PATIENT RISK DATA AND THE PATHWAY TO TRANSFORMATION

July 2015
WEBINAR OBJECTIVES

- Discuss how collecting and acting on patient non-clinical data support patient/population care management, and position health centers to improve outcomes, lower total cost of care, and be ready to participate in new payment arrangements.
- Present tools designed to collect and address STANDARDIZED non-clinical data.
- Discuss how this relates to California’s Alternative Payment Method demonstration.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Facilitators</th>
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<tbody>
<tr>
<td>Importance of Collecting Data on the SDH</td>
<td>Michelle Proser, NACHC and Tuyen Tran, AAPCHO</td>
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<tr>
<td>How We Created PRAPARE</td>
<td>Michelle Jester, NACHC</td>
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<td>How You Can Use PRAPARE at Your Health Center</td>
<td>Michelle Jester, NACHC</td>
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<td>Getting Ready to Implement PRAPARE</td>
<td>Alicia Atalla-Mei, OPCA</td>
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<td>Status of PRAPARE</td>
<td>Alicia Atalla-Mei, OPCA</td>
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<td>California APM Demonstration</td>
<td>Andie Patterson, CPCA</td>
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<td>Q&amp;A</td>
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WHY IS IT IMPORTANT TO COLLECT STANDARDIZED DATA ON THE SOCIAL DETERMINANTS OF HEALTH?
WHAT IS DRIVING THE NEED TO COLLECT DATA ON THE SOCIAL DETERMINANTS OF HEALTH (SDH)?

Figure 1

A Framework for Health Equity

- **Socio-Ecological**
- **Medical Model**

**UPSTREAM**
- Discriminatory Beliefs (ISMS)
  - Race
  - Class
  - Gender
  - Immigration status
  - National origin
  - Sexual orientation
  - Disability
- Institutional Power
  - Corporations & other businesses
  - Government agencies
  - Schools
- Social Inequities
  - Neighborhood conditions
    - Social
    - Physical
  - Residential segregation
  - Workplace conditions

**DOWNSTREAM**
- Risk Factors & Behaviors
  - Smoking
  - Nutrition
  - Physical activity
  - Violence
  - Chronic Stress
- Disease & Injury
  - Infectious disease
  - Chronic disease
  - Injury (intentional & unintentional)
- Mortality
  - Infant mortality
  - Life expectancy

**HEALTHCARE ACCESS**

**INDIVIDUAL HEALTH KNOWLEDGE**

**GENETICS**

**How well do we know our patients?**

**Are services addressing SDH incentivized and sustainable?**

**Are community partnerships adequate and integrated?**

Care teams must have an understanding of their patients’ complexity in order to make appropriate and informed care decisions.
Overall Project Goal
To create, implement/pilot test, and promote a *national standardized patient risk assessment protocol* to assess and address patients’ social determinants of health (SDH).

In other words, position health centers to

- Document the extent to which each patient and their total patient populations are complex
- Use that data to improve patient health, affect change at the community/population level, and sustain resources and create community partnerships necessary to improve health.
PRAPARE POSITIONS HEALTH CENTER STAFF TO IMPROVE INDIVIDUAL AND COMMUNITY HEALTH

- **Individual-level**
  - Patient and Family
  - Care Team Members

- **Local-level**
  - Health Center
  - Community Policies
  - Local Health System

- **State and national-level**
  - Payment Negotiation
  - State and National Policies

**Improve health**

- Better manage patient needs with services
- Better understand patient population
- Inform advocacy efforts related to local policies around SDH
- Provide comparison data for other local clinics and to inform partnerships
- Demonstrate the relationship between patient SDH and cost of care for fair provider comparisons (risk adjustment)
- Improve health center capacity for serving complex patients (payment reform)
FROM DATA TO PAYMENT: CONNECTING THE DOTS

Community Context
- Upstream socio-ecological factors impact behaviors, access, outcomes, and costs

Understand Patients
- Inquiry and standardized data collection
- Understand extent of patient & population complexity

Transformation of Care
- Linkages to non-clinical partners
- New or Improved Non-Clinical Interventions and Enabling Services
- Improve patient and staff experiences

Impact
- Impact root causes of poor health
- Produce better outcomes
- Lower total cost of care

Demonstrate Value
- Negotiate for payment change
- Ensure sustainability of interventions

Analyze standardized data
NEED
- Standardized data on patient risk

RESPONSE
- Standardized data on interventions

Together, these data can demonstrate the value of health centers in effectively meeting needs of complex patients and benefiting the overall health system.
Enabling Services Accountability Project (ESAP)

