Advancing Health Equity through Patient and Community Partnership

2025 National Webinar Series: Strategies from the Field

January 29, 2025

AHE Advancing Health Equity
Leading care, payment, and systems transformation

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Welcome to AHE's 2025 Webinar Series - *Strategies from the Field*

- The Advancing Health Equity program facilitates cultural – not simply operational – systems change, with the goal of creating anti-racist care transformations and integrated payment models that are wide-reaching, sustainable, and replicable.

- Each "Strategies from the Field" webinar will:
  - Share our learnings and feature members of AHE's multi-stakeholder Learning Collaborative teams and other experts in the field
  - Center our Roadmap to Advance Health Equity
  - Reflect AHE's approach to payment reform and healthcare innovation, describing barriers, solutions, and a way forward

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Today's Session: *Advancing Health Equity through Patient and Community Partnership*

- Advancing Health Equity Program Overview
- Patient and Community Partnership Strategies
- Perspectives from the Field – IL AHE Team
- Perspectives from the Field – ME AHE Team
- Q & A
- Closing

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Housekeeping

- Mute when not speaking
- Use the “raise hand” feature during the Q and A session
- Send questions/comments anytime via chat
- Take care of yourself and loved ones (e.g., bio breaks)
- To enable closed captioning:
  - Click **Show Captions** (CC) at the bottom of your zoom screen
  - Select your speaking language

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The Advancing Health Equity Program

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Program History

- Advancing Health Equity: Leading Care, Payment, and Systems Transformation (formerly Finding Answers)
  - 2005 - present
  - 36 healthcare organization partners (>200 clinical sites); some payer involvement
  - Quantitative data
  - Qualitative data
  - 12 Systematic reviews of the health/healthcare disparities intervention literature

- Some successful, some not, some “middling”
- Original plan: “Box” and disseminate successful interventions

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Program History

- While there are often common root causes for inequities, there are just as often unique root causes.
- All healthcare provider organizations and systems are unique
- Shifted to a roadmap model - Began regional and national Learning Collaboratives
  - Collected cost data and tracked the influence of cost
  - Shifted to focus on payer/provider partnerships

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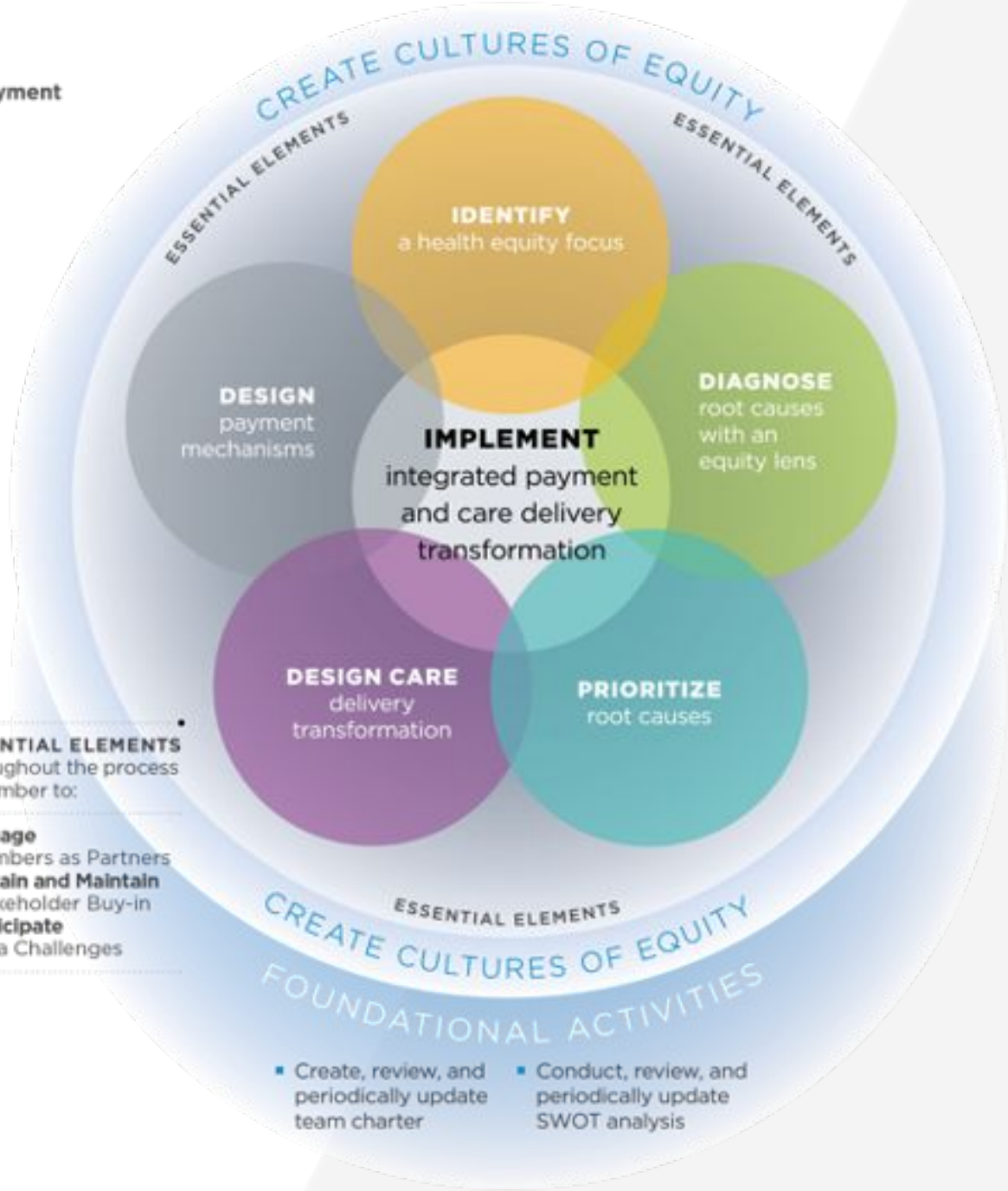
Integrated Care Delivery and Payment Transformation



ESSENTIAL ELEMENTS
Throughout the process remember to:

- **Engage** Members as Partners
- **Obtain and Maintain** Stakeholder Buy-in
- **Anticipate** Data Challenges

