Getting the Value From Value-based Care

Summer Institute
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Learning Objectives

1. Participants will gain an in-depth understanding of Arizona's HIE, what clinical data it contains and where to find it.

2. Participants will obtain knowledge about detailed strategies for aligning their contract performance metrics with data and clinical management strategies for population health use cases.

3. Participants will understand advanced HIE uses for accomplishing the organization's clinical and business goals, including introduction of social risk factor assessment via the Arizona social determinants of health (SDOH) referral system, coming fall 2021.
Health Current Overview
About Arizona’s HIE

About Health Current

- **Who We Are**
  Health Current, Arizona's health information exchange (HIE), helps healthcare partners transform care by bringing together communities and information across Arizona in an era of changing expectations.

- **Our Purpose**
  We integrate information with the delivery of care to improve individual and community health and well-being.

- **Our Mission**
  We help our partners realize their highest potential to transform care.

- **Our Vision**
  Make healthcare transformation a reality.
About HIEs

- Bring together disparate information on a single patient across multiple providers/services to provide a comprehensive record (based on submissions from participants)
- Record is longitudinal (all records remain in the patient’s HIE data)
- Updated in real-time (based on submissions from participants)
- HIPAA secure platform
- Secure flow of patient data among healthcare providers
- Single sign-on portal for authorized users
Who is participating with Health Current?

923
Organizations participating in the HIE, representing tens of thousands of healthcare practitioners as of 6/08/2021.

HIE Operations & Data Exchange

<table>
<thead>
<tr>
<th>Activity</th>
<th>Dec. 31, 2016</th>
<th>Dec. 31, 2020</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Users</td>
<td>359</td>
<td>2,202</td>
<td>513%</td>
</tr>
<tr>
<td>Total Patients in the MPI</td>
<td>7.6 M</td>
<td>14.6 M</td>
<td>92%</td>
</tr>
<tr>
<td>Total Patients with Clinical Data</td>
<td>6.9 M</td>
<td>12.9 M</td>
<td>87%</td>
</tr>
<tr>
<td>Patients Accessed via Portal Monthly</td>
<td>7.7 K</td>
<td>779 K</td>
<td>10,017%</td>
</tr>
<tr>
<td>L7 V2 Transactions Received Monthly</td>
<td>9.8 M</td>
<td>26.1 M</td>
<td>169%</td>
</tr>
<tr>
<td>CCDs Received Monthly</td>
<td>121 K</td>
<td>2.1 M</td>
<td>16630%</td>
</tr>
<tr>
<td>Alerts Received Monthly</td>
<td>51 K</td>
<td>10.4 M</td>
<td>20292%</td>
</tr>
<tr>
<td>Participating Acute Inpatient Discharges</td>
<td>83%</td>
<td>97%</td>
<td>17%</td>
</tr>
<tr>
<td>Participating ED Visits</td>
<td>91%</td>
<td>99%</td>
<td>9%</td>
</tr>
</tbody>
</table>
HIE Services

The Portal

Provides secure web-based access that allows selected patient/member data to be viewed online. Examples include:

- Portal User associated with a healthcare provider organization is able to view data from physical health and behavioral health providers that do not have federally-recognized substance abuse treatment programs.
- With a patient's/member's 42 CFR Part 2 Consent or with a licensed medical provider declaring a medical emergency, users are able to view information from behavioral health providers that do have federally-recognized substance abuse treatment programs.
- Portal User associated with a health plan is able to view data from physical health providers and behavioral health providers that do not have federally-recognized substance abuse treatment programs. Additionally, these Portal Users would not have access to a patient's “self-pay” information.
The Portal Dashboard
Summary tab includes all the patient's clinical information. The main page features the Dashboard, which can be configured to your specifications.

Portal Data Available (varies by data source)

- Demographics
- Allergies/Adverse Reactions
- Medications
- Diagnosis/Problem List
- Procedures/Treatments
- Diagnostic Test Results
- Immunizations
- Vital Signs
- Advance Directives
- Payers
- Family History
- Social History
- COVID-19 Tests & Immunizations
- Clinical Documents
  - Discharge Summary
  - Emergency Room Report
  - Encounter Summary
  - History & Physicals
  - Operative Notes
  - Consultation Notes
  - BH Court Orders
Portal Uses

- Search for and download any external clinical information
  - A quick view of a patient's last vitals
  - A view of a patient's last visit note with an outside provider
  - Patient medication list
- Download Continuity of Care Document (CCD) for an episode of care
- Patient demographics
- View anything listed on the prior slide

HIE Alerts

Events-driven notifications triggered by admissions, discharges, registrations and clinical/laboratory results.

