



HHS Public Access

Author manuscript

Med Care. Author manuscript; available in PMC 2021 June 01.

Published in final edited form as:

Med Care. 2020 June ; 58(Suppl 6 1): S60–S65. doi:10.1097/MLR.0000000000001296.

“Not Alone Anymore”:

The Experiences of Adults With Diabetes in New York’s Medicaid Health Home Program

Victoria L. Mayer, MD, MS^{*,†}, David Siscovick, MD, MPH[‡], Crispin Goytia, BS^{*}, Daphne Brown, BA^{*}, Emily Hanlen, MEd, MPH^{*}, James Flory, MD, MSCE[§], M. Diane McKee, MD, MS^{||}, Carol R. Horowitz, MD, MPH^{*,†}

*Department of Population Health Science and Policy

†Department of Medicine, Division of General Internal Medicine, Icahn School of Medicine at Mount Sinai

‡New York Academy of Medicine

§Memorial Sloan Kettering Cancer Center, New York, NY

||Department of Family Medicine and Community Health, University of Massachusetts Medical School, UMass Memorial Health Care, Worcester, MA

Abstract

Background: New York State Medicaid’s Health Home program is an example of a natural experiment that could affect individuals with diabetes. While evaluations of interventions such as the Health Home program are generally based solely on clinical and administrative data and rarely examine patients’ experience, patients may add to the understanding of the intervention’s implementation and mechanisms of impact.

Objective: The objective of this study was to qualitatively examine the health and nonmedical challenges faced by Medicaid-insured patients with diabetes and their experiences with the services provided by New York’s Health Homes to address these challenges.

Research Design: We performed 10 focus groups and 23 individual interviews using a guide developed in collaboration with a stakeholder board. We performed a thematic analysis to identify crosscutting themes.

Subjects: A total of 63 Medicaid-insured individuals with diabetes, 31 of whom were enrolled in New York’s Health Home program.

Results: While participants were not generally familiar with the term “Health Home,” they described and appreciated services consistent with Health Home enrollment delivered by care managers. Services addressed challenges in access to care, especially by facilitating and reminding participants about appointments, and nonmedical needs, such as transportation, housing, and help

Correspondence to: Victoria L. Mayer, MD, MS, Department of Population Health Science and Policy, Icahn School of Medicine at Mount Sinai, 1 Gustave L. Levy Place, Box 1077, New York, NY 10029. victoria.mayer@mountsinai.org.

The authors declare no conflict of interest.

Supplemental Digital Content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal’s website, www.lww-medicalcare.com/.

at home. Participants valued their personal relationships with care managers and the psychosocial support they provided.

Conclusions: From the perspective of its enrollees, the Health Home program primarily addressed access to care, but also addressed material and psychosocial needs. These findings have implications for Health Home entities and for research assessing their impact.

Keywords

qualitative research; vulnerable populations; diabetes mellitus; social work; Medicaid

Diabetes disproportionately affects low income, undereducated, and racial/ethnic minority individuals.^{1–10} Individuals with comorbidities in addition to diabetes are at greater risk of poor outcomes. Over half of patients with diabetes have at least one other chronic condition, and a large proportion of these have ≥ 2 .^{11,12} The prevalence of diabetes among patients with serious mental illness is higher than the general population, and increased mortality in people with serious mental illness is partially attributable to higher rates of cardiometabolic disease.^{13,14} Patients with serious mental illness and diabetes are less likely to receive indicated services and care, and more likely to be admitted to the hospital with ambulatory care sensitive conditions.^{13,15}

As part of the Patient Protection and Affordable Care Act of 2010, Congress authorized “health homes” to provide services to individuals enrolled in Medicaid with complex chronic conditions. Six services are eligible for reimbursement: comprehensive care management, care coordination, and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services, and use of health information technology to link services.¹⁶ As of March 2019, 23 states and the District of Columbia had approved Health Home programs.¹⁷ New York State established a Medicaid Health Home program in 2012; eligible individuals include people living with human immunodeficiency virus, with serious mental illness, or with ≥ 2 chronic conditions.¹⁸ Given the eligibility criteria, many Health Home eligible individuals likely have diabetes.