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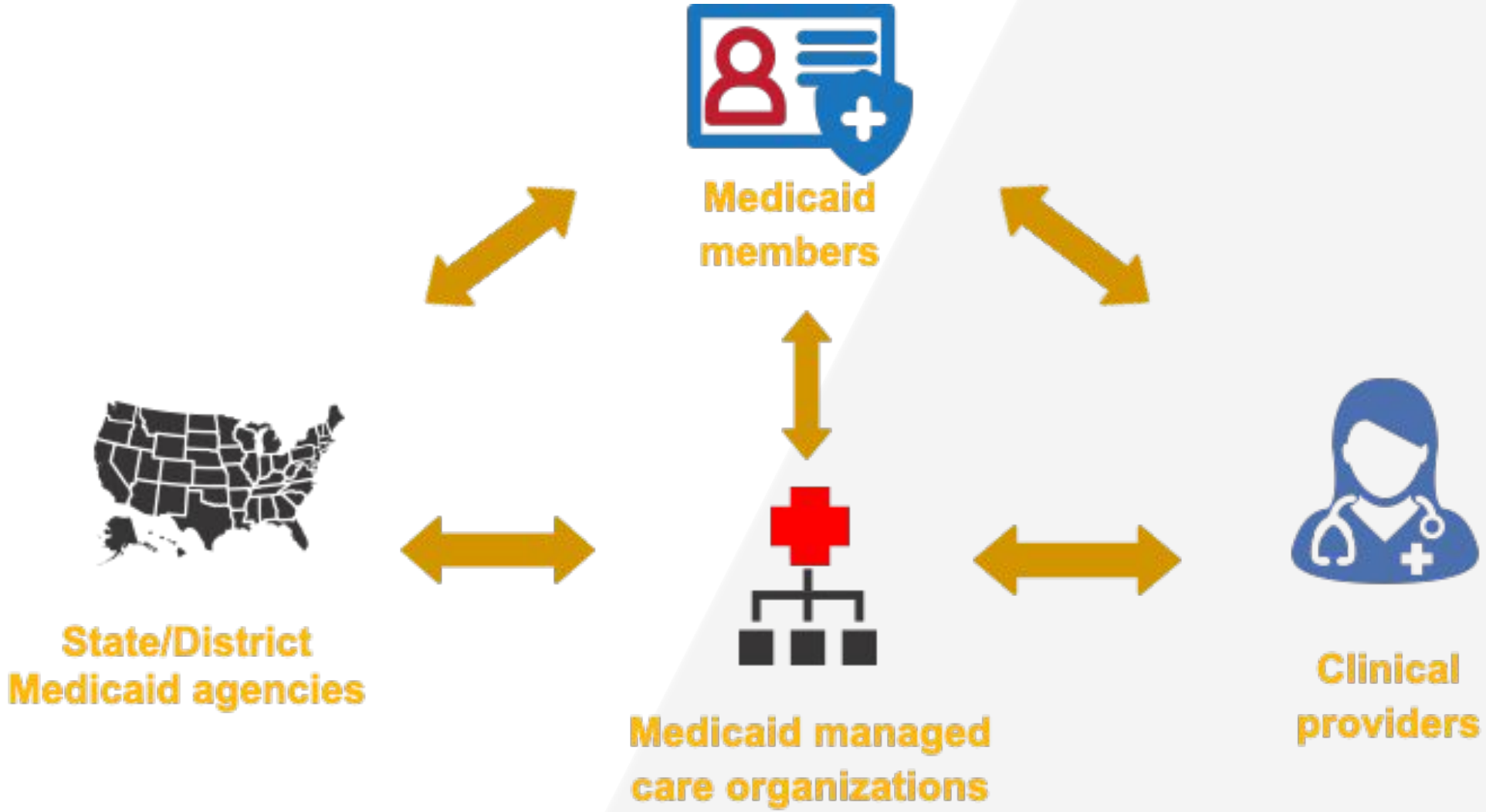
Bringing Key Stakeholders Together



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The Team


THE UNIVERSITY OF
CHICAGO


Robert Wood Johnson Foundation


Center for
Health Care Strategies

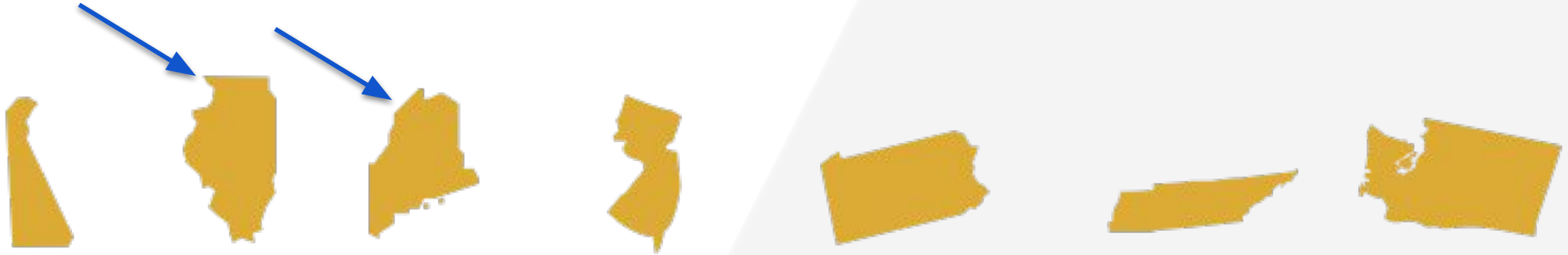

THE JUSTICE COLLECTIVE


INSTITUTE FOR
MEDICAID INNOVATION


AHE
Advancing
Health
Equity

The Learning Collaborative

Cohort 1



Delaware Illinois Maine New Jersey Pennsylvania Tennessee Washington

Cohort 2

Louisiana Mississippi New York Washington D.C. Pennsylvania (2)

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Why Partner with Patients and Community Based Organizations?

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Here is why their voice matters

Members/Patients/Individuals…

- have a need, right, and expectation to have their experience valued and perspectives heard
- experience health/health care inequities; can say if a care transformation plan is likely to succeed (i.e., advance health equity)

Community-Based Organizations…

- have long standing and trusting relationships with community members - they are mission-driven and dedicated to serving local populations
- are highly culturally competent, humble, and relevant to the local context - have deep knowledge of local social drivers of health

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Types and Levels of Engagement

Breadth and Depth

Single Point

Less resource intensive; high breadth, low to medium depth

- Surveys (e.g., phone, text, email)
- Interviews (in person or virtual)
- Focus Groups (in person or virtual)

Ongoing

More resource intensive; medium breadth and depth

- Committees/Advisory Groups

Partnership

Resource intensive; high depth, potentially high breadth

- Embedded member, patient, and/or community councils with decision making power/authority
- Can begin with smaller pilot projects
- Mutual respect and trust leads to a rewarding experience for all parties

