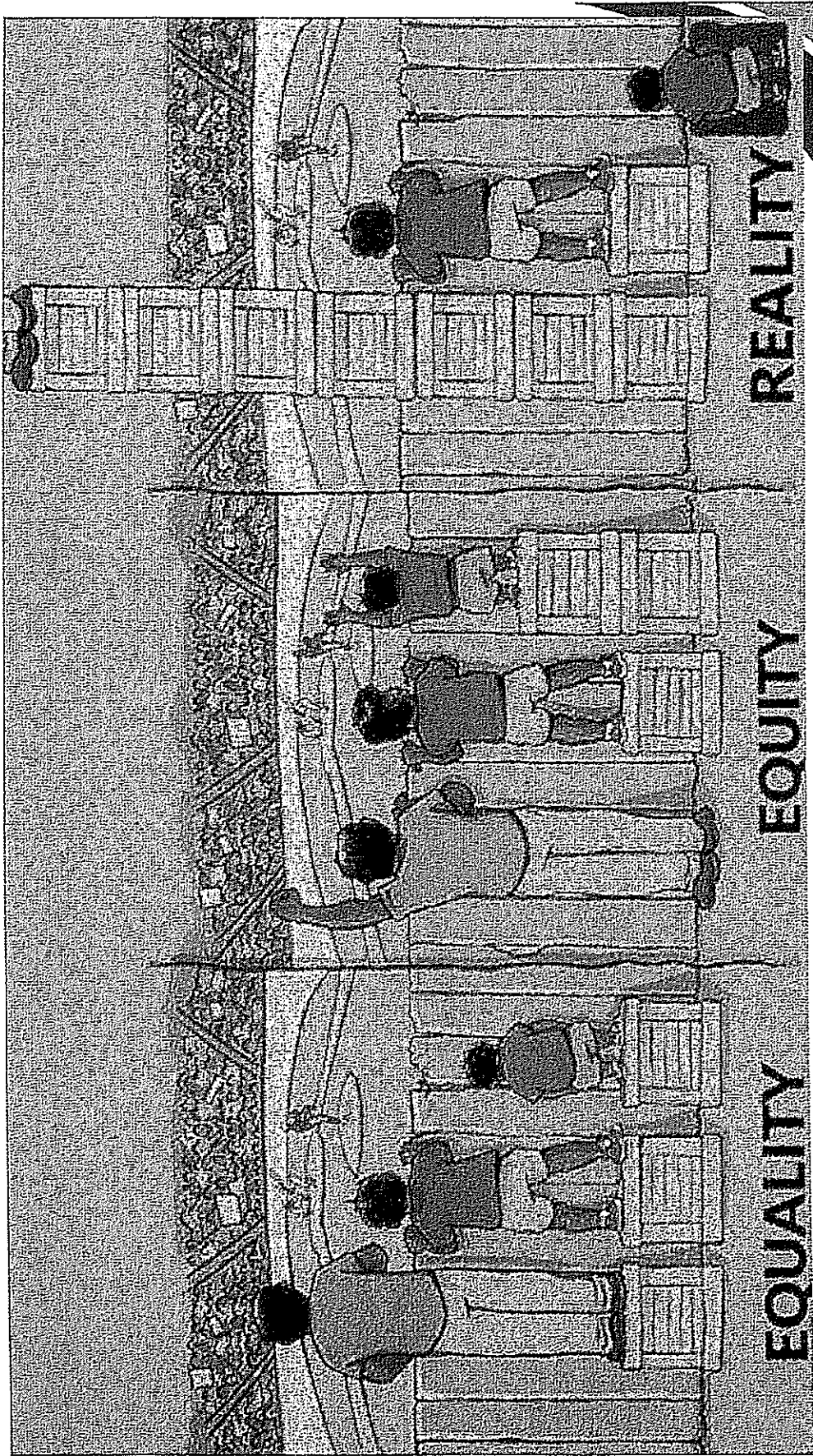
- General internist – urban academic centers in Chicago, San Francisco, Boston; Boston Chinatown CHC
 - Multilevel, mixed method researcher
 - RWJF Finding Answers – TA to frontline
 - University of Chicago equity initiative
 - Multistakeholder committees - e.g. NQF
 - New Zealand and U.S. comparison
 - Institute for Medicaid Innovation – Medicaid managed care plans
- 

World Health Organization

“*Equity* is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. *Health inequities* therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms.”



