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An Information Technology Journey

WHY AND HOW THE PARTNERS IN CARE FOUNDATION UNDERTOOK AN UPDATE OF ITS EXISTING INFORMATION TECHNOLOGY SYSTEM

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Why and How the Partners in Care Foundation Undertook an Upgrade of Its Existing Information Technology System

Identifying the Pain Points

Partners in Care Foundation (*Partners*) worked, during this three-year project, to strengthen its role as a Community Care Hub (CCH) by developing an integrated Information Technology (IT) solution to deliver the highest quality evidence-based Social Determinants of Health (SDOH) services for California adults.

At the beginning of this journey, *Partners* lacked adequate IT systems to support several programs, specifically Care Management, Care Coordination, and Hub services. Additionally, the agency lacked the ability to see and analyze data at an organization wide level. This impacted our goal of continuous quality improvement and service model evolutions and providing tools for strengthening the agency's position as a CCH[1].

The Partners Community Care Hub supports three large service delivery departments within the Partners in Care Foundation. These include Short-Term Services and Supports (STSS), Long-Term Services and Supports (LTSS), and Community Wellness.

The Partners Community Care Hub is also responsible for the administrative and business operations management of a network of growing number of specialty community-based organizations across the state of California. Currently there are more than fifty network members within the Hub. The Hub provides services across many lines of business, including Medicare, Medicaid, Commercial Insurance, health systems, Federal, State, and County programs. These currently represent fourteen healthcare contracts with health care organizations (health systems, health plans, medical groups) with twenty-seven different Scopes of Work.

Three years ago, with strong encouragement from *Partners*' Board of Directors, the agency's Management Team took the first steps towards an Information Technology upgrade. Initially, this involved engaging an outside firm to perform a full IT Assessment, which served as the first step towards acquiring a comprehensive IT Care Management system that would address any identified gaps and more.

[1] *Partners* uses the abbreviation of CCH for Community Care Hub which in some organizations is also referred to as an NLE, which stands for Network Lead Entity.

Project Goal

Partners' goal was to implement a software solution that supports all Partners' Community Care Hub functions.

Project Objectives

The following points were identified by the team as significant objectives for the project:

I. Develop an IT data solution that will produce financial, clinical, operations and quality performance reports and analytics.
II. Integrate *Partners'* evidence-based tools into the new IT solution.
III. Integrate all *Partners'* contracts and services to streamline oversight and increase productivity and effectiveness (**No Wrong Door**) of services.

Partners will enhance its delivery of a broad range of SDOH services for older adults and people with disabilities through a **No Wrong Door** approach already incorporated into our organization/network.

It is anticipated a new IT solution will fully integrate *Partners'* services, contracts, and multiple systems, thus enabling our new platform to serve as a single point of entry. Platform and software features will enable us to better manage all aspects of our Community Care Hub role. For example, we anticipate the new software will assist Care Management staff in better identifying other internal and external programs and services that members may be eligible for or who could be helped by if referred. A key benefit will be allowing members referred to fully receive all available programs and services within *Partners* – such as HomeMeds, Medicaid nursing home diversion program, Community Wellness programs, Enhanced Care Management (Medi-Cal), or Home and Community Based Alternatives waiver.

Outcomes

To meet our project goal of implementing a software solution supporting all Community Care Hub functions, we proposed the following outcomes:

I. No double-entry will be required of Hub staff, health plan staff, or network member staff.
    - Staff will have decision support to meet workflow requirements for each contract they work on - they often work on several contracts in order to serve with sufficient caseload in a given geography.
    - The new software will reduce the number of times staff will have to open up different systems to complete their work, but there will remain some healthcare payor requirements requiring *Partners* to use the payor systems as well.

II. Performance standards and parameters for each contract can be set and will generate alerts for Community Care Hub staff to increase compliance and quality – serves as decision support for staff and review tool for supervision.
III. Health plans and provider groups will accept bidirectional data exchange with network software – eliminate administrative complexity like faxing and other inefficient modes of exchange.
IV. HomeMeds and standard assessments such as Health-Related Needs Assessments (HRSA) or Social Determinants of Health (SDOH) Assessments will be fully integrated with the selected IT solution.
V. The Community Care Hub will be supported by a dashboard of quality and performance measures and produce/track Quality Indicators and National Committee for Quality Assurance (NCQA) programs.

