State of Wisconsin
Department of Health Services
Tony Evers, Governor
Kirsten L. Johnson, Secretary

March 21, 2024

The Honorable Howard L. Marklein
Joint Committee on Finance Co-chair
Room 316 East State Capitol
Madison, WI 53702

The Honorable Mark Born
Joint Committee on Finance Co-chair
Room 308 East State Capitol
Madison, WI 53702

Dear Senator Marklein and Representative Born:

In accordance with Wis. Stat. § 49.45 (26g) (h), I am submitting a report on the Intensive Care Coordination Pilot (ICCP) program.

Sincerely,

Kirsten L. Johnson
Secretary-designee

Intensive Care Coordination Pilot Program
(2017 Wisconsin Act 279)

Preliminary Report

to the

State of Wisconsin Legislature's

Joint Committee on Finance

P-03590 (03/2024)

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EXECUTIVE SUMMARY

Emergency Department (ED) visits can be both costly and preventable. To address this, Wisconsin has implemented a care coordination pilot which aims to reduce both visits and costs of high utilizers of the ED. Specifically, 2017 Wisconsin Act 279 funds up to $1,500,000 each fiscal year for pilots of intensive care coordination. These services are being offered to select populations at three health systems in Wisconsin: Ascension Wisconsin, Aurora Health Care Inc., and Froedtert Health.

Act 279 outlined requirements of care coordination for components including discharge instructions, referral information, medication instructions, intensive care coordination, and information about other social resources such as transportation and housing. Each health system has their own processes for care coordination, but all health systems aim to address social determinants of health.

There are four rounds of the program, each lasting six-months. Round 1 began March 1, 2022, and Round 4 will conclude on February 29, 2024. Participants may enroll in up to two consecutive rounds and must be enrolled in Medicaid but not Medicare. Each health system also specified different definitions of frequent ED use and had flexibility to focus on specific populations who met the criteria.

Starting in care coordination period three, the time between eligibility determination and the start of the care coordination significantly decreased. The participating health systems expressed a belief that this change would allow them to intervene on determinants of health care utilization in a timelier and more effective manner.

The evaluation will compare individuals who received the intensive care coordination (i.e., the ICCP group) with a comparison group that, due to funding or staffing constraints, did not receive the care coordination but were eligible to. We will compare outcomes for these two groups before and after the start of the care coordination program using the statistical difference-in-differences methodology. In addition, we will re-weight the comparison group to ensure it is similar in terms of health care utilization, costs, and health measures prior to the start of the program.

Outcomes evaluated will include the number of ED visits, both total and return; costs of ED visits; total costs to Wisconsin Medicaid; the use of relevant services such as primary care visits, specialty care visits, behavioral health resources, and alcohol and other drug abuse resources as applicable; and enrollment in other social services such as AFDC and FoodShare. We will perform subgroup analysis based on policy relevant groupings and evaluate relevant outcomes for non-emergent or primary care preventable visits and for emergent, non-preventable visits.

Act 279 required a report submitted to the Wisconsin Legislature's Joint Committee on Finance (JFC) no later than 24 months after the start of this program, detailing demonstrated outcomes and results of the program in its entirety. Due to the timing of the ICCP program start and the need for mature data, DHS plans to submit this final report approximately 16 months after the end of the final treatment period. In the interim, this report has been created to provide a descriptive summary of the program and an update on program activities. There will be a final report, including data results and cost savings, provided to JFC after 6/30/2025 once the program has ended and all final data and calculations have been evaluated.

THE INTENSIVE CARE COORDINATION PILOT PROGRAM

Emergency department (ED) visits are costly and may be preventable. Through 2017 Wisconsin Act 279 the Wisconsin State Legislature created the Intensive Care Coordination Pilot (ICCP) Program. The Act funds up to $1,500,000 each fiscal year in at least two health systems for intensive care coordination services to Medicaid recipients who are not enrolled in Medicare with the stated goal of reducing emergency department use among these Medicaid recipients.

The Wisconsin Medicaid program seeks to understand whether this program achieves its intended goals of reducing ED visits and costs. This report contains preliminary information about program implementation as well as the study design for the evaluation. The study design will compare changes in outcomes for participants who received care coordination services versus a comparison group of similar participants – i.e., individuals that did not receive the intervention but who experienced frequent ED visits at the same health system.

