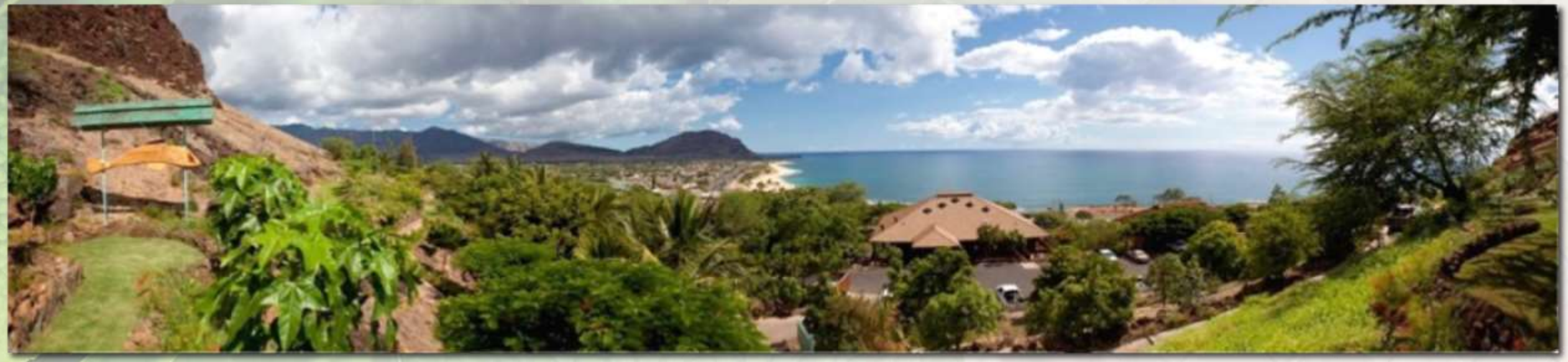
Report on Recent Initiatives and Opportunities – Waianae Perspective



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WAIANAE COAST COMPREHENSIVE HEALTH CENTER
Healing • Learning • Innovation

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Chief Quality Officer

AHARO Hawaii Workshop
September 9, 2019 | Ko'olau Ballrooms | Hosted by Waimanalo Health Center

Hawaii's Medicaid Rebid

- Proposals due November for February contract
- Reduces Health Plans serving Statewide – How does that affect AHARO Hawaii?

CURRENTLY	**BID**
5 Health Plans	2 Health Plans Statewide
Kaiser AlohaCare HMSA Blue Cross WellCare UnitedHealthCare	2 Additional ONLY Oahu

- Opportunities/Challenges: Address Primary Care Medical Homes And Hope Initiatives – And more

Framework for Health Plan/Health Center Relationship – Addressing Social Determinants of Health

A. Share, discuss, utilize and integrate PRAPARE social assessment and accountable community assessment surveys and develop related for risk stratification tools.

B. Prepare, negotiate and finalize appropriate data sharing agreement(s). (see www.AHARO.net website)

Framework for Health Plan/Health Center Relationship – Addressing Social Determinants of Health