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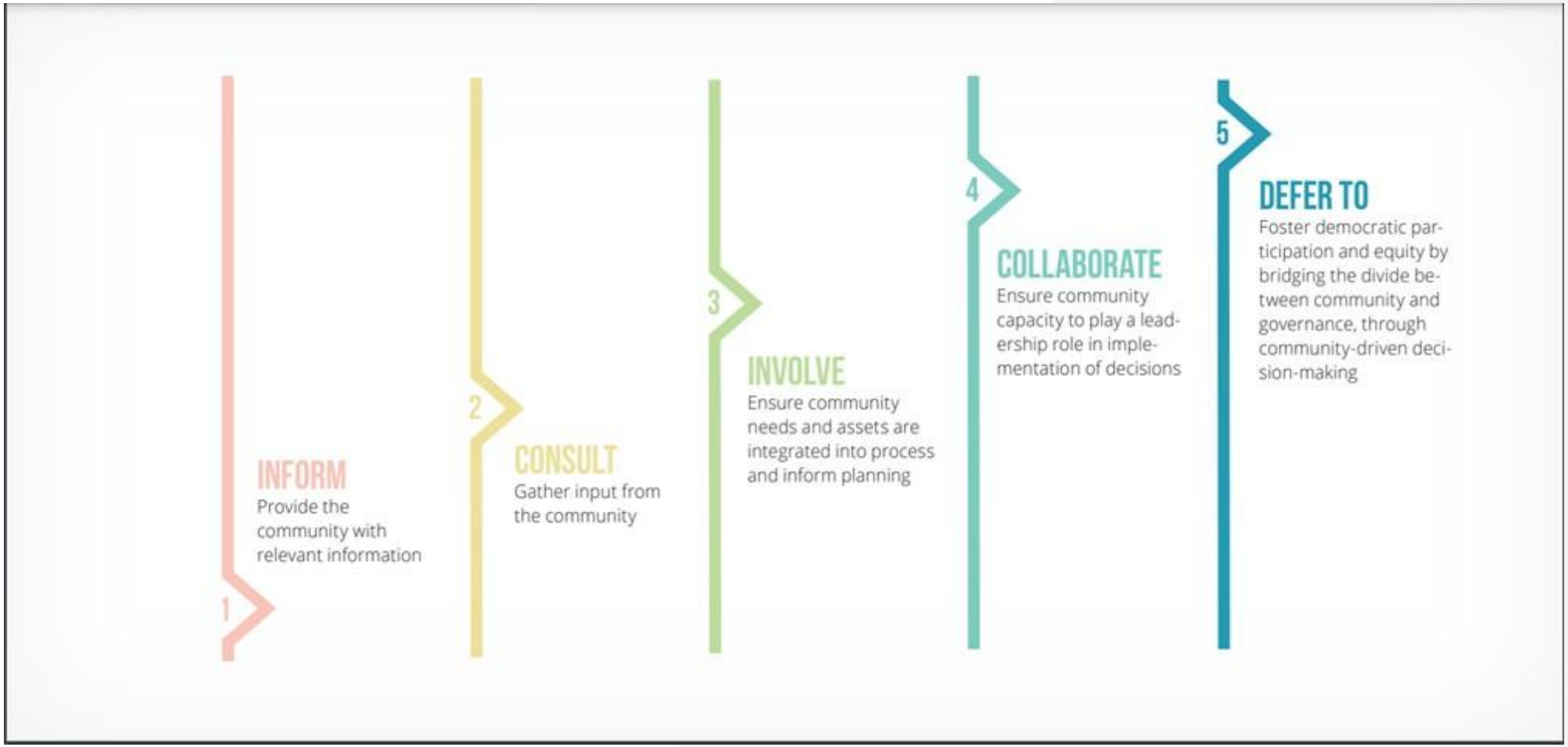
The Spectrum of Community Engagement to Ownership



Gonzalez, Rosa. The Spectrum of Community Engagement to Ownership. Facilitating Power. Accessed Jan 23, 2023. https://movementstrategy.org/wp-content/uploads/2021/08/The-Spectrum-of-Community-Engagement-to-Ownership.pdf

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RECOMMENDATIONS

Partnering for Health Equity

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Building Strong Relationships

Meaningful Inclusion	Meaningfully include the people most impacted and informed. Avoid symbolic efforts and move towards a true participatory approach.
Relevance	Speak to what motivates patients and communities
Value	Include community in deliberate, thoughtful ways and be explicit about the immense value of having them at the table

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Building Strong Relationships

Individuals/communities will spot inauthenticity from miles away + there is earned skepticism of the healthcare industry	This will be a barrier to building the trust and respect necessary for partnership. Determine how you can demonstrate your genuine interest and a desire to evolve.
Prepare to have honest conversations about societal and organizational bias, oppression, and discrimination	This means exploring racism, ableism, sexism, homophobia, classism, xenophobia. **Prepare to get uncomfortable to be authentic.**

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Communities and Organizations: Giving Before Getting

- Build rapport by giving first
- Meet folks where they are
- Consider existing, trusted relationships
- Understand and honor what's involved in the commitment
- Meet individual community contacts 1:1 before pulling together as a group
- Follow up and follow through on your commitments

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PERSPECTIVES FROM THE FIELD

IL Advancing Health Equity Team

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Illinois Team:
Flexible Housing Pool and Uplifting Community Voices

Paige Clincy, Housing Coordinator, CountyCare
Deirdre Rizzo, Senior Manager-Special Projects, Center for Health and Housing

1/29/2025

Center for Housing & Health

CountyCare
A MEDICAID HEALTH PLAN

Agenda

- Overview of CountyCare and Center for Health and Housing
- The Housing Challenge
- Our Response: Flexible Housing Pool
- Community Partnerships
- Lived Experience Advisory Committee

CountyCare
A MEDICAID HEALTH PLAN

Who are we?


CountyCare
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HH
Center for Housing & Health

Mission & Vision

Mission

As a public, provider-led health plan, we improve our members' lives by partnering with communities, supporting a vibrant safety-net, advancing health equity, and empowering providers to deliver integrated, member-centered health care

Vision

To transform the health of our members and the communities we serve.

[CountyCare Health Plan Website]

Fast Facts

- Illinois has a Managed Care Model for Medicaid and 5 Medicaid Health Plans
- CountyCare has 417,000 Medicaid members
- Our Network:
  - 70 Hospitals
  - 150 Urgent Care Sites
  - 2/3 of Members are BIPOC
- Majority of members live in Chicago's West and South Side and South suburbs

COOK COUNTY HEALTH

Primary Care Medical Homes (Family Health Care)

1. Arlington Heights Health Center • Arlington Heights, IL
2. Logan Square Health Center • Chicago, IL
2. Belmont-Cragin Health Center
3. Austin Health Center • Chicago, IL
4. North Riverside Health Center • North Riverside, IL
5. Dr. Jorge Prieto Health Center • Chicago, IL
6. Englewood Health Center • Chicago, IL
7. Robbins Health Center • Robbins, IL
8. Cottage Grove Health Center • Ford Heights, IL

Regional Outpatient Centers

(Includes Primary Care Medical Homes, specialty, diagnostic and procedural services)

9. John Sengstacke Health Center at Provident Hospital • Chicago, IL
10. Blue Island Health Center • Blue Island, IL
11. Cook County Health
    Central Campus • Chicago, IL
    - Professional Building
    - Specialty Care Center (Clinics A - V)
    - Women & Children's Center at Stroger Hospital
12. Ruth M. Rothstein CORE Center • Chicago, IL

