WAIANAE COAST COMPREHENSIVE HEALTH CENTER
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INNOVATION IN PARADISE

RISK ADJUSTING FOR SOCIAL DETERMINANTS OF HEALTH

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"Poorer people live shorter lives and are more often ill than the rich. This disparity has drawn attention to the remarkable sensitivity of health to the social environment."

Wilkinson & Marmot, 2003. WHO

How do we prove our patients are sicker than “the average bear”?

Complex Patient Model

- Provider retention issues
- Adult medicine providers were burning out due to overwork and frustration
- Providers concerned they did not have the time or resources to effectively address their patients' myriad concerns – many of which were exacerbated by SDoH.


WE'RE NEVER GOING TO REACH OUR RECRUITMENT TARGETS IF WE LET A LITTLE THING LIKE DEATH GET IN THE WAY... ARE YOU SURE WE'RE NOT ALLOWED TO DIG HIM UP?
DR WN JONES
" DIED OF OVERWORK"
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WCCHC's Most Complex Patients

- Two or more chronic disease diagnosis with depression or another behavioral health diagnosis and socioeconomic based health disparities.
- Greater than 50% of the patients seen in our Adult Medicine Clinic last year fit this diagnosis.

The Waianae Coast Primary Service Area

- Highest number of households in the state receiving financial aid and food stamps
- Highest number of obese adults, adults with diabetes, and adult smokers
- Highest cancer and heart disease mortality

2009 State of Hawaii Primary Care Needs Assessment Data Book (Hawaii State Department of Health, January 2010)

Highly Complex Patients

- Consume more resources
- Take more time to manage effectively
- Require support
- Contribute to physician frustration

Need to focus on preventable costs.

NOT ALL BEACH FRONT HOMES ARE THE SAME

1991 - Perinatal Support Services Program Established

- Continuously state grant funded for 24 years
- Despite pregnant women having access to good prenatal care, their birth outcomes were not ideal:
  - Low birth weight infants, prematurity, infant mortality
  - High teen pregnancy rates
- Identified social determinants of health issues:
  - Homelessness, poor education, domestic violence

Addressing Perinatal Social Determinants of Health

- Hired staff to address these issues and attempt to reverse some of the social determinants.
- Collaboration between Women's Health, Pediatrics, and Supportive Services was instrumental to success of program.
- Today, birth outcomes have substantially improved despite persistence of many risk factors.

Our Journey So far

- Objectively defined our patients as complex and adversely affected by SDoH
- Proven with our Perinatal Program model that resources dedicated to addressing SDoH can improve pregnancy outcomes
- Seen models from other countries that directly address SDoH
- Next step – funding care coordination

Our Value is in Providing Comprehensive, Integrated Medical Care to our Patients

- Highly complex patients receive fragmented medical care at best and over-utilize emergency rooms and hospitals.
- They consume more resources, take more time to manage effectively and contribute to physician frustration.
- CHCs are the ideal patient-centered healthcare home because of the integrated services they provide.

Payer Contract Negotiations

- Savings are in coordinating care for our most complex patients.
- Payer system needs to recognize the value of the services CHCs provide.
- Opportunity to decrease costs and improve care for our patients.