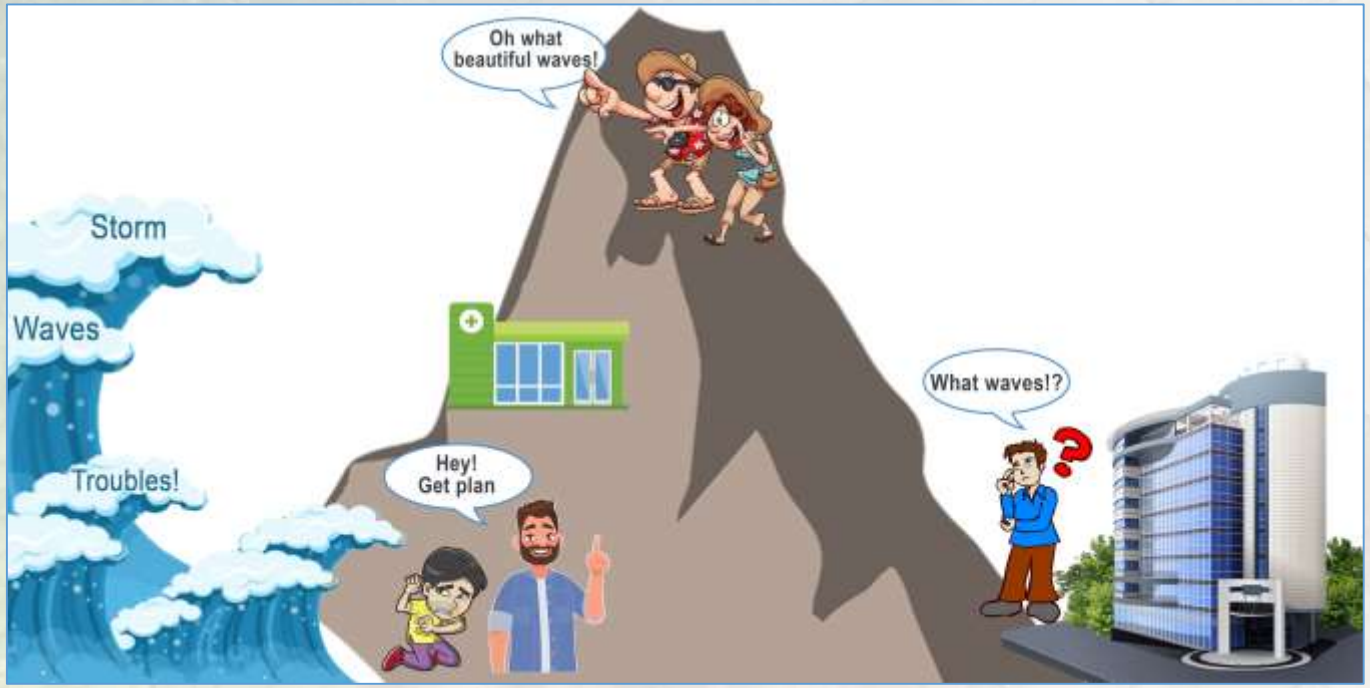
C. Explore, develop and sign interagency agreements with social service agents in the service area to measure and address socio-economic conditions.

D. Review and support appropriate cultural proficiency, job training/community economic development, community engagement, and care enabling programs through continuous quality improvement methodology. (see www.AHARO.net website)

E. Code and track care enabling and develop accountable care metrics to evaluate and measure risk factors and care enabling services.

Framework for Health Plan/Health Center Relationship – Addressing Social Determinants of Health

F. Learn with the community rather than teach the community – to address SDOH in a medically underserved community, the parties must genuinely dialogue and openly engage with those most affected by the socio-economic-environmental conditions they face, including as to base-line assessment, allocation of resources, and evaluation of the effectiveness of innovation.



Framework for Health Plan/Health Center Relationship – Addressing Social Determinants of Health

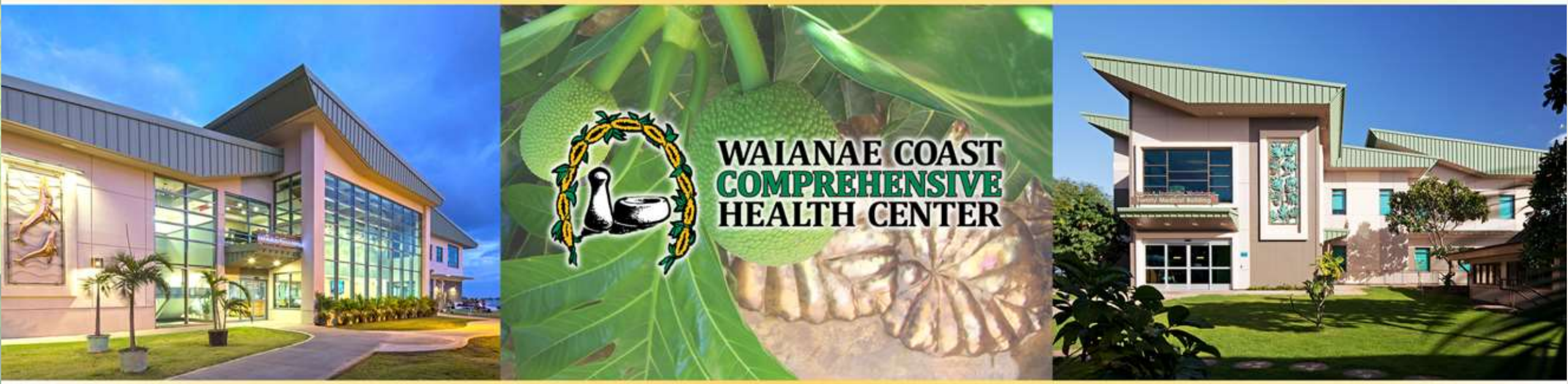
G. Pursue any funding for SDOH initiatives based on a prospective capitation model.