Selection of Participating Health Systems

The Department of Health Services (DHS) requested applications for health systems interested in participating in the pilot (RFA #140). Applications were due March 11, 2020, and five health systems submitted applications. All five health systems were selected to participate in the pilot. With assistance from the University of Wisconsin-Madison Institute for Research on Poverty (IRP), DHS worked with the health systems to assign a cap on the number of participants in each care coordination period. The cap was based on the number of participants each health system anticipated accepting in their initial applications and the number of participants that could be supported with the $1.5 million available per year."

However, due to staffing concerns related to the COVID-19 pandemic, implementation of the pilot was delayed several months. Further, two health systems decided that they would not participate in the pilot program due to staffing.

The remaining three health systems, Ascension Wisconsin, Aurora Health Care Inc., and Froedtert Health began the pilot in March 2022. Health systems worked with DHS to decide the total number of enrollees.

The ICCP Intervention in Each Health System

The 2017 Wisconsin Act 279 laid the groundwork for defining the core elements of the intensive care coordination program. Care coordination teams are defined in the Act to consist of:

- Health care providers who are not physicians, such as nurses;
- Social workers, case managers, or care coordinators;
- Behavioral health specialists;
- Schedulers.

The Act also defines that programs provide the following array of services:

- ED discharge instructions and contacts for follow-up care;
- Referral information;

- Appointment scheduling;
- Medication instructions;
- Intensive care coordination by a social worker, case manager, nurse, or care coordinator to connect the participant to a primary care provider or managed care organization, and;
- Information about other health and social resources, such as transportation and housing.

Beyond these core elements of the program, each health system further defined their own processes of care coordination to be most effective within their own system. Key elements of each program are summarized below with additional details in **Appendix A.**

Ascension's pilot program utilizes Health Promoters (HP) who frequently engage with participants and assess social determinants of health (SDOH). The process starts when ED high utilizers who are 18 years and older are flagged in Ascension's care management platform. HPs make three outreach attempts by phone and will outreach in-person if the participant checks-in to the ED. The program's intake assessment includes SDOH questions and triggers to address issues the participant may be facing. Based on the intake assessment, HPs develop care plans for the participant, connect them with a Primary Care Physician (PCP), educate on appropriate care settings, refer to the right health team member to address their needs, help establish transportation for appointments, refer to financial assistance, and share helpful resources. Follow-up calls are made at least every two weeks to work on care plan goals and address any of the participant's questions or needs.

Aurora's pilot program utilizes social workers and involves specialized, intensive case management services. The process starts with a site-specific, monthly report of participants identified as high utilizers through the electronic health record (EHR). A forensic chart review is done, and participants are met face-to-face in the ED, where they receive clear discharge and follow-up instructions and support. Social workers conduct SDOH screenings, followed by individualized care coordination and planning. Social workers contact participants a minimum of three to five times monthly for check-ins, appointment reminders, follow-up calls for ED visits and appointments, home visits, and referrals. Interdisciplinary monthly participant management plan meetings—with ED director and staff from the public safety, behavioral health, and social work fields—help tailor care plans to individual circumstances which could include ED use, comorbidities, social needs, and medical interventions. To address SDOH, social workers may accompany the participant follow-up appointments; enroll them into a local food program; refer to public benefits to assist with insurance applications; provide advanced care planning education; and connect participants with legal assistance, day programs, housing shelters, or numerous other community resources. HPs may also connect participants with Health Maintenance Organization (HMO) case managers who can provide additional outreach and care coordination. As staff awareness of the program increased, referrals increased as well.

Froedtert's pilot program utilizes three social workers to offer flexible care coordination to Medicaid participants with at least three ED visits over the measurement period. Coordination ranges from weekly calls to contact only after ED visits based on the participant's needs and ED utilization. Initial outreach involves two phone calls. If there is no response, a MyChart message or letter is sent to the participant that includes alternative care options and resources available within the health system. Upon enrollment, each participant receives an SDOH needs evaluation to determine additional resources the program can provide and to understand the impact of SDOH on that participant's medical care. Social workers then call or message participants via MyChart to provide support, education, and resources. The social workers

provide additional education on alternative care options for less critical symptoms, establish participants with a PCP, schedule follow-up PCP appointments after an ED visit (sometimes with the help of Medical Assistants), and communicate with providers regarding participant questions or if orders are needed for equipment, home care, behavioral health, dietician, etc. To address SDOH, the program provides the participant with resources for housing, finances, food, transportation, behavioral health, advocacy, and dentistry, or connects them with an organization who can assist the participant. Froedtert even created a free virtual visit code to remove the cost deterrent for these participants. Froedtert increasingly standardized the resources provided to each participant after the first year so that they all receive alternative care resources, behavioral health resources, and Health Care Power of Attorney documents. Upon discharge, they established connections with multiple insurance providers to offer additional support for medical and community resource needs after leaving the program, which Froedtert reported as a successful endeavor.