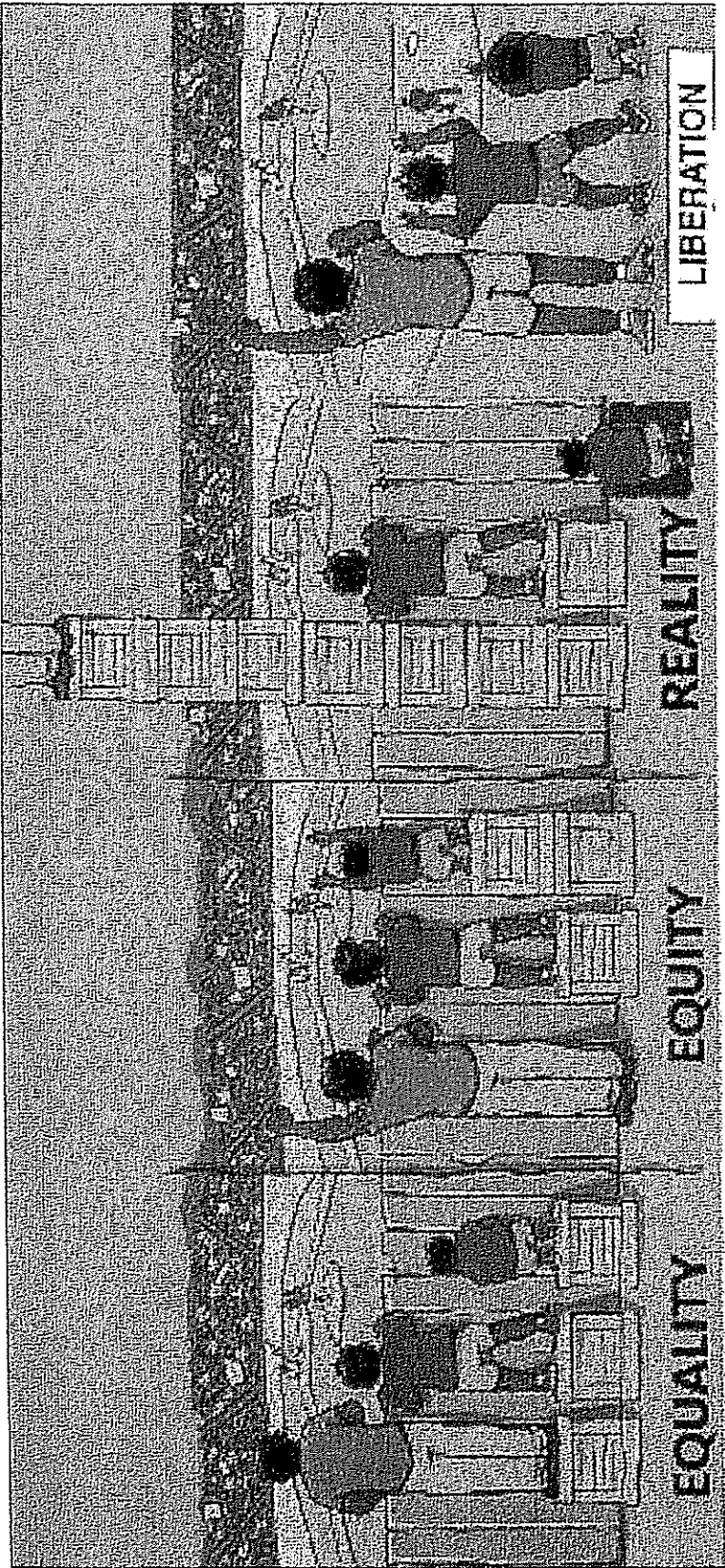




REALITY

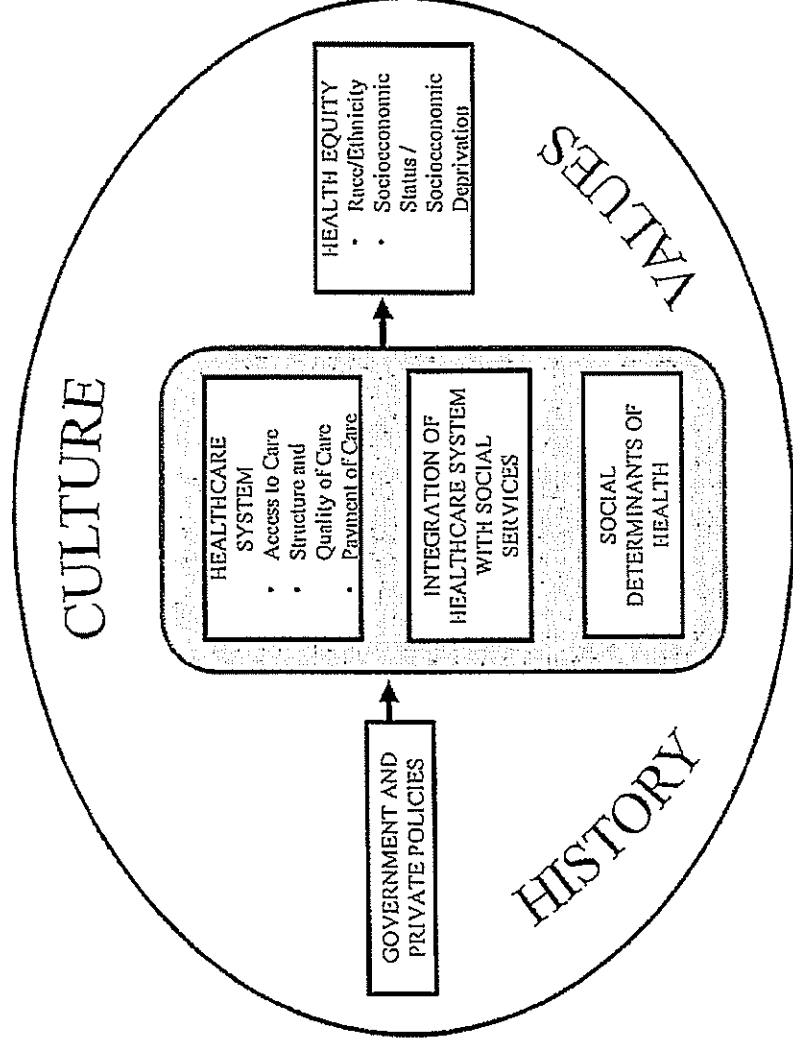
EQUITY

EQUALITY



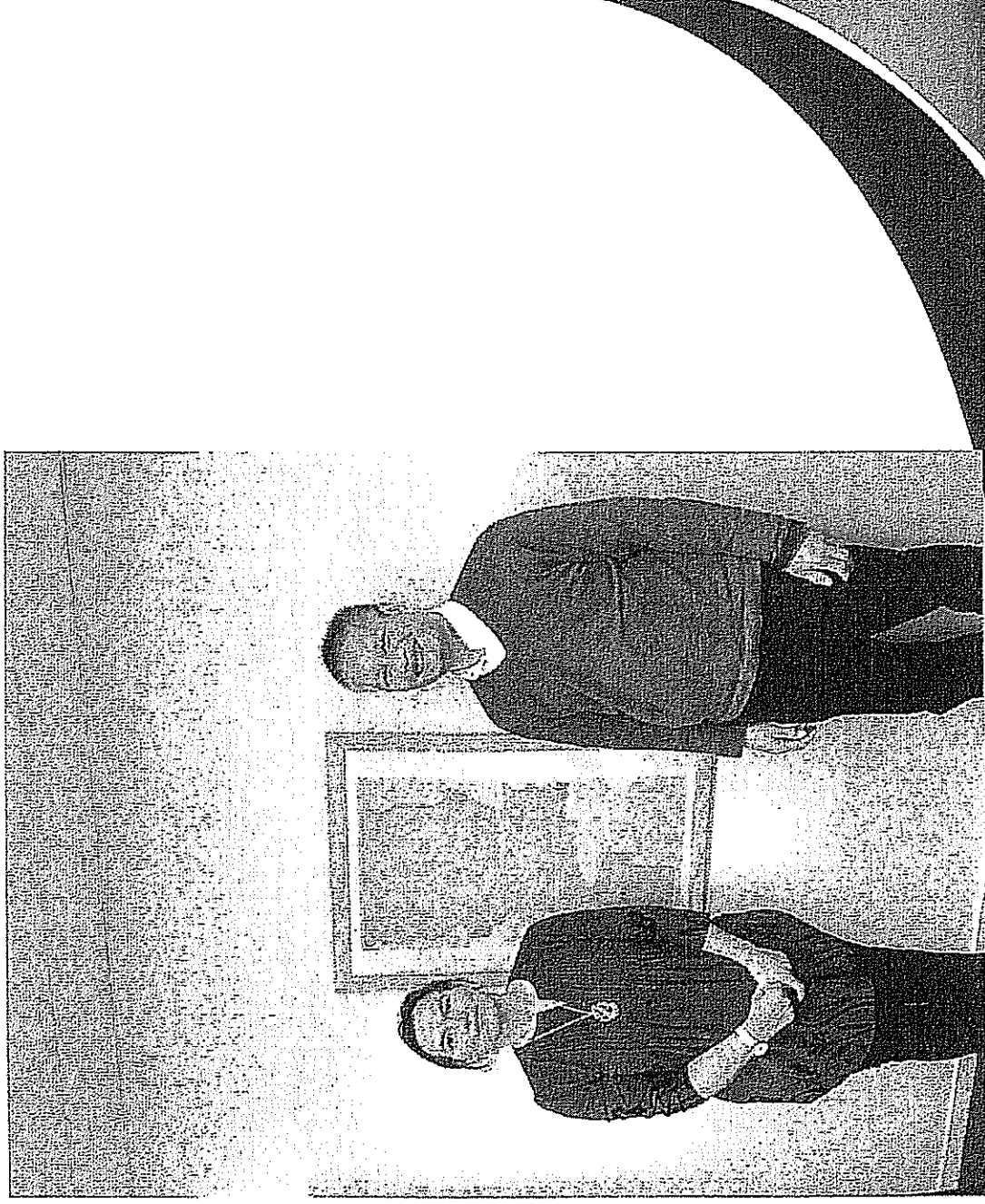
Liberation

Conceptual Framework – Cut #1



Chin MH, King PT, Jones RG, Jones B, Ameratunga SN, Muramatsu N, Derrett S. Lessons for achieving health equity comparing Aotearoa/New Zealand and the United States. Under review.

History: Treaty of Waitangi 1840



History: Civil Rights Act of 1964

- “We are confronted primarily with a moral issue. It is as old as the scriptures and is as clear as the American Constitution. The heart of the question is whether all Americans are to be afforded equal rights and equal opportunities, whether we are going to treat our fellow Americans as we want to be treated.” Discussing the right of African Americans to be served in a public restaurant, he declared “This seems to me to be an elementary right. Its denial is an arbitrary indignity that no American in 1963 should have to endure, but many do.”

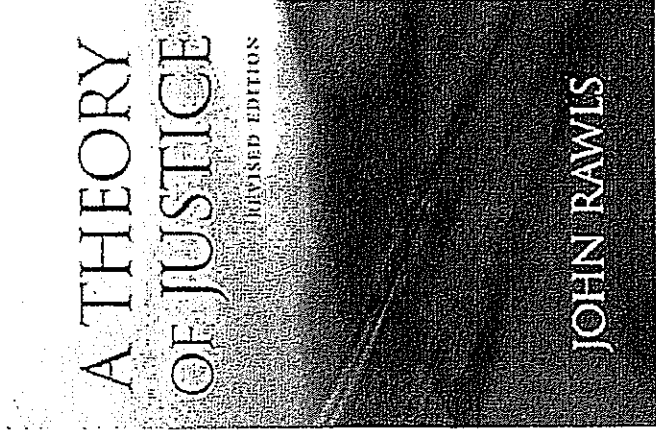
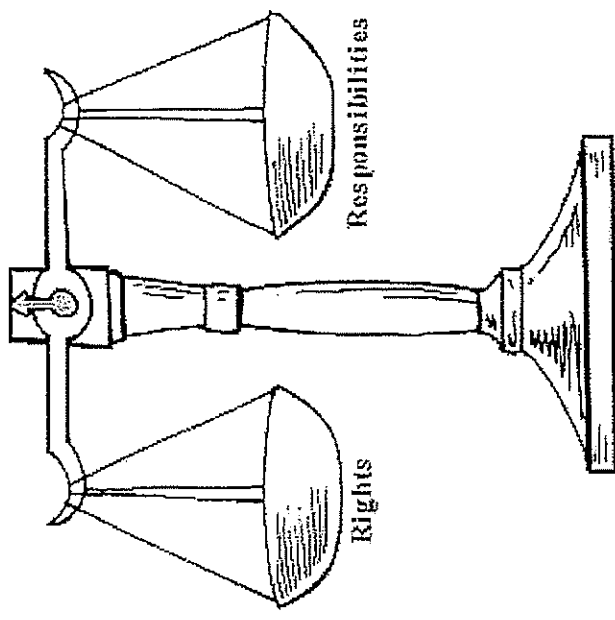
- President John F. Kennedy, 1963



