Texas MCO NMDOH Learning Collaborative

February 22, 2023

TREATY OAK
STRATEGIES

Opening Remarks

- Dr. Ann Barnes, CEO, EHF
- Kay Ghahremani, CEO, TACHP
- Jessica Lynch, Director of Policy & Medicaid Operations, TAHP
- Dr. Ryan VanRamshorst, Chief Medical Director, MCD HHSC

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Year 4 MCO LC Topics

- Similar to HHSC's Action Plan, Year 4 will focus on infrastructure needs:
  - **Meeting1: Screening**
    - Goal C: Develop policies and programs that incentivize MCOs and providers to identify and address health-related social needs while containing cost
  - **Webinar: EHF Reports – Milliman Study, Housing Case Management Evaluation, etc.**
  - **Meeting 2: Referral Platforms** (virtual)
    - Goal B: Coordinate services and existing pathways throughout the delivery system
  - **Meeting 3: Legislative Recap** (virtual)
  - **Meeting 4: Data Sharing** (in-person) and **Meeting 5: Advancing APMs** (in-person)
    - Goal A: Build infrastructure for state-wide quality measurement and evaluation
    - Goal B: Coordinate services and existing pathways throughout the delivery system
    - Goal C: Develop policies and programs that incentivize MCOs and providers to identify and address HRSN while containing costs
    - Goal D: Foster opportunities for collaboration with key partners
  - **Workgroups:**
    - Data Sharing
    - Addressing Food Insecurities: Food Bank/MCO Partnerships and Food Rx Programs
    - Developing MCO – CBO Relationships

TREATY OAK STRATEGIES

MCO NMDOH Survey

- EHF, Treaty Oak Strategies, TAHP, and TACHP initiated a 3rd MCO Survey in December 2022
- 14 of the 16 MCOs responded – findings were posted this week on EHF website here
- Findings can help inform Learning Collaborative sessions, be used by policy makers, and the survey provides information about all the work taking place within MCOs to address non-medical needs
- Survey focused on: Current MCO NMDOH Investments, MCO and Food Bank Collaborations, MCO NMDOH Screening and Referrals, Data Sharing, Alternative Payment Models

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Survey Findings

Top Four Non-Medical Needs Identified by MCOs

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Data Sharing

The primary challenge we have with sharing data with Providers on NMDOH is providing timely, meaningful, actionable data that fits into Provider workflows so the data can be easily used. The primary challenge with receiving data from providers is to identify which information is most important and receiving that data in a format that is quickly actionable so it can be used. Exchanging data without a specific need or purpose adds administrative burden for Providers and does not help.

- Recommendations include:
  - Develop a fee schedule and allow for follow-up visits and reimbursement to address NMDOH
  - Align questions being asked and metrics being tracked to ensure that the MCOs are requesting the same information from providers
  - Need for more connectivity and integrated systems that share information about the outcomes of Member referrals