Child & Adolescent Services

13. Morton East Health Center • Cicero, IL

HOSPITALS

14. John H. Stroger, Jr. Hospital • Chicago, IL
15. Provident Hospital • Chicago, IL

ADDITIONAL SERVICES

Public Health

16. Cook County Dept of Public Health • Forest Park, IL

Correctional Health Services

17. Cook County Jail • Chicago, IL
18. Juvenile Temporary Detention Center • Chicago, IL

CountyCare

19. Medicaid Managed Care Plan

Center for Housing & Health

Our Mission

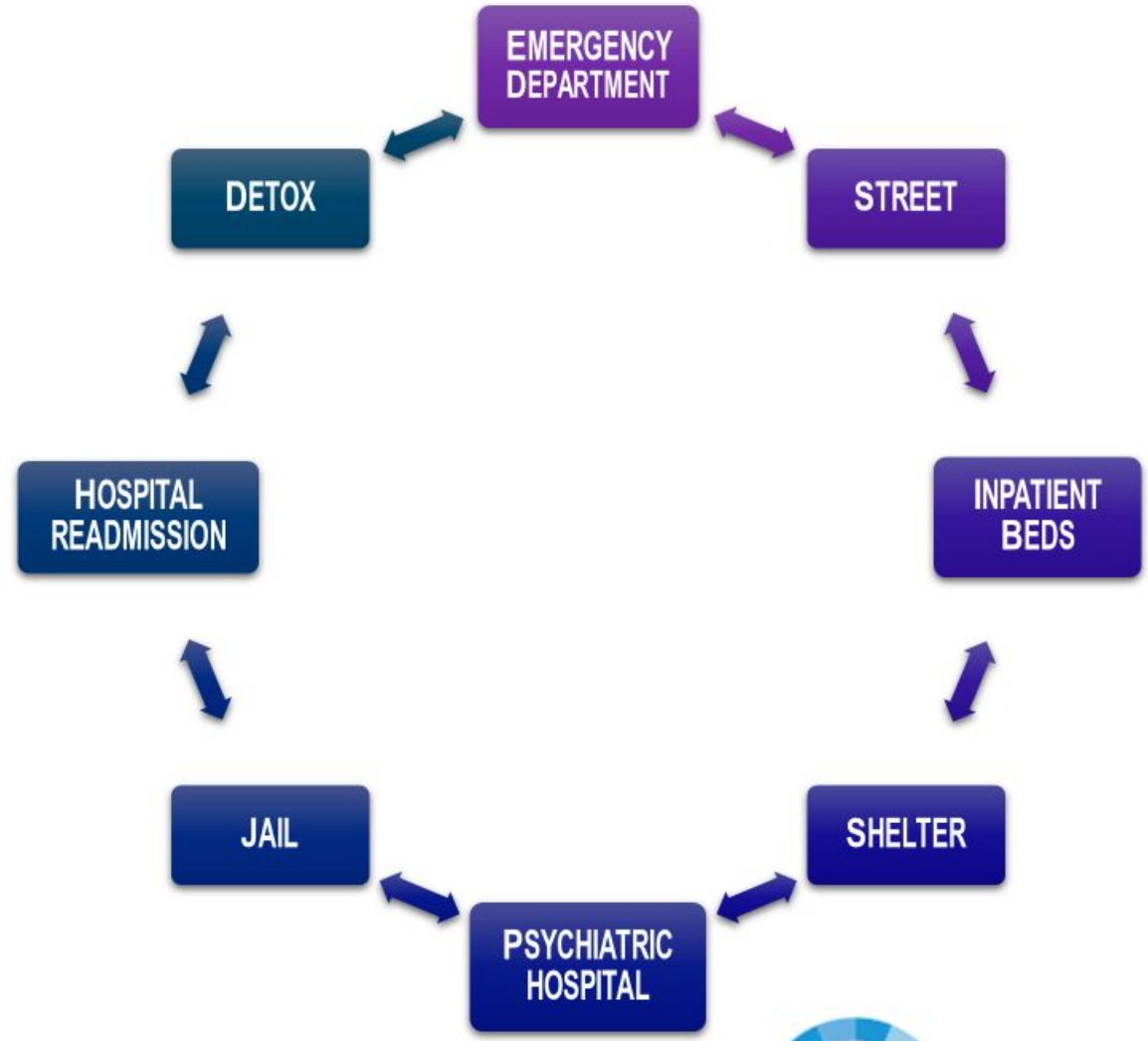
CHH honors every person's right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness.

Our Vision

Every person has a place to call home that helps them reach their full potential.

Flexible Housing Pool Overview

The Challenge: Homeless Patients Cycle Through High-Cost Settings



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Flexible Housing Pool's Vision

To promote cross-sector investment in an integrated housing and service delivery strategy that will dramatically increase supportive housing for individuals impacted by homelessness with complex health needs and a history of justice involvement.

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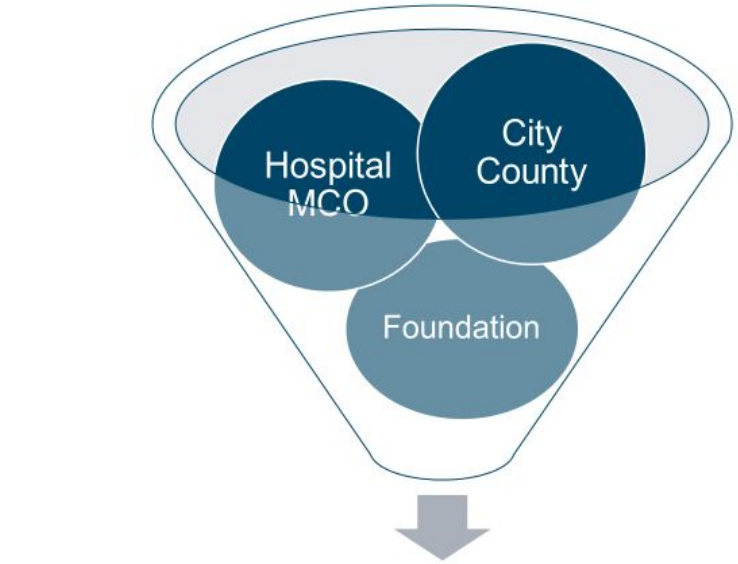
Subsidies and Case Management/Tenancy Supports



Center for Housing and Health
FHP Coordination Agency

Outreach & Case Management/Tenancy Supports

Clinical Services

Participating Health Care Entities

Health Care Services, Care Coordination

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Goals and Outcomes

Goals

↑

- Housing Stability
- Increasing Income
- Improved Health
- Improved Outpatient Utilization

↓

- ED and Inpatient Utilization
- Jail/Prison Stays
- Emergency Shelter Days
- Crisis Services

Outcomes

Process

- 1373 Persons housed in 806 households
- 77% of head of households are Black or African—American
- 97% program retention

Impact

- 33% reduction of inpatient stays compared to control group
- 19% reduction of emergency dept visits compared to control group
- 22% reduction of jail registrations compared to control group
- 30% reduction in all cause mortality

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Funding – Escrow Account

Public	Private	Philanthropy
City of Chicago	Managed Care Organizations	Private Foundations
Cook County	Hospitals	
*State of Illinois	Healthcare Transformation Collaboratives	