Culture and Values: Liberalism, Communitarianism, Distributive Justice

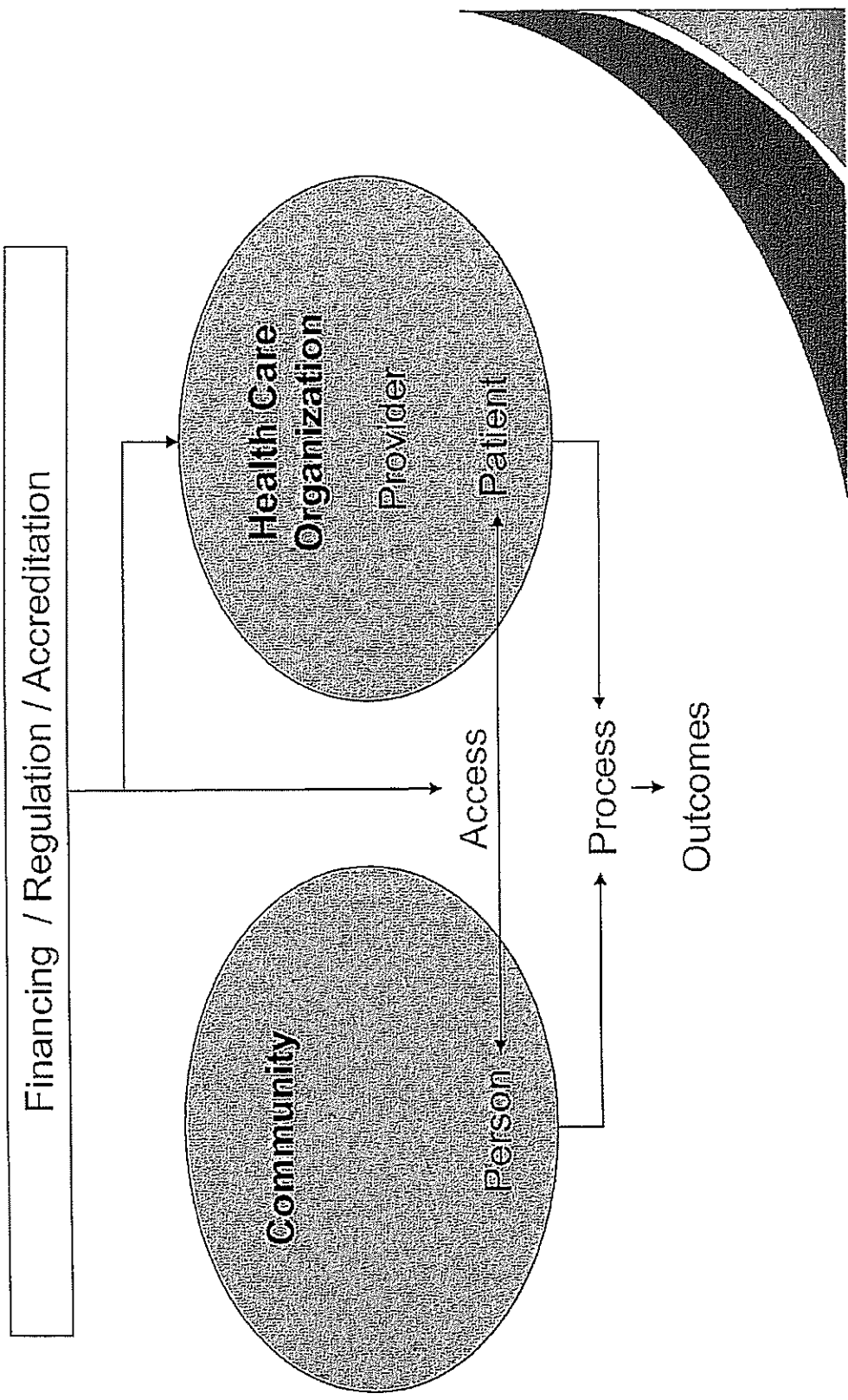


Communitarianism

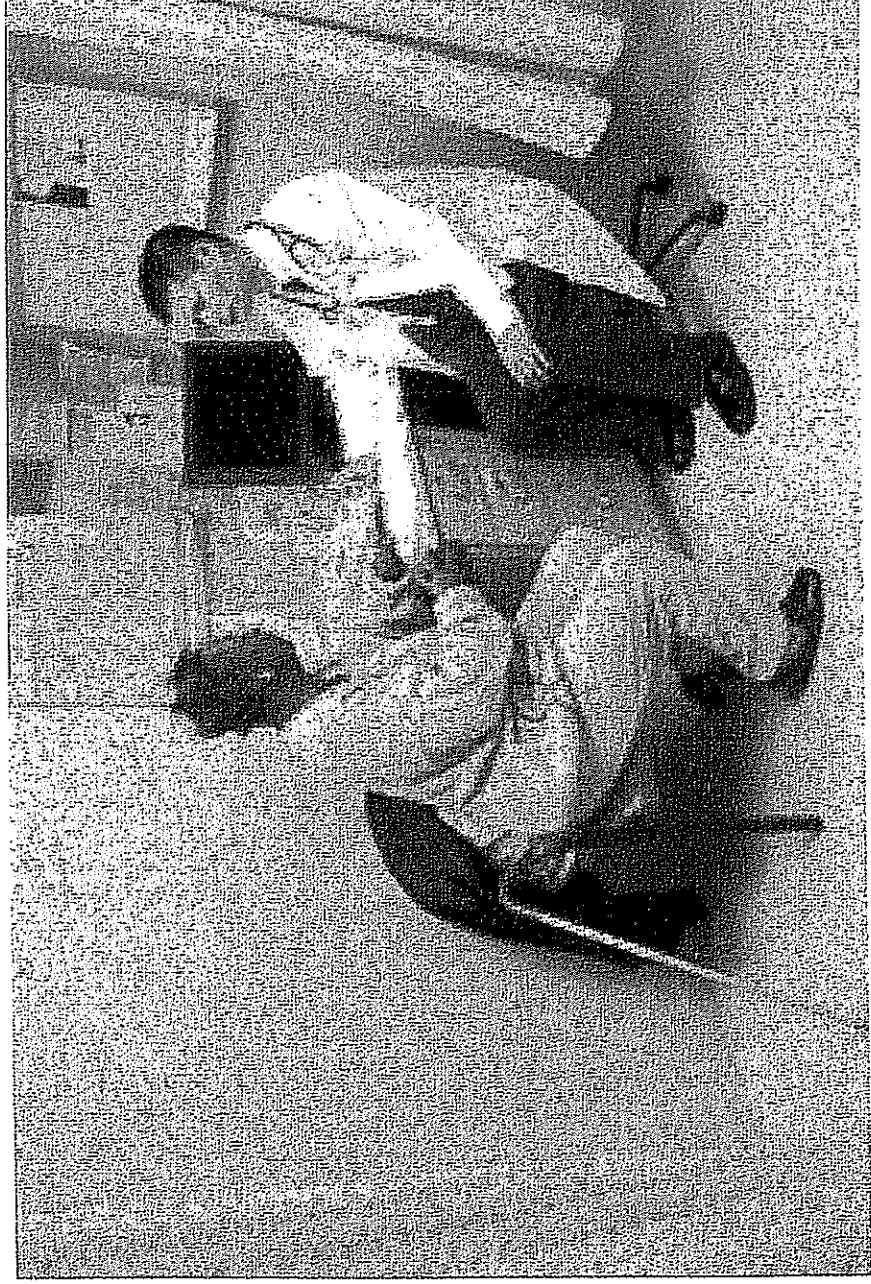


Conceptual Framework Cut #2

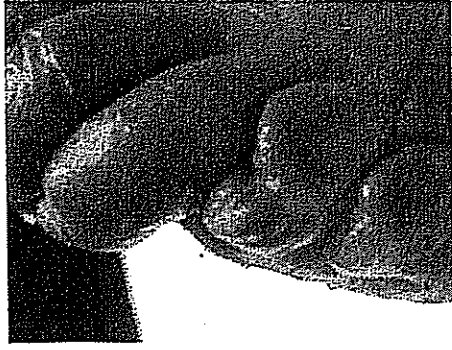
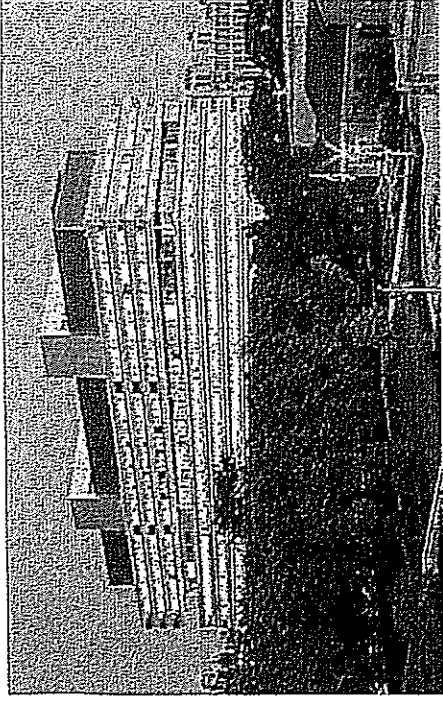
– Multiple Levels



Challenge of DM and Obesity

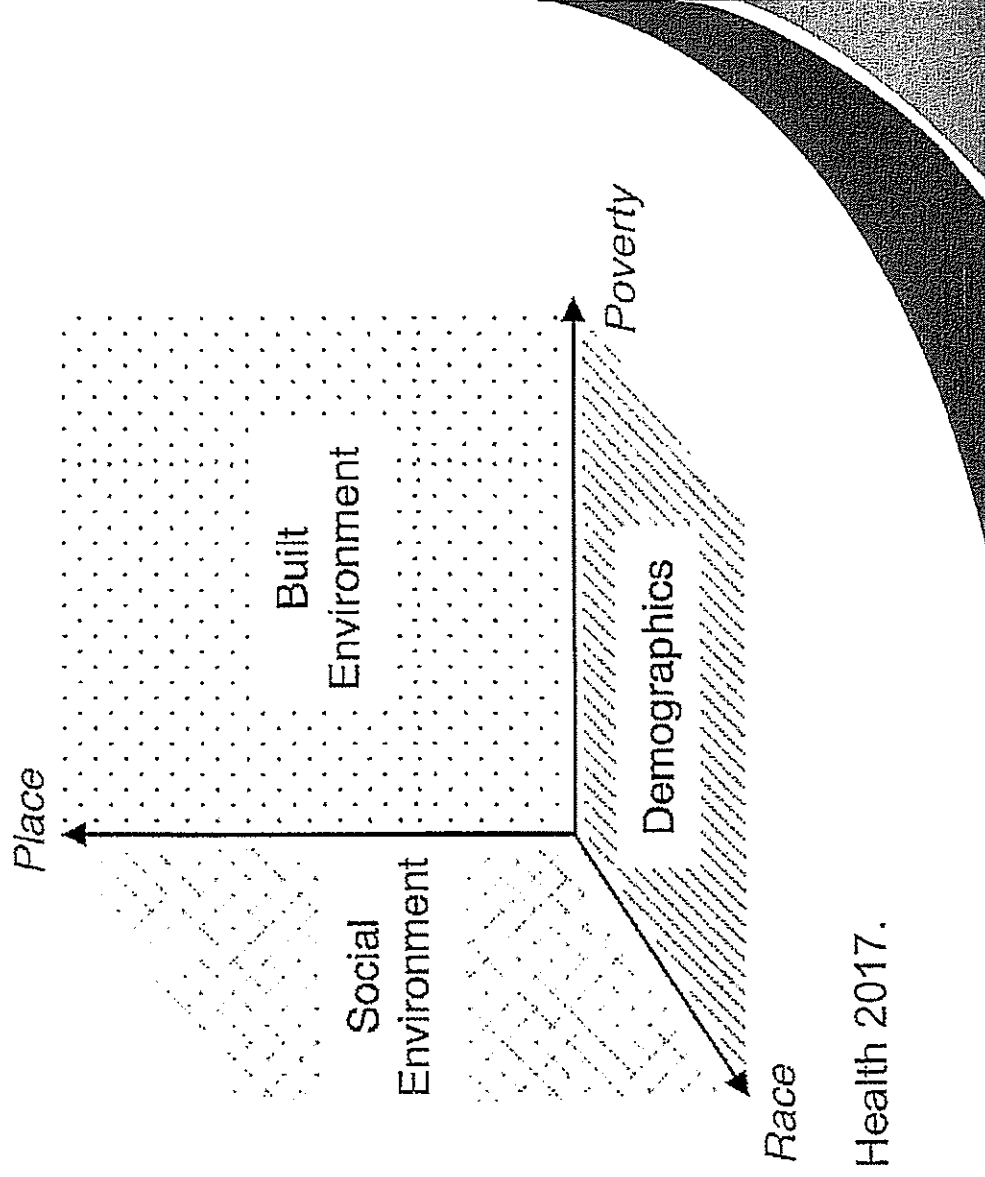
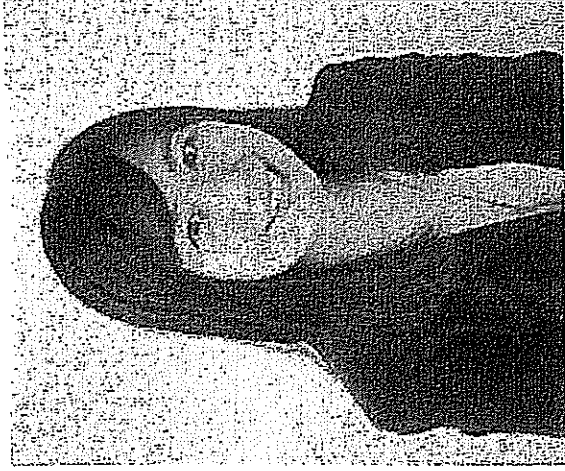


A Diabetic Foot Ulcer



Conceptual Framework Cut #3 – Place

Elizabeth Tung, MD

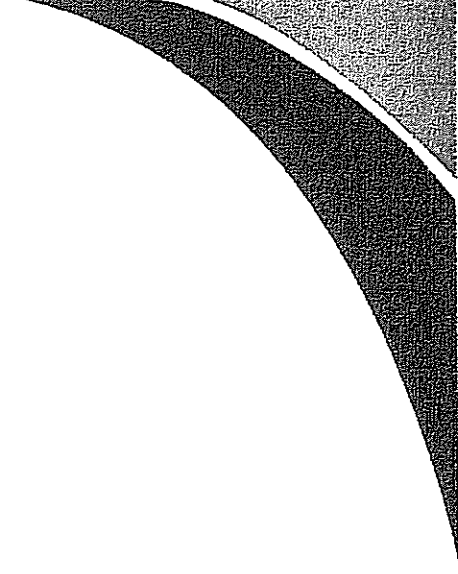


Tung E, et al. J Urban Health 2017.

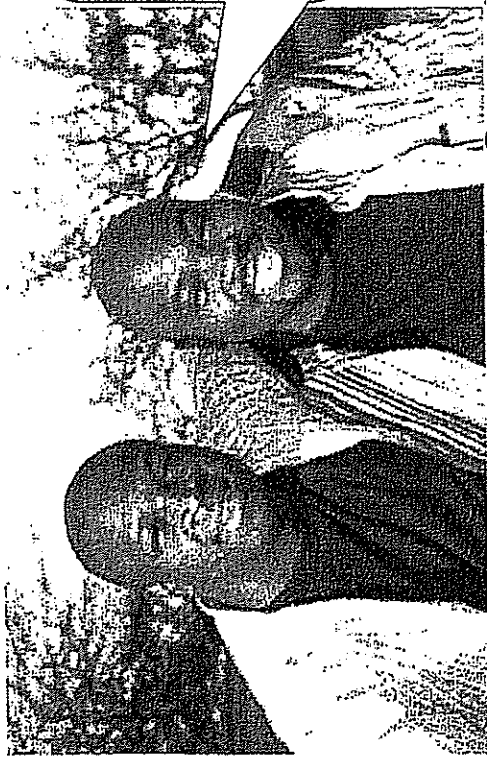
Intersectionality

- Combination of intersecting systems of oppression that perpetuate discrimination and disadvantage based on factors such as race, class, sex, and gender identity.

Crenshaw K. University of Chicago Legal Forum 1989,
p. 140.