Natural experiment studies (ie, research where the circumstances are not modified or controlled by researchers) offer an opportunity to gain knowledge of the impact of large-scale policy interventions on the care and outcomes of patients with diabetes.^{10,19–22} Engaging patients and other stakeholders and understanding their perspectives is recognized as an essential aspect of program evaluation²³ and patient-centered outcomes research.^{24,25} However, natural experiment studies often utilize data sources, such as medical claims and electronic health record data, which do not readily include patient perspectives. Gathering data directly from patients and other stakeholders adds context, elucidates potential mechanisms, and helps to prioritize analyses.^{20,21,26} However, evaluations of similar policy interventions related to the care of patients with diabetes typically have not included patients’ perspectives.^{27–30}

Our research, funded by the Patient-Centered Outcomes Research Institute within the Natural Experiments for Translation in Diabetes 2.0 (NEXT-D2) Network, studies the Medicaid Health Home program in New York as a natural experiment. We assess the impact

of this intervention on processes of care, health outcomes, and racial and ethnic disparities for people with diabetes using administrative data sets.

In the qualitative study reported herein, we sought to describe the challenges to good health and diabetes management faced by people who are insured by Medicaid and were either enrolled in a Health Home or would meet criteria for enrollment. Specifically, we explored patients' perspectives and experiences with the Health Home program to understand how the intervention addresses these challenges.

METHODS

Study Setting

The quantitative component of the study uses electronic health records from 7 health institutions in New York City³¹ and New York State Medicaid claims data. A complementary qualitative study consisting of focus groups and informant interviews was designed to provide information on patient experiences and perspectives.

The study utilized a research “accelerator” model that catalyzes collaborations by bringing together the transdisciplinary skills and interests of all stakeholders to actively engage in the research process.³² The diabetes accelerator grew out of a stakeholder board for the New York City Clinical Data Research Network/INSIGHT.³¹ Our Patient/Stakeholder Advisory Board is comprised of 6 individuals representing patients, providers, Health Home programs, federally qualified community health centers, and community-based organizations. Accelerator members collaborated to inform the natural experiment study, suggested we enrich our quantitative findings with qualitative patient perspectives, and helped identify the types of questions and stakeholders we should engage in this qualitative study.

Design

We reviewed relevant literature and worked with our stakeholders to inform the development of our focus group moderator guide (Supplemental Digital Content 1, <http://links.lww.com/MLR/B955>). The guide included semi-structured questions and prompts covering the topics of challenges to and facilitators of good health and diabetes control, understanding of and experiences of Health Home enrollment, and feedback on the principle natural experiment study (not addressed in this report). To compare experiences of care needs, we included individuals both enrolled in a Health Home, and those not enrolled, but who would likely meet Health Home enrollment criteria. All study materials were developed in English and Spanish.

We convened focus groups so that groups of individuals with some common characteristics would interact to explore their thoughts, beliefs, and experiences.³³ After several iterations, the investigator group and the Board finalized the moderator guides and recruitment strategy. Four months into recruitment, the data collection team shared with the Board that potential participants faced formidable barriers to attending focus groups, including mobility, transportation, and scheduling issues due to frequent medical appointments and competing demands. To include a broader and more representative group of participants, the Board

recommended we also conduct individual interviews. We, therefore, modified our protocol to include individual interviews (a methodology with precedent in qualitative literature).³³

We recruited patients from 4 of the 7 academic medical centers in New York City included in our natural experiment study. We developed local data queries at each site to select patients with diabetes [at least 1 inpatient or at least 2 outpatient visits with an International Classification of Diseases, ninth/10th revision (ICD-9/10) code for diabetes] who were insured by Medicaid and were either enrolled in a Health Home or who were potentially eligible, as they had at least 1 other condition, but were not enrolled (of note, we are not able to discern the reasons they were not enrolled, which could have included never being contacted or invited to enroll, or declining). A coordinator mailed introductory letters to potential participants, phoned those who did not decline to gage interest, and scheduled those interested for a focus group. If interested participants were unable to attend a focus group, the coordinator offered to interview them by phone. We continued recruitment until the research team reviewed transcripts and judged that we had reached theoretical saturation (ie, no new themes emerged).³⁴ We collected data between July 2017 and June 2018.