Shared Risks – Shared Savings

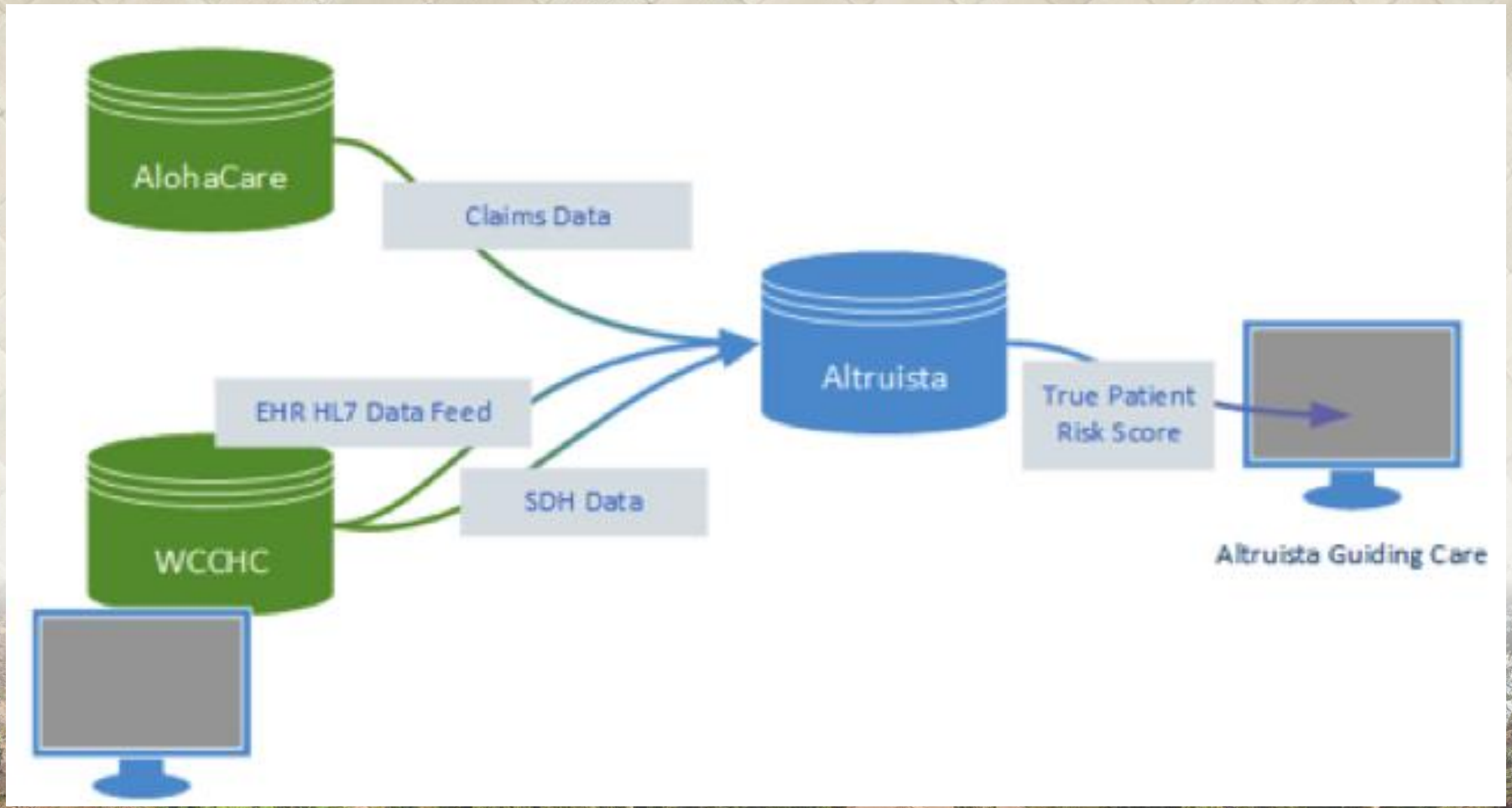
New Medicaid Contracts

- Patient Centered Healthcare Home pilot project with Medicaid payer, AlohaCare.
- Purpose was to identify complex patients and develop cost-saving methods while maintaining or improving quality of care.
- Recognized that SDoH played a significant role in defining the complexity of these patients.