Shared Decision Making for Chronic Conditions: Experiences of LGBTQ African American Patients

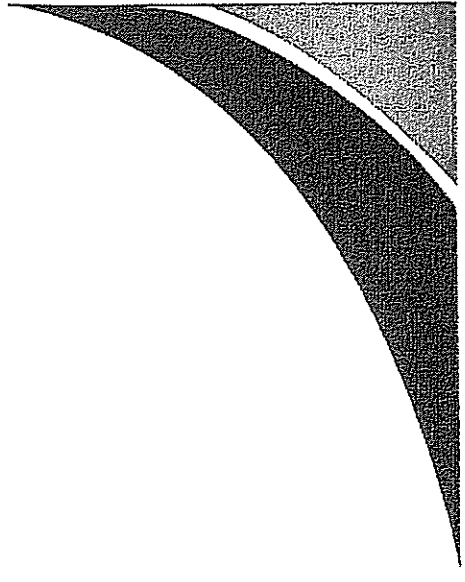
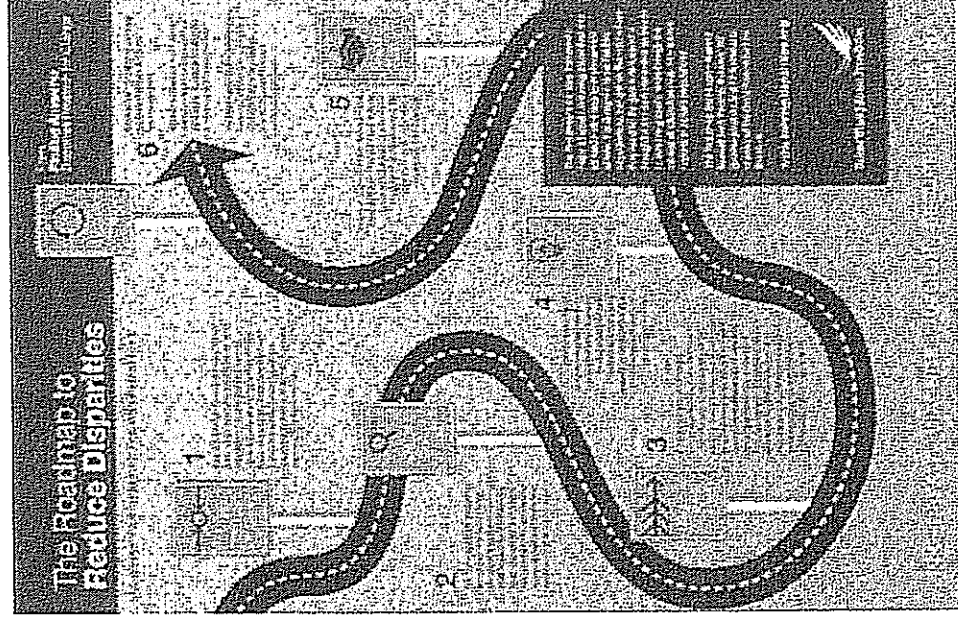


“When I used to identify as a [black] male, there is this idea that I was dangerous, right. So I’d walk in and I had a white nurse practitioner, their body language would change.”
(Pansexual Transgender Woman)



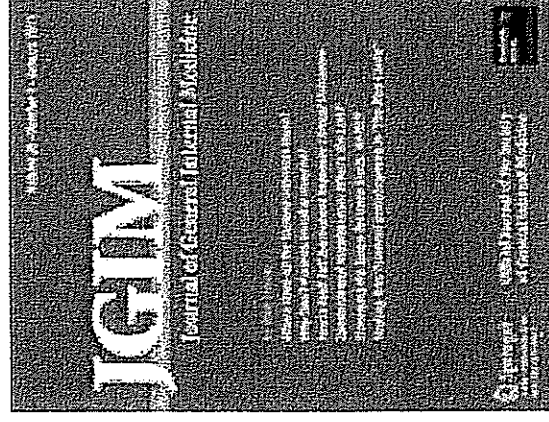
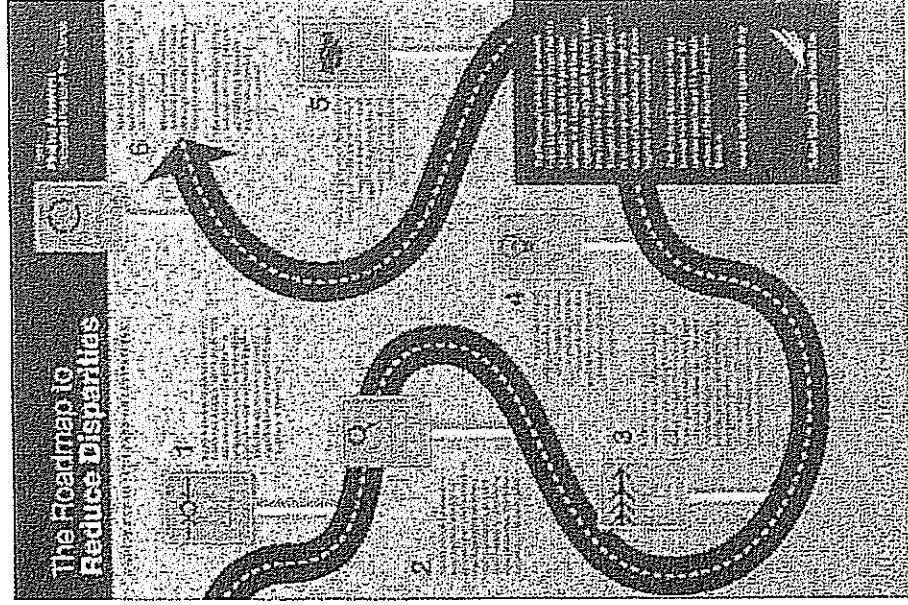
“I don’t wear an ‘I am a lesbian’ sign- so you don’t see that. But I do wear the ‘I am black’ sign.
There’s almost this preconception that I am going to be somehow less of a patient.” (Lesbian Woman)

Conceptual Framework Cut #4 – Implementation Science and Changing Behavior



Roadmap to Reduce Disparities

www.solvingdisparities.org



Chin MH, et al. JGIM 2012



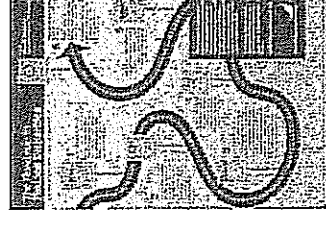
Roadmap Principles

- No magic bullet
- Systematic process - awareness and prioritization of achieving equity, tailoring of solutions to local organizational and patient contexts, iterative QI addressing specific barriers and facilitators to change, implementation science.
- Menu of evidence-based interventions; organizations/providers like options/model



Roadmap for Reducing Racial and Ethnic Disparities in Care

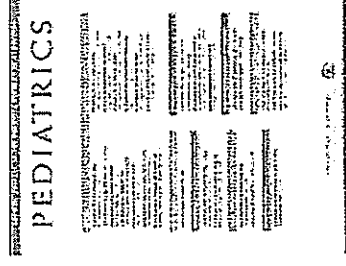
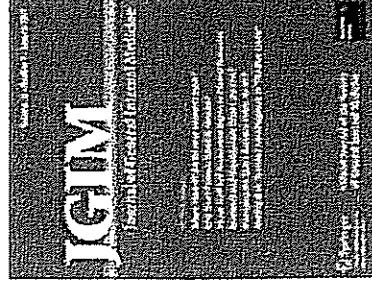
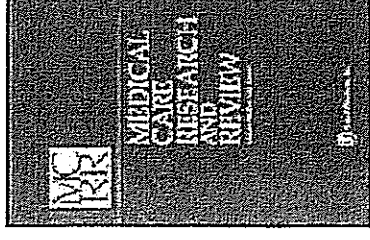
- 1) Recognize disparities and commit
- 2) Implement QI infrastructure and process
- 3) Make equity an integral part of quality
- 4) **Design intervention(s)**
- 5) Implement, evaluate, and adjust intervention(s)
- 6) Sustain intervention(s)



Chin MH et al. JGIM 2012; 27:992-1000

Evidence-based Interventions

- Multifactorial attacking different levers
- Culturally tailored QI
- Team-based care
- Families and Community partners
- Community health workers
- Interactive skills-based training



Consolidated Framework for Implementation Research

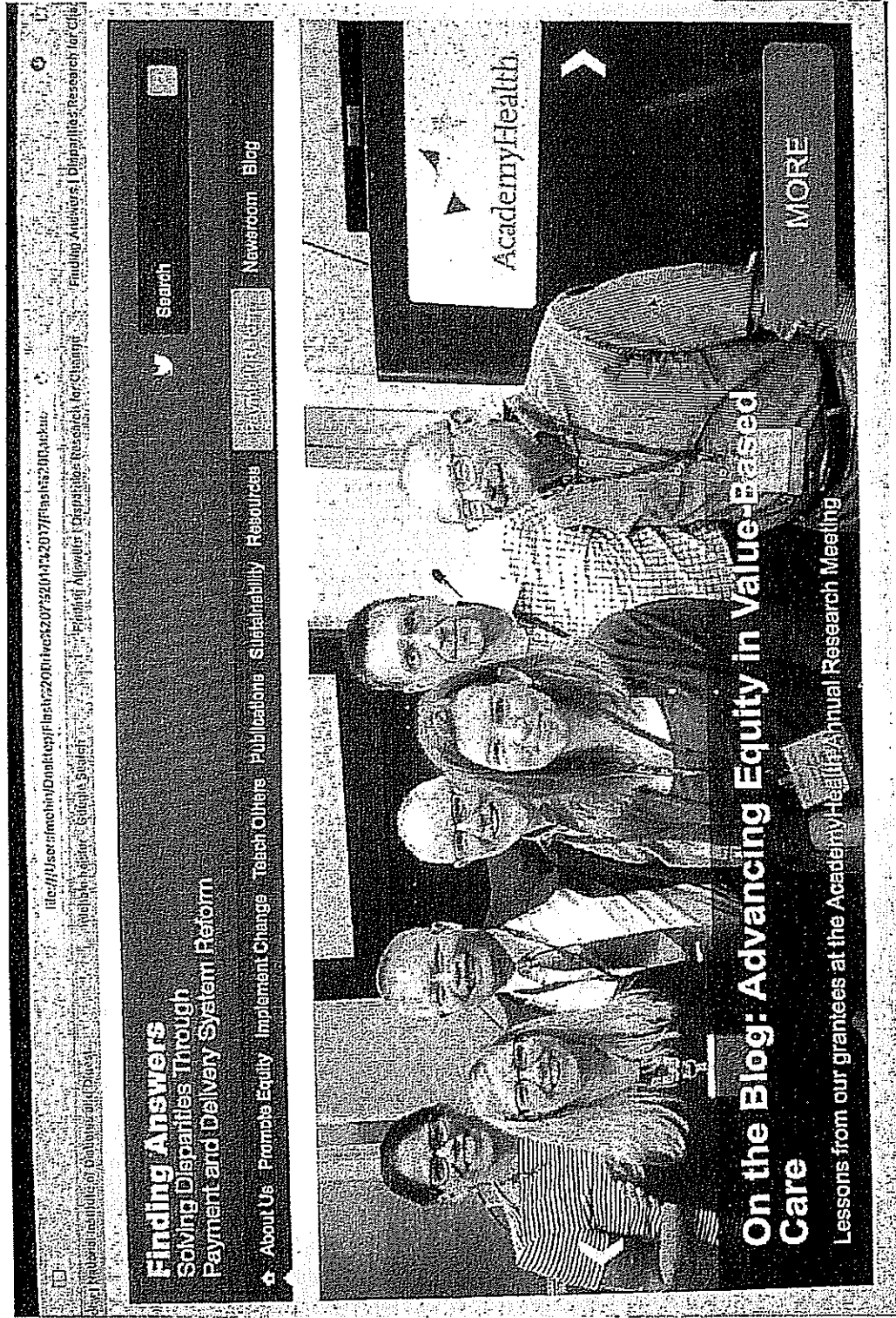
- Intervention (relative advantage)
- Outer (external incentives)
- Inner (culture)
- Individuals (beliefs)
- Process (plan, execute, evaluate)