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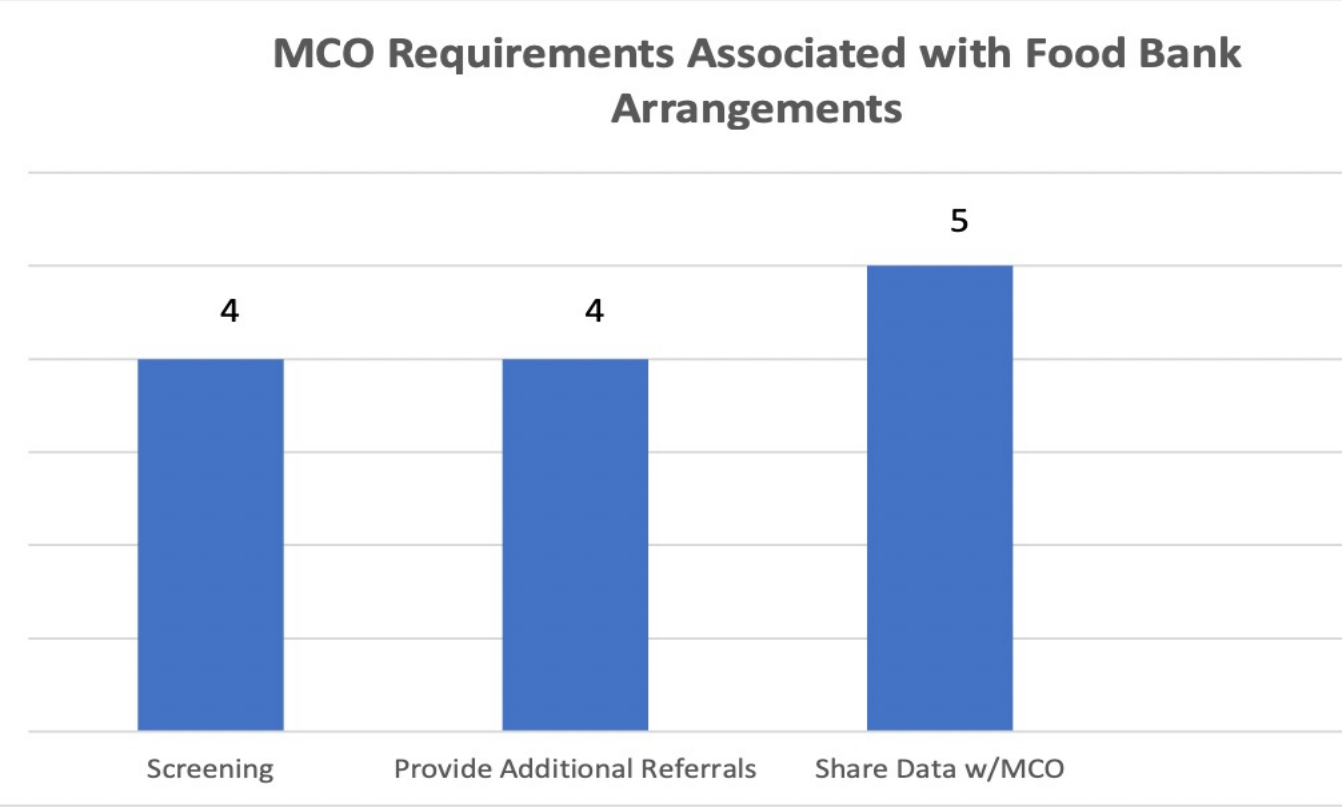
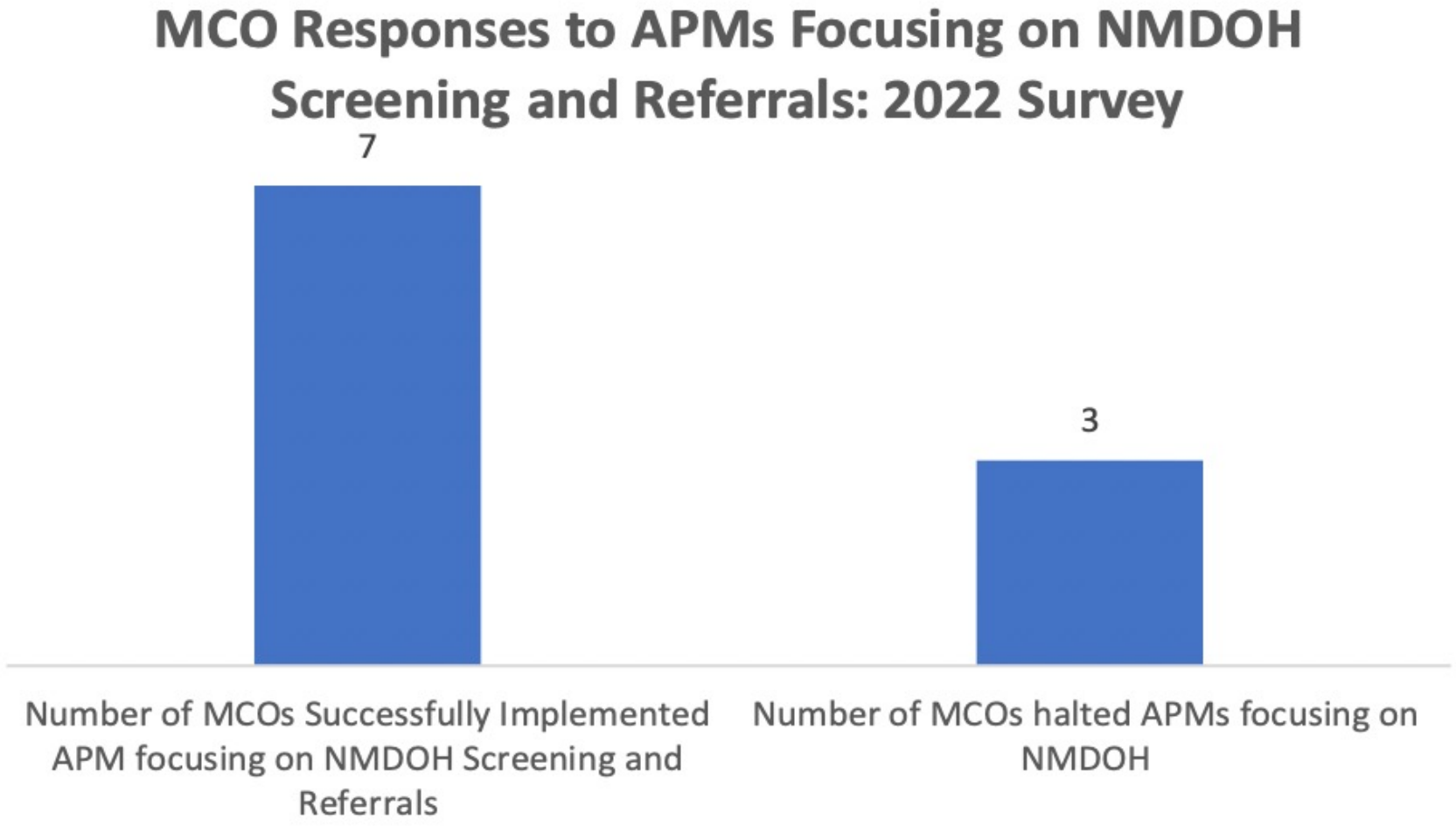
MCO - Food Bank Collaborations

- 5 MCOs responded that they currently have an agreement with a food bank
- One MCO commented they are working on alternative solutions to address food insecurities at local grocers rather than just focusing on food banks
- One MCO indicated they have a Food Rx program
- All MCOs indicated they would invest more to address food insecurities if they were allowed to classify the investment as QI or interventions were Medicaid covered benefits



Alternative Payment Models

We have found that incorporating NMDOH often requires tailoring arrangements to each provider based on their current workflows or interest in expanding activities.