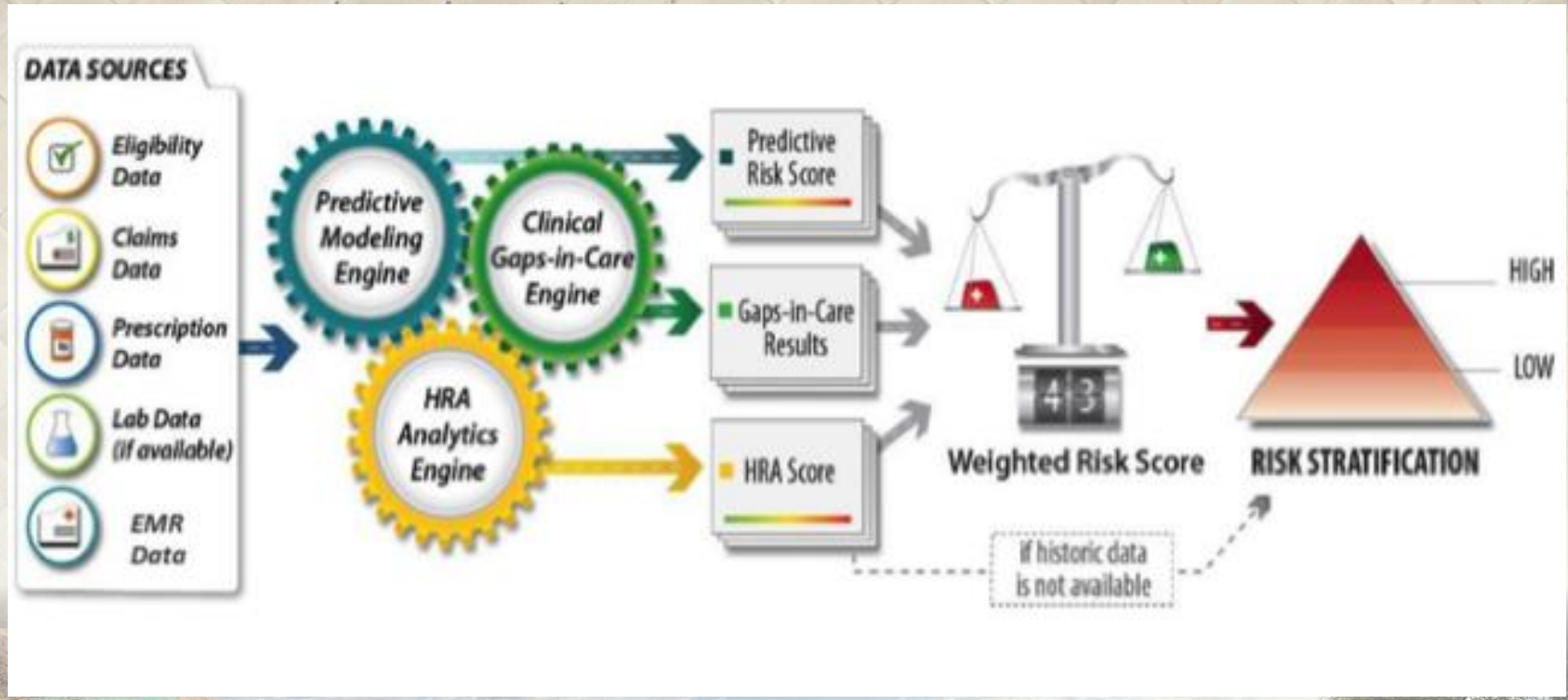
Partnership with Altruista Health

- A population management, predictive modeling and care management program.
- Stratifies patients into various risk levels based on:
  - Probability of complications
  - Cost
- Uses a combination of:
  - Payer claims data
  - EHR data
  - Pharmacy claims

Dataflow from WCCHC to AlohaCare to Altruista



Summary of Weighted Risk Calculation Methodology



Altruista Health Guiding Care

- Has the capacity to incorporate SDoH and psychosocial factors to produce a holistic risk score.
- These more holistic risk scores would then dictate the level of intervention needed.
- Intention was for those with moderate to high risk scores to be referred to a care coordinator for more thorough assessment and care plan development.