*Direct grant to CHH

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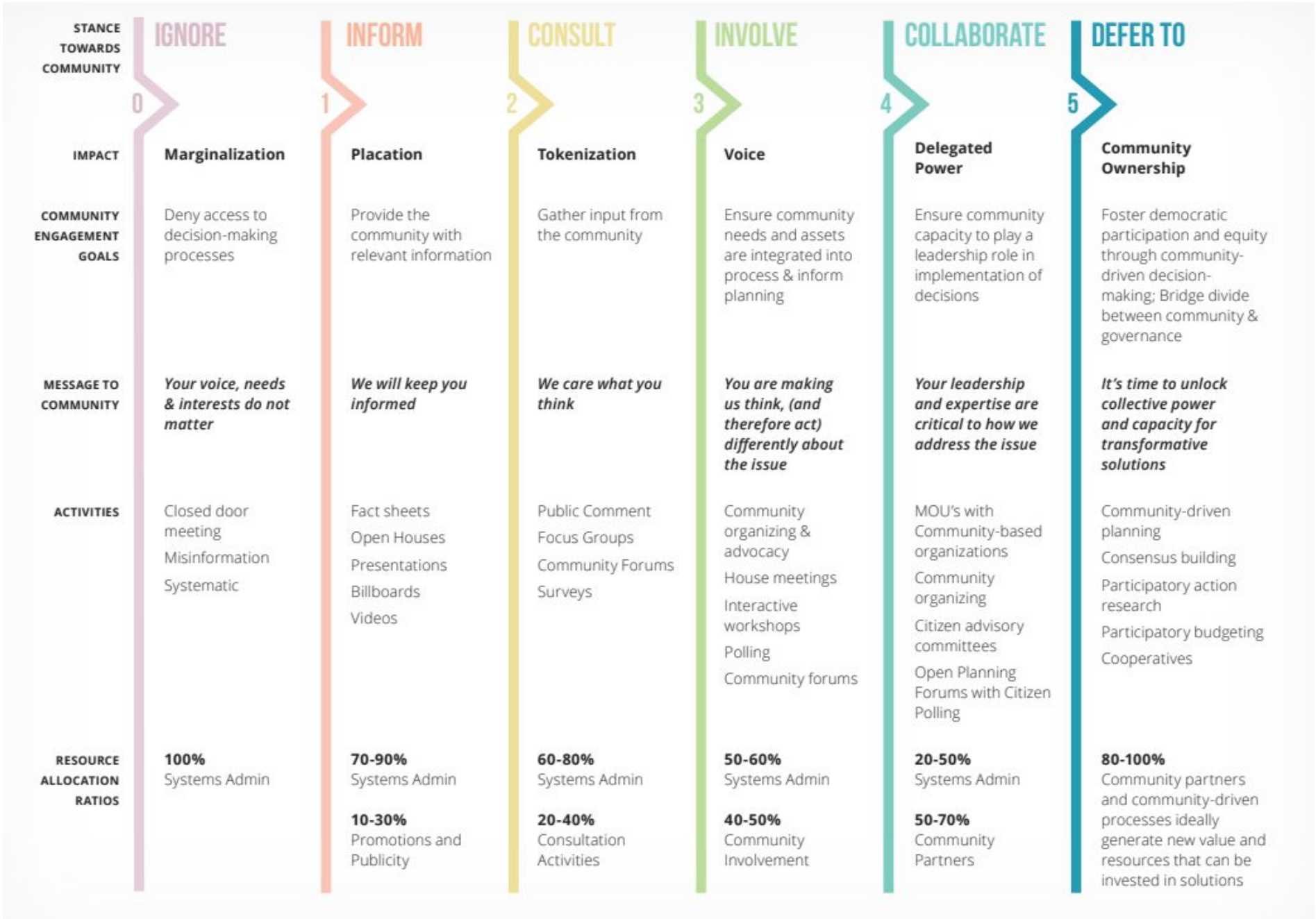
Partnership and Collaboration

How do we partner with community?

- There are some "wrong" ways of engaging community, but MANY ways to do it "right"
- Different partners will have different perspectives of how they partner with community

[Spectrum of Community Engagement to Ownership]



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Access Community Health Network
TRANSFORMING COMMUNITY HEALTH CARE

Cook County Health

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AHE Illinois Team

HFS
Illinois Department of Healthcare and Family Services

HH Center for Housing & Health

THRESHOLDS

The Boulevard

housing FORWARD

Sample of Housing Partners

RENAISSANCE SOCIAL SERVICES

Solutions to homelessness

Deborah's Place

CHRISTIAN COMMUNITY HEALTH CENTER

Lived Experience Advisory Committee (LEAC)

What is the purpose of the LEAC?

Statement of purpose: To inform the operation of the Flexible Housing Pool based on our lived experience, learn about supportive housing, and share resources or advocacy opportunities.

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LEAC Overview

Implementation:

- Intentionally launched the LEAC in parallel of the program implementation – include the LEAC on "how the sausage gets made"
- Recruited community residents with lived experience so they could inform development of processes, procedures and work flows

Member Composition

- Roughly **12-15 active** members
- After individuals were placed in housing, members were recruited to participate along with those who have lived experience
- Invited both adult and youth participants to join the LEAC

Compensation:

- Consultant rate of $50/hour
- Socialized to expect compensation for any work or contributions to FHP.

Structure

Monthly 2-hour long hybrid meetings

Invited to participate in other work groups, such as evaluation and sustainability work group.

Election of 2 LEAC member to participate in the Governance Committee.

LEAC Member is selected to facilitate and co-design agenda

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LEAC Agenda

Approach: Bring ideas vs polished documents

- "We have a policy! Thumbs up or thumbs down?" VS "We have this idea, what do you think?"
- Different approach so that folks are part of the process and not just seeking approval

Common Topics:

- Program policy development
- Raising and addressing concerns raised by clients
- Identify and act on opportunities for advocacy

Sharing and Disrupting Power Dynamics

Ask your community what they need to ensure that everyone can fully participate.

- Tech like headsets, tablets or hot spots?
- Timing of meetings to fit their schedule?

Who "owns" or leads the community meeting?

- Have your staff collaborate with your members to co-develop the agenda and priorities so that they reflect what the community wants and needs

Ensure your members feel supported as leaders.

- Prep them and offer training to ensure they can fully participate
  - Example: If you want them to opine on your budgeting process, ensure they are trained and understand how the budget was developed before asking for input.

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Challenges and Lessons Learned

- Consistent participation from current FHP tenants
- "Close the Loop" - Need to be explicit and transparent with community on how feedback is used
- Protecting your community partners
  - Avoid scope creep
  - Ensure there are guard rails to ensure community members are not over-tapped for anything and everything community-related

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Successes

- Safe space for honest (sometimes brutal) feedback
- Dependable structure to rapidly get feedback and insights from community
- Everyone feels like they have a voice at the table
- Shared Power
- Buy-In and Trust
- Mutually beneficial experience with resource sharing and shared learnings
- Springboard for other community efforts led by community insights
    - Tenant Workshops

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Questions?
Thank you

paige.clincy@cookcountyhealth.org
drizzo@housingforhealth.org

PERSPECTIVES FROM THE FIELD

ME Advancing Health Equity Team

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Post-Incarceration Incentive Payment Pilot - Advancing Health Equity through Patients and Community Partnerships

Loretta Dutill
Operations Manager
Delivery System Reform Unit, MaineCare Services

Kaley Boucher
Behavioral Health Home and Opioid Health Home
Program Coordinator
Delivery System Reform Unit,
MaineCare Services

January 29, 2025

Justice Initiatives Overview

Post-incarceration Incentive Payment Pilot

- The goal of this incentive is to strengthen community-based services by rewarding providers who can connect with members upon release and establish relationships that will lead to continuity of home and community-based utilization.
- We aim to better understand how providers are connecting with these members and engaging in partnerships with members upon release to inform future efforts.
- Implementation: 2024