The ONLY standardized data system to track and document non-clinical enabling services that help patients access care.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CODE</th>
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<tbody>
<tr>
<td>CASE MANAGEMENT ASSESSMENT</td>
<td>CM001</td>
</tr>
<tr>
<td>CASE MANAGEMENT TREATEMENT AND FACILITATION</td>
<td>CM002</td>
</tr>
<tr>
<td>CASE MANAGEMENT REFERRAL</td>
<td>CM003</td>
</tr>
<tr>
<td>FINANCIAL COUNSELING/ELIGIBILITY ASSISTANCE</td>
<td>FC001</td>
</tr>
<tr>
<td>HEALTH EDUCATION/SUPPORTIVE COUNSELING</td>
<td>HE001</td>
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<tr>
<td>INTERPRETATION</td>
<td>IN001</td>
</tr>
<tr>
<td>OUTREACH</td>
<td>OR001</td>
</tr>
<tr>
<td>TRANSPORTATION</td>
<td>TR001</td>
</tr>
<tr>
<td>OTHER</td>
<td>OT001</td>
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</table>
HOW DID WE CREATE PREPARE?
Literature reviews of SDH associations with cost and health outcomes

Monitored and/or aligned with national initiatives

- HP2020
- RWJF County Health Rankings
- IOM on SDH in MU Stage 3
- NQF on SDH Risk Adjustment
- SBM & NIH

Collected existing protocols from the field

- Collected 50 protocols
- Interviewed 20 protocols
- Identified top 5 protocols

Engaged stakeholders for feedback

- Braintrust (advisory board) discussion
- Surveyed stakeholders
- Distributed worksheet to potential users for feedback

IDENTIFYING CORE DOMAINS

Identified 15 Core Domains
# CRITERIA: HEALTH IMPACT, RELEVANCE, AND FEASIBILITY

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Rationale</th>
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<tbody>
<tr>
<td><strong>Alignment with national initiatives</strong></td>
<td>• Better chance of comparison data</td>
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<tr>
<td></td>
<td>• Existing buy in</td>
</tr>
<tr>
<td><strong>Tied to research for cost outcomes</strong></td>
<td>• Can be used to predict patient cost and intervention needs</td>
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<td><strong>Stakeholder consensus</strong></td>
<td>• Evidence of health impact or face validity</td>
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<tr>
<td></td>
<td>• Health centers committed to addressing it</td>
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<tr>
<td></td>
<td>• Must be applicable to all CHCs</td>
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<tr>
<td><strong>Amount of additional burden of data collection</strong></td>
<td>• The lower the burden of data collection, the easier it is to collect</td>
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<tr>
<td></td>
<td>quality data in a consistent, standardized way</td>
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<td><strong>Actionable for individual patient management</strong></td>
<td>• This makes the data meaningful and useful for the individual patient</td>
</tr>
<tr>
<td></td>
<td>reporting it (clinically relevant for quality goals)</td>
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<td><strong>Actionable for advocacy purposes</strong></td>
<td>• Useful for discussions with community partners and payers</td>
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<td></td>
<td>• Demonstrates uniqueness of CHC patients</td>
</tr>
<tr>
<td><strong>Sensitivity of domain information to patients and staff</strong></td>
<td>• A highly sensitive domain may not be captured accurately and reliably</td>
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<td></td>
<td>• Highly sensitive information may have legal implications for the patient</td>
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</table>
PRAPARE asks 15 questions to assess 14 core SDH domains.

- 9 domains already asked for UDS reporting
- 5 non-UDS domains informed by MU3

PRAPARE has 6 optional domains.
<table>
<thead>
<tr>
<th>PRAPARE Domain</th>
<th>UDS</th>
<th>ICD-10</th>
<th>IOM</th>
<th>Meaningful Use (2 and 3)</th>
<th>HP2020</th>
<th>RWJF County Health</th>
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<tr>
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<tr>
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<td>Seeking comments</td>
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HOW CAN YOU USE PRAPARE AT YOUR HEALTH CENTER?
PRAPARE CAN AID IN BETTER ASSESSING AND MANAGING PATIENT NEEDS WITH APPROPRIATE SERVICES.

Maria’s Story: Example of a care narrative without PRAPARE

<table>
<thead>
<tr>
<th>MEDICAL HISTORY</th>
<th>DIAGNOSIS</th>
<th>INTERVENTION</th>
<th>FOLLOW-UP</th>
<th>SDH INVESTIGATION</th>
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<tr>
<td>Uncontrolled diabetes, missed appointments, and poor medication adherence</td>
<td>Sleep apnea, hypertension, and dangerously high blood sugar</td>
<td>Hospitalized for blood sugar, prescription for hypertension, and placed on a CPAP machine for sleep apnea</td>
<td>Two weeks later, Maria is back with the same clinical presentation of symptoms</td>
<td>Care team discovers she has not been taking her medicine or using the CPAP machine because she can’t afford them</td>
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Uncontrolled diabetes, missed appointments, and poor medication adherence

Sleep apnea, hypertension, and dangerously high blood sugar

Hospitalized for blood sugar, prescription for hypertension, and placed on a CPAP machine for sleep apnea

Care team discovers she has not been taking her medicine or using the CPAP machine because she can’t afford them

PRAPARE CAN AID IN BETTER ASSESSING AND MANAGING PATIENT NEEDS WITH APPROPRIATE SERVICES.