Workflow Process to Capture SDoH Data

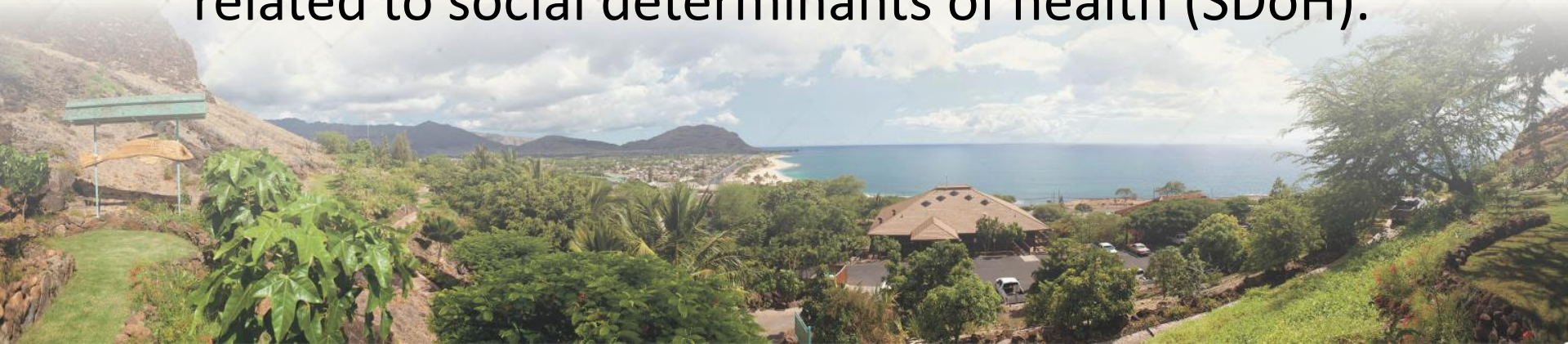
- Capture data without having to develop another tool
- EHR – Social and family history templates and ICD9 codes
- Use enabling codes – fine tuned over 10 years
- EPM – General demographics and UDS tabs
- “No wrong door” – everyone is an agent of change
- Create redundancy
- Pull SDoH information from existing EHR data

NOTHING IS SIMPLE


Then the stars aligned!

PRAPARE

- **P**rotocol for **R**esponding to and **A**ssessing **P**atient **A**ssets, **R**isks, and **E**xperiences
- September 2013, NACHC, AAPCHO, OPCA, and IAF launched a project funded by the Kresge Foundation, Kaiser Community Benefit, and Blue Shield of CA Foundation to create, implement and promote a national standardized **patient risk assessment protocol** going beyond medical acuity to identify risk related to social determinants of health (SDoH).



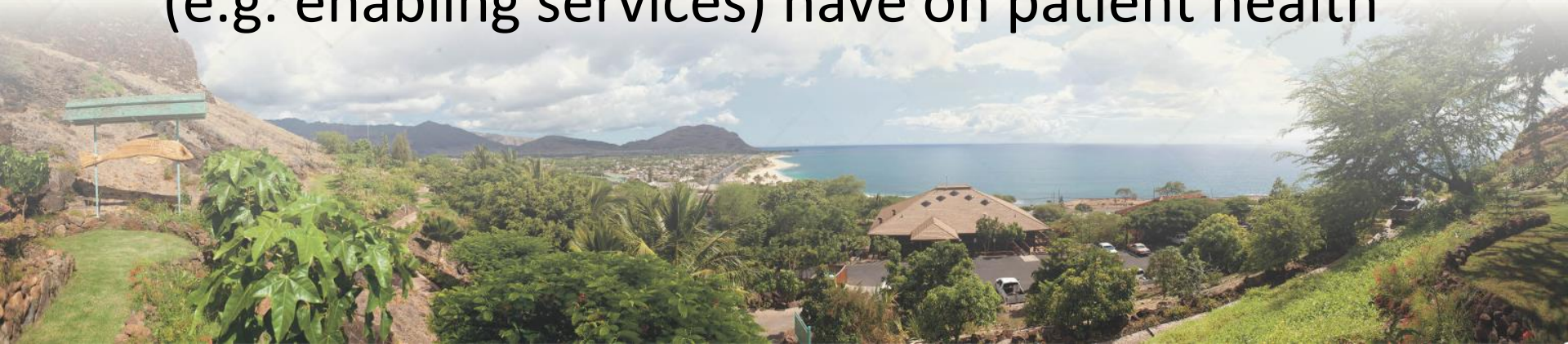
PRAPARE Project Goal

- Develop and pilot a consensus-driven national standardized patient risk assessment protocol in partnership with CHCs and their networks.
- Help CHCs better understand and manage their patient population.
- Support development of a more appropriate payment methodology that sustains SDoH-related interventions.