All three programs target ED high utilizers, connect patients with appropriate care providers, address medical and social needs, and repeatedly follow-up with patients. Social workers (Aurora & Froedtert) and health promoters (Ascension) perform the role of ED care coordinator. Patients were identified through electronic reports that flagged ED high utilizers. Initial outreach was done via phone calls at Ascension and Froedtert and in person at Ascension. Aurora's program included interdisciplinary meetings to help tailor patient care plans to their individual circumstances. Froedtert offered a free virtual visit for patients. Comprehensive efforts to connect patients with community resources beyond medical care are evident in all three programs. Resources include transportation, housing, and financial assistance. Social workers in both the Aurora and Froedtert programs directly connect patients with outside resources to provide additional support, as needed for Aurora and upon discharge for Froedtert.

Target Population and Inclusion Criteria

Health systems used ED utilization data to identify Medicaid recipients who frequently used the ED to target this group for intensive care coordination. The health systems defined the exact criteria for "frequent" ED use to trigger care coordination services. Examples listed in Act 279 include visiting the emergency department three or more times within 30 days, six or more times within 90 days, or seven or more times within 12 months. This target population included adults aged 18–64 who were Medicaid recipients in managed care or fee-for-service Medicaid. People concurrently enrolled in Medicare were not eligible to join the pilot program.

Each health system was allowed to tailor their inclusion criteria based on staffing levels and the characteristics of their participant populations. **Table 1** shows the inclusion criteria selected by each health system participating in the pilot program according to the health systems' initial applications and responses to the Inventory of Practices. DHS worked with the health systems to give them the opportunity to enroll the maximum number of participants allowed under funding from Act 279. In practice, some health systems chose to enroll fewer people based on staffing concerns. The health systems reported their inclusion criteria to be unchanged throughout the pilot program to date, except for Froedtert. The Froedtert criteria changed in rounds 2 and 3 to additionally exclude participants from prior episodes with discharge status of Declined, Closed, Graduated, or Ineligible. In treatment period 3, Froedtert included everyone who met the exclusion criteria with 4+ emergency department visits as before, but also included some participants with three or more visits with the highest Epic adult risk score until they reached the maximum number of participants allowed.

Table 1: Inclusion Criteria for Each Health System

Health System	Inclusion Criteria for Enrolling in Pilot
Ascension	6+ ED visits with at least one in Ascension during the eligibility period
Aurora	5+ ED visits with at least one in Aurora during the eligibility period
Froedtert	• 4+ ED visits with at least one in Froedtert during the eligibility period • At most 10 ED visits to Froedtert • Exclude participants who are homeless or who have an external primary care provider, sickle cell disease, opioid use disorder, alcohol abuse, participants with more inpatient admissions than ED visits, or who visited an inclusion clinic

Financial Compensation to Health Systems

Act 279 established a reimbursement and incentive system for participating health systems. The reimbursement given to health systems for the intensive coordination services are based on the volume of services provided and the reductions in emergency department utilization after coordination services are received.

First, hospitals receive up to two incentive payments. The health system may enroll each participant in an additional 6-month period and receive the same reimbursement.

- The health system receives $250 for each eligible participant not also enrolled in Medicare.
    - This incentive payment occurs four times throughout the pilot program, once at the beginning of each Treatment Period. Participating health systems have received all four of these payments.
- If the health system demonstrates progress in reducing ED visits for at least half of participants, it receives an additional $250 for each participant at the end of 6 months.
    - This incentive payment occurs four times throughout the pilot program, once after each Treatment Period has been completed for 14 months. Participating health systems have received payment for Treatment Period 1 and Treatment Period 2.