- Notification that an identified event has happened to a member of a pre-defined population (patient panel uploaded to the HIE); e.g., high-needs patients, chronic care panels, SMI condition-specific panels.
- Use determined by organization need.
Alert Delivery

Real-time Alerts
- An individual identified event based on patient panel
- Dynamic alerts based on individual registration

Batch Alerts
- Aggregate reports for all patients on a panel experiencing the event or condition being monitored

Patient Panels

Patient panels can include:
- All active patients
- By population (such as):
  - Diagnosis
  - Risk
  - Care manager or provider assignments
  - Others – whatever you need to track for your patients
Types of Alerts – ADT

Admission/Discharge/Transfer Alerts
- Emergency Department
- Inpatient Facilities
- Urgent Care
- Ambulatory Visits

- Can be sent in real-time or as a batch (according to a predetermined schedule)

- Can be delivered three ways:
  1. Secure email
  2. Secure File Transfer Protocol (SFTP)
  3. Directly into your EHR (only specific systems accommodate this)

Patient Centered Data Home™ (PCDH) ADT Alerts

PCDH ADT Alerts
Uses ZIP code matching to route notifications that a specific patient has been admitted to or discharged from an ED/inpatient facility outside the patient's home state and allows the home or away facility to query for additional patient records.
SHIEC HIEs Cover >90% of the U.S. Population

Connecting Whole Communities
HIEs are designed to provide critical information in real time. By facilitating the real-time electronic transfer of clinical information, including test results and hospital admissions to providers and public health authorities, HIEs provide critical infrastructure for those working on the frontlines of the COVID-19 response.

ADT Alert Composition

[Image: Map of the United States with states highlighted in blue.]

[Image: ADT Alert form with fields for Patient Name, Gender, Date of Birth, Hospital Name and City, and various encounter and insurance provider details.]
Types of Alerts – Clinical Result Alerts

- Notification when a specified type of clinical result, such as a radiology report, lab report, certain document types, like discharge summary, has been received by the HIE for an individual on a patient panel.

- The actual result or document is attached to the Alert or may be an Alert only notifying you to check the portal.

Types of Alerts – COVID-19 Results

- Participants can choose to receive one of two types of COVID-19 Alerts:
  1. For both positive and negative lab results; or
  2. For positive lab results only.

- Can be sent in real-time or as batch according to a predetermined schedule (daily, weekly, etc.) and can be delivered two ways:
  1. Secure email; or
  2. Secure file transfer protocol (SFTP).
Types of Alerts – COVID-19 Dynamic Alerts

Real-time updates on a patient’s COVID-19 status during the registration or intake process. The new COVID-19 Alerts delivery option takes a real-time registration received by the HIE, typically based on an emergency or inpatient registration, and queries the database to extract any COVID-19 results back into the originating EHR system. These “dynamic” alerts are ideal for ensuring that emergency department and inpatient staff have the most up-to-date COVID-19 lab result at first patient contact.

**Health Current - COVID-19 Report**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Lab Code</th>
<th>Label</th>
<th>Lab Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elkins Regional</td>
<td>41288</td>
<td>COVID-19 Test 005</td>
<td>Positive</td>
</tr>
<tr>
<td>ED</td>
<td>56222</td>
<td>COVID-19 Test 006</td>
<td>Positive</td>
</tr>
</tbody>
</table>

**Clinical Results Composition**

ED Discharge Summary (via secure email)
Clinical Results Composition
Radiology Report

Real-time Alerts Sent via Direct Secure Email
Types of Alerts – EMS Alerts

Emergency Medical Service Alerts
Health Current receives patient demographics and the electronic Patient Care Report from Image Trend (a health information hub) on behalf of several EMS agencies participating with the HIE. When an EMS patient is later discharged from the hospital, Health Current sends a discharge alert back to close the loop.

Other Alerts

Dynamic EDNA (Emergency Department Notification Alert)
Alerts uses a real-time registration received by the HIE, typically based on an emergency or inpatient registration, queries the database and sends back into the originating EHR system an ED Utilization Risk Report based on the following threshold parameters:

- 6 or more ED visits in 180 days
- 3 or more ED visits in 30 days
- 3 or more Acute facilities in 90 days
Other Alerts

- **Psychiatric Hospital Alerts**
  ADT event notification from an approved (mixed-use only) inpatient behavioral health hospital based on patient panels uploaded to the HIE.

  Can be sent in real-time or as batch according to a predetermined schedule (daily, weekly, etc.) and can be delivered two ways:
  1. Secure email; or
  2. Secure file transfer protocol (SFTP).

- **COVID-19 Immunization Alerts**
  Notification for a COVID-19 test result based on patient panel or ED/Inpatient registration. The actual document is attached to the Alert.

Reports

Reports are data extracts based on participants’ requests for data during a timeline, such as:

- Standardized Clinical Summary Reports and files of the most recent patient clinical/encounter information
- Standardized PDF reports for data aggregation and measurement tracking
- Alert Summary containing summary data of alerts for a specific date range
- Clinical Summary containing 36 months of recent clinical information for new patients/members
- HIE High Risk Report – Risk stratification and scoring based on specified risk factors for a patient panel
- Other participant-defined information
• Data without context and analysis are meaningless. To make the most positive and sustainable impact on patient care, you must perform data analysis through reporting.

