Care Coordination Meeting Notes 11-8-2023

During the meeting, the group discussed ways to improve Medicaid reenrollment efforts in Baltimore neighborhoods. The importance of sharing information about reenrollment was emphasized, while zip code information to target specific areas was inquired about. Neighborhood-level information was provided and feedback on a forthcoming survey was encouraged. The group also discussed ways to improve referral pathways between healthcare, community, and social services, with a speaker proposing a revised goal to enhance referral systems. Additionally, they discussed the collection and utilization of social needs data to optimize health outcomes, with a speaker emphasizing the importance of measuring outcomes in social services.

Action Items

- [ ] Share draft survey questions with group for additional feedback.
- [ ] Volunteer to test the draft survey form before it is sent out.
- [ ] Send out notes from meeting including draft survey questions for group review.
- [ ] Launch survey next week pending no major feedback.
- [ ] Schedule interviews starting week of November 28th.
- [ ] Present survey findings and get input on priorities in February/March meetings.
- [ ] Develop final report and implementation plan by April/June 2024.

Outline

Medicaid reenrollment and targeted outreach in Baltimore.

- Neighborhoods within Baltimore city have been disproportionately affected by Medicaid changes.

Medicaid reenrollment and community health needs assessment.

- Neighborhoods in Baltimore city with high levels of unre enrolled individuals are at risk of losing benefits.
- Speaker 2 seeks feedback on timeline and goals for bi-directional work.
- The group will be conducting surveys and interviews with stakeholders from November to February to gather information on referral systems in the city.
- The findings from these efforts will be used to create an implementation plan and report, which will be shared with the group for input and recommendations.

Improving referral systems in a healthcare organization.

- Speaker 2 explains that the implementation plan involves enhancing or building referral pathways, with a focus on improving existing platforms or connecting with existing ones like CRISP.

- Speaker 1 asks about the intent to build a new platform, and Speaker 2 clarifies that the goal is to enhance or improve existing pathways, possibly connecting with CRISP.
- Speaker 1 suggests meeting with Barbara from the University of Maryland School of Nursing to better understand her role and how to support her.
- Speaker 1 and Speaker 2 are willing to share their referral information and questionnaire responses with CRISP, but want to use their current platform for their organization and poor health systems.

Improving healthcare referral pathways.

- Elise and Lorena discuss the need for a shared platform to connect community referral programs, with Elise emphasizing the importance of collaboration and Lorena suggesting a phased approach to implementation.
- The group discusses key dates for the implementation planning, including going live with the service next week, conducting interviews the week of November 28th, and sharing findings in February and March.
- Speaker 2 proposes two objectives for the group: improving care coordination and developing a community health care and government informed plan.
- The group provides feedback on the survey, including suggestions for language and a broader focus on mental health care.

Referral arrangements for social services.

- Speaker 2 asks the group to provide examples of referral arrangements to clarify the definition (27) and add an example to the list (28).
- The group discusses potential options for referral arrangements, including data use agreements, memorandums of understanding, financial incentives, and resource sharing.
- Speaker 1 clarifies referral definition as connecting individuals to social services or basic resources, not clinical referrals.
- Speaker 4 from NAMI raises the point that their organization doesn't send out referrals, so question 7 may not apply.

Using social needs data to improve health outcomes.

- Speaker 2 mentions that some Chief Diversity Officers (CDOs) are sending network referrals, while others are providing feedback on social needs data.
- Speaker 1 shares an example of a platform being used in Allegheny County to screen and refer members to other community-based organizations.
- Reduce lower utilization among patients with unmet needs.
- Lorena suggests reducing duplication of referrals to CBOs to improve efficiency.

Assessing social needs and referrals in healthcare.

- Organization seeks input on what outcomes are important for improving healthcare services.
- CEOs lack access to outcome data, making it challenging to track trends and measure success.
- Organizations measure impact of social needs assessments and referrals through various methods, including EMR metrics and open-ended feedback.

Survey development for social needs assessment.

- Partnerships with CBOs are crucial for measuring outcomes, as they provide access to data and analysis.
- Speaker 2 proposes refining a question with Michelle's recommendation and plans to share the draft survey with the group for final feedback before finalizing it next week.
- Speaker 2 seeks feedback on survey before sending it to the entire group.