Second, health systems may receive shared-savings payments up to 50% of the savings from reducing emergency department use:

- Savings are calculated by subtracting the incentive payment total from the estimated cost of visits to the emergency department that would have occurred without intensive care coordination.
- If savings are positive for members who participated in 6 months of program implementation, 25% of the savings will be distributed to the health system.
- If savings are positive for members who participated in 12 months of program implementation, 50% of the savings will be distributed to the health system.

- The shared savings payment, if applicable, will be provided to each health system 16 months after the end of the fourth and final treatment period.

Implementation Periods of the Intervention

During the pilot program, the initial enrollment for each recipient lasts 6 months; each program participant may be enrolled for one additional consecutive 6−month period if desired. The pilot program includes funding for health systems to recruit and treat four 6-month cohorts of program participants. Thus, there are four groups of participants in each health system, though there may be overlap in participants across the 6-month periods.

Table 2 shows key dates and groups for the implementation of the pilot program. The first column includes the period of data used for determining pilot program eligibility for each group of participants. For example, when determining the potential list of participants for Group 1, Ascension recruited people with six or more emergency department visits including at least one to Ascension during June 1, 2020, through May 31, 2021. The second column indicates the date by which the health system needed to submit their list of potential enrollees to DHS. This list was vetted by DHS to confirm eligibility of the proposed participants—for example, determining that the proposed enrollees were not concurrently enrolled in Medicare. The third column indicates the date by which health systems submitted the final list of eligible people recruited to participate in the care coordination program. The fourth column indicates the 6-month period during which care coordination was delivered and emergency department use was observed. It should be noted that initially, in care coordination period 1 and 2, there was a lag between the eligibility period and the start of enrollment. This lag was in place because IRP was initially asked to confirm eligibility based on the number of ED visits. However, based on health system feedback, the time between eligibility and enrollment was significantly shortened for care coordination periods 3 and 4.

Table 2. Key Dates for Implementation of the Pilot Program

Group #	Official Eligibility Period	List of Potential Enrollees Due	Final List of Enrollees Due	Care Coordination Period
1	6/1/2020 – 5/31/2021	12/13/2021	2/14/2022	3/1/2022 – 8/31/2022
2	12/1/2020 – 11/30/2021	6/13/2022	8/15/2022	9/1/2022 – 2/28/2023
3	2/1/2022 – 1/31/2023	12/12/2022	2/13/2023	3/1/2023 – 8/31/2023
4	8/1/2022 – 7/31/2023	6/12/2023	8/14/2023	9/1/2023 – 2/29/2024

RESEARCH QUESTIONS AND DESIGN

Research Questions

IRP and DHS agreed on a set of three main hypotheses with several related research questions to be evaluated.

Hypothesis 1: Intensive care coordination will decrease use of the emergency department among Medicaid beneficiaries, particularly related to primary-care treatable and non-emergent conditions.

Q1-1: What are the patterns over time in emergency department visits, and return visits by the same person, among Medicaid beneficiaries in Wisconsin?

Q1-2: Does intensive care coordination reduce emergency department visits (total visits, and return visits by the same person) among Medicaid beneficiaries? Does the effect vary by clinical group, or for policy relevant groups (Medicaid eligibility group, e.g., people with disabilities, childless adults, and parents and caregivers)?

Q1-3: Does the impact of intensive care coordination on emergency department visits differ for non-emergent or primary care preventable visits and for emergent, non-preventable visits?

Hypothesis 2: Intensive care coordination will decrease emergency department care costs among Medicaid beneficiaries, particularly related to primary-care treatable and non-emergent conditions.

Q2-1: What are the characteristics of Medicaid beneficiaries who drive emergency department health care costs (top 10^{th} percentile, top 25^{th} percentile)?

Q2-2: Does intensive care coordination reduce costs of emergency department care among Medicaid beneficiaries? Does the effect vary by clinical group, or by Medicaid eligibility group?

Q2-3: Does the impact of intensive care coordination on emergency department care costs differ for non-emergent or primary care preventable care relative to other types of ED visits?

Hypothesis 3: Intensive care coordination will increase use of primary care and specialty care visits and increase enrollment in other relevant social services. Total costs to Medicaid will decrease.

Q3-1: Will intensive care coordination increase use of relevant services (primary care visits, specialty care visits, behavioral health resources, and alcohol and other drug abuse resources as applicable)?