APM Recommendations

MCO recommendations for additional flexibilities or policy changes that could help improve the development and implementation of APMs focused on NMDOH:

- Include APMs with CBOs or other organizations that cannot submit claims in calculations for APM targets.
- Develop billable codes for addressing SDOH and/or reimburse z-codes.
- Require providers to screen for NMDOH needs and share that information with the MCOs.
- Develop methods to track data in a timely way to impact improvements in providing care, cost savings and standardization of non-medical drivers.

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HHSC NMDOH Action Plan

Non-Medical Drivers of Health Action Plan

Emily Sentilles, Deputy Associate Commissioner
Quality & Program Improvement, Medicaid & CHIP Services

Noelle Gaughen, Director of Quality Evaluation
Joelle Jung, Senior Policy Advisor
Delivery System Quality & Innovation, Medicaid & CHIP Services

What is the NMDOH Action Plan?

Guiding priorities and strategic goals for Medicaid & CHIP Services (MCS) to coordinate new and ongoing NMDOH activities

Actions support the work of MCOs and providers, for example:

- Recommended screenings and follow-up best practices
- Policy guidance like Quality Improvement costs
- Aligning incentives or requirements (VBP requirements, P4Q metrics, DPP metrics, etc.)

Success requires collaboration across HHS and with MCOs, providers, and community-based organizations

Non-Medical Drivers of Health (NMDOH) are the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.

Definition adapted from the CDC www.cdc.gov/socialdeterminants/about

Why did MCS make the Action Plan?

1. Advance the goals and objectives of the Texas Managed Care Quality Strategy
2. Potential cost savings from improved population health management and reduced utilization
3. Respond to requests from MCOs and providers for state guidance

Non-Medical Drivers of Health Action Plan

Priorities

- **Food Insecurity**
- **Housing**
- **Transportation**

Goals

- **A)** Build data infrastructure for statewide quality measurement and evaluation
- **B)** Coordinate services and existing pathways throughout the delivery system
- **C)** Develop policies and programs that incentivize MCOs and providers to identify and address health-related social needs while containing costs
- **D)** Foster opportunities for collaboration with key partners

Goal A) Build Medicaid NMDOH data infrastructure for statewide quality measurement and evaluation

1. Recommend a set of food insecurity measures and clinical quality measures for HHS, MCOs, and providers to use for quality programs and evaluation purposes. Include measure specifications, screening questions/tools, target population, demographic stratifications, and other data elements.
2. Identify and implement a strategy for collecting Medicaid member-level food insecurity data. May leverage existing HHS or MCO processes to screen members for food insecurity.
3. Evaluate statewide trends on the impact of addressing food insecurity on clinical quality measures and progress on promoting health equity among beneficiaries

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Health and Human Services

Goal B) Coordinate services and existing pathways throughout the delivery system to address food insecurity, housing, and transportation for Texas Medicaid beneficiaries

1. Identify and facilitate strategic partnerships and a systematic approach for MCOs, providers, and community-based organizations (CBOs) to coordinate their service delivery models and referral systems to address identified food insecurity among Medicaid beneficiaries
2. Identify options to assess and enhance the impact of SNAP benefits and WIC resources to address identified food insecurity among Medicaid beneficiaries
3. Assess and enhance the impact of the 2-1-1 system on the HRSNs of Medicaid beneficiaries

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Health and Human Services

Goal C) Develop policies and/or programs to incentivize MCOs and providers to identify and address food insecurity, housing, and transportation for Medicaid beneficiaries while demonstrating cost containment

1. Propose and develop policies to reimburse Medicaid providers for completing recommended NMDOH screenings and follow-up actions (e.g., referrals or connections to resources) for Medicaid beneficiaries.
2. Develop and implement MCO incentives or requirements for NMDOH into existing initiatives, such as Performance Improvement Projects, recommended Value-Based Payment models, Pay-for-Quality metrics, Quality Improvement costs, and In-Lieu-of Services
3. Incorporate and standardize recommended NMDOH measures and clinical quality measures from A.1 in MCO and provider incentive programs
4. Explore statutory authorities to test health care delivery models for managed care (e.g., accountable care and population health approaches) and financial models (e.g., social risk-adjusted capitation)

Goal D) Foster opportunities for collaboration with partners internal and external to Health & Human Services

1. Sustain and strengthen an internal workgroup of NMDOH subject matter experts across the HHS agency to share best practices and collaborate
2. Sustain and expand external workgroups or learning collaboratives with key stakeholders (including MCOs, providers, CBOs, other state Medicaid agencies, and CMS) to share best practices and collaborate
3. Strengthen or establish a stakeholder engagement process with Medicaid beneficiaries to solicit feedback and inform NMDOH policy and program development with an understanding of the needs and experiences of the people served by MCS

How can MCOs get involved?