Trained qualitative researchers obtained informed consent and conducted focus groups at participating medical centers and individual interviews by telephone. Trained note-takers recorded key elements of each focus group. Focus groups lasted ~1 hour and individual interviews lasted ~40 minutes. We referred study participants who had questions about the Health Home program to their medical providers, as the program was open to the enrollment of eligible individuals at the time of the study.³⁵ Participants received a \$40 gift card in appreciation for their time. All interviews were audio-recorded and transcribed in English. This study was approved by the Biomedical Research Alliance of New York's Institutional Review Board.

Analysis

Qualitative coding and data interpretation followed an iterative process for thematic analysis guided by grounded theory.³⁶ The data collection and data analysis team discussed their general impression that the data from focus groups and interviews were similar. Two members of the team independently developed initial coding schemes on the basis of close reading of the focus group data, compared codes, resolved discrepancies, and revised the coding scheme with the full team. Three team members tested the coding scheme by coding 3 transcripts and calculated the interrater reliability (κ statistic = 93%). One team member then coded all transcripts, including those from focus groups and interviews. When we found that we did not need to add new codes from the individual interviews, this supported the understanding that the data from the 2 data collection modes were similar, and we combined the data for analysis. The team collaborated to summarize data in each code and to identify cross-cutting themes.^{37,38} Four members of the team (V.L.M., C.G., D.B., and E.H.R.) each summarized several codes and then reviewed all summaries together. These team members suggested a set of candidate themes, which we then refined through discussion, writing, and editing, coming to consensus, and resolving discrepancies through repeated iterations. We subsequently reviewed the data in each code by data collection

mode; we confirmed the similarity of the focus group and interview data, but do note that the focus group data was, on the whole, richer. We used Dedoose³⁹ to manage data analysis.

RESULTS

We sent letters to 531 people. We successfully reached 48% (256), of which 7% (17) were ineligible, 18% (47) declined. We reached theoretical saturation and thus stopped enrolling while we were still in contact with 50% (129). Of the 63 participants, 31 were enrolled in a Health Home (Table 1). We performed 10 focus groups (range of 2–10 per focus group) and 23 personal interviews.

We identified several cross-cutting themes around knowledge and overall opinion of the Health Home program and 3 domains of services provided by the program (Table 2).

Theme 1: Lack of Familiarity With the Health Home Program, But Overall Satisfaction

The name “Health Home” was unfamiliar. Many participants whose records indicated they were enrolled in a Health Home were not familiar with the term. Some thought a Health Home was a physical place, like a hospital, or meant getting health care or assistance in their home (ie, a home health aide). However, most people enrolled endorsed receiving care coordination/care management services through a care manager, social worker, or someone else who reached out to them. Among those not enrolled, some of those who had not heard of the program thought they were likely eligible and should already have been alerted about the program.

Most enrolled participants expressed satisfaction and were positive about the services provided by the Health Home. They found the services “great” and “helpful.” One participant stated: “This is what needs to be done to make your life easier, it’s the best thing in the world” (male focus group participant). One participant expressed dissatisfaction with the program, explaining that he found phone calls not useful and did not feel the team addressed his concerns.

Theme 2: Access to Care

Study participants cited problems with health insurance and with affording copays as challenges to overall health and diabetes management. Difficulty navigating the health care system also led to difficulty obtaining prescribed medications and scheduling appointments. For example, 1 participant described how difficult it was to make an appointment with a specialist due to the doctor’s limited availability.

Most Health Home participants described receiving help in addressing access challenges and coordinating their medical care. In fact, the services most consistently described as helpful were assistance in making medical appointments and appointment reminders. Care managers provided lists of appointments, calendars, and/or reminder phone calls, and also helped to reschedule missed appointments. One participant said, “so the challenge was to me was my appointments ... I have so much appointments that I forget and then in that morning I’m like, did I go? ... The social worker is helping me with that now ... she will give me a calendar of all my appointments ... I go here every day and look at the refrigerator.”