The Information Technology Assessment

Purpose

Partners sought to engage in a thorough and comprehensive IT Assessment project to determine the best strategy to move us to a strong care management platform. Such a platform will exhibit the following characteristics:

- Has workflows embedded based on specific scopes.
- Alerts staff to the next task or tasks that are due or past due.
- The "standard" (aka SDOH) assessment is embedded in the system.
- Helps generate a care plan/action item.
- Captures contacts and progress notes.
- Integrates with *Partners*' Engagement Center.
- Supports billing and required reporting.
- Allows Hub members and internal staff to easily work in the system.
- HIPAA/HITECH compatible.
- Allows for supervisors/managers to have ability to look across programs/staff for productivity, outcomes, etc.
- Will/can have ability to integrate with other IT systems, like healthcare payor systems - interoperability.

First Step – the Vendor Selection Process for the IT Assessment

In order to begin the process of searching for a vendor with the IT Assessment skills, knowledge, cost structure, and cultural attributes that were in line with *Partners*' requirements, a Request For Proposals (RFP) document was drafted.

This document included:

- A Project Overview, which provided background on our agency and existing challenges posed by the current program operations circumstances.
- A Project Objective, which described the desired future state that would result from the work provided by the selected vendor.
- Submission Guidelines that explained how a vendor interested in providing an RFP should construct its proposal.
- A Description of Evaluation Criteria to be used in evaluating each RFP, and
- A timeline outlining the decision-making process to select a software partner (see attached PDF below).

IT Assessment RFP.pdf

The universe of recipients for the RFP was developed by *Partners*' Senior Director of Information Technology and the Assessment consultant, connecting with professional contacts to ask for suggested vendors. She then reviewed each vendor by checking their website to identify the types of services they provided, and then chose those that fit the agency's need for inclusion on the RFP recipient list. She was assisted in this and throughout this IT project by a Project Manager funded through the ACL No Wrong Door LC.

Following release of the RFP to pre-selected vendors and posted on appropriate RFP list-serves, *Partners* received six proposals for this project. Following the criteria and timeline laid out in the RFP, each was reviewed and scored by executives and staff from the following areas:

- Partners' CEO
- Finance
- Information Technology
- Staff from each of the three Operating Divisions

Additionally, an IT Executive from a for-profit organization participated as a volunteer reviewer. This outside perspective was invaluable to the process.

The top-scoring responders were invited to interview with a selection committee made up of representatives from each of the internal staff stakeholders with an interest in the success of the project. In addition, outside volunteer IT experts were part of this oversight and input team. At the conclusion of this process, *Partners* selected RSM, a Canadian firm whose response aligned best with our criteria (see attached PDF of RSM's proposal below).

RSM - Partners in Care Foundation - Prc

Starting the Assessment

Once RSM was chosen to undertake the project, the first crucial step was to develop a Project Plan and Timeline for its work (see attached PDF).

IT Assessment - Project Plan.pdf

RSM undertook a deep dive discovery of agency operations which included a gap analysis through intensive interviews with key executives from Partners staff including individuals from the following areas:

- Partners' CEO
- Finance
- Information Technology
- Staff from each of the three Operating Divisions

The project was broken into discrete stages of work covering assigned periods of time. The Assessment required a significant amount of time involving participants from all the stakeholder areas. Investing in this valuable resource resulted in a comprehensive IT Assessment covering the current state and needs of those parts of the agency described in the RFP.

In September of 2021, Partners learned that ACL was willing to support the agency's information technology update. This ACL funding helped with many of the costs related to the consultants who were providing specialized knowledge and the Partners staff who were committing large blocks of time to the initiative. What wasn't covered by ACL was supported by additional grants from the Ahmanson Foundation, California Wellness, and State of California IPP Funding.

Outcome of IT Assessment

RSM identified two gaps within *Partners* related to IT Care Management Systems – one for programs that do not utilize any structured program systems, for example programs using solely Microsoft Excel to track progress. The second was Data Integration systems to help coordinate data and provide analytic support for the multiple care management data systems across the organization to achieve the goal of having an organization wide ability to access program data/information.

Data integration is the process of bringing data from disparate sources together to provide users with a unified view, making data more freely available and easier to consume and process by systems and users.