Q3-2: Do various characteristics of the referral providers influence the use of care after a referral (e.g., shorter distance to public transportation, have PCMH characteristics, have after-hours care)?

Q3-3: Will intensive care coordination increase enrollment in social services such as AFDC (welfare) or FoodShare (SNAP)?

Q3-4: Will intensive care coordination decrease total health care costs for Medicaid members?

Research Design and Analytic Sample

To ensure that any changes in ED use and costs are attributable to the care coordination intervention and no other factors, we will construct a comparison group that is similar to the control group. Specifically, we worry that people who receive care coordination qualify for the pilot during a time they have unusually high ED use, and this will revert to their typical level, even without the care coordination. Regression to the mean occurs if the ICCP group would have decreased their use of care in the absence of the program. Because of regression to the mean, pre-post comparisons may suggest that intensive care coordination interventions reduce

care visits even if a more rigorous study with a randomized control group would find no impact (Finkelstein et al., 2020; Sevak et al., 2018).

Due to funding limitations (i.e., the cap on total fiscal year expenditures) and staffing concerns within the health systems, some people who frequently use the emergency department in participating health systems will not be able to enroll in the ICCP. Potential participants that met eligibility criteria but were not enrolled into the ICCP will be used as a comparison group for the evaluation. We will use a matching scheme to ensure that the two groups are as similar as possible.

More specifically, the evaluation will use a difference-in-differences quasi-experimental research design. This research design compares changes in ED outcomes before versus after program enrollment for a group of participants receiving the care coordination program (i.e., the ICCP group) versus a similar group of participants that did not receive the program (i.e., the comparison group). In the primary analysis, we will include participants across all health systems. In this analysis, participants who meet eligibility criteria and receive the intervention from any health system will be included into the ICCP group; people who did not receive the intervention but met eligibility criteria from at least one health system will be included in the comparison group. In a secondary analysis, we will conduct the analysis separately by health system. In this secondary analysis, the ICCP group include participants who meet eligibility criteria and received the intervention from the health system of interest; the comparison group will include people who meet that health system's eligibility criteria but did not receive the intervention.

To ensure that the ICCP and comparison groups are as similar as possible, we will re-weight the comparison group. The weights will ensure that the comparison group is similar to the ICCP group in terms of their ED visits and costs, as well as key predictors of ED visits and costs, before the intervention began. This method has been used extensively in the medical program evaluation literature (Aaskoven et al., 2022; Chen & Jin, 2012; Fu et al., 2017; Strumpf et al., 2017). The matching process will be conducted for the primary analysis and repeated for the secondary analyses stratified by health system.

Data Sources

The main data source for this evaluation will be Wisconsin Medicaid claims and encounter data. These data include every service that the state of Wisconsin pays for through Medicaid, as well as the amount paid by the state for fee-for-service participants or the allowed amount for HMOs. Claims data include diagnostic codes, procedure codes, and billing codes.

We will also use Medicaid enrollment data during the matching process to ensure that the ICCP and comparison groups are similar in terms of their Medicaid enrollment history. Though less of an issue for the first care coordination period, this will become more important in the third and fourth care coordination periods since they coincide with the unwinding of the public health emergency.

Administrative data will be supplemented with qualitative information provided by the health systems. Health systems completed an Inventory of Practices Survey to provide information on additional services for participants in the care coordination intervention, above and beyond what was provided to all participants as part of usual care. Health systems were surveyed in all four care coordination periods.

NEXT STEPS

The ICCP program is ongoing and in the fourth and final treatment period, ending on 2/29/2024. Due to the need for mature data required to calculate the second incentive payment and shared savings payment, this evaluation will not be available until roughly 16 months after the final treatment period has ended. After 2/29/2024, health systems will no longer be required to identify Medicaid recipients who frequently used the ED, nor will there be any additional treatment periods funded by DHS.

DHS will continue meeting with health systems to discuss ongoing data and results pertaining to the pilot program. The health systems involved in this pilot program have indicated their strong interest in continuing these types of interventions after the final treatment period has ended, and to assist in the creation of a long-term ICCP program by the State. There is a deep investment across all health systems to continue these efforts.