Another participant explained that she asked her care manager, “do I have any appointments, can you please list them down and send me that information? And she’ll do that.” Several participants explained that workers accompanied them to medical and other appointments and helped them to obtain prescriptions and refills.

Enrollees also discussed how care managers assisted them in addressing health insurance problems. One participant described how her social worker intervened when her health insurance was going to expire: “... I didn’t even know ... She realized it and we immediately mobilized. She called me, and I was on top of it and everything was done in time.” (Female focus group participant)

Theme 3: Nonmedical Challenges: “Not Just Medically”

Participants described numerous nonmedical factors that impact their health and diabetes management. For many participants, financial constraints were a barrier to eating healthy foods and therefore to managing diabetes and being healthy. Other barriers included competing financial demands such as rent, electricity, and healthy food for the rest of one’s family and limited choices available in food pantries. Social and community context of participants’ lives played a role: food customs, family traditions and neighborhood food availability were barriers to healthy eating and inspired unhealthy eating.

Health Home enrollees described multiple situations in which a care manager helped them to address nonmedical factors affecting their health. Care managers advocated for them by facilitating communication, liaising with doctors, attending nonmedical appointments, and court proceedings. One participant’s social worker assisted with translation: “When I had an appointment or something and they called me on the phone speaking only English and I couldn’t speak or understand anything, she was the one that would make the appointment.” Another participant shared that “If I have to go to an appointment for housing or social security, they’ve gone with me.” Care managers secured transportation, home health aides, housing, and assisted with entitlement applications. Help with setting up Access-a-ride or a car service allowed participants to attend medical visits. One participant shared that her care manager “... did it to where she’s trying to benefit me, so that I can be stable, not just medically, but financially, home wise, family.” (Female focus group participant) Support for nonmedical needs was particularly important for 1 participant, in that it allowed him to focus back on medical issues:

“... with this homelessness and everything that I forget about my appointments, my medical issues, everything, and all of that because my mind is set on getting the housing. ... I skip doctor’s appointments. Sometimes I don’t go get prescriptions to be taking my insulin and stuff like that But with this [Health] Home thing, they help me out a lot. She reminds me about my doctor’s appointments and you’ve got to help yourself with your medical issues ... and learn how to put some other problems on the side sometimes and take care of my health.” (Male focus group participant)

Theme 4: Support: “I’m Not Alone Anymore”

Certain demands on participants, including stress, mental health issues, and a feeling of frustration with illness interfered with their efforts to be healthy and manage diabetes.

Health Home care managers provided personal and mental health support. Several participants mentioned how the personal investment and caring provided by the care manager was important to the relationship and its success. One participant said, “I feel more comfortable because I’m not alone anymore She’s very concerned about my life And that makes me happy because it helps me.” (Female focus group participant) Another mentioned that although the service the care manager was advocating for was not ultimately agreed to by the participant’s doctor, she was still satisfied: “I felt good because I saw the effort she was putting forth to help me.” (Female focus group participant) Another described how interactions with a social worker led to feeling “very comforted.” Others described how workers went beyond providing mental health referrals, to provide mental health support.

“I agree because my social worker, she’s also like a therapist. I’ll break down in front of her because I feel so comfortable because she knows a lot of what I’m going through and she helps me with every single aspect, housing, financial, everything. And she gives me advice. She listens to me, and she even stays in and gives me a tissue when I cry.” (Female focus group participant)

The attention of care managers and social workers was strongly appreciated by program participants. In addition, several participants viewed their Health Home care managers as sources of education and encouragement regarding diabetes self-management.

DISCUSSION

This study investigated the perspectives of Medicaid-insured patients who have diabetes and comorbidities about challenges to good health and how the Health Home program helped them to address these challenges. Our findings provide insight into the different challenges encountered by complex Medicaid-insured patients with diabetes and the different ways the Health Home program assists. Although they may not have recognized the term Health Home, most enrollees did confirm receiving services consistent with Health Home enrollment and were satisfied with them. Participants described challenges with access to and relationships with the health care system. Health Home care managers helped them to improve access to care and to navigate the system. Participants discussed nonmedical challenges and how these affect their health, including lack of financial resources and their social and community context. Enrollees believed that care managers were helping them to address some of these challenges. Finally, participants struggled with stress and mental illness, and enrollees reported that care managers provided social and mental health support and referrals. The personal level of care provided by the care manager was recognized as particularly important.