H. Aspire to extend or replicate this MOU to and with AHARO Hawaii and other Hawaii federally qualified health centers with similar community engagement standards and procedures.

I. Form steering committee with Plan partner that represents open forum between health plan and health center consumer board members and management.

PRAPARE

(Protocol for Responding to and Assessing Patient's Assets, Risks and Experiences)



RISK STRATIFICATION LEARNING COLLABORATIVE

LEARNING COLLABORATIVE PARTICIPANTS

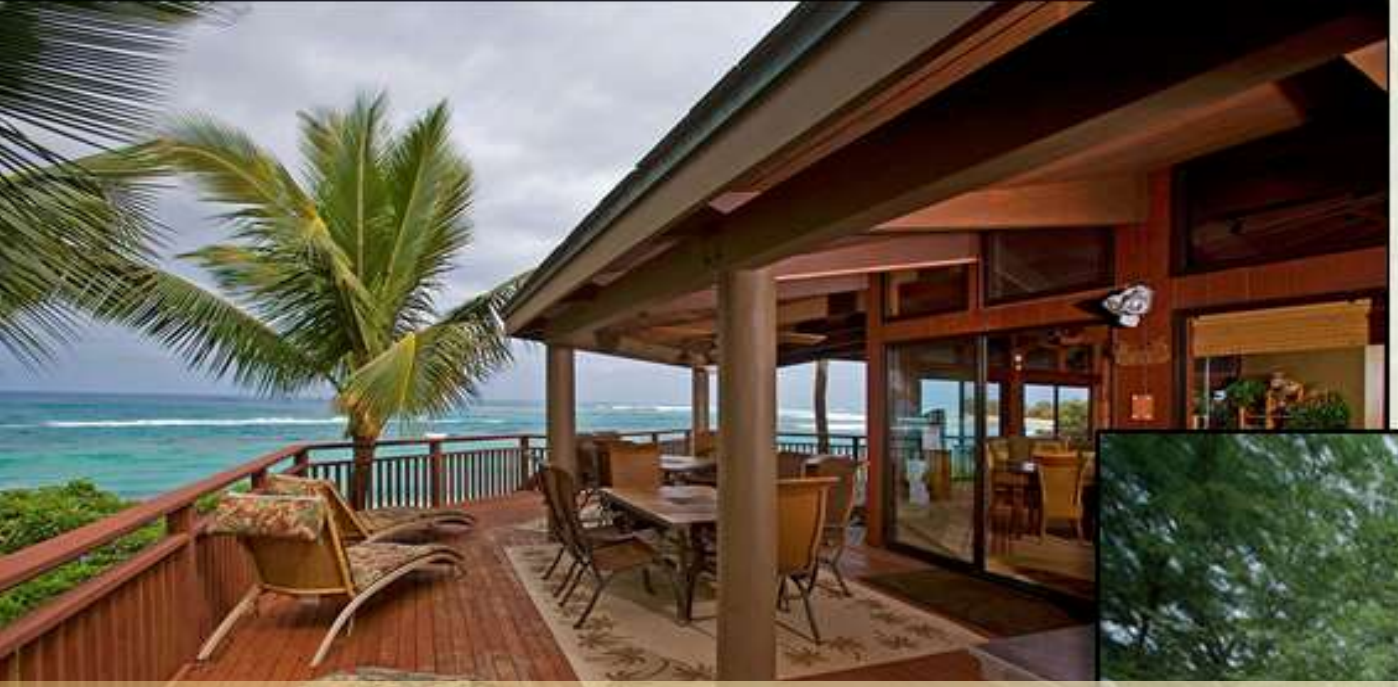
CPCA w/ CCALAC, CHP and NEVC (California)	Iowa PCA/Siouxland Community Health	Community HealthNet, Inc. (Indiana)
Charles B. Wang CHC (New York)	Missouri PCA	Waianae Coast Comp CHC (Hawaii)
Compass Community Health (Ohio)	Callen-Lorde CHC (New York)	STRIDE CHC (Colorado)