Community Health Centers can identify patients with poor outcomes; however they cannot always identify the root causes of these outcomes.

Assessing SDoH will allow CHCs to:

- Comprehensively address patient health needs
- Predict which patients are at risk for chronic disease, poor outcomes and preventable utilization of costly health care services
- Work with payers to ensure that CHCs model of care is adequately reimbursed
- Evaluate the impact specific interventions (e.g. enabling services) have on patient health



Implementation Teams

- Alliance/Iowa Team
  - EHR System: GE Centricity
  - Health Centers Involved:
    - Peoples CHC – Iowa
    - Siouxland CHC – Iowa
    - Waikiki Health - Hawaii
  - Networks involved:
    - Alliance of Chicago Community Health Services
    - INConcertCare
    - Iowa Primary Care Association

Implementation Teams *(cont.)*

- New York Team
  - EHR system: eClinicalworks
  - Health Centers Involved:
    - Open Door Family Medical Centers
    - Hudson River HealthCare
  - Network Involved:
    - Health Center Network of New York

Implementation Teams *(cont.)*

- Oregon Team
  - EHR System: EPIC
  - Health Center Involved:
    - La Clinica del Valle
  - Network Involved:
    - OCHIN

Implementation Teams *(cont.)*

- Hawaii Team
  - EHR System: NextGen
  - Health Center Involved:
    - Waianae Coast Comprehensive Health Center
  - Networks involved:
    - AlohaCare
    - Altruista Health

PRAPARE Primary Aims

- Develop a free, open-source EHR vendor-specific data collection protocol based on a national standard tool developed and designed in partnership with the four implementation teams.
- Implement and test the patient risk protocol.
- Leverage existing efforts and collect new data on non-clinical patient risk.

PRAPARE Primary Aims *(cont.)*

- Document and evaluate the implementation process.
- Develop plans for dissemination of the vendor-specific protocol.
- Share best practices and resources to leverage strengths and resources with other implementation teams that will contribute to the refinement of the national protocol.

PRAPARE Long-term Goals

- Define and better understand patient complexity
- Improve patient care and drive health center practice transformation
- Enable CHCs to advocate for policy changes that positively shape SDoH and ensure that favorable interventions are sustainable

PRAPARE Long-term Goals*(cont.)*

- Lay foundation for development of appropriate risk adjustment methodologies and payment systems that fully support the integration of clinical and non-clinical care.
- Aggregate data and test the impact of population-based interventions on morbidity, health disparities and costs.
- Link patient complexity factors to effectiveness of CHC enabling services.

Contents of PRAPARE

Autopopulated Domains
Socioeconomic Domain
Psychosocial Domains

Currently Captured

- Income
- Insurance Coverage
- Transportation
- English Proficiency
- Neighborhood