Our findings are consistent with a large body of literature showing that multiple factors contribute to health outcomes and health behavior in diabetes, including access to care, nonmedical factors, stress, and social support.⁴⁰⁻⁴² Our study adds to the limited literature evaluating care management programs from the perspective of patients. While several

studies have addressed this topic in the United Kingdom and Canada (which may limit comparability),^{43–46} there are few studies in the United States.^{27–29} Our findings that enrollees may not be aware of enrollment or the details of programs in which they are apparently enrolled are consistent with several of these studies.^{27,43,44} In addition, our findings echo this previous work in that participants generally found services helpful. The importance of personal connection with and commitment of care managers/coordinators was also found by both Sheff and colleagues and Sefcik and colleagues.^{28,29} While previous research also found that similar US programs facilitate access to care and provide psychosocial support, our participants' experience of assistance in nonmedical domains, particularly housing and entitlement needs, appears to be a special aspect of the Health Home program.

These findings provide useful information for the Health Home and similar care management programs in that they highlight some of the more successful services in the eyes of patients, some of the gaps in understanding the program, and potential areas of unmet need. Participants may be better able to advocate for themselves within the program if they are more familiar with the program's title, intent, and components. While participants noted that food costs were a major barrier to good health and diabetes management, few participants mentioned services that addressed food insecurity.

These qualitative findings also have implications for natural experiment studies and other research on Health Homes. First, our study indicates potential mechanisms through which Health Homes could impact care and outcomes for people with diabetes. According to the program's recipients, this intervention acts on both distal (eg, social support, housing) and proximal (eg, access to care, medication adherence) determinants of diabetes-related health.² To the extent that measures of these determinants are available in the principle administrative data sources, they can be tested as mediators and moderators of the relationship between Health Home enrollment and diabetes-related outcomes in the natural experiment analysis. Second, the facilitation of medical visits, transportation, and prescription fills is an important function of the Health Home in the eyes of participants. Therefore, certain utilization measures may be expected to increase for enrollees. In addition, data collection/evaluation efforts should keep in mind that patients may not be aware of what services are delivered from which program or individual. Finally, this study indicates that in addition to the traditional services provided through care management and care coordination programs, Health Homes also address nonmedical needs including social and economic issues. To date, there is little evidence on the longitudinal effects of interventions that address these risks.⁴⁷ Examining the Health Home as a natural experiment can provide more evidence to this area of inquiry.

The study results should be considered in light of some limitations. We collected limited demographic or clinical data on participants so we were not able to analyze participants' responses in relation to these characteristics (eg, age, presence of a disability). These characteristics could be associated with certain biases in our data, which we are not able to examine. Overall, responses regarding the experience of the Health Home were limited by participants' lack of familiarity with the program name. We did not know the specific Health Home enrollees were a part of so were not able to further probe or remind participants using

information about their Health Home, such as the name or affiliation. Some participants might have been better able to discuss the Health Home program with this information which may have resulted in richer or different themes. It is possible that individuals who were willing to participate in the study also had more positive experiences with the Health Home than those who choose not to participate. Therefore, our data may be biased away from themes of negative or ambivalent experiences with the Health Home program.