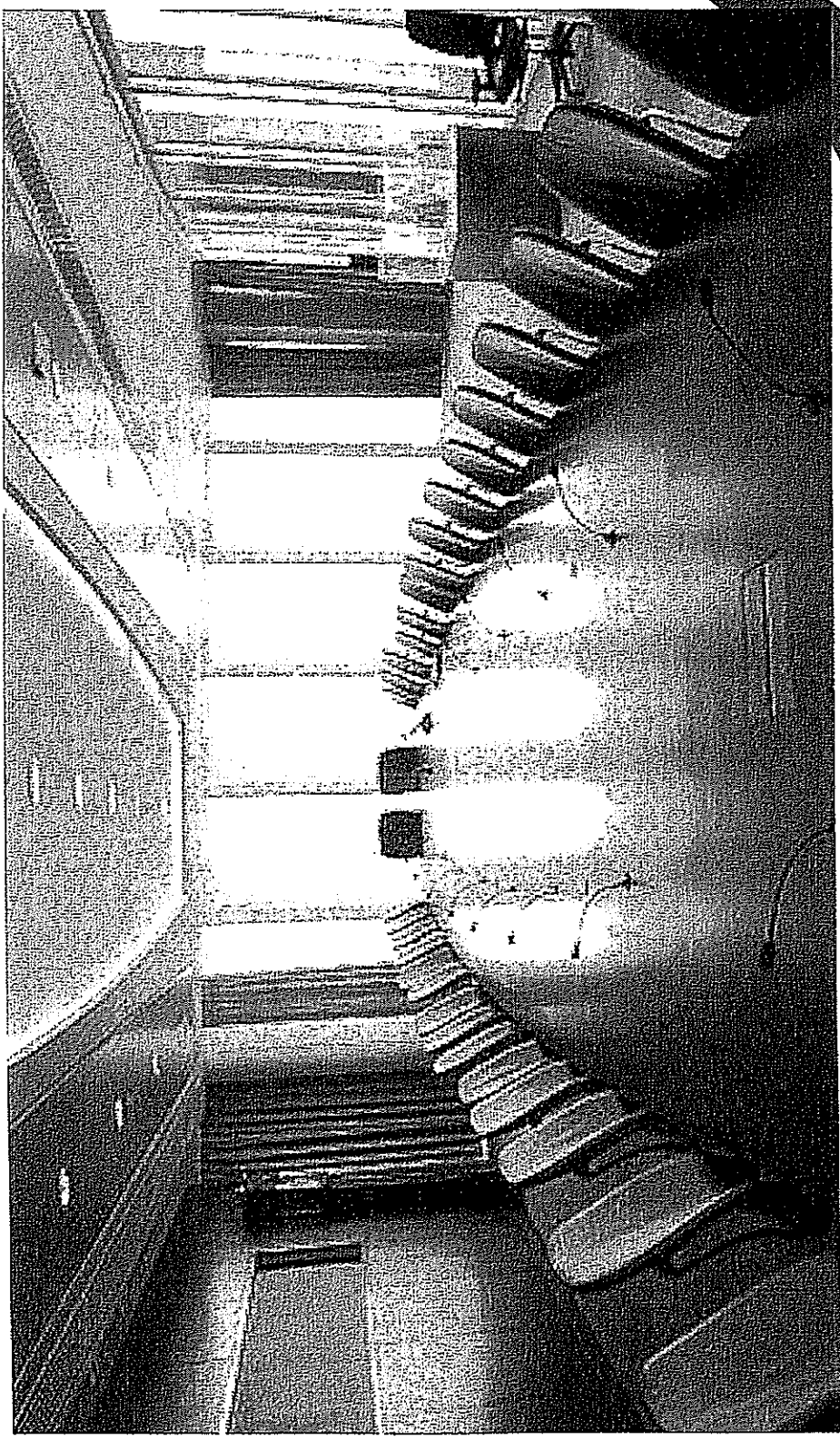
IMPLEMENTATION SCIENCE

Implement Sci 2009; 4:50.

Conceptual Framework Cut #5 – Economic Drivers and Motivation



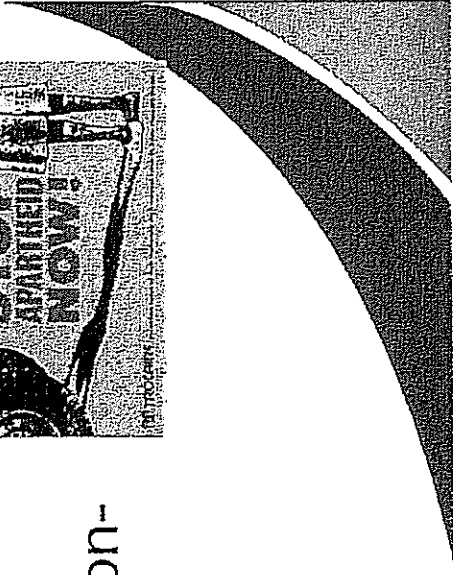
UChicago Medicine



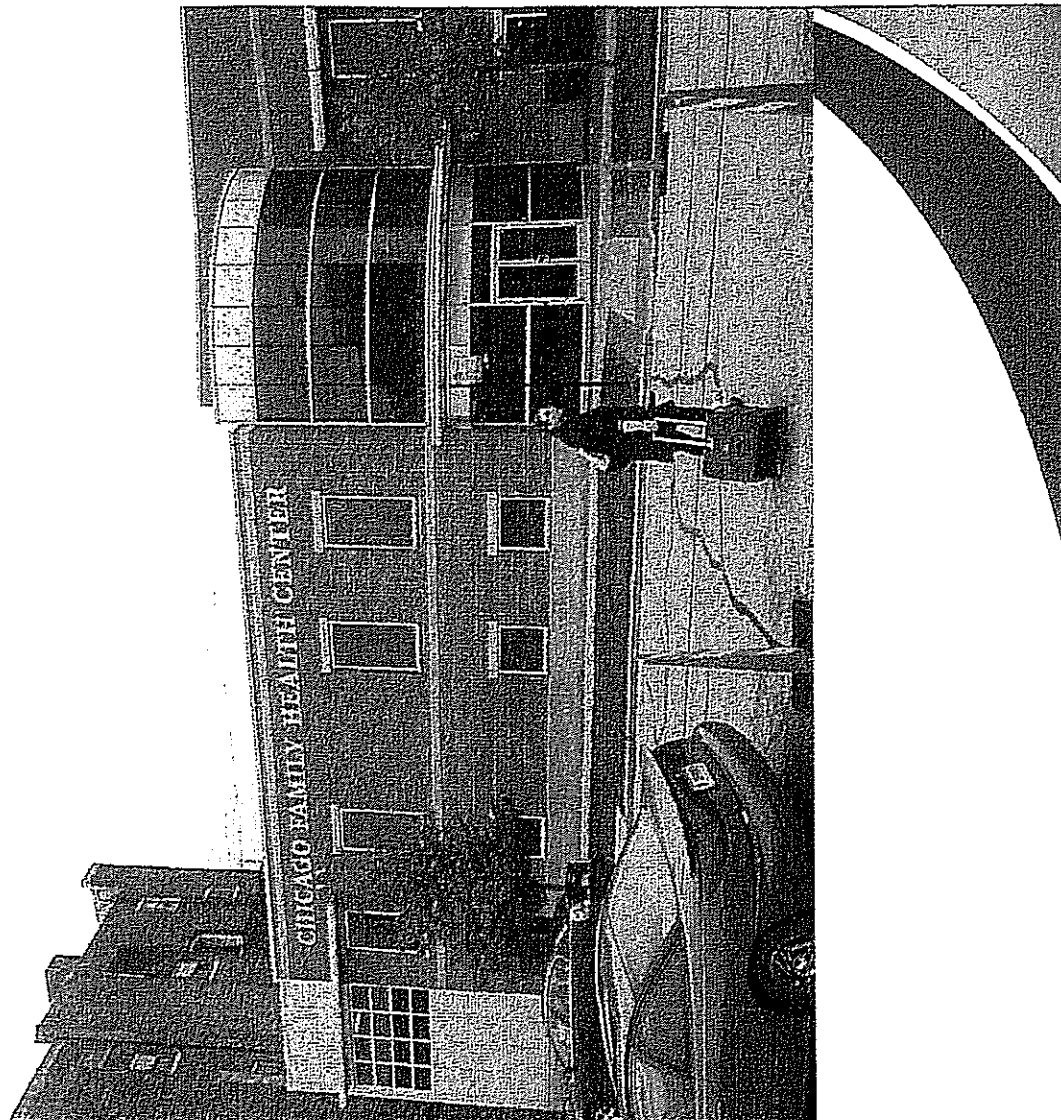


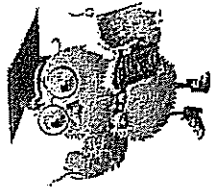
Values and the Business Case for Equity

- It's the right thing to do
- **Business Case – Align incentives**
 - Global payments
 - Population health
 - Community needs assessment for non-profits



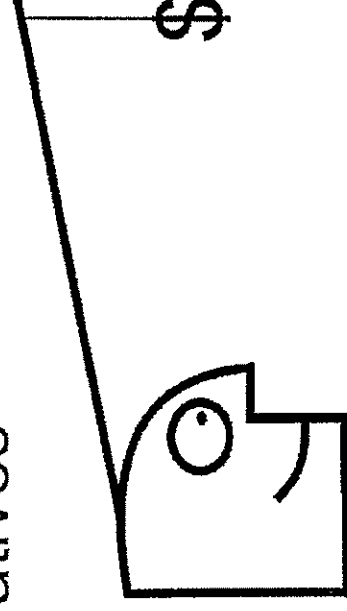
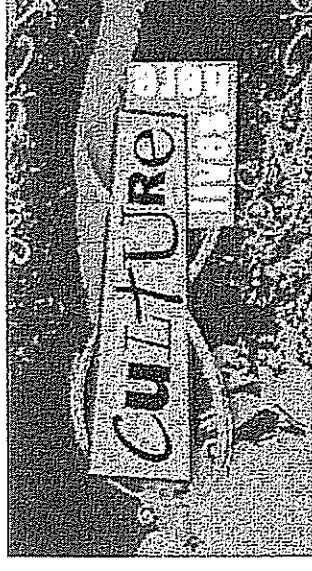
FQHC Leadership Meetings