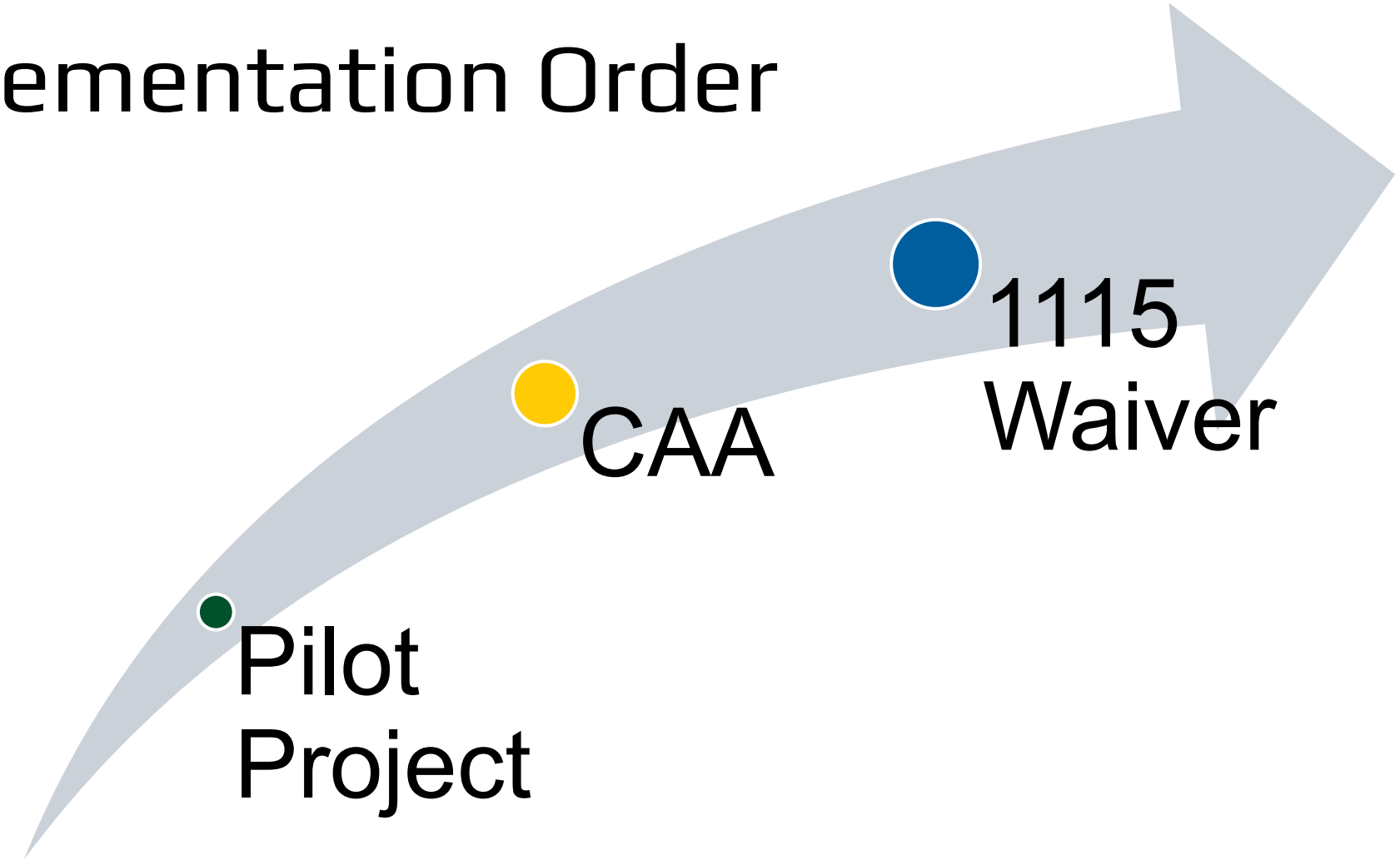
Consolidated Appropriations Act: Changes for Justice-Involved Youth

- The goal is to increase Medicaid coverage for youth up to age 21 and foster involved individuals up to age 26, who are post-adjudication, thirty days pre-release.
- Ensure a standard of physical and behavioral health care is provided and coordinated for release.
- Implementation:2025
- Link to More

1115 Re-entry Waiver

- **Increase coverage**, continuity of coverage, and appropriate services
- **Improve access** to services prior to release and improve transitions and continuity of care into the community upon release and during reentry
- **Improve coordination and communication** between correctional systems, Medicaid systems, and community-based providers
- Increase **additional investments** in health care and related services, aimed at improving the quality of care
- **Improve connections** between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs
- **Reduce all-cause deaths** in the near-term post-release
- Implementation: 2026
- Link to More

Implementation Order



Maine AHE Project Overview

Maine Collaborative Team

- MaineCare
- Aroostook Mental Health Care
- Maine Primary Care Association
- Community Care Partnerships of Maine
- Alliance for Addiction and Mental Health

Pilot Project Overview

Project Focus:
Advancing health equity among MaineCare members who have a history of incarceration

Performance Incentive:

- Create an incentive program to specifically target timely follow-up following transitions of care
- The performance-based measure would address the timeliness of service connection for those transitioning back to the community from jail/prison.
- The goal is to assess and address their immediate need for support and action after release to successfully transition back to a community setting save lives and build pathways towards engagement in further treatment and recovery

Post-Incarceration Incentive Payment

What is it?

- This is an incentive payment that is from March 2024 to June 2025 that encourages providers to connect with individuals being released from incarceration within two calendar days of their release.

How Does it Work?

- It's easy! If a provider submits an eligible claim for an eligible member, with a date of service within two calendar days of release from prison or jail, this claim may count for an incentive payment!

How much can providers get payment through this incentive payment?

- Providers can receive $236.77 per eligible claim.

Why are providers getting this incentive payment?

- People who have a history of incarceration face barriers to health care including costs, stigma, and long waiting times. MaineCare is encouraging providers to connect with these members to improve care transitions.

Maine AHE Project Overview- Focus Groups

Focus Groups

- Focused early in the project on gathering feedback from individuals who could be impacted by this project. Held focus groups in two county jails and a recovery group that consisted of people with a history of incarceration to understand their needs.
- Primary themes from the initial focus groups:
  - Quick access to care upon release
  - Person who understands their needs
  - Assistance signing up for MaineCare/Medicaid Coverage
- Lessons Learned:
  - Power dynamics could have been a factor
  - A need for continuous feedback from impacted stakeholders as project evolves

Future Focus Groups

Additional Focus Groups- Upcoming in 2025

Addressing some of the lessons learned in the next round of conversations:

- Collaborated with AHE TA team to understand how we could address power dynamics
  - Justice Collective discussion and feedback
  - Review of questions asked to participants
- Contracted with a Community-Based Organization that have peers who could conduct focus groups
- Through the partnership, will be able to compensate individuals for their participation
- Long-term goal: to be able to engage with individuals impacted by the initiatives to gather valuable input (ex. Advisory Committee)

Community Engagement Purpose & Goals

To successfully build relationships with a diverse partners in a vast variety of settings it is imperative to meet and build trust through strategic community engagement. We set the following goals

- Better understand the legal and criminal landscape

- Understand the community and the resources of each jail and prison (BH, MAT, PCP etc.…)

- Actively listen and hear from individuals, families, and communities with lived experience

- Meet and engage community providers throughout the state of Maine

- Comprehend the complexity within our internal partners within state government

Community Engagement

Jails & Prisons

Maine County Jails
- Androscoggin
- Aroostook
- Cumberland
- Franklin
- Hancock
- Kennebec
- Knox
- Lincoln
- Oxford
- Penobscot
- Piscataquis
- Sagadahoc
- Somerset
- Waldo
- Washington
- York

DOC Maine State Prisons
- Buldoc Correction Center
- Down East Correctional Facility
- Long Creek
- Maine Correctional Center
- Women's Center
- Maine State Prison
- Mountain View
- Women's Reentry Center

Correctional Facility Providers

Alternative Correctional Healthcare
- Aroostook County Jail
- Franklin County Jail
- Somerset County Jail
- Lincoln County Jail
- Oxford County Jail
- Penobscot County Jail
- Sagadahoc County

Correctional Psychiatric Services
- Androscoggin County Jail
- Kennebec County

WellPath
- All Maine State Prisons / DOC

Armor Health
- Cumberland County Jail
- York County Jail

Single Inpependent Provider
- Washington County Jail
- Hancock County Jail
- Waldo County Jail
- Knox County Jail
- Piscataquis County Jail