In conclusion, Medicaid-insured individuals with diabetes face many challenges to good health, and a sample of enrollees in a Health Home believe this program helps them to address some of these challenges. This knowledge of patients' experiences can inform both program administrators and researchers who are interested in the ultimate health impacts of New York State's Health Home and similar programs that seek to improve care and outcomes for vulnerable populations.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

ACKNOWLEDGMENTS

The authors thank the members of the Patient/Stakeholder Advisory Board for their essential collaboration on this work: Laurie Edelman Jamillah Hoy-Rosas, Guedy Arniella Henry Cruz, Antonette Mentor, and Anitta Ruiz. Information reported in the publication was supported in part by the INSIGHT Clinical Research Network from the People Centered Research Foundation. The content is solely the responsibility of the authors and does not necessarily represent the official views of the INSIGHT Clinical Research Network, Patient Centered Outcomes Research Network (PCORnet), or Patient Centered Outcomes Research Institute (PCORI). The authors thank Christian Ugaz for his work on recruitment and data collection. We thank Andrea Cassells, Jonathan Tobin and the Clinical Directors Network, as well as the Family Health Centers of NYU—Sunset Park Family Health Center for their collaboration on this project.

Supported through the Patient-Centered Outcomes Research Institute Award, NEN-1508-32252. The NEXT-D2 Network is supported through Cooperative Agreements jointly funded by the US Centers for Disease Control and Prevention (CDC), the National Institute of Diabetes and Digestive and Kidney Disease (NIDDK), and the Patient-Centered Outcomes Research Institute (PCORI). In addition, this work was supported by the NYC-CDRN (INSIGHT), funded by the Patient-Centered Outcomes Research Institute Award, CDRN-1306-03961 (PI: Rainu Kaushal, MD, MPH).

REFERENCES

1. Beckles GL, Chou CF. Disparities in the prevalence of diagnosed diabetes—United States, 1999–2002 and 2011–2014. *MMWR Morb Mortal Wkly Rep*. 2016;65:1265–1269. [PubMed: 27855140]
2. Brown AF, Ettner SL, Piette J, et al. Socioeconomic position and health among persons with diabetes mellitus: a conceptual framework and review of the literature. *Epidemiol Rev*. 2004;26:63–77. [PubMed: 15234948]
3. Harris MI, Eastman RC, Cowie CC, et al. Racial and ethnic differences in glycemic control of adults with type 2 diabetes. *Diabetes Care*. 1999;22:403–408. [PubMed: 10097918]
4. Lanting LC, Joung IM, Mackenbach JP, et al. Ethnic differences in mortality, end-stage complications, and quality of care among diabetic patients: a review. *Diabetes Care*. 2005;28:2280–2288. [PubMed: 16123507]
5. McBean AM, Li S, Gilbertson DT, et al. Differences in diabetes prevalence, incidence, and mortality among the elderly of four racial/ethnic groups: whites, blacks, Hispanics, and Asians. *Diabetes Care*. 2004;27:2317–2324. [PubMed: 15451894]