DHS and IRP will continue working together to produce final data results and payments to the health systems. After the end of the final treatment period, multiple data checks will occur within the final 16 months of the program to determine recipient eligibility and emergency department visits. These data findings will contribute to the results of the remaining payments to hospital systems. The remaining payments consist of:

- The second payment for Treatment Periods #3 and #4. If the health system demonstrates progress in reducing ED visits for at least half of participants in these Treatment Periods, it will receive an additional $250 for each participant at the end of 6 months.

- The shared-savings payment of up to 50% of the savings from reducing emergency department use.

Upon the completion of the ICCP Pilot Program, there is a final report to be submitted to JFC. This final report will encompass complete data results and cost savings for the program as a whole, in addition to results pertaining to each individual treatment period. The intention of this report is to allow JFC to review and understand the impacts of ED utilization and determine the potential future of an ongoing program.

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Appendix A: Intensive Care Coordination Intervention for Each Health System

Health System	Facilitating Health Care Visits	Interactions with the Participant	Resources Specific to Social Determinants of Health
Ascension	• Health Promoter (HP) refers participants to RN for chronic disease management recommendations. HP completes the ongoing behavior management and reinforces education for disease management. HP refers to Social Worker for behavioral health needs. HP does participant check-ins and PCP connection and follow-up. • If a participant doesn't have a PCP, the participant is connected with a PCP within Ascension or at a FQHC. • Care plan goal for PCP engagement and evaluate goal of three successful appointments. • Outreach to participants every 2 weeks and work on care plan goals.	• Flagging all pilot participants in their care management platform so that they are able to engage them onsite. • Proactive outreach to participants to get them enrolled in the program. Three outreach attempts by phone. • If a participant refuses, and they come to the ED, try to engage them in person to offer the program again.	• Health Promoter (HP) is the associate who engages the participant frequently and addresses Social Determinants of Health (SDOH) issues. • Intake assessment: Questions include SDOH questions and triggers to address issues that participants are dealing with. • Education on right care, right place and given flyer on ED, Urgent Care and Primary Care visits and how and when to use. • Care plan development based on chronic disease management or/and SDOH care plan if participants agree to participate in the program.

Health System	Facilitating Health Care Visits	Interactions with the Participant	Resources Specific to Social Determinants of Health
Aurora	• Individualized care coordination and planning. • Forensic chart review of participant's electronic medical record. • Appointment scheduling and transportation support. Appointment reminder calls. Care planning with participants' insurance provider/case management • Care planning with internal care teams to better direct care when participant presents to emergency department. (Emergency department Medical Doctor, Emergency department Social Worker, and Public Safety)	• Face-to-face meeting with participants while in emergency department. • Clear discharge/ follow-up instructions and support.	• SDOH screening. • Participants provided with resources specific to SDOH or medical needs. • Promoter (HP) addresses SDOH issues.

Health System	Facilitating Health Care Visits	Interactions with the Participant	Resources Specific to Social Determinants of Health
Froedtert	• Provide access to additional assistance on establishing with a PCP or setting up follow up PCP appointments after an ED visit. • Social work is able to provide available PCP options within Froedtert and also connect participants to My Health Direct to schedule with Federally Qualified Health Centers. • Social work is able to refer participants to MA staff for further assistance in scheduling follow up PCP appointments. • The MA staff can assist in finding an earlier appointment with another provider if the participant needs to be evaluated sooner. • If needed, social work is able to assist in communicating with participant's PCP regarding participant concerns/questions or if orders are needed for equipment, home care, behavioral health, dietician etc. • Created a free virtual visit code for these specific participants, so out of pocket cost does not deter these participant's from using the virtual visit option. • Coordinate with the in-person ED Social Workers to collaborate on next steps for our participants. • When enrolled in the program, social work can provide care coordination to these participants as often as needed. • Established communication with case management teams though MHS, UHC, Anthem and Children's Community	• Have three social workers that provide care coordination to these specific participants. The participants enrolled in this program receive additional education on how to use their health resources appropriately. This is done by providing participants with Urgent Care/Fast Care and virtual visit options when symptoms are non-emergent. • Contact participants via phone or MyChart to provide support, education, and resources. • Help ranges from weekly calls to contacting a participant only after ED visits. • The resources are provided via phone, email, mail, or MyChart.	• Social work provides participants with assistance for housing, finances, food, transportation, and behavioral health. • Refer participants back to their insurance companies to provide additional support with their medical needs and community resource needs if needed. Many of these programs can assist participants with member advocacy, housing, transportation, behavioral health, dentistry etc.