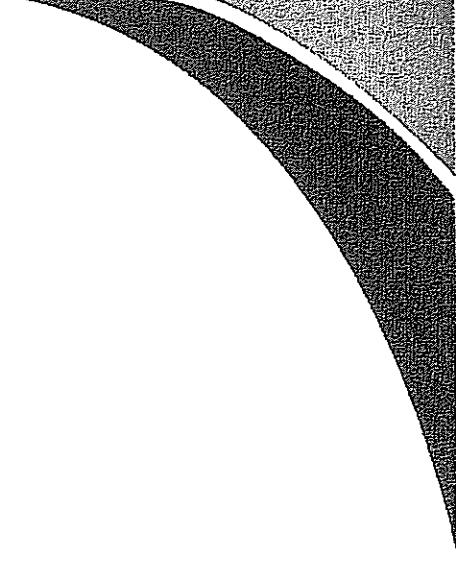
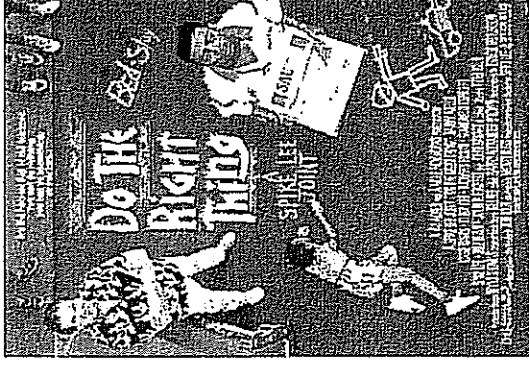
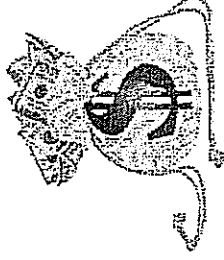
Behavior Change Theory

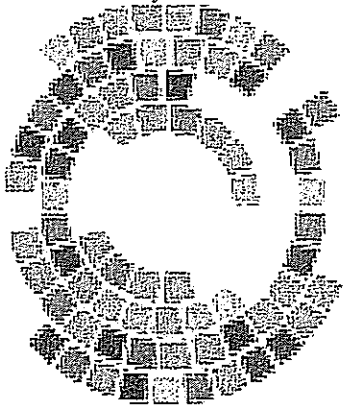
- Beliefs and knowledge
 - Why innovations are good
- Social norms
 - It's the culture / QI collaboratives
- Environmental factors
 - Incentives
 - Self-efficacy
 - Coaching / QI collaboratives



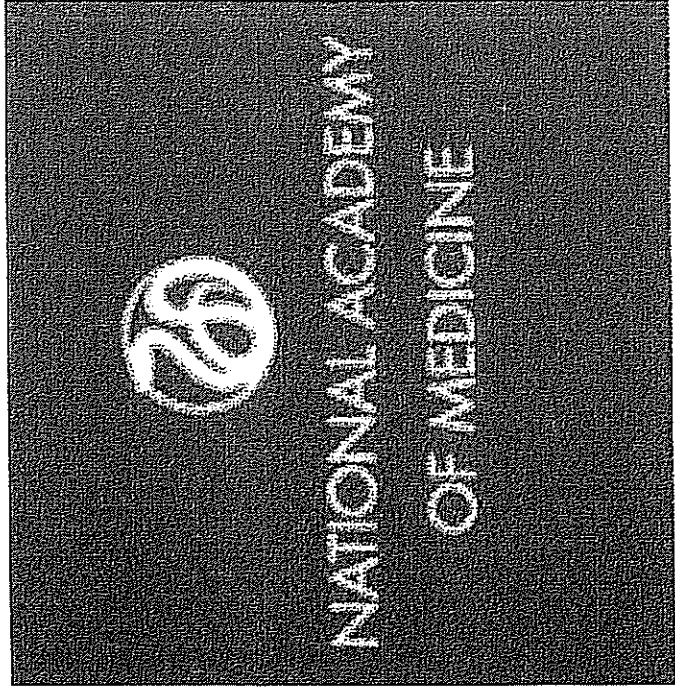
Motivation

- Intrinsic
 - Professionalism
 - Do the right thing
- Extrinsic
 - Financial
 - Other rewards

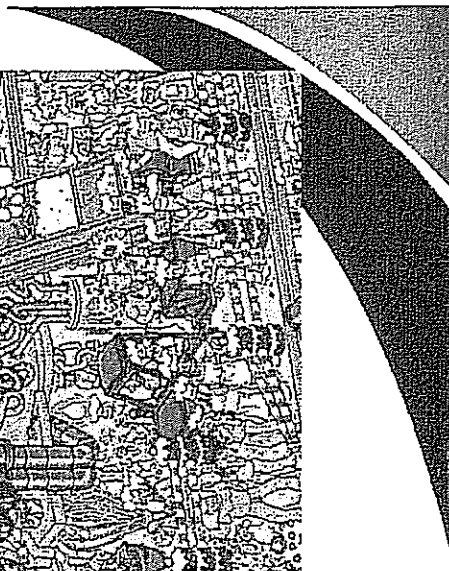
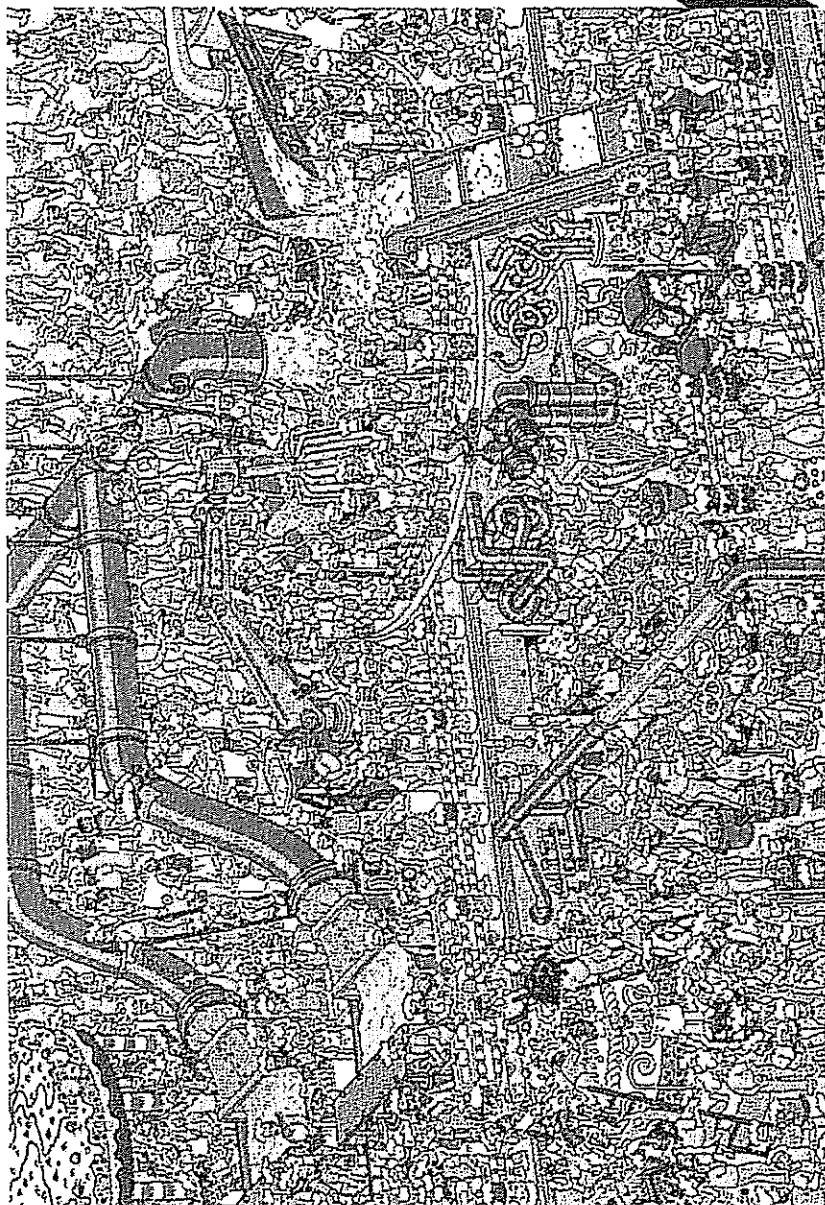
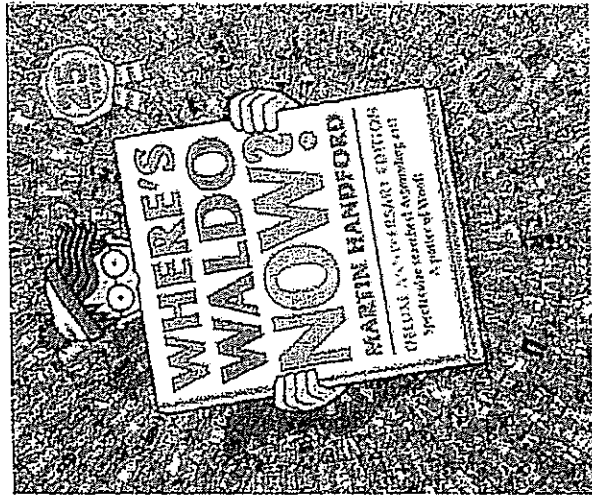