6. Link CL, McKinlay JB. Disparities in the prevalence of diabetes: is it race/ethnicity or socioeconomic status? Results from the Boston Area Community Health (BACH) Survey. *Ethn Dis*. 2009;19:288–292. [PubMed: 19769011]
7. Robbins JM, Vaccarino V, Zhang H, et al. Socioeconomic status and diagnosed diabetes incidence. *Diabetes Res Clin Pract*. 2005;68: 230–236. [PubMed: 15936465]
8. Signorello LB, Schlundt DG, Cohen SS, et al. Comparing diabetes prevalence between African Americans and whites of similar socioeconomic status. *Am J Public Health*. 2007;97:2260–2267. [PubMed: 17971557]
9. Centers for Disease Control and Prevention. National Diabetes Statistics Report; 2017 Available at: www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf. Accessed January 18, 2018.
10. Duru OK, Mangione CM, Rodriguez HP, et al. Introductory Overview of the Natural Experiments for Translation in Diabetes 2.0 (NEXT-D2) network: examining the impact of US health policies and practices to prevent diabetes and its complications. *Curr Diab Rep*. 2018;18:8. [PubMed: 29399715]
11. Wolff JL, Starfield B, Anderson G. Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. *Arch Intern Med*. 2002;162:2269–2276. [PubMed: 12418941]
12. Druss BG, Marcus SC, Olfson M, et al. Comparing the national economic burden of five chronic conditions. *Health Aff*. 2001;20: 233–241.
13. Goldberg RW, Kreyenbuhl JA, Medoff DR, et al. Quality of diabetes care among adults with serious mental illness. *Psychiat Serv*. 2007;58:536–543.
14. De Hert M, Correll CU, Bobes J, et al. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*. 2011;10:52–77. [PubMed: 21379357]
15. Druss BG, Zhao L, Cummings JR, et al. Mental comorbidity and quality of diabetes care under medicaid: a 50-state analysis. *Med Care*. 2012;50:428–433. [PubMed: 22228248]
16. Patchias EM, Detty A, Birnbaum M. Implementing Medicaid Health Homes in New York: Early Experience. New York: Medicaid Institute at United Hospital Fund; 2013.
17. www.Medicaid.Gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.Html. Accessed June 20, 2019.
18. www.Medicaid.Gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.Html. Accessed March 12, 2015.
19. Basu S, Meghani A, Siddiqi A. Evaluating the health impact of large-scale public policy changes: classical and novel approaches. *Annu Rev Public Health*. 2017;38:351–370. [PubMed: 28384086]
20. Craig P, Katikireddi SV, Leyland A, et al. Natural experiments: an overview of methods, approaches, and contributions to public health intervention research. *Annu Rev Public Health*. 2017;38:39–56. [PubMed: 28125392]
21. Leatherdale S Natural experiment methodology for research: a review of how different methods can support real-world research. *Int J Soc Res Methodol*. 2019;22:19–35.
22. Ali MK, Wharam F, Kenrik Duru O, et al. Advancing health policy and program research in diabetes: findings from the Natural Experiments for Translation in Diabetes (NEXT-D) Network. *Curr Diab Rep*. 2018; 18:146. [PubMed: 30456479]
23. Centers for Disease Control and Prevention (CDC). Framework for program evaluation in public health. *MMWR Recommendations and Reports* 1999;48(Rr-11):1–40.
24. Selby JV, Beal AC, Frank L. The Patient-Centered Outcomes Research Institute (PCORI) National Priorities for Research and Initial Research Agenda. *JAMA*. 2012;307:1583–1584. [PubMed: 22511682]
25. Domecq JP, Prutsky G, Elraiyah T, et al. Patient engagement in research: a systematic review. *BMC Health Serv Res*. 2014:14–89. [PubMed: 24410755]
26. Poger JM, Yeh HC, Bryce CL, et al. PaTH to partnership in stakeholder-engaged research: a framework for stakeholder engagement in the path to Health Diabetes Study. *Healthcare (Amst)*. 2019;pii: S2213-0764(18)30151-9.

