PRAPARE SURVEY EXPERIENCES *(cont.)*

- Resistance noted on some questions, specifically regarding household income.
- Surveyors felt flow of survey as written did not flow smoothly, they therefore modified the order in which they asked specific questions.

WCCHC PRAPARE DATA

- Race:
  - 56% Native Hawaiian
  - 13% Asian
  - 13% White
  - 12% Other Pacific Islander

- English Proficiency
  - 96% prefer speaking in English

Note: Preliminary PRAPARE data

WCCHC PRAPARE DATA (2)

- Housing
  - 94% had housing
  - 5% were homeless

- Education
  - 78% had a HS diploma or GED
  - 17% had more than a HS education
  - 4% had less than a HS education

Note: Preliminary PRAPARE data

WCCHC PRAPARE DATA (3)

Employment

- 46% were unemployed but not seeking work
- 20% worked full-time
- 17% worked part-time
- 14% were unemployed and seeking work

Comments: In future need to explore this category in more depth, i.e. why are so many unemployed and yet not seeking work?

Note: Preliminary PRAPARE data

WCCHC PRAPARE DATA (4)

Material Security (unmet need):

Utilities	17%
Clothing	15%
Food	15%
Rent/Mortgage	14%
Transportation	11%
Phone	6%
Medicine or medical care	4%
Child care	2%
No unmet need	46%

Note: Preliminary PRAPARE data

WCCHC PRAPARE DATA (5)

Social integration (how often do you see or talk to people you feel close to?)

- 66% - More than 5 times per week
- 14% - 3-5 times per week
- 7% - 1-2 times per week
- 10% - Less than once a week

Note: Preliminary PRAPARE data

WCCHC PRAPARE DATA (6)

Stress (How stressed are you?):

- 36% - Not at all
- 22% - A little bit
- 19% - Somewhat
- 8% - Quite a bit
- 12% - Very much

Note: Preliminary PRAPARE data

WCCHC PRAPARE DATA ANALYSIS

- This cohort appeared to demonstrate fairly low risk for the social determinants of health assessed.
- Most had at least a high school education; spoke English; had housing; were socially integrated and had little or no stress.
- Almost 50% had no unmet material security needs

SUGGESTIONS FOR PRAPARE MODIFICATIONS

Expand certain categories to include assessing:

- Stability of housing situation
- Access to health care
- Work situation
- Legal concerns and rights
- Social and emotional health to include screening for depression and domestic violence

PONDERING PRAPARE RESULTS

- Cohort was one that has been followed for past 3 years as part of a pilot accountable care project with a payer.
- All have Medicaid insurance.
- When initially selected this cohort was risk stratified as moderate to high risk based on claims based predictive modeling.
- With 3 years of care coordination had their risk improved?

RESULTS OF PILOT WITH PAYER

- Cohort of 500 adult non-pregnant, non-SMI Medicaid patients with DM and/or CVD followed by care coordination since 2013
- Hospitalization rate has remained relatively stable, averaging around 3-4%, as has length of stay

PAYER PILOT RESULTS (2)

- Hospital readmission rates have improved over course of pilot – initially averaging around 12% and now averaging 6%, with no readmissions during the 1st quarter of 2016.

- Medication adherence has also steadily improved for the cohort over the past 3 years.

CALCULATING RISK SCORES

- 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.

ALTRUISTA SDoH PROJECT

- Interface built between WCCHC EHR and Altruista.
- Initial intent to transfer pertinent existing EHR data to Altruista.
- Now transferring PRAPARE data instead.
- Sample of 100 patients out of the cohort discussed previously.

ALTRUISTA SDoH PROJECT (2)

- Weights assigned to the PRAPARE responses
  - Subjective process at times – unlike claims based actuarial predictive modeling developed with large data samples.
- Validation between Claims based scores and SDoH scores.
- Preliminary results on sample indicate a moderate risk score – consistent with the results noted from PRAPARE.

FUTURE PLANS

- Disseminate PRAPARE tool to a larger population – one that has not had intensive care coordination.
- Develop a patient mode of PRAPARE to allow patients the ability to self administer the survey.
- Continue work with Altruista using PRAPARE to ultimately develop a holistic risk score incorporating SDoH with claims based data.

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.

MAHALO!