Integrator software is especially beneficial when the complexity of multiple payers is taken into consideration. When different data is collected and stored in different program data systems it does not allow *Partners* to look at programs across the agency holistically. It fragments the ability to see staff productivity, especially for

those who work on multiple programs. It prevents us from easily pulling data for grant opportunities, internal analysis, or other agency needs.

A data integrator provides the ability to pull as little or as many data elements and reports as are needed, since the multiple systems (i.e., Care Management System and/or any other system that we are not able to house under one system) can have data linked through the data integrator.

RSM created a Requirements List for each solution. Based on the IT Assessment, RSM provided the following list of options to consider as requirements of the solution we would choose. Considering the findings from their discovery, RSM determined that *Partners* needed a product with the following capabilities and functionalities.

Capability and Functionality List

a. **Activity Dashboard**: Shows a summary of sales activities, participant entry, amendments, etc.
b. **Activity Tracking**: Tracks ongoing and completed activities, such as phone calls, home visits, care plan updates, etc**.**
c. **Appointment Management**: Manages the scheduling of appointments and bookings for participants**.**
d. **Billing & Invoicing:** Facilitates payment requests and provides details on purchase sales.
e. **Calendar Management:** Manages calendars and easily organizes meetings, events, and tasks.
f. **Member Profiles:** Manages profiles and tracks requisite member information.
g. **Case Management Case List:** Manages active cases in an easily readable case list.
h. **Document Management:** Receives, tracks, manages, and stores documents relevant to the specific care management program – referral forms, eligibility documents if applicable, medication lists, care plans, assessments, and any other documents pertaining to the member referred.
i. **Eligibility Verification:** Verifies a participant's insurance in terms of coverage status, active or Inactive status, and eligibility status.
j. **HIPAA Compliant:** HIPAA Compliance is the process by which covered entities need to protect and secure healthcare data or Protected Health Information.
k. **Interoperability:** Able to exchange information with other payors and providers.
l. **Medical History Records:** Manages records that identify the participant's past medical history, personal and contact details, health information, habits, living standards and family medical history with their consent to the terms and conditions.
m. **Patient Management:** Captures and stores the medical history, treatment required, details of their previous visits, upcoming appointments if any, reports, insurance details and more.
n. **Patient Records Management:** Manages and effectively governs patient records and associated participant data / information.
o. **Payment Processing:** Enables financial transactions, commonly employed by a merchant, to handle transactions with customers from various channels such as credit cards and debit cards or bank accounts.

p. **Referral Management:** Manages the process by which participants are transitioned to include other outside resources for the next step in their care.
q. **Reporting & Statistics:** Enables the automated reporting and analytics / statistics of information and data stored in the system.
r. **Task Management:** Tracks tasks from beginning to end, delegating subtasks to teammates, and setting deadlines to make sure projects get done on time.
s. **Treatment Planning:** Facilitates the joint process with key medical stakeholders, with the clinician offering a range of choices to engage the patient on a journey of recovery.

RSM presented the capabilities/functionalities list to *Partners* for validation along with a recommendation that the agency should meet those by acquiring two pieces of complementary software: Data integration software and care Management software. These recommendations were reviewed and agreed to.

Following that agreement RSM then performed a market scan and identified possible software/vendor candidates with software matching the identified list of capabilities/functionalities.

a. **Data Integrator**: Oracle, Rivery, K2 View, Adeptia, Microsoft, Panoply, Qlik Q, Boomi, Denodo, Cinchy, Informatica, Collibra, Talend, IBM, SAP, Precisely, SAS, Mulesoft
b. **Care Management**: Salesforce, Epic, Penelope, Netsmart, EHR, CCS, apricot, Caspio, WellSky, WELL Health, Microsoft

Recap of the steps taken in the IT Assessment phase of the journey:

a. Met with the Project Sponsor, Project Lead, and Project Manager
b. Prepared for and Conducted Kickoff Meeting(s)
c. Developed Project
d. Created Charter and Developed Interview Schedule
e. Scheduled Workshops
f. Gathered and Analyzed New and Updated Information
g. Developed Facilitation Materials
h. Prepared for and Conducted Workshops with *Partners*' Staff
i. Synthesized and Presented Current and Future State Findings
j. Undertook Gap Analysis across People, Process, and Technology
k. Confirmed Prioritized Gaps
l. Developed Final Roadmap
m. Consolidated Findings into Draft Final Report and Presentation
n. Presented Final Assessment Report and Presentation

IT Vendor Selection

Vendor Selection Process

As *Partners* began deliberating the challenges associated with identifying a vendor (or vendors) to help implement both the Care Management and the Data Integrator software, the decision was made to hire RSM once again to help us with this phase. They already knew our agency, the team understood what our needs were, and they understood the challenges a vendor would need to address as each piece of software was brought online and implemented.