LEARNING COLLABORATIVE OBJECTIVES

1. Help participants and national PRAPARE team better understand and assess potential risk stratification strategies and possible pathways toward a common national standardized approach with options for localized methodologies

2. Help the national PRAPARE team understand how organizations apply and use risk stratification as a strategy for improving population health

3. Help participants identify best practices and lessons learned as well as resources to improve organizations' capacity to apply risk stratification methodologies.



Not All Beach Front Homes Are the Same

PRAPARE Survey: Demographics

- Ethnicity
- Race
- Farm Worker Status
- Veteran Status
- English Proficiency
- Income (% Federal Poverty Level)
- Health Insurance Status

PRAPARE Survey: Social Determinants of Health

- Housing Situation
- Housing Stability
- Education
- Employment
- Material Security – (food, clothing, utilities, childcare, phone, medicine)
- Transportation
- Social Integration
- Stress

PRAPARE Risk Stratification Learning Collaborative

- **Target Population:** Complex adult patients based on general population of adult patients.
- **Top Risk Stratification Goals:**
    - Identify complex patients to facilitate appropriate interventions (clinical/community)
    - Demonstrate complexity of patients (policy)

DATA RESOURCES

- **Predictor Variables:**
  - Clinical (cancer; heart disease; chronic lung disease; asthma; diabetes; hypertension; obesity)
  - Behavioral health (depression; anxiety; tobacco use disorder; substance related disorders)
  - Demographic variables
  - Social determinants of health
- **Outcome Variables:**
  - Cost
  - Utilization
  - Medications

SEGMENTATION PROCESS

- Compile data from all active patients, from all data sources
- Assign a score for each data component
- Combine total scores for each data component
- Sort by risk score and stratify patients into risk groups
- Validate risk groups with clinic staff
- Target interventions based on risk

RISK STRATIFICATION AND RESOURCES

Risk Stratification Groups

- Urgent/Emergent Need
- High Risk
- Average Risk
- Low Risk

Resources

- Intensive Care Coordination
- Case management or community health worker intervention
- Community Referral


OKAY, MR. COLLINS, I'M GOING TO REFER YOU TO OUR ANALYTICS SPECIALIST, WHO MIGHT BE ABLE TO MAKE SENSE OF ALL THIS DATA THAT I COLLECTED ON YOU, AND TELL ME WHAT SEEMS TO BE AILING YOU.

PRAPARE NATIONAL RISK STRATIFICATION CALCULATOR

Clinical Variables (highest possible score = 5)	Cancer (abnormal cervical findings)
	Heart Disease
	Chronic Lower Respiratory Diseases
	Asthma
	Diabetes
	Hypertension
	Obesity
Mental Health/ Substance Abuse Variables (highest possible score = 5)	Depression and other mood disorders
	Anxiety disorders including PTSD
	Other mental disorders, excluding drug or alcohol dependence
	Tobacco use disorder
	Other substance related disorders (excluding tobacco use disorders)
SDH variable (highest possible score = 5; Enter only one	Number of SDH=6
	Number of SDH=7
	Number of SDH=8
	Number of SDH=9
	Number of SDH=10 or more

Column	Definition/Purpose
Total Score	Sum of column A-Q, highest possible score is 15. Range 0-1
High Risk or Urgent Risk?	If a patient's total score in column R is between 1 SD [including 1 SD) and 2 SD (not including 2SD)] of the mean total score, the patient is "high risk"; if a patient's total score is no less than 2 SD of the mean total score, the patient is "urgent risk"; otherwise, the patient is "neither". Three possible values: "High Risk", "Urgent Risk" or "neither".