1. Voluntarily align with MCS priorities
2. Collaborate with MCS and other stakeholders to accomplish goals
3. Participate in learning collaboratives
4. Identify and share best practices

Potential Next Steps for MCS

Goal A: Data Infrastructure

Guidance on screening and follow-up best practices

Consensus sets of screening tools and quality measures for screening and referral

Goal B: Coordinating the Delivery System

- A landscape scan of CBO capacity for partnerships, including rural capacity
- A report that describes partnership models

Goal C: Policies & Programs

Guidance on existing opportunities to reimburse or financially reward Medicaid providers

Identify policy barriers to the widespread adoption of NMDOH screening and referral activities

**Actions may be driven by legislative direction*

Goal D: Collaboration

- Leverage the work of existing collaboratives
- Identify new opportunities for collaboration

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Health and Human Services

Questions about the NMDOH Action Plan?

MCS Delivery System Quality & Innovation
Email: DSQI@HHS.texas.gov
Website: Non-Medical Drivers

Break Out Sessions

Goal A: Build infrastructure for state-wide quality measurement and evaluation

Goal B: Coordinate services and existing pathways throughout the delivery system

Goal C: Develop policies and programs that incentivize MCOs and providers to identify and address HRSN while containing costs

Goal D: Foster opportunities for collaboration with key partners

Questions

1. In general, what did you like about the Action Plan?
2. For this goal, what do you like?
3. For this goal, is there anything missing that HHSC should consider?
4. For this goal, are there existing opportunities in your current work that we could build off of to achieve these goals?
5. What do MCOs need from HHSC to help reach these goals?
6. Do you have any additional implementation ideas?

Break Out Session Reports

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LUNCH BREAK


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Center for
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Better care where it's needed most


Michael & Susan Dell
FOUNDATION


TREATY OAK
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The Texas Consortium for Research, Policy, and Practice on the Nonmedical Drivers of Health

Rice University's Baker Institute for Public Policy
Elena Marks, JD, MPH
Jacquie Klotz, MA

Our Purpose

The purpose of The Texas Consortium is to improve health outcomes and reduce health disparities through investment by the health system in nonmedical drivers of health (NMDOH).

We will accomplish this by bringing together organizations across Texas that are working to advance this approach to health through research, policy, and practice.

The Texas

Resource Hub with Abstracts

1. Who sponsors the program?
2. What is the program?
3. Which driver(s) does the program address?
4. What population(s) are targeted?
5. Which county(ies) are being served?
6. Has this program been evaluated?

We Want to Hear From You—Please Join Us

Elena Marks

emm4@rice.edu

Jacquie Klotz

jk90@rice.edu

The Texas

Screening Members/Patients

TEXAS Health and Human Services

Center for Health Care Strategies
Better care where it's needed most

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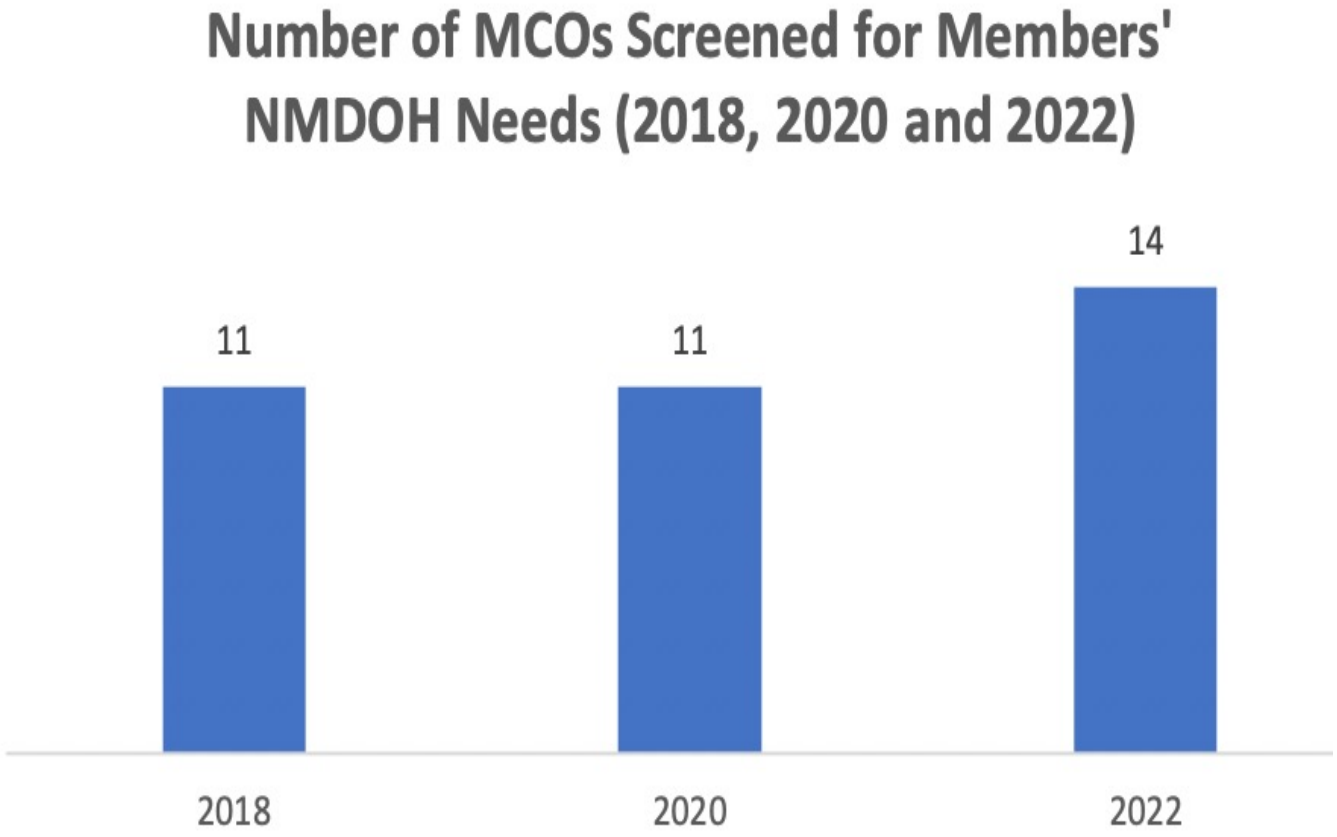
Current MCO Contract Requirements