With input and consultation from *Partners* staff, RSM created a Project Plan for this next phase of the IT Journey (see attached pdf).

Data Integration and
Care Management Pr

With RSM's assistance, an RFP for each of the two desired pieces of software was crafted and a large list of potential vendors was curated to a shorter, more manageable list of potential vendors. Each RFP was then sent to the appropriate vendor on the curated list.

Care Management
Solution RFP V2.pdf

Data Integration
Solution RFP.pdf

An internal Project Manager was engaged to help manage/support the next steps of our journey. We also ensured that our quality lead was included in the next steps to ensure that quality standards are part of our decision-making process as we are NCQA accredited.

Demonstration and Evaluation Team Created

In order to best evaluate the individual pieces of software, a Demonstration and Evaluation Team was created. This staff team included specific program and analytic subject matter experts from across the organization, including from:

- Community Care Hub
- Long-Term Services and Support
- Short-Term Services and Supports
- Community Wellness
- Information Technology
- Quality / Compliance
- Outside volunteer Information Technology experts

Members of the Demonstration and Evaluation Team were tasked to participate in every software product demonstration in order to provide a fair evaluation across all vendors. Members were reminded to keep in mind the needs and wants of their own programs/functions as they evaluated each vendor, specifically as it relates to managing services across multiple delivery network members. In advance of the demonstrations, RSM created individualized scorecards for each team member to use in evaluating each product. After all the demos were completed, the team then scored/evaluated vendors based on the requirements list developed earlier by RSM.

RFP Evaluation Workbook.xlsx

Business and Technical Requiremer

Demo Scorecard - Care Mgmt.xlsx

Based on RFP and demo evaluation scorecards, finalists were chosen. Where additional questions had arisen, they were passed along to the finalists to provide clarification. Based on these final pieces of information, a preferred vendor was recommended to the *Partners* Executive Team and *Partners* Board of Directors for approval. Once the final approval was received, an award letter was sent to each of the selected vendors.

Recap of steps taken to this point in the journey:

a. RSM reengaged for this phase of IT Vendor selection process.
b. RFP drafted and sent out to the IT Vendors on RSM's initial shortlist.
c. RFP responses returned with RSM organizing interviews with vendors.
d. Individual Vendor Demos completed.
e. Evaluation teams met separately to score demos based on scoring sheet.
f. Scores and recommendations reviewed with Executive Team
g. Additional questions sent to finalists.
h. Recommendation on finalist presented by the *Partners* CEO to the Board of Directors
i. CEO and Board approved recommendation
j. An award letter was sent out and a contract signed.

Pre-Implementation

Internal Committees Formed

With software and vendors chosen, the next step was to begin preparation for implementation. This involved creating three internal committees which would each be charged with specific pieces of the implementation process:

- Steering Committee
- Core Team
- Extended Team

The **Steering Committee** was created with key internal stakeholders and its job was to drive forward the implementation process. This group would:

1. Provide guidance and strategic direction.
2. Create a roadmap for approval and ongoing oversight.
3. Manage Oversight of Core Team, ensuring deliverables are met.
4. Provide financial oversight.
5. Identify Risk
6. Note: This is a "reviewing" team - not a "working" team. It assists in guiding decision making.

The **Core Team** defines and owns the implementation roadmap. This includes:

1. Ensuring the Extended Team successfully implements each identified task.
2. Managing Resources, including the time of the staff affected by the project and any other requirements arising from the need for additional personnel or supporting individuals essential for the project.
3. Monitor and Manage all deliverables and assignments of the Core Team, including evaluating findings and workflows, generating documents, and scheduling discovery sessions- all essential components to guarantee the successful implementation of the system.
4. Meet Financial Targets

The **Extended Team** does the actual work of software programming/ implementation.

1. It creates workflows that are provided to Core Team
2. Develops and maintains a list of deliverables per program.
3. Identifies the KPI's (internal controls) necessary per program.

The **Internal Committees** were created with the purpose of generating:

1. Document workflows
2. Identifying Common aspects vs Unique aspects
3. Standardized Data Definitions
4. Forms – Common vs Unique.