Column	Definition/Purpose
Cost	Identify the percentile of the patient's cost among all patients. Two possible values: 0 or 1.
Utilization	Identify if patient is at risk in terms of ER visits 1. Medicare aged 65+ years: four or more ER visits per year 2. Medicare aged 1-64 years: six or more ER visits per year 3. Private insurance aged 1-64 years: four or more ER visits per year 4. Medicaid aged 1-64 years: six or more ER visits per year Two possible values: 0 or 1.
Medication	Identify if patient is at risk in terms of number of patient's daily medications. Two possible values: 0 or 1.
Combined	Identify number of patients considered high risk among cost, utilization and medication components. Range 0-3.

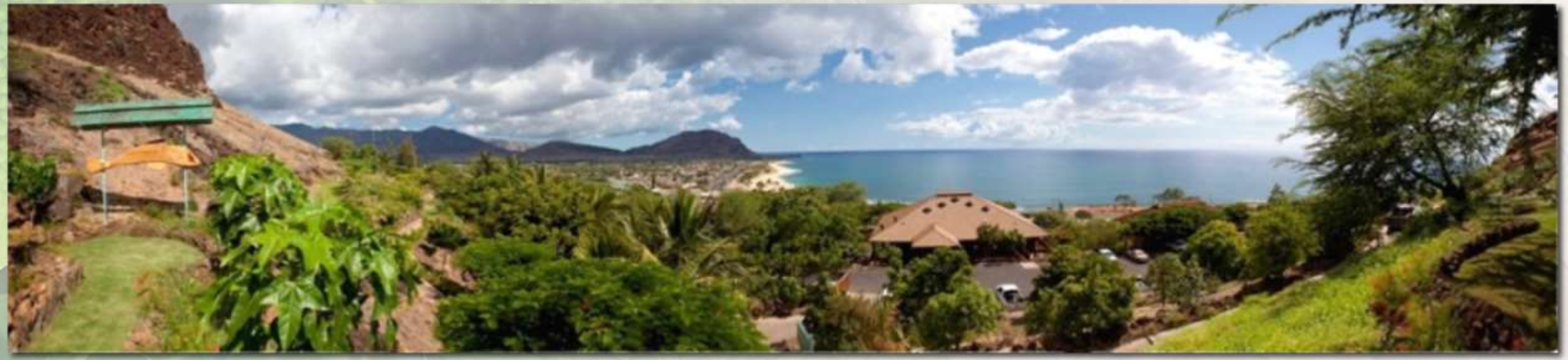
CALCULATED RISK SCORES

Automated Cells		Outcomes - Enter 1 or 0			Automated Cells	
Total Score	High Risk or Urgent Risk?	Cost	Utilization	Medication	Combined	Validation
9.8	High Risk		0	1	1	Yes
8.8	High Risk		0	0	0	No
10.7	Urgent Risk		0	0	0	No
7.7	High Risk		0	0	0	No
11.3	Urgent Risk		1	1	2	Yes
10.5	Urgent Risk		0	1	1	Yes
11.3	Urgent Risk		0	0	0	No
9.8	High Risk		0	1	1	Yes
10.3	Urgent Risk		0	1	1	Yes
10.7	Urgent Risk		0	1	1	Yes
9.0	High Risk		0	0	0	No
6.7	High Risk		0	1	1	Yes
8.7	High Risk		0	1	1	Yes
10.7	Urgent Risk		0	1	1	Yes
8.7	High Risk		0	1	1	Yes
7.8	High Risk		0	1	1	Yes
11.5	Urgent Risk		0	1	1	Yes
14.5	Urgent Risk		0	1	1	Yes
5.8	neither		0	1	1	No
9.8	High Risk		0	0	0	No

WORK IN PROGRESS

- In process of internally validating predictor variables collected through automatic data pulls
- Automate collection of cost, utilization and medication data
- Expand collection of SDoH data – use of PRAPARE survey not yet wide spread throughout entire organization
- Examine potential biases – National tool may serve as template, however local/cultural nuances important to consider

MAHALO!



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