- Initial Health Needs Screening: The MCO must conduct an initial health needs screening to gauge the need for a more comprehensive assessment, to identify MSHCN, and to prioritize Members for Service Coordination.
- Service Coordination means the service performed or arranged by the MCO to facilitate development of a Service Plan, or Individualized Service Plan as appropriate, and coordination of services among a Member's PCP, specialty providers and non-medical providers to ensure appropriate access to Covered Services, Non-capitated Services, and community services.
- CBOs: The MCO must implement a systematic process to coordinate Non-capitated Services and enlist the involvement of community organizations that may not be providing Covered Services but are otherwise important to the health and wellbeing of Members. The MCO also must make a best effort to establish relationships with State and local programs and community organizations, such as those listed below, in order to make referrals for MSHCN and other Members who need community services.

MCO Survey Findings

All 14 responding MCOs indicate they screen members for NMDOH either through the initial health needs screening or through Service Coordination activities



MCO Screening Practices

- Even though all fourteen health plans screen for non-medical needs, the screening tools that are used by health plans vary.
  - One plan indicated they use the tool imbedded in the Findhelp platform.
  - Three health plans indicated that they use a population health management database to assist with identifying NMDOH needs.
  - Seven plans indicate that they have their own internal health needs screenings and risk assessments.
  - Two health plans use the PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences) tool.
  - One MCO uses the American Academy of Pediatrics' (AAP) and American Medical Association (AMA) screening along with other tools as appropriate to the age of the Member.

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MCO Screening and Providers

- Three MCOs indicated that they require providers to screen for non-medical needs in various situations and to share screening information with the MCO.
- One MCO requires medical home contracted providers to screen Members and to provide aggerate reporting on the needs identified during those screenings.
- A second MCO explained that they have arrangements with in-home long-term services and supports providers that require aggregate reporting on any non-medical needs identified and any actions taken to address those needs.
- A third MCO shared that they are currently in the first year of a pilot program in which the MCO is sharing all NMDOH ICD10 Z-Codes they receive for their population PCPs – the pilot will inform future APMs used to incentivize PCPs to screen for NMDOH needs though a pay-for-reporting arrangement.
- Six of the MCOs indicated that while they do not require screening, they do provide education and highly encourage their providers to screen for social needs.

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MCO Referral Practices

- Nine of the MCOs responded that if a provider refers a client for a non-medical need that information is shared with the MCO
- Main reasons that keep MCOs from requiring providers to address social needs or share information
  - Lack of reimbursement and provider burden issues were the main reasons
  - We try to balance what is asked of our providers based on all they are expected to accomplish
  - Some Providers find it difficult and resource intensive in screening for social needs and do not have resources available
  - If providers are not comfortable doing formal screenings for NMDOH, requiring the assessment may not be best for Members because assessments may not be paired with follow-up, or may cause provider frustration
  - We prioritize finding ways to help providers act on needs identified rather than sharing info
  - When a Member is comfortable sharing a need with a provider or community partner, we believe the best next step is for that trusted person to help the Member connect to resources if the Member wants help. Our focus has been on trying to support providers to act as if that is part of their process.
  - Workforce constraints, and communication tools vary/non-existent, there is not a consistent platform at this time between MCOs nor are providers truly incentivized to take time to assess and report.
  - We have met with providers to understand their screening practices but many of them have shared concerns about responsibility/resources to help if a Member screens positive for social needs

Center for Health Care Strategies

Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

- **Effective models for prevention and care delivery** that harness the field's best thinking and practices to meet critical needs.
- **Efficient solutions for policies and programs** that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.
- **Equitable outcomes for people** that improve the overall wellbeing of populations facing the greatest needs and health disparities.

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Trend 1:

More organizations will screen for social needs, in response to shifting norms and new federal and state requirements.