In addition to creating the Internal Committees, *Partners* engaged an external Business Analyst/Project Manager through our care management vendor, Provisio, for the purpose of working with subject matter experts (SMEs) to:

- Create a workflow diagram.
- Help identify the common vs unique workflows.
- Create a Data dictionary.
- Standardize the terminologies.
- Identify the forms that can be consolidated into one (standardized).

Additionally, the Business Analyst/Project Manager worked with internal and external SMEs to:

- Identify the programs to be migrated to the Care Management System.
- Identify the programs to be migrated to the Data Integrator System.
- Identify the programs that use other existing systems.
- Ensure the work stays within time and budget.

Finally, a key aspect of the Business Analyst/Project Manager's role was to develop a detailed project plan, and both monitor and track progress on the project.

Project Plan.pdf

This project plan is designed to provide a broad and complete roadmap to ensure deliverables are on time and within scope & budget, create and maintain comprehensive project documentation, ensure resource availability and allocation, coordinate with internal and external parties for the flawless execution of projects, perform risk management analysis to reduce project risks, and lastly, report and escalate to upper management any issues that arise and when needed. The Business Analyst/Project Manager will continue to work through the full implementation phase.

IT Governance Committee Created

Recommendations came from both RSM as well as our volunteer IT professional advisor, that *Partners* establish an IT Governance Committee. Distinct from the Care Management and Data Integrator project, its primary aim is to offer direction for IT-related choices across the full agency. Comprised of key IT executives, external stakeholders, CEO and agency board member, this committee is tasked with supporting IT strategies and ensuring alignment with the organization's business objectives. Frequently serving as a mediator, the IT Governance committee is designed to play a pivotal role in reconciling the challenges of prioritizing multiple important IT requests and the challenge of aligning IT strategies with business goals arising from communication gaps and multiple needs for IT solutions.

Moving to Implementation

Implementation - Current State (as of January 2024)

Both pieces of software are scheduled to go live at the same time during July 2024.

Steps yet to complete:

a. Design the software - began in November 2023 and is currently underway.
b. Programming – initial programming also began November 2023 and is currently underway.
c. Test,
d. Train,
e. Go live - scheduled for 7/2024

Who is involved in the Implementation Phase?

a. Internal teams, including the Steering Committee and Core Team,
b. Provisio,
c. Business Analyst/Project manager, and
d. any other individuals who may be required throughout the process.

Partners is a nationally recognized leader in promoting innovative community and home approaches in care coordination/management, health promotion, chronic disease management, and introducing positive practice change. As *Partners* grew the landscape of the services, it has encountered technological challenges:

- Manual data collection and storing data in disparate sources (no central repository.)
- Limited reporting capabilities including ability to build standardized or custom reports.
- Limited ability for conducting data analysis.

After an extensive discovery process the following solutions were identified:

- Centralized Case Management software system
- Data Integrator
- Data Warehouse
- Reporting
    - Payer required specific reports.
    - Internal productivity reports.
    - Billing reports
    - Compliance reports
    - Etc.

Consequently, *Partners* is implementing the system upgrade project that includes:

- Implementation of Salesforce Health Cloud (referred to Salesforce 2.0 by *Partners*) as *Partners* enterprise solution for Case Management for the majority of programs including CalAIM services throughout the agency.
- Implementation of Talend as the Data integrator.
- Implementation of a Data Warehouse system.
- Configuration of Tableau for reporting, analyzing data for better business decision making.
- Salesforce will be configured to increase efficiency in every phase of case management:
    - Outreach: Calling campaigns can quickly be created based on set criteria such as geolocation and language. These calling campaigns will be used by the dialer for on-demand outreach and automated documentation of call results.
    - Case Assignment: Cases will be auto assigned based on set criteria such as geolocation, language, and expertise. Where a human decision-making factor is needed, set criteria will be readily available for informed decision making.
    - Assessment: As an effort for standardization, a library of assessments will be available to address specific needs of each program. Workflows will be configured to auto-generate draft goals for care plans based on responses to specific questions on the assessments, building skip logic in the assessments.
    - Care Plan: The software supports the creation of unique care plans for each individual under care and adapted for the multiple payers and services partners.
    - Compliance: Automated workflows will generate tasks with due dates and send reminders and alerts to ensure timely deliveries.
    - Cross Referral: The system will automatically flag participants for all services for which they are eligible.
    - Billing: The services will be tracked by their specific service codes, ready for easy billing.
    - Application Programming Interface (API): Seamlessly connect data in the interest of integrating medical and social care. Through interface with LANES (a platform for Health Information Organization HIO) the participants who have returned to a hospital will be flagged immediately, allowing us to tailor our care appropriately.