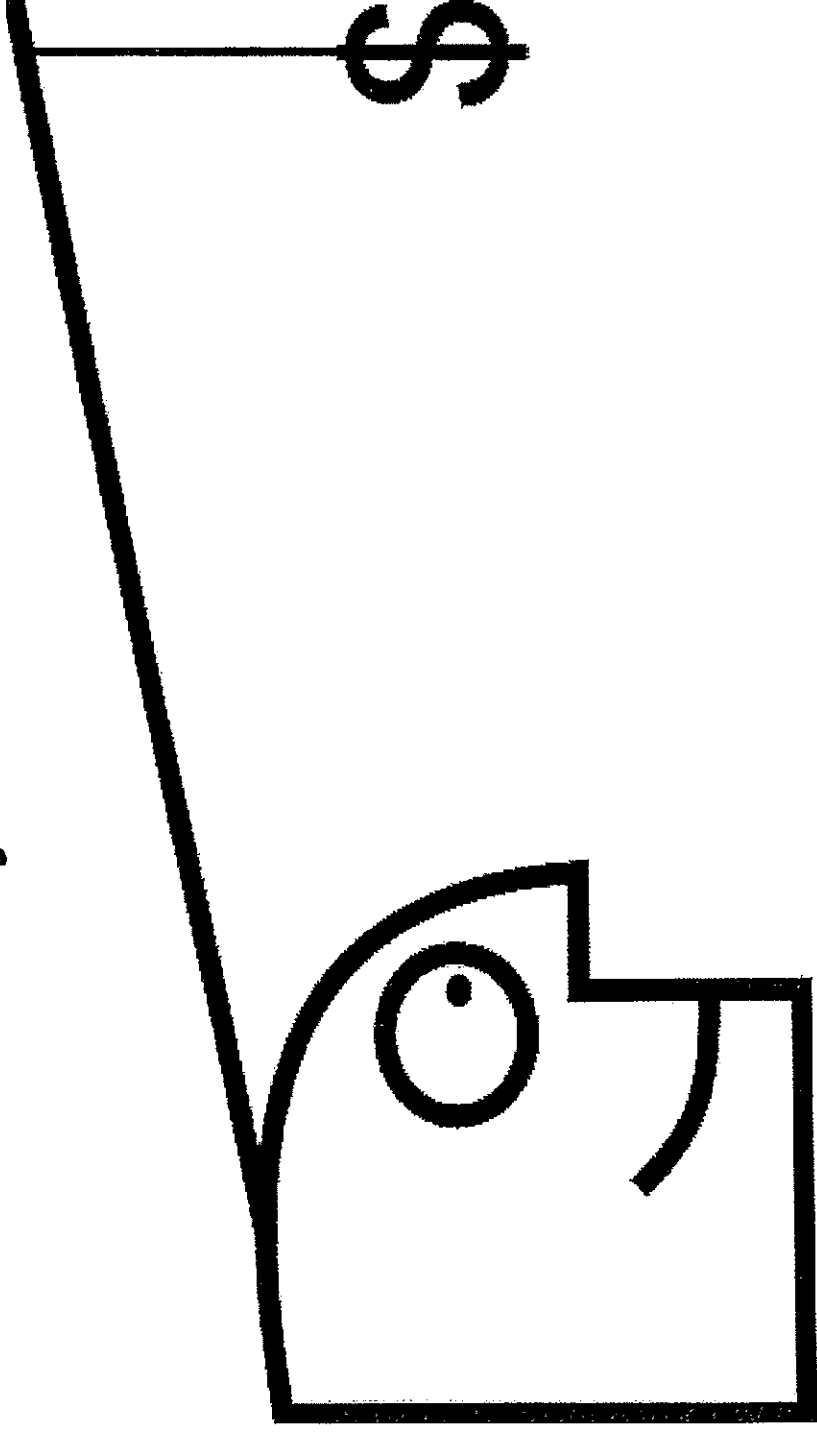
NATIONAL QUALITY FORUM



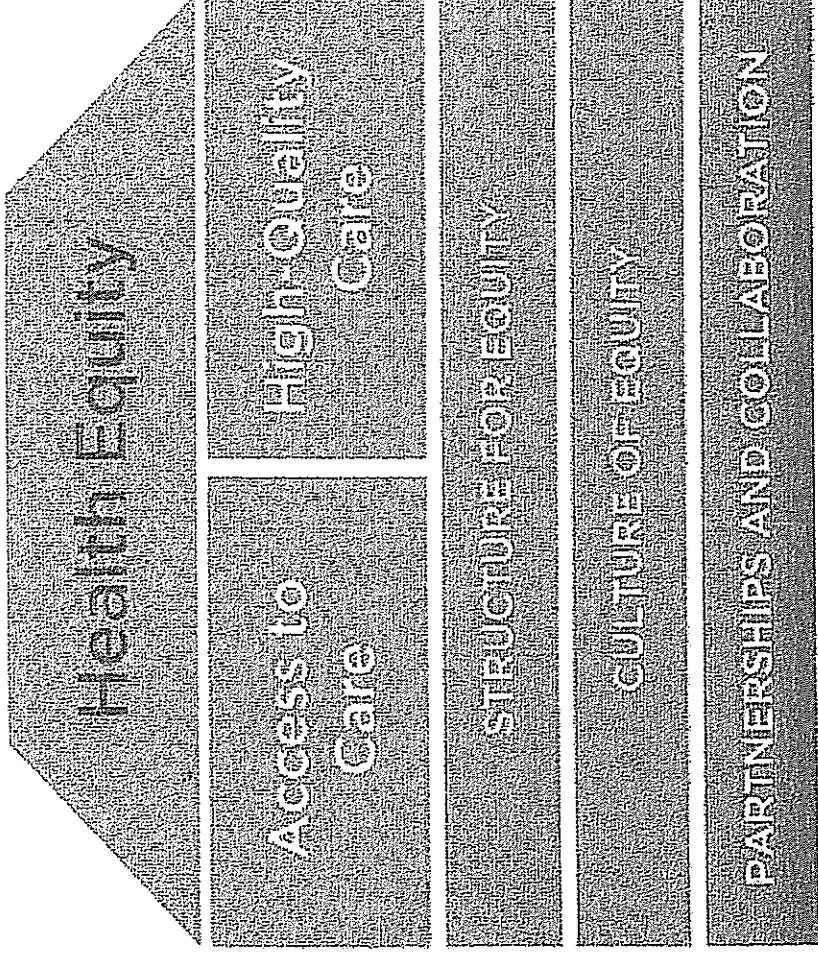
Where's Equity?



Disparities Context: Quality of Care and Payment Policies



National Quality Forum Equity Measurement Domains



NQF 4 I's for Health Equity

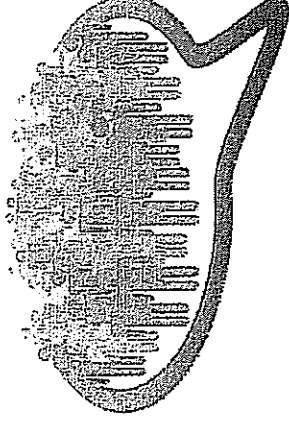
- Identify priority disparity areas
- Implement evidence-based interventions to reduce disparities
- Invest in health equity performance measures
- Incentivize the reduction of health disparities and achievement of health equity

NQF. A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity. September 14, 2017.



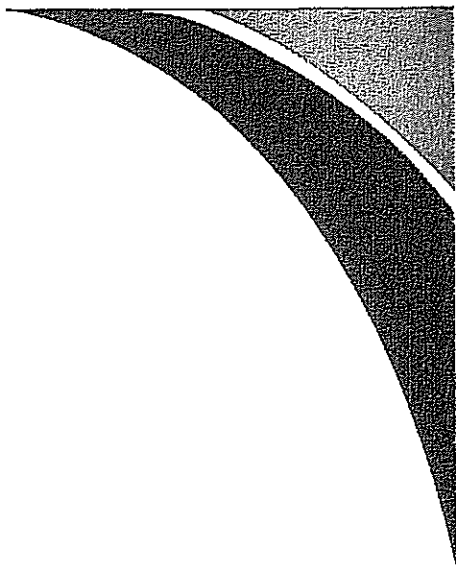
NQF 10 Incentivize Recs

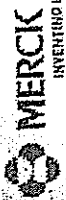
- Accountability
 - Stratified health equity outcome measures
- Redesign payment models to support health equity
 - Infrastructure – capitation
 - Specific processes - P4P
 - Integrate health and social services
- Tailor the safety net – QI and \$



NQF 10 Incentivize Recs (cont)

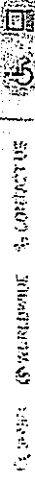
- Fund care delivery and payment reform demonstration projects to reduce disparities
- Assess economic impact of disparities from multiple perspectives
 - Business case
 - Societal perspective





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INVENTIONS FOR LIFE

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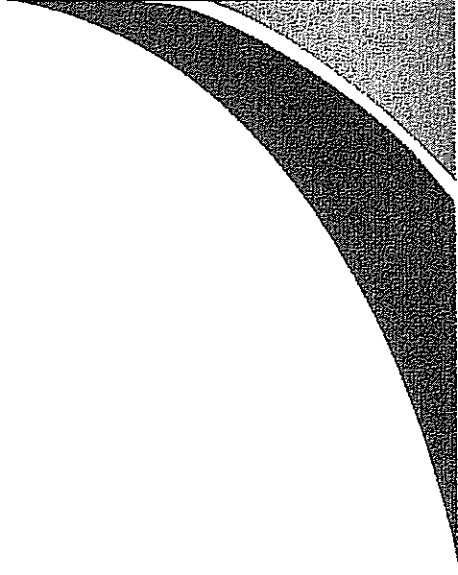
BRIDGING THE GAP. REDUCING DISPARITIES IN DIABETES CARE

This new initiative will bring together elite health care sector and other sectors to support innovative approaches to diabetes treatment and management.

An estimated 30 million people have diabetes in the U.S., and underserved populations in our communities are the most affected by the disease and its related complications. Too often, these individuals are unable to effectively manage their diabetes, including addressing other health conditions, access to healthy foods and safe opportunities for physical activity.

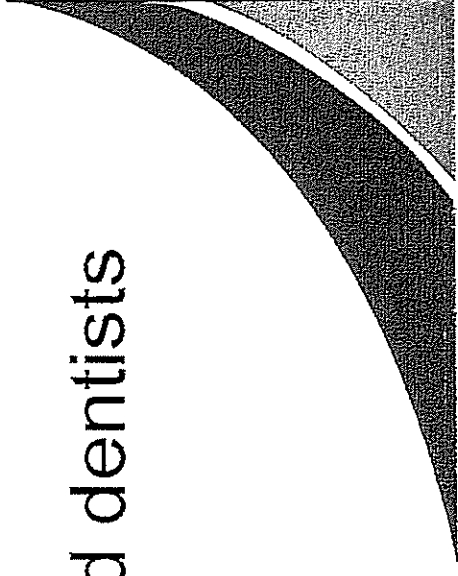


RWJF Finding Answers: Solving Disparities Through Payment and Delivery System Reform



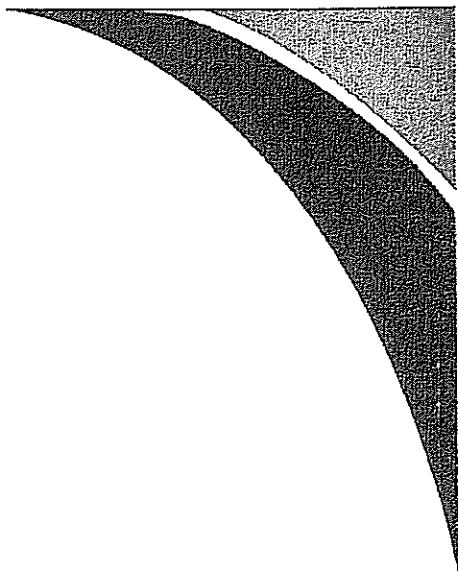
Univ. of Washington & Advantage Dental

- Improve dental care for low-income mothers and children in Oregon
- Prevention, Low complexity: Community-based expanded practice dental hygienists
- High complexity: Office-based dentists
- Capitated, global budget
- Team-based P4P



George Mason & Fairfax County

- DM, HTN, cervical cancer disparities – 3 public clinics
- Population health mgtmt; Care mgtmt
- Capitated, global budget
- Team-based incentive
 - RVU productivity
 - Processes of care



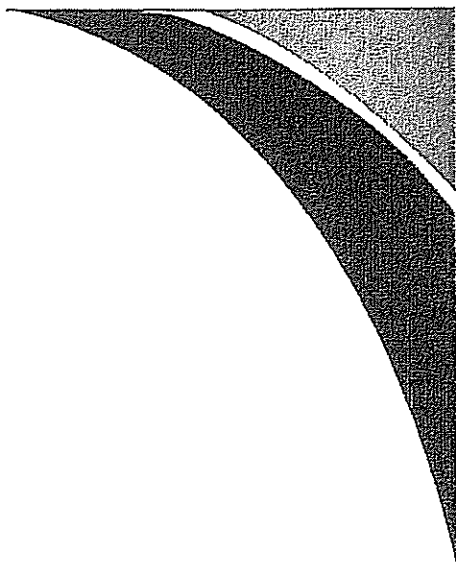
Mount Sinai, NYC

- Timely postpartum care for at-risk mothers
- Social worker and care coordinator
- P4P – Ob-Gyns



Organizational Motivation to Reduce Disparities

- Generate evidence
- Make the **business case**
- More **efficient** care
- Disparities reduction



“Every dollar that you spend on a child that doesn’t need any care, is a dollar you’re taking away from someone else. And the company in particular because it uses this global budgeting approach is concerned about caring for adults because Oregon has an adult benefit on their Medicaid. And so if they can be more economical about the way they care for children, then they will have more money to spend on the adults because the adults are by far more expensive.”