Primary Data Collection

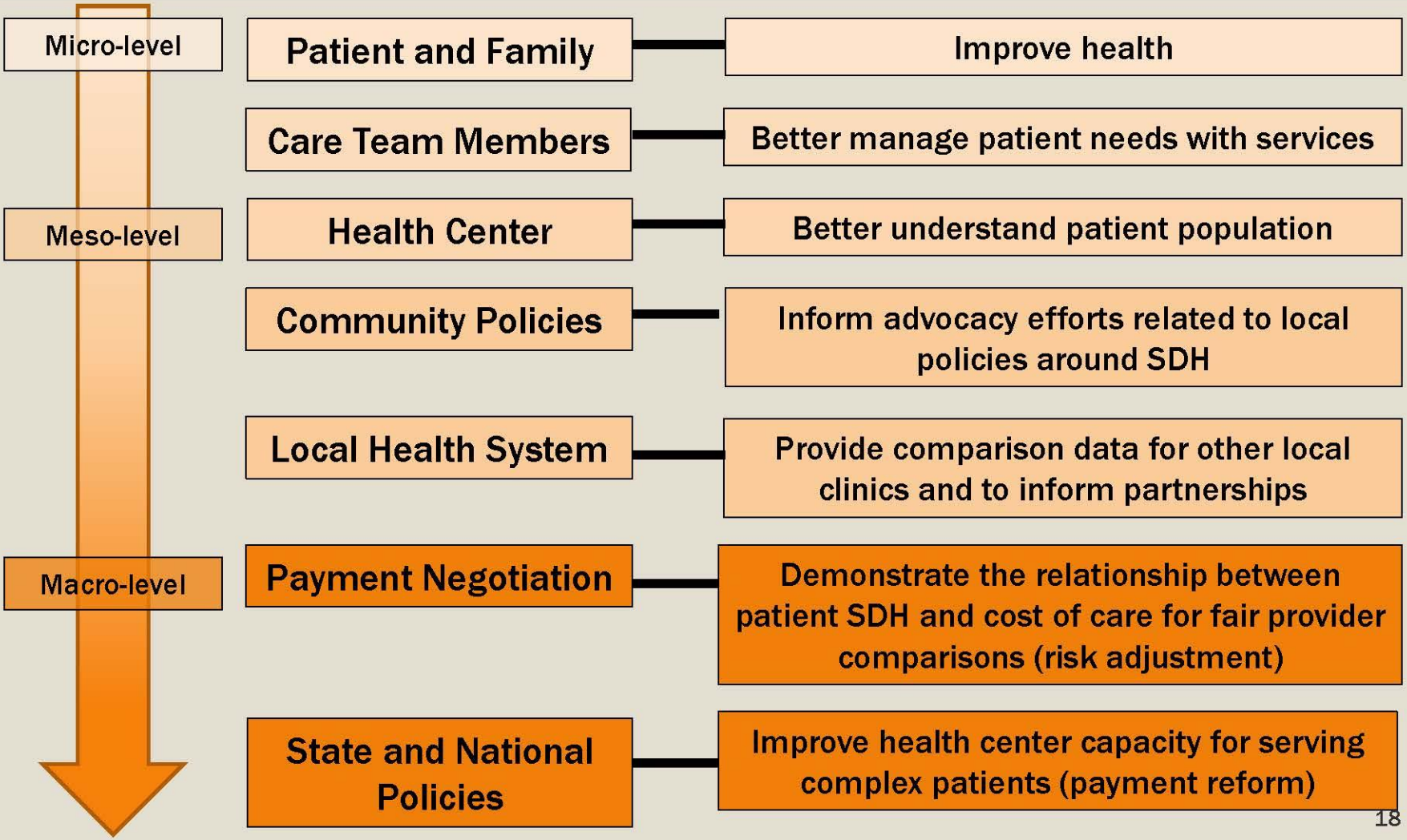
- Education
- Employment
- Material Security
- Housing Security

- Social Support and Connectedness

Secondary Domains

Psychosocial Domains	Self-Management and Resourcefulness
	Health Literacy
Behavioral Domains	Nutrition and Physical Activity
Socioeconomic Domain	Legal Risk

WHY IS IT IMPORTANT TO COLLECT DATA ON THE SOCIAL DETERMINANTS OF HEALTH?



Risk Scores

- The impact that social determinants may have on the health of an individual, panel, or patient population.
- Based on an algorithm that quantifies the relative impact each social determinant factor has on patients' risk for poor outcomes.

Risk Scores *(cont.)*

- At the patient level, risk scores should function as “risk profiles” such that the information is useful to patients.
- At the population level, the algorithm quantifies the relative impact that social barriers have on the population’s disparate health outcomes and its resultant predisposition to higher healthcare utilization and higher cost.

Risk Scores *(cont.)*

- The value of the risk score can be associated with the relative amount of additional resources required to support those patients compared to patients with a lower risk profile.

Risk Scores *(cont.)*

- Developing a risk score that predicts poor outcomes is outside the scope of the PRAPARE project but an important next step. It cannot be done until non-clinical patient risk data are collected in a standardized way.
- However…with Altruista's Predictive Modeling, we are already on our way in calculating a risk score which incorporates SDoH.

Risk Adjustment

- Statistical methods to control or account for patient or population-related factors when computing performance measure scores
- Health based risk adjustment – comparing populations, adjusting outcomes, or adjusting health plan payments using health status
- How would the performance of various units compare if hypothetically they had the same mix of patients?