• DHHS Involvement

Primary Care Providers
- PCPlus

Substance Use (SUD)
- OHH
- IMD SUD Waiver

Mental Health
- Certified Community Behavioral Health Clinics

Case Management
- Intensive Case Management

Psychiatric Hospitals
- Riverview Hospital
- Dorothea Dix Hospital

Residential Providers
- Private Non-Medical Institutions

Enrollment, Eligibility, & Systems
- OFI policy
- MIHMS
- Provider Enrollment

Community Service Providers

Primacy Care Providers
- Federal Qualified Health Centers
- Maine Primary Care Association

Substance Use (SUD) Providers
- Medication Assistance Treatment
- Outpatient
- Intensive Outpatient
- Peer Led Support
- Recovery Residences

Mental Health & Behavioral Health Providers
- Outpatient
- Intensive Outpatient
- Psychiatry
- Community Mental Health Centers
- Hospitals

Case Management Providers
- Targeted Case Management
- Case Management – HH/ACT

Justice Impacted Community Members

Board of Visitors (County Jail Specific)

Maine Prisoner Advocacy Coalition

Wabanaki Nations & Wabanaki Health Alliance

Veterans

LGBTQIA2S+ Organizations

Visits to Maine Jails and Prisons to Date

County Jails

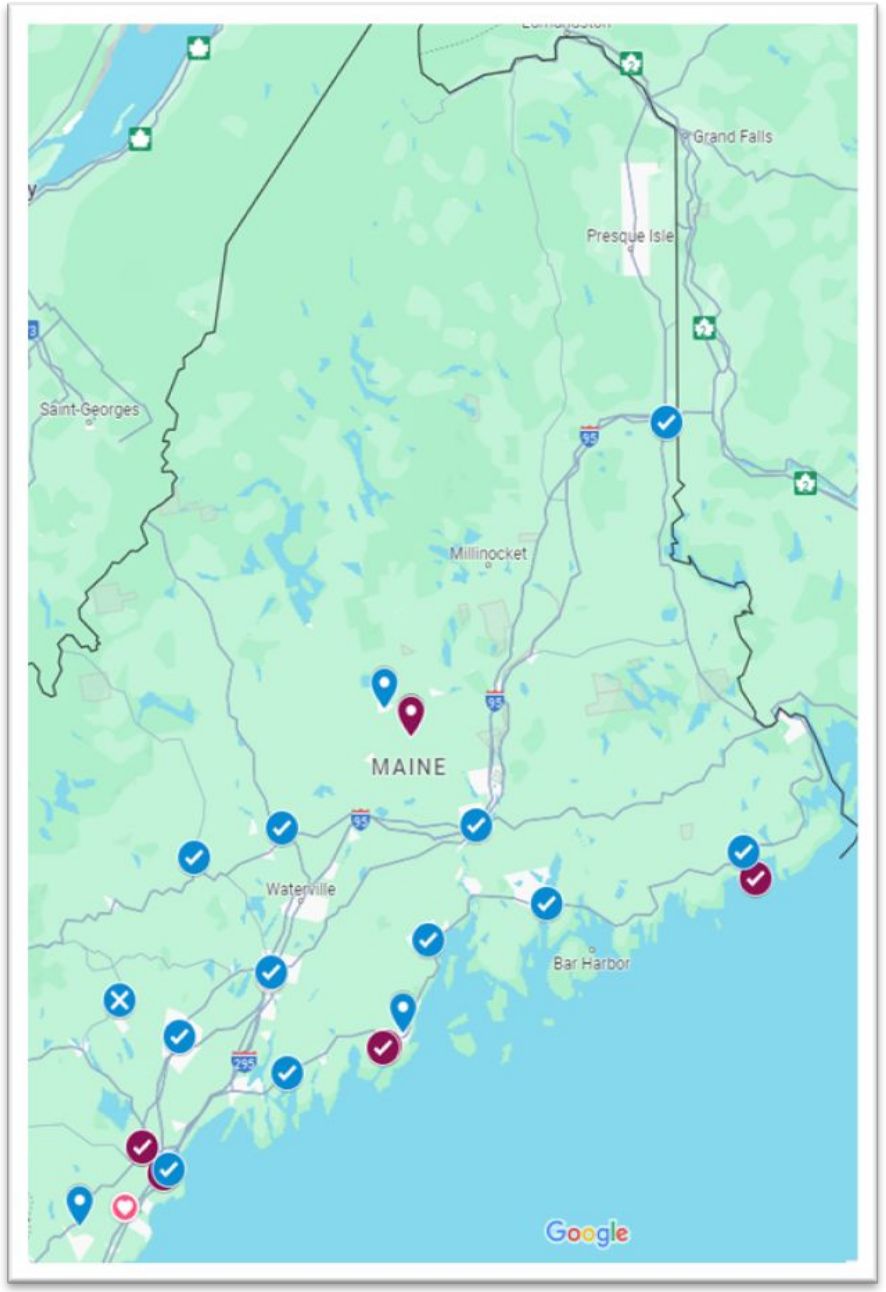
- ✔ Somerset County Jail
- ✔ Franklin County Jail
- ✔ Kennebec County
- ✔ Hancock County Jail
- ✔ Penobscot County Jail
- ✔ Aroostook County Jail
- ✔ Cumberland County Jail
- ✔ Waldo County Jail
- ✔ Washington County Jail
- ✔ Lincoln County
- ✔ Sagadahoc County
- ✔ Androscoggin County Jail

Knox

- ✔ Oxford
- ✔ Piscataquis
- ✔ York

Maine State Prisons

- ✔ Maine Correctional Women's Center
- ✔ Maine Correctional Center
- ✔ Women's Reentry Center
- ✔ Maine State Prison
- ✔ Bolduc Correctional Facility
- ✔ Long Creek Youth Development Center
- ✔ Down-East Correctional Facility
- ✔ Mountain View / Charleston Facility