Social Needs Screening and Intervention (SNS-E) – New Quality Measure for HEDIS® 2023

- Members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
  - *Food Screening.* Members who were screened for food insecurity.
  - *Food Intervention.* Members who received a corresponding intervention within 1 month of screening positive for food insecurity.
  - *Housing Screening.* Members who were screened for housing instability, homelessness or housing inadequacy.
  - *Housing Intervention.* Members who received a corresponding intervention within 1 month of screening positive for housing instability, homelessness or housing inadequacy.
  - *Transportation Screening.* Members who were screened for transportation insecurity.
  - *Transportation Intervention.* Members who received a corresponding intervention within 1 month of screening positive for transportation insecurity

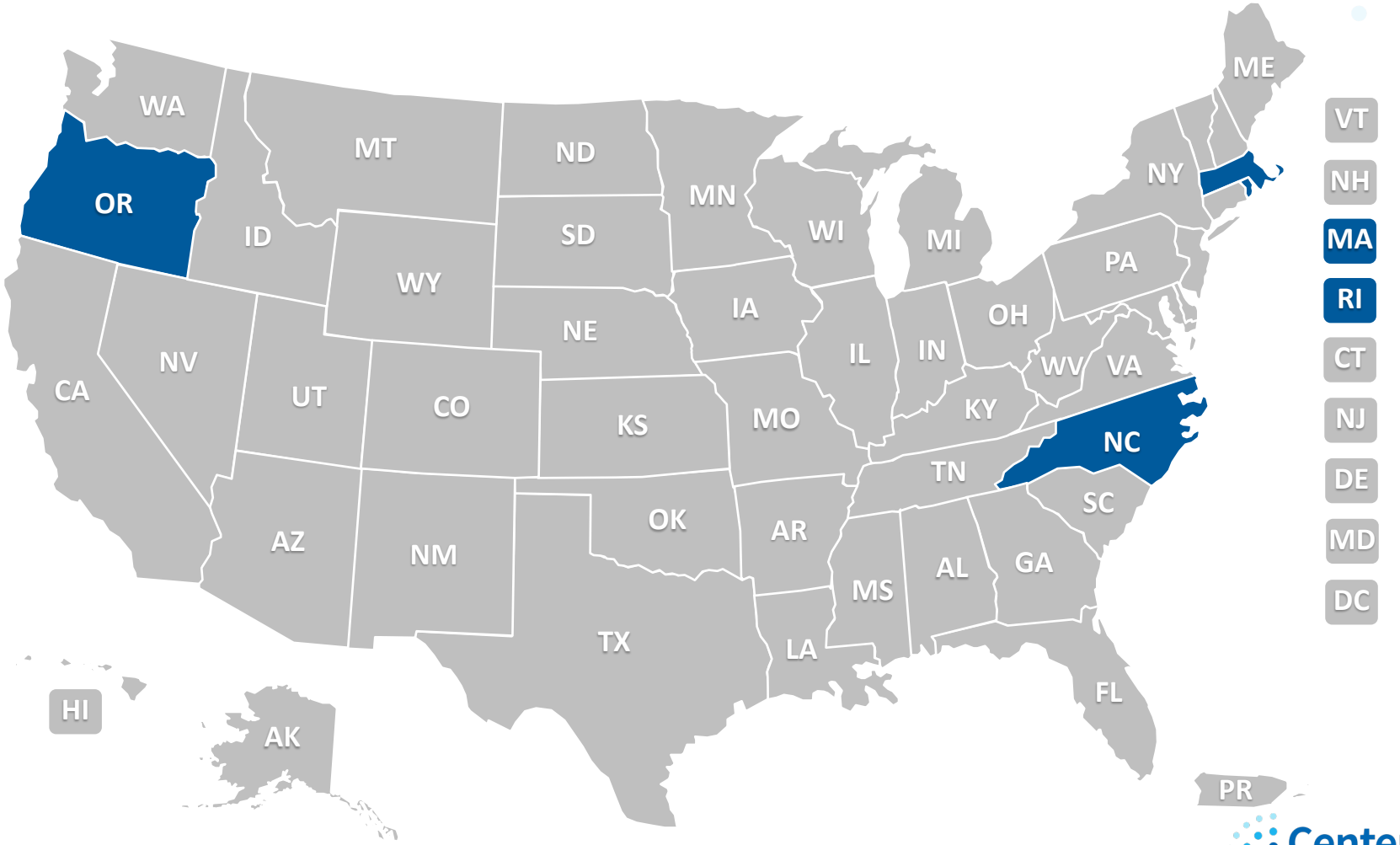
https://www.ncqa.org/news/ncqa-updates-releases-new-quality-measures-for-hedis-2023-with-a-focus-on-health-equity-stratifying-measures-by-race-ethnicity-and-affirming-gender-identity-helps-tackle-health-disparities/

New CMS Measures

- Two Measures
  - → Screening for Social Drivers of Health measure
    - Rates reported for five domains: food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety
  - → Screen Positive Rate for Social Drivers of Health measure
- Included in:
  - → Hospital Inpatient Quality Reporting Program (mandatory reporting starting in 2024)
  - → 2023 MIPS (voluntary)

https://www.federalregister.gov/documents/2022/08/10/2022-16472/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

State Measures



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Special Needs Plan Health Risk Assessments

- "We proposed to require that all SNP HRAs include specific standardized questions on housing stability, food security, and access to transportation – all of which we know to be important contributors to overall health. Based on the comments we received, we are finalizing a requirement that **all SNP HRAs include at least one question from a list of screening instruments specified by CMS on each of these three domains**, but we are not requiring that all SNPs use the same specific standardized questions."

https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-advantage-and-part-d-final-rule-cms-4192-f

Joint Commission Standards (Effective January 2023)

- "The [organization] assesses the [patient's] health-related social needs and provides information about community resources and support services."
  - → Note 1: [Organizations] determine which health-related social needs to include in the [patient] assessment.
  - → Note 2: Health-related social needs may be identified for a representative sample of the [organization's] [patients] or for all the [organization's] [patients]

https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf

Trend 2:

New data standards will make it easier to document information about social needs, even if organizations are using different tools.