- The Data Integrator, Talend, will be an innovative technology for the agency creating efficiency across data collection:
    - Aggregating data from various sources for uniform reporting.
    - Help standardize and reformat the referrals before uploading them into Salesforce or the data warehouse.
    - Connect the data across Salesforce and all other payor specific systems (for example Med-Compass used by the HCBA program).
    - Address the deduplication of the data (deduping).
    - Reformat the data and prepare for reporting back to the payers according to their specifics.
    - Data exchange with outside systems including Electronic Medical Records (EMR) and Health Information Organization networks (HIO).

- The Data Warehouse will be the central repository for the integrated data at participant level such as date of birth, zip code, discharge reason, care plan outcomes etc.

- Tableau will be configured for better reporting:
  - Easily and quickly create complicated reports mandated by the payers.
  - Clear and concise reports to diverse stakeholders regarding community impact.
  - Uncover and describe relationships in our data for a clearer insight into our organization.
  - Reports that cover cross program data rather than isolated program reports.

This innovative technology will support Partners in Care Foundation and our Community Care Hub with seamless interactions with external applications, automate workflows, allow for data- driven and evidence-based decision making to refine programs and services and stay on top of outcomes and quality measures. Having a robust system will also be a value add for CBOs to participate in our Hub and provide them with sophisticated IT systems that on their own would not be sustainable with small volume.

Lessons Learned To-Date

What worked well?

One of the best decisions was to designate an internal executive-level leader to manage / facilitate the entire process. Equally important was having an executive-level leader from the Information Technology Department. The two roles allowed for full consideration of perspectives from both the operations area and the IT infrastructure area. Equally important was building in the required time commitment for each of the stakeholders needed to participate, the impact on staff already managing significant daily workloads, and the overall requirements for successful completion.

Unexpected complications?

Partners saw a significant growth in service volume and operations at about the same time we began this IT journey. As a result, the Subject Matter Experts (SMEs) were pulled in many directions at the same time, necessitating careful planning for the use of their time. This was crucial. Important to early on think through how to work with SMEs to continue the daily of running programs and operations but at the same time, making sure the IT upgrade received sufficient time from a crucial stakeholder group. This was something that came up and still comes up.

Steps to avoid if were to do again?

As mentioned earlier, *Partners* saw growth in service volume, which resulted in operations staff involved in the IT upgrade needing to also respond to unanticipated demands for recruiting staff, training those new employees, and making sure the IT and operations infrastructure could absorb this growth. A handful of new grants were also won, which came with an additional layer of unanticipated work. All of this came on top of the existing tasks already underway as part of the IT upgrade. This suggests a need for greater coordination and cooperation among all areas of an organization so growth, grants, and upgrade tasks can all comfortably accommodate each other's needs without too greatly impacting staff or those in the organization's care. Prioritization of initiatives is crucial.

Thank You

This process has been both time-consuming, but incredibly valuable. Has taught us so much and made us rethink the way we have been setting up siloed systems by having us focus more on standardization and common elements.

It is also important to note that there need to be key folks helping make this journey fun for the staff/SMEs who are pulled to help support it and ensuring that they not forgot what lies ahead with a finish product that will save them so much time and effort and help support the work they are doing.

The Partners in Care Foundation would like to thank the following individuals and organizations for their generous gifts of time, knowledge, funding, and support as we have worked our way through this complex but important initiative.

We were able to achieve this success due to the generosity of the Administration for Community Living (ACL), The Ahmanson Foundation, and The California Wellness Foundation.

We also would like to extend our thanks for the encouragement and support shown by the Partners in Care Foundation Board of Directors and Sheila Minton for her generous expertise.

Definitions

a. CCH- Community Care Hub -
b. SDOH- Social Determinants of Health -
c. HomeMeds- HomeMeds℠ is an invaluable evidence-based tool for identifying potential patient medication-related errors through medication screening during in-home visits by care coordinators or community health workers.
d. QI- Quality Improvement
e. NCQA- National Committee for Quality Assurance