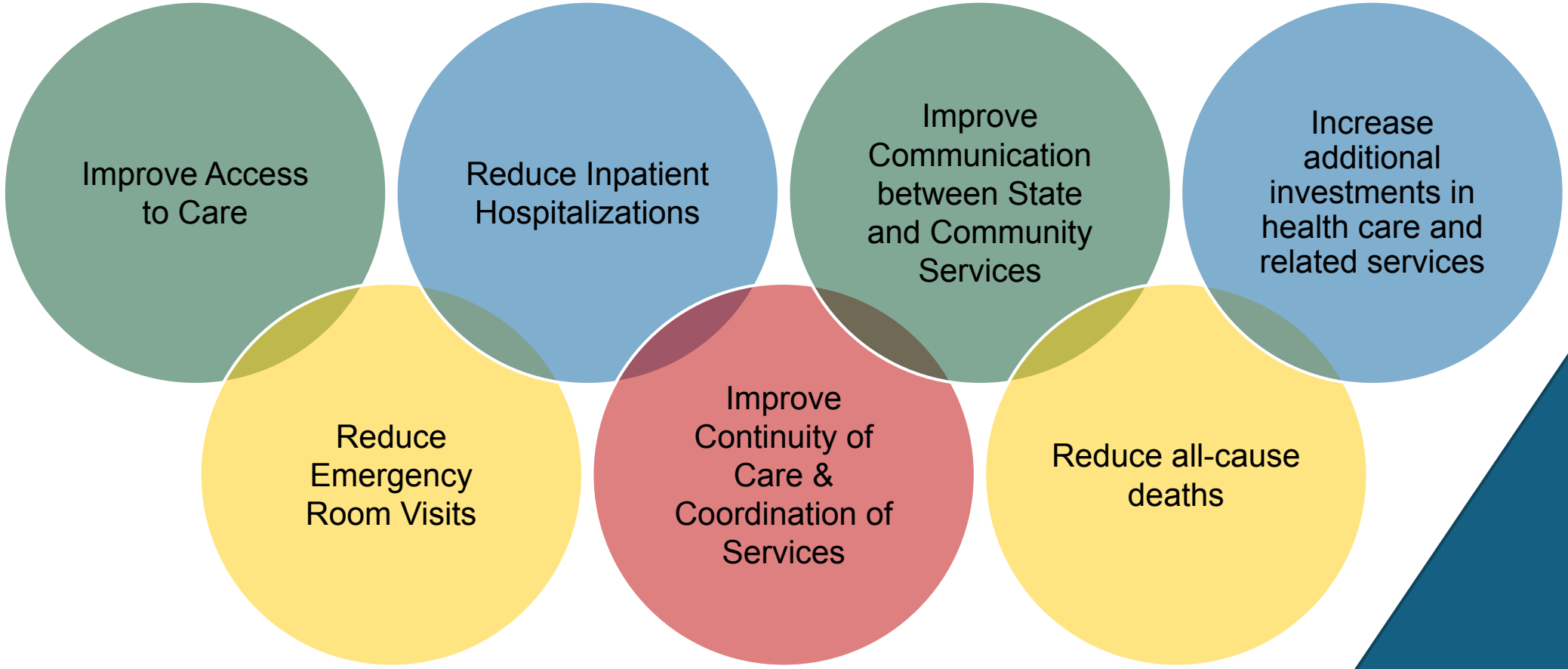
Highlights from Individual Provider Meetings

Successes

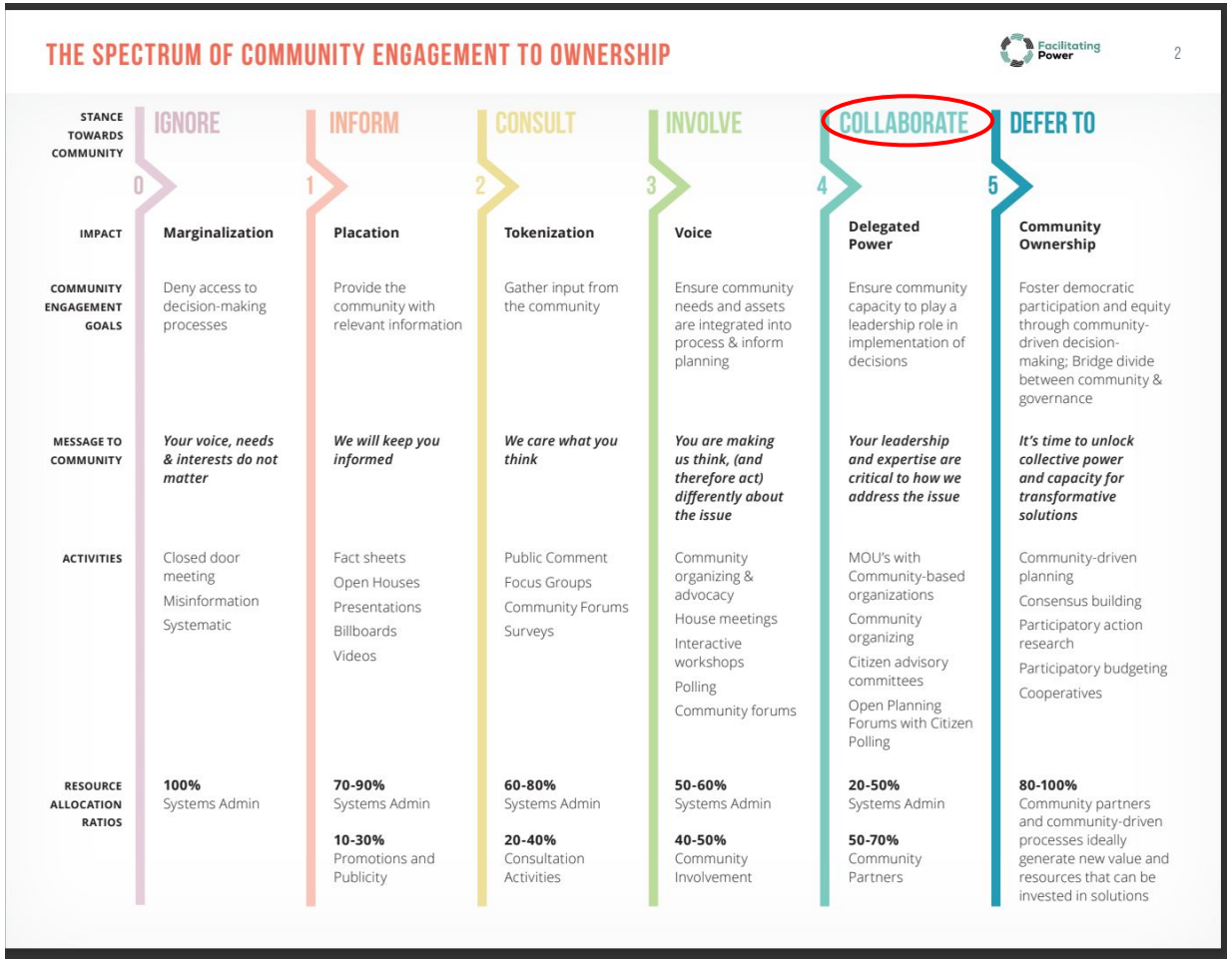
- Strong partnerships with jail/prison/treatment court
- Established referral processes
- Supports initial transitional needs of residents (phone, transportation support, toiletry items)
- Offers same day access to care
- Had a previous connection/contact person (peer, patient navigator)prior to incarceration

Challenges

- Unplanned releases
- Transportation/Housing
- Delays in MaineCare eligibility
- Space/technology—preventing connecting prior to release
- Priority shifting once released
- Multiple organizations involved



Goals of the Re-entry Waiver



The Spectrum of Community Engagement to Ownership

Thank you!

Kaley Boucher

Behavioral Health Home and Opioid Health Home Program Coordinator
Delivery System Reform Unit,
MaineCare Services

Kaley.Boucher@maine.gov

Loretta Dutill
Operations Manager
Delivery System Reform Unit,
MaineCare Services

Loretta.a.dutill@maine.gov

Q&A with IL and ME AHE Teams

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Closing

Join Us for the Rest of the Webinar Series!

- **March 19, 1-2pm CT || 2-3pm ET - Transforming care to Advance Health Equity**
  AHE's Learning Collaborative teams will provide specific examples of strategies for planning and implementing care transformations that address the root causes of health and health care inequities, using an anti-racist lens

- **April 23, 1-2pm CT || 2-3pm ET - Payment Transformation & Contracting Approaches to Advance Health Equity**
  AHE's Learning Collaborative teams discuss how to incorporate equity in value based payment program design and how to leverage contractual requirements to prioritize, support, and advance health equity at the provider, plan, and state level.

To access resources and register for upcoming AHE *Strategies from the Field* webinars, visit: https://bit.ly/AHE-webinar

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