Data standards and codes have changed the national conversation around screening tools.

- The Gravity Project
  - → Identified LOINC panel codes through the Gravity Project community consensus voting process.
  - → Established and maintains current value sets representing screening assessments across domains, including food, housing, and transportation.
- The United States Core Data for Interoperability version 3 (USCDI v3) includes SDOH Assessments as a data element.
- ICD-10 Z Codes are still available, and a tool.

https://www.healthit.gov/isa/representing-social-determinants-health-screening-assessments

https://www.cms.gov/files/document/zcodes-infographic.pdf

Trend 3:

Health care organizations continue to fine-tune their approach to screening, and work on related partnerships.

Social Risk Factor Screening: Persistent Questions

- How can providers and plans coordinate their approaches?
  - → E.g., California will create a Population Health Management Service with pre-populated fields, with data sourced from the state, health plan, and provider. State is clarifying that initial health risk assessments can be delegated to a provider.
- How can organizations ensure that their screening approach is effective and trauma-informed?
  - → E.g., Accountable Health Communities in Texas have a wealth of best practices.
- What happens next?
  - → E.g., States and federal partners are increasingly thinking about infrastructure to support this work – e.g., workforce, technology, community resources.

MCO and Provider Panel: Screening Practices

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Best Practices for NMDOH Screenings from an FQHC Perspective

El Centro de Corazón
Quality Health Care

About Us

erving Houston's East End community since 1994, El Centro de Corazón (El Centro) is an accomplished Federally Qualified Health Center (FQHC) with hree health centers with the following services:

Healthcare:

- Primary Care
- Women's Health Services
- Behavioral Health Services
- Dental Services

Ancillary Services:

Case Management

Eligibility Services

Health Happens Outside The Clinic Walls

El Centro's objective in CCHH was to address obesity-related health conditions and food insecurity in the East End.

- **Fresh RX Program with The City of Houston**
- **Food RX in Partnership with The Houston Food Bank**
- **Growing Roots East End Network**
- **Commit To Be Fit**

We recognized that people want to make healthier choices but do not have the resources. So, it was important to establish ways to readily screen patients inside our clinic walls .

Moving towards best practices: The Implementation of NMDOH Screenings

Multidisciplinary Approach

Working with Providers, Behavioral Health, and Community Health Worker to implement screenings.

PRAPARE Tool in EHR

Training team to implement screenings via EHR at every visit within BH team.

Hired CHW specific to Behavioral Health

Community Health Worker was hired for additional screening implementation and referral support. Closing the loop.

Partnered with UNITE US

Partnered with Unite Us as a way to address the needs of those services we could not fulfill.

Healthy Communities Begin with Healthy Foods

Comunidades Saludables Empiezan con Alimento Saludable

LAB GROCERY

El Centro de Corazón
Quality Health Care

3401 HARRISBURG BLVD. SUITE G, HOUSTON, TX

Utilizing data to form strong and intentional partnerships for our community of patients and the needs they express.

Stat & Numbers/ Outcomes

230 Screenings completed in 2022

68 Closed Loop Referrals within BH department

Partnerships formed with Little Red Box for Medically Tailored Groceries and The Common Market for Fresh Farm Produce Boxes

COMMUNITY FIRST
HEALTH PLANS

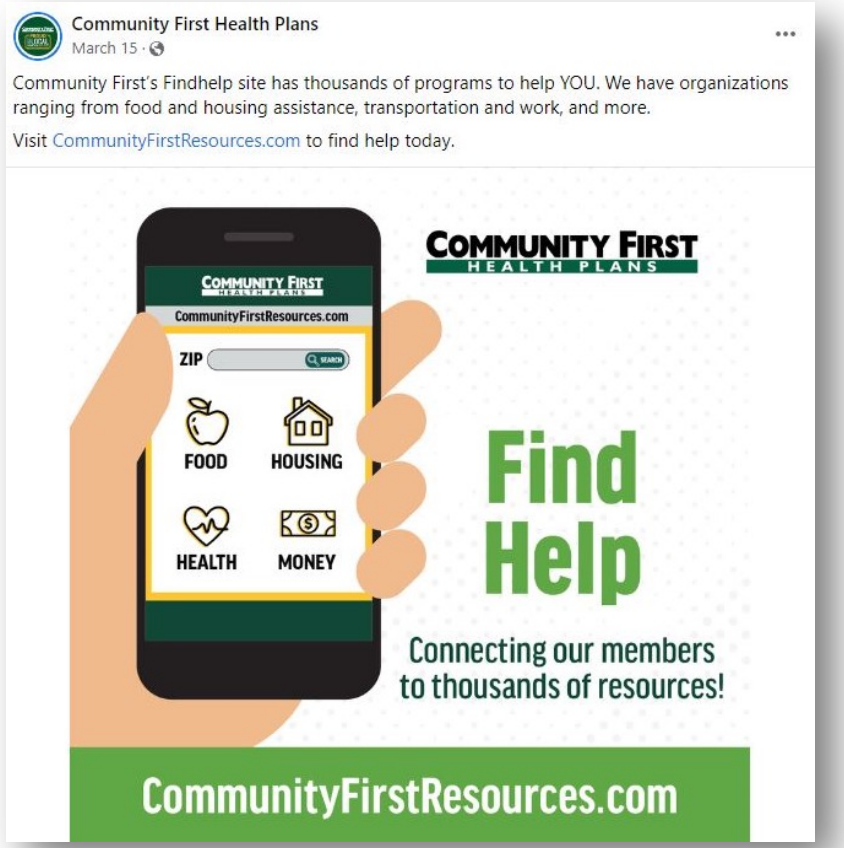
We employ a multi-level strategy to address NMDoH