27. Ganguli I, Orav EJ, Weil E, et al. What do high-risk patients value? Perspectives on a care management program. *J Gen Intern Med.* 2018; 33:26–33. [PubMed: 28983741]
28. Sheff A, Park ER, Neagle M, et al. The patient perspective: utilizing focus groups to inform care coordination for high-risk medicaid populations. *BMC Res Notes.* 2017;10:315. [PubMed: 28743288]
29. Sefcik JS, Petrovsky D, Streur M, et al. “In Our Corner”: a qualitative descriptive study of patient engagement in a community-based care coordination program. *Clinical Nursing Research.* 2018;27:258–277. [PubMed: 28038504]
30. McDonald KM, Sundaram V, Bravata DM, et al. *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol 7: Care Coordination).* Rockville, MD: Agency for Healthcare Research and Quality (US); 2007.
31. Kaushal R, Hripcsak G, Ascheim DD, et al. Changing the research landscape: the New York City Clinical Data Research Network. *J Am Med Inform Assoc.* 2014;21:587–590. [PubMed: 24821739]
32. Horowitz CR, Shameer K, Gabrilove J, et al. Accelerators: sparking innovation and transdisciplinary team science in disparities research. *Int J Environ Res Public Health.* 2017;14:E225. [PubMed: 28241508]
33. Lambert SD, Loiselle CG. Combining individual interviews and focus groups to enhance data richness. *J Advanc Nursing.* 2008;62: 228–237.
34. Chapman AL, Hadfield M, Chapman CJ. Qualitative research in healthcare: an introduction to grounded theory using thematic analysis. *J R Coll Physicians Edinb.* 2015;45:201–205. [PubMed: 26517098]
35. New York State Department of Health. Medicaid Health Homes—Comprehensive Care Management. 2019 Available at: www.Health.Ny.Gov/Health_Care/Medicaid/Program/Medicaid_Health_Homes/. Accessed June 20, 2019.
36. Pope C, Ziebland S, Mays N. Qualitative research in health care. analysing qualitative data. *BMJ.* 2000;320:114–116. [PubMed: 10625273]
37. Giacomini MK, Cook DJ. Users’ guides to the medical literature: Xxiii. Qualitative Research in Health Care B. what are the results and how do they help me care for my patients? Evidence-Based Medicine Working Group. *JAMA.* 2000;284:478–482. [PubMed: 10904512]
38. Pope C, Mays N, eds. *Qualitative Research in Health Care.* London, United Kingdom: BMJ Books; 2000.
39. Dedoose. Dedoose Version 8035, Web Application for Managing, Analyzing, and Presenting Qualitative and Mixed Method Research Data. Los Angeles, CA: Sociocultural Research Consultants LLC; 2018.
40. Walker RJ, Smalls BL, Campbell JA, et al. Impact of social determinants of health on outcomes for type 2 diabetes: a systematic review. *Endocrine.* 2014;47:29–48. [PubMed: 24532079]
41. Hill J, Nielsen M, Fox MH. Understanding the social factors that contribute to diabetes: a means to informing health care and social policies for the chronically ill. *Perm J.* 2013;17:67–72. [PubMed: 23704847]
42. Clark ML, Utz SW. Social determinants of type 2 diabetes and health in the United States. *World J Diabetes.* 2014;5:296–304. [PubMed: 24936251]
43. Hudon C, Chouinard MC, Diadiou F, et al. Case management in primary care for frequent users of health care services with chronic diseases: a qualitative study of patient and family experience. *Ann Fam Med.* 2015;13:523–528. [PubMed: 26553891]
44. Gowing A, Dickinson C, Gorman T, et al. Patients’ experiences of a multidisciplinary team-led community case management programme: a qualitative study. *BMJ Open.* 2016;6:e012019.
45. Williams V, Smith A, Chapman L, et al. Community matrons—an exploratory study of patients’ views and experiences. *J Adv Nurs.* 2011;67:86–93. [PubMed: 21158904]
46. Sargent P, Pickard S, Sheaff R, et al. Patient and carer perceptions of case management for long-term conditions. *Health Soc Care Community.* 2007;15:511–519. [PubMed: 17956403]
47. Hessler D, Bowyer V, Gold R, et al. Bringing social context into diabetes care: intervening on social risks versus providing contextualized care. *Curr Diab Rep.* 2019;19:30. [PubMed: 31037356]

TABLE 1.

Participant Characteristics

Characteristics	Focus Groups (N = 10)	n (%)	
		Focus Group Individuals (N = 40)	Individual Interviews (N = 23)
Female		22 (55)	17 (74)
Male		18 (45)	6 (26)
Spanish speaking	4	15 (38)	7 (30)
Health home enrollee Health care institution	4	21 (53)	10 (43)
1	3	14 (35)	6 (26)
2	3	10 (25)	9 (39)
3	2	8 (20)	0
4	2	8 (20)	8 (35)

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

TABLE 2.

Cross-Cutting Themes

Theme	Illustrative Quotations
Theme 1: Lack of familiarity with the Health Home program, but overall satisfaction	“This is what needs to be done to make your life easier, it’s the best thing in the world.”
Theme 2: Access to care	“So the challenge was to me was my appointments ... I have so much appointments that I forget and then in that morning I’m like, did I go? ... The social worker is helping me with that now... she will give me a calendar of all my appointments ... I go here every day and look at the refrigerator.”
Theme 3: Nonmedical challenges	“[My care manager] did it to where she’s trying to benefit me, so that I can be stable, not just medically, but financially, home wise, family.”
Theme 4: Support	“I feel more comfortable because I’m not alone anymore [my care manager’s] very concerned about my life And that makes me happy because it helps me.”