How could PRAPARE change this narrative?

MEDICAL HISTORY

DIAGNOSIS

INTERVENTION

COMPLAINT

Maria fell asleep at the stove and almost caused a fire

Uncontrolled diabetes

Sleep apnea

Hospitalized for blood sugar

Administer PRAPARE and assess SDH interfering with clinical care

Connect with resources for material insecurity

Two weeks later, Maria is back with the same clinical presentation of symptoms

Two weeks later, Maria is back with the same clinical presentation of symptoms

Connect with resources for material insecurity

Maria is monitored for treatment plan adherence and seen before the 2 week mark due to her high risk profile

SDH INVESTIGATION

FOLLOW-UP

Uncontrolled diabetes, missed appointments, and poor medication adherence

Sleep apnea, hypertension, and dangerously high blood sugar

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GETTING READY TO IMPLEMENT
PREPARE
Group of advanced clinics that are participating in an APM which allows them to create a patient-centric model of care to:

- Improve clinic population outcomes
- Improve patient and staff engagement
- Support open access
- Contain costs

**APCM IN OREGON: USING PRAPARE TO EXPLORE PATIENT SEGMENTATION WITH OREGON CHCS**

1. Teams use actionable, real-time information/data
2. Teams expand/enhance access
3. Teams proactively reach out and provide acute care
4. Teams engage patients and provide self-management support
5. Teams enhance appropriate care and work to reduce unnecessary utilization

*Draft as of 10/24/14*
EXPERIMENTING WITH PRAPARE

- We invited clinics to pick a patient population and interview 10 consumers using 3 questions from PRAPARE

- Afterwards, clinics met face-to-face to share their experiences
  - How did you and the patient discuss these questions?
  - What did you observe about the process (your experience, patient’s reaction)?
  - Did asking these questions lead to conversations about other topics?
What did we hear?

- Everyone did the assignment
- “Now we understand people better”
- Patients appreciated being asked
- Some clinics expressed wanting more ownership of the tool (i.e. participation in the development of the questions)
- Overall: lots of positivity around the exercise!
WHAT IS THE STATUS OF PRAPARE?
PILOT TESTING PRAPARE WITH A LEARNING COMMUNITY OF IMPLEMENTATION TEAMS

Teams reach states across the country, aiding with the national dissemination of PRAPARE.
NEXT STEPS

2015

Complete pilot-test and implementation

2016

Complete Implementation & Action Toolkit

National Dissemination of PRAPARE

Plan for Phase II

Refine and revise protocol based on stakeholder feedback

Including:
* Free EHR Templates
* Training Materials
* Models of Interventions to Address the SDH

Including:
* Validation and Translation
* Standardized data on Interventions
* National PRAPARE Learning Network
RESOURCES AVAILABLE TO YOU

PRAPARE resources under Social Determinants of Health Folder - [www.healthcarecommunities.org/ResourceCenter.aspx](http://www.healthcarecommunities.org/ResourceCenter.aspx)

- Implementation steps and timeline
- PRAPARE Tool
- Data Documentation
- Educational materials about PRAPARE and other health center SDH projects

AAPCHO’s ESAP technical and other resources at [http://enablingservices.aapcho.org](http://enablingservices.aapcho.org).
CALIFORNIA ALTERNATIVE PAYMENT METHODOLOGY DEMONSTRATION
CPCA, in partnership with CAPH and LA Care, are sponsoring SB147 (Hernandez)

The legislation will authorize a payment reform demonstration in California

- Health Centers that volunteer will instead of PPS per visit, receive a PPS equivalent capitation per member per month
- Health centers will track social determinants of health
- Health centers will track enabling services/ alternative touches
- Health centers will track a series of other outcome/process measures as well

Long Term GOAL

- Develop a payment methodology that appropriately and fairly pays health centers for all the care they provide including enabling services.
- Receive appropriate payment for patients identified with high levels of complexity based on a risk stratification tool that factors in social determinants of health
We have not yet determined what tool/ or which social determinants will be tracked.
We have not yet determined what alternative touches will be tracked nor how they will be tracked.
We aim to align with the national tools being used.

Decision has to be made in concert with the managed care plan and state helping to construct the payment reform demonstration.
Any and all data collection on enabling services and social determinants of health will help position health centers, not just those in the payment reform demonstration, for the future of value based payment.

CPCA encourages all health centers to consider using the PRAPARE tool and tracking enabling services.
QUESTIONS & DISCUSSION

CONTACT INFO:

PRAPARE info and listserv signup: Michelle Jester, mjester@nachc.org

AAPCHO ESAP technical assistance: Tuyen Tran, ttran@aapcho.org

OPCA APCM demonstration: Alicia Atalla-Mei, Aatalla-mei@orpca.org

Health Centers Leveraging Social Determinants Lessons Learned: Clem Bezold, cbezold@altfutures.org