1. We connect individual members to the services they need
2. We design and implement interventions to address the highest needs within our enrolled membership population
3. We invest in partners and sustainable strategies to improve the health of our community

Target Populations

COMMUNITY FIRST HEALTH PLANS

NMDoH tools for Members



COMMUNITY FIRST HEALTH PLANS

Molina Healthcare Screening Members for NMDOH

MOLINA® HEALTHCARE

Your Extended Family.

Screening Members Based on Claims

- Monthly Z-code report
- Molina Insights
  - Predictive data stratification software
    - Identifies potential NMDOH needs based on things such as
      - Member's location
      - Past medical history
      - Other demographics

Health Equity and Healthcare Services Internal Referrals

- Health Equity team
  - Addresses the situations with more complex NMDOH factors
  - Offers periodic internal trainings
    - NMDOH trends and resources
      - Support for other Molina departments

Health Equity and Healthcare Services Internal Referrals Lessons Learned

Lessons learned:

- Urgency patterns identified
  - Internal referrals more responsive
- Internal communication assists with better outcomes

Challenges in Identifying NMDOH

- Z-codes can have misleading information
  - Working with a structured system
- Member expectations
- Members not always responsive/reachable

Screening Members/Patients: Where do we go from here?

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EpiscopalHealth.org

Brief Update of EHF's NMDOH & APM Work

MCO NMDOH Learning Collaborative Meeting

February 22, 2023

Ann Barnes, M.D., M.P.H., President and Chief Executive Officer
Shao-Chee Sim, Ph.D., Vice President for Research, Innovation and Evaluation

DRIVING CHANGE ON NMDOH & APM

RESEARCH, PLANNING, & CONVENING PROJECTS

NMDOH Approaches: Lanscape Study and Actuarial Analysis

Moving Upstream Report on In Lieu Of Services (ILOS)

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APM Planning Project with Food Banks and MCOs

FEEDING TEXAS

houston foodbank

TAHP
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NMDOH Environmental Scan and Expert Panel Review

Center for Health Care Strategies
Better care where it's needed most

The Health and Wellness Landscape in Southeast Texas

TREATY OAK

Texas Children's Health Plan

LAMAR UNIVERSITY
MEMBER THE TEXAS STATE UNIVERSITY SYSTEM

Promising Practices to Address Food Insecurity through Positive Deviance

DRIVING CHANGE ON NMDOH & APM

EVALUATION PROJECTS

San Antonio Housing Case Management Intervention

superior healthplan

DECEMBER 2022

A QUASI-EXPERIMENTAL STUDY OF A COLLABORATIVE SERVICE MODEL BETWEEN A SUPPORTIVE HOUSING PROVIDER AND A MANAGED CARE ORGANIZATION

UTHealth The University of Texas Health Science Center at Houston School of Public Health

CHW Intervention in Waco

CHW — CLIENT

Scott&White HEALTH PLAN

Waco Connect
Linking people to resources they need

San Antonio Pathway Community HUB CHW Intervention

CHW

superior healthplan

UTHealth The University of Texas Health Science Center at Houston School of Public Health

COMMUNITY FIRST HEALTH PLANS

PCHI | Pathways COMMUNITY HUB INSTITUTE MODEL CERTIFICATION

aetna

Food Rx for High-Risk Pregnant Women

UTHealth The University of Texas Health Science Center at Houston School of Public Health

houston foodbank

COMMUNITY HEALTH CHOICE
COMMUNITY CARES

FQHC Capacity Building Initiative

United Healthcare

UTHealth The University of Texas Health Science Center at Houston School of Public Health

FQHC Maternal Health APM Pilot

URBAN INSTITUTE

Ob Hospitalist GROUP

HSG

KEY LEARNINGS AND NEXT STEPS

LEARNINGS

- Trust, partnership and relationships matter
- Neutral convenor to facilitate peer learning
- Access to experts and thought leaders in Texas and nationally
- Willingness to pilot, experiment and take risk

NEXT STEPS

- Deepen EHF work with HHSC, MCOs and Other Stakeholders
- Align MCO NMDOH Learning Collaborative & NMDOH Work Group within HHSC VBPQI Advisory Committee
- Invest resources to build NMDOH evidence base
- Invite peer philanthropies to join

Texas MCO NMDOH Learning Collaborative

February 22, 2023