Risk Adjustment *(cont.)*

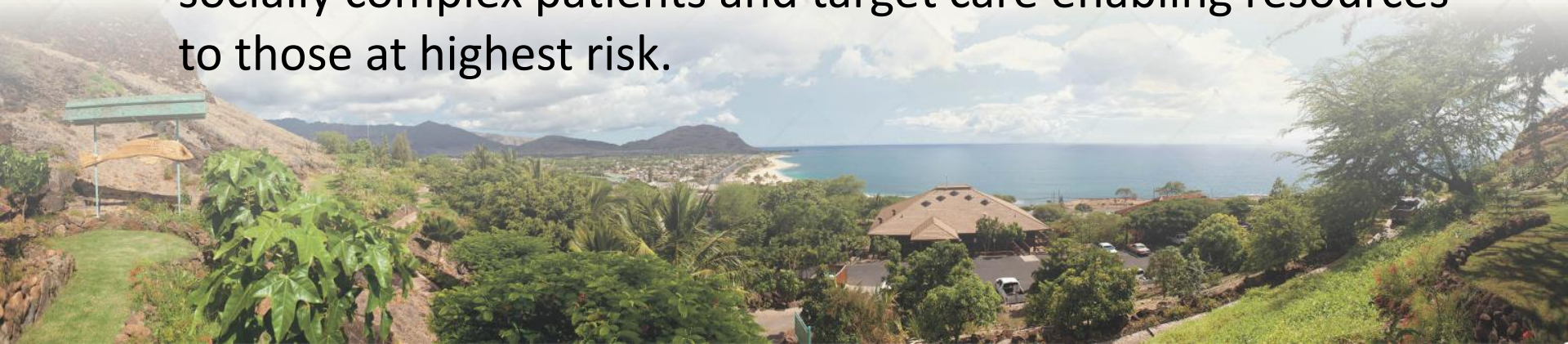
- SDoH contribute to the severity and complexity of the patient population served.
- Without risk adjustment, health care facilities with a disproportionate share of disadvantaged patients may appear to provide lower quality of care than they actually do.
- As performance driven payment becomes the norm, outcome measures must be adjusted for varying levels of risk in the patient population served.

Risk Adjustment *(cont.)*

- As Accountable Care/Shared Savings programs continue to proliferate, Risk Adjustment is paramount to being able to receive gain share.

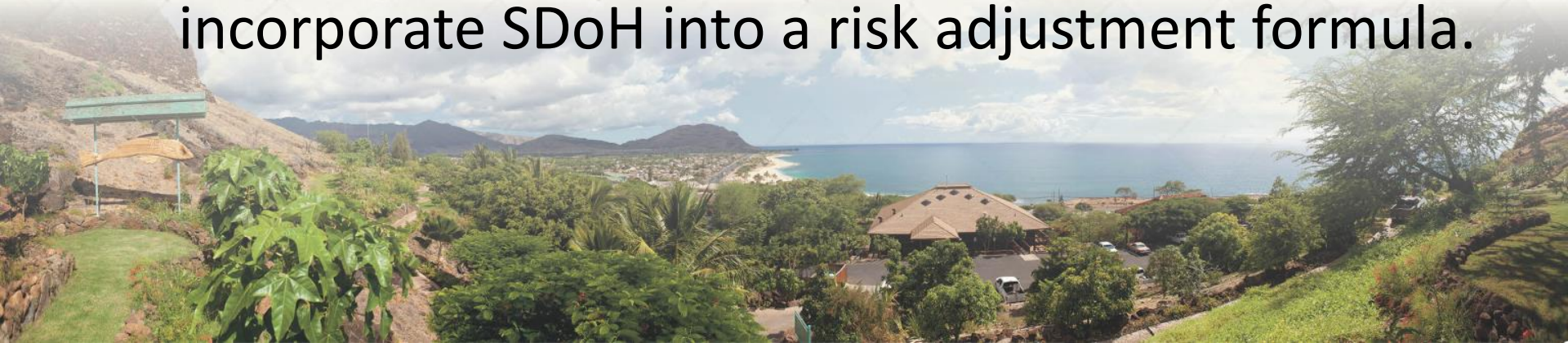
Community Health Centers are uniquely positioned to address the needs of the hardest to serve with our model of coordinated care.