-Project Leadership

Non-financial Motivation to Reduce Disparities

- Aligns with **personal and professional identity**
- Improve care processes and patient outcomes



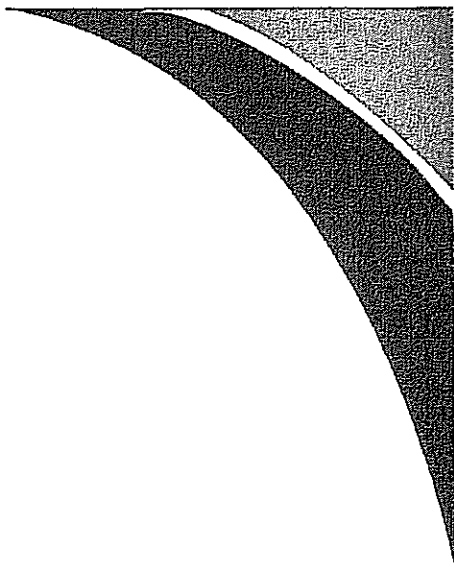
“So I think that’s probably been the biggest gain I have gotten out of this. I mean, that incentive is great and all, but it is really – it’s being able to transform the care that we deliver in these clinics.”

- Health Care Org, Senior Manager



Benefits of Individual and Team-based Financial Incentives

- Engages staff across roles
- **Collective goal**
- **Routinizes** behavior change



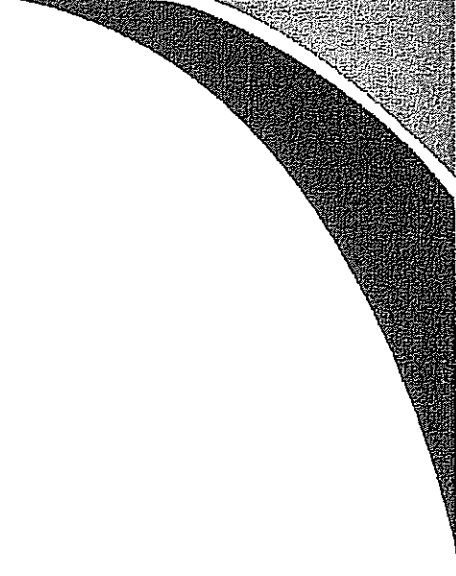
“I think when incentives came in and they identified certain key points that we need to look at and give that holistic care, then it became a standard. And so everybody is doing the same thing, not just this provider over here. All three sites are doing the exact same thing. So it’s now standardized.”

- Nurse Clinic Manager



Challenges of Individual and Team-based Financial Incentives

- Financial incentives may not prompt care delivery changes in all settings
- **Other resources may offer more tangible benefits**



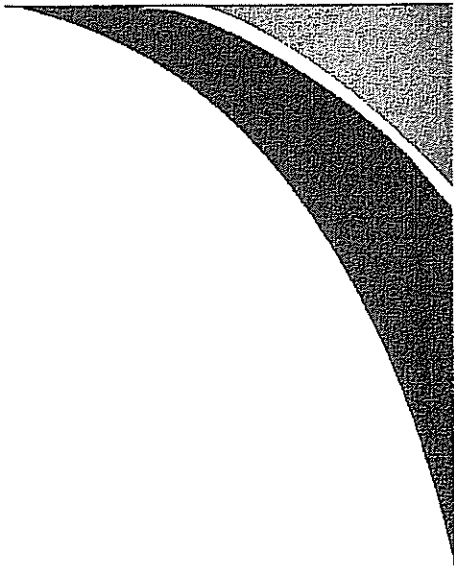
“A lot of clinicians do things because it’s the right thing to do especially if people make it easy for them to do it. So it’s not about the financial incentive, it’s about the non-financial incentive.... the struggle in clinical medicine is that we often don’t have the resources we need to take the best care of our patients. And so I thought the primary part of this study that was going to be most impactful was this extra resource [social worker and navigator] and making it easier for clinicians to do the right thing.”

- Project Leadership



Implementation Facilitators

- Buy-in and leadership support
- Align with organizational priorities
- **Data tell a compelling story** about previously unknown disparities
- Staff engagement



“I think everybody was sort of like me. “Oh we don’t treat people differently or we don’t have any disparities between our populations. And then lo and behold the data show that we do.... So I don’t know that we’ve changed our behaviors yet in addressing disparities, but I think we’re moving in that direction because we started the discussions around what is the real root cause of why there are disparities and what can we do to change this.”

- Payer, Design/Implementation Team



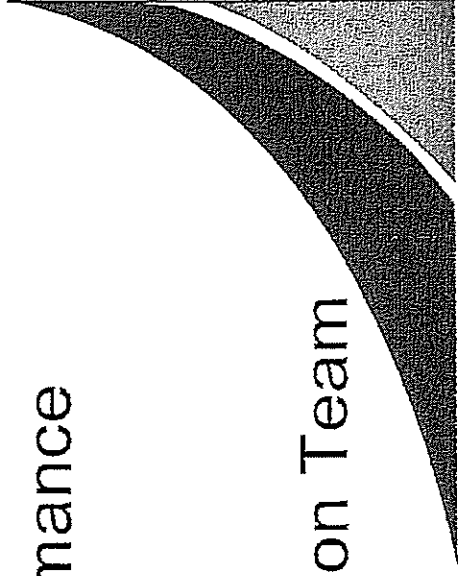
Implementation Challenges

- **Linking incentives to individuals in health care organization**
- Addressing concerns from community stakeholders
- Unexpected organizational changes impact continuity and sustainability
- Information technology (IT) support for accurate data tracking and reporting



“...making it meaningful to the individual providers when these incentives are paid at the practice level. Part of the system change is at the practice level, not just kind of the payer level and the policy level. And they didn't have the practices figure out how to tie those payments back to providers and how they want to organize their practices around that kind of performance incentive.”

- Payer, Design/ Implementation Team



Other State Medicaid Models for Health Equity

- Minnesota's Hennepin Health Safety-Net ACO
 - Blewett LA & Owen RA. AJPB 2015.
 - Sandberg SF, et al. Health Affairs 2014.
- Oregon Coordinated Care Organization (CCO)
 - McConnell KJ, et al. Health Affairs 2017.



Implications for Managed Care Contracts: Be Proactive for Equity

- Implement equity proactively as an explicit goal
 - Not de facto ignore
 - Not just examine for unintended negative consequences



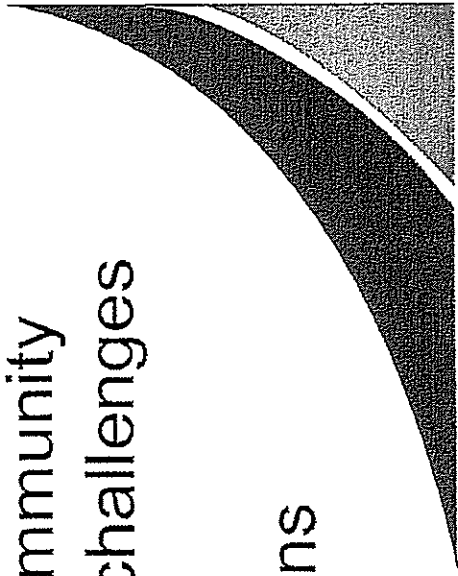
Understand Drivers

- Understand factors driving disparities
 - Social determinants
 - Place
 - Culture, values – Of society and HFS
- Understand what causes clinicians, health care organizations, and health plans to reduce disparities



Performance Measurement and Payment as Tools

- Understand how performance measurement and payment can be used to explicitly incentivize and support the reduction of disparities
 - Capitation - direct money towards disparities infrastructure, addressing social determinants E.g. – Teams, community health works, geomapping for challenges and assets
 - P4P – incentivize specific actions



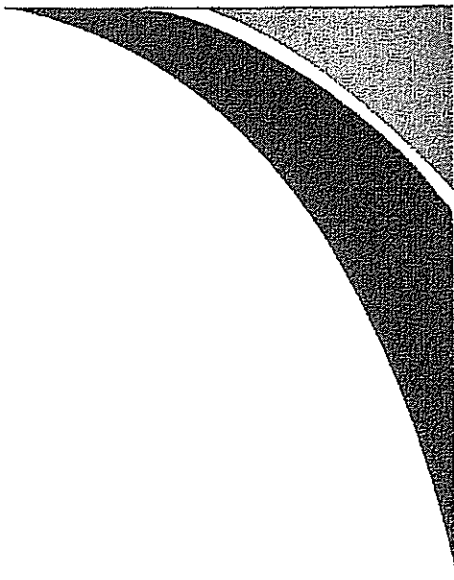
Tools 2

- Social risk factors
 - Risk adjustment and stratification – fairness and addressing disparities
- Performance
 - Reward improvement, attainment of threshold, reduction in disparities, combination



Contract Levers

- Managed care contract levers
 - Equity as a priority – value, culture
 - Equity performance measurement and accountability – public reporting and payment
 - Use payment levers



Partners; National Momentum

- Partner with other sectors and agencies
- Recognize momentum for using payment, performance measurement, and care transformation to reduce disparities
 - National Quality Forum
 - Patient and consumer advocacy groups - Families USA



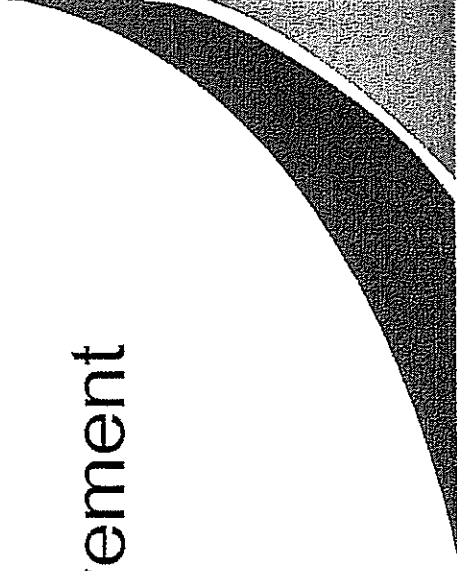
Immediate Takeaway Points

- Proactively design programs to explicitly advance health equity
- Consider piloting a few health equity performance measures in value-based purchasing programs
- Consider rewarding improvement, attainment of threshold, reduction in disparities, combination



NQF Disparities-Sensitive Measure Selection Criteria

- Prevalence and impact of condition on patients with social risk factors
- Size of the disparity
- Strength of evidence linking improved in performance measure to improved patient outcomes
- Ease and feasibility of improvement



NQF Hypertension Example

- Applies 4 disparities-sensitive measure selection criteria to HTN
- Applies 4 I's of NQF Roadmap to HTN (Identify, Implement, Invest, Incentivize)

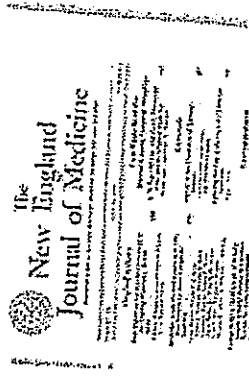
Anderson A, O'Rourke E, Chin MH, et al. Promoting health equity and eliminating disparities through performance measurement and payment. Health Affairs 2018.



Eliminating Health Disparities



Leadership Matters



“Leadership matters. It is our professional responsibility as clinicians, administrators, and policymakers to improve the way we deliver care to diverse patients. We can do better.”

Chin MH. NEJM 2014.