- The system must fairly reimburse CHCs to raise the quality of health in vulnerable communities and ensure everyone is cared for in a culturally appropriate way.
- CHCs need sustainable resources to provide comprehensive care coordination and care enabling services.
- Need to develop a reliable method of objectively measuring the adverse impact of social determinants of health.
- Justify higher reimbursement rates for CHCs' most medically/ socially complex patients and target care enabling resources to those at highest risk.



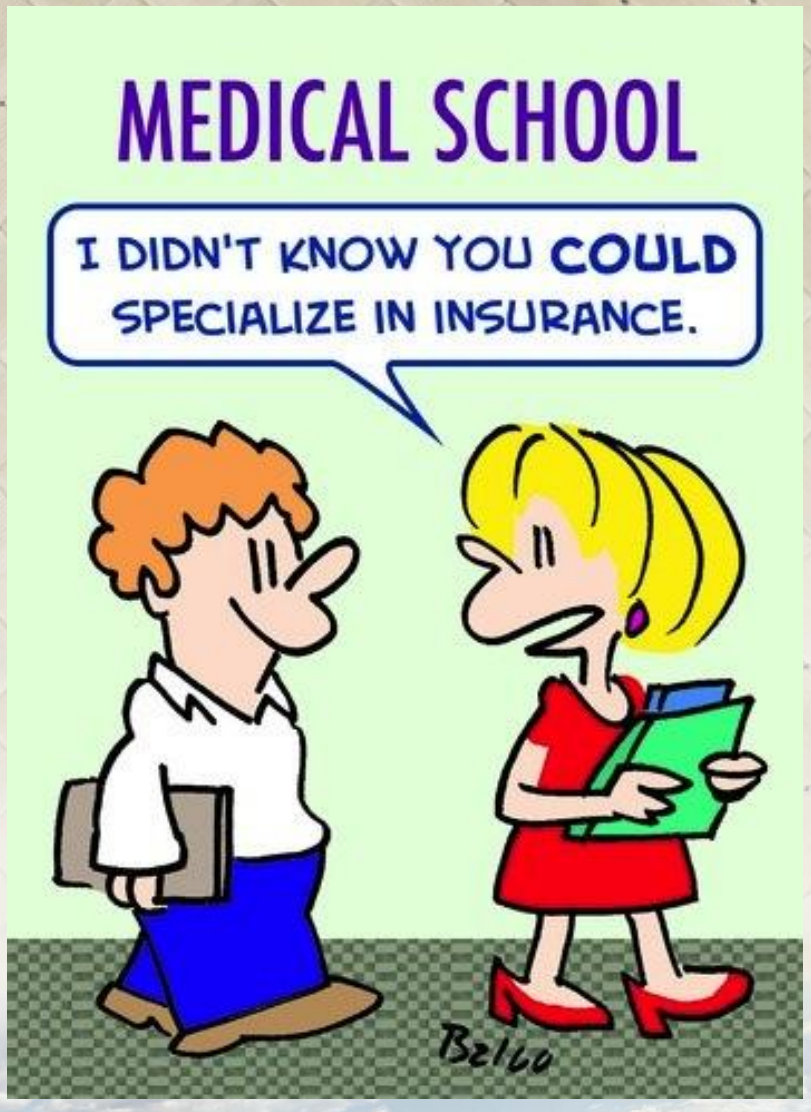
Summary

- CHCs well positioned to address SDoH
- CHCs have long sought solutions to providing care enabling services with limited resources – used to doing “more with less”.
- When budget is tight – care enabling services lose resources.
- Need to accurately define, measure and incorporate SDoH into a risk adjustment formula.



Summary *(cont.)*

- CHCs need to be appropriately compensated for the medically, psychologically and socially complex patients they serve.
- With appropriate compensation, targeted intensive care enabling services can be provided.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MAHALO

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