• HIE reports can augment your population health efforts by including clinical data from all care providers.
  - HIE reports can assist you with tracking your performance over time or comparing periods of time to each other to see if changes in workflow or an updated clinical intervention improved outcomes.
  - Through a report, the HIE can provide your information to a third party.
  - Patients can be risk stratified using your own criteria.
  - Hospital and ED overuse can be tracked.

• Health Current offers a variety of report templates as well as custom reports.

• A list of the reports available, along with their descriptions, fields, format and applications follows. Data fields available for custom reports is also included.

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Description</th>
<th>Format</th>
<th>Data Fields</th>
<th>Applications</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report 1</td>
<td>Description of report 1</td>
<td>Format of report 1</td>
<td>Data fields of report 1</td>
<td>Applications of report 1</td>
<td>Notes about report 1</td>
</tr>
<tr>
<td>Report 2</td>
<td>Description of report 2</td>
<td>Format of report 2</td>
<td>Data fields of report 2</td>
<td>Applications of report 2</td>
<td>Notes about report 2</td>
</tr>
<tr>
<td>Report 3</td>
<td>Description of report 3</td>
<td>Format of report 3</td>
<td>Data fields of report 3</td>
<td>Applications of report 3</td>
<td>Notes about report 3</td>
</tr>
</tbody>
</table>

**Available Reports**
Other HIE Services

- **Public Health Reporting**
  - ADHS Immunization Registry (ASIIS)
  - ADHS Electronic Lab Reporting (e-LR)
  - ADHS Prehospital Information & EMS Registry System (AzPIERS)
  - ADHS Arizona Surge Line – Hospital Bed Capacity
  - ADHS Communicable Disease Surveillance Reporting (e-CR)

- **Emergency Preparedness, Response & Recovery**
  - Reporting Intelligence System for Emergencies (RISE)

Other HIE Services

- **Community Registries & Care Coordination Tools**
  - Arizona Healthcare Directives Registry (AzHDR), secure repository for completing, storing and accessing advance directives
  - Social determinants of health (SDOH) closed loop referral system
  - OTP Central Treatment Registry

- **Direct Secure Messaging (DSM)**
  - DSM is a secure communication for sensitive information through the internet. Reports and Alerts can be delivered to participants through DSM or participants can send messages using it.
  - Even providers without electronic medical records can use DSM to receive data on their patients.
Aligning Contract Performance Metrics With HIE Data & Clinical Management Strategies

Value-based Contracting

The volume-to-value drive is accelerating in Arizona and across the country. Increasingly payers such as Medicare and Medicaid are requiring healthcare organizations to adopt performance-based payment agreements, where the provider’s mastery of clinical data management can make the difference between survival and success.
How is the U.S. doing on outcomes versus cost?

The Link Between Payment & Performance

- The dominant payment method in U.S. healthcare today is **Fee For Service (FFS)**
  - A provider is paid a set rate for every service delivered/billed.
  - Payment rate does not vary based on quality of the care or the patient outcome.
  - FFS incentivizes delivering **more** (quantity) not **better** (quality) care.
  - FFS increases fragmentation and “silos of care” (poor communication, duplicate tests & procedures, frustrated patients).
- As a state and a nation, the healthcare system is increasingly moving toward “value-based payment” models to drive a transformation in America’s healthcare and health outcomes.
Value-based Goals

Center for Medicare & Medicaid Services (CMS) Goals

<table>
<thead>
<tr>
<th>Our Goal Statement</th>
<th>Medicaid</th>
<th>Commercial</th>
<th>Medicare Advantage</th>
<th>Traditional Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>15%</td>
<td>15%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>2022</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>2025</td>
<td>50%</td>
<td>50%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models.

AHCCCS Goals & Targets

AHCCCS Goals & Targets

<table>
<thead>
<tr>
<th>CYE 18</th>
<th>ACUTE ACC</th>
<th>ALTCS EPD (E/P MA-BSNP)</th>
<th>CRS CYE 18</th>
<th>RBHA SML-INTEGRATED</th>
<th>NON-INTEGRATED</th>
<th>DDD SUBCONTRACTED HEALTH PLANS</th>
<th>LTSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>35% / 35%</td>
<td>50%</td>
<td>25%</td>
<td>10%</td>
<td></td>
<td>20%</td>
<td>5%</td>
</tr>
<tr>
<td>CYE 19</td>
<td>50%</td>
<td>50% / 50%</td>
<td>N/A</td>
<td>35%</td>
<td>20%</td>
<td>35%</td>
<td>10%</td>
</tr>
<tr>
<td>CYE 20</td>
<td>60%</td>
<td>60% / 60%</td>
<td>N/A</td>
<td>50%</td>
<td>25%</td>
<td>50%</td>
<td>20%</td>
</tr>
</tbody>
</table>
Value-based Payment

Healthcare payment models that hold providers accountable for both the cost and quality of care they provide:

- **PM/PM**
  Set monthly budget per patient (Per Member/Per Month), regardless of the costs they incur.

- **Pay for Performance**
  Bonus paid to providers for achieving or exceeding negotiated quality indicators, usually on top of FFS payments.

- **Population-based Payment**
  Payment for all healthcare a person receives across all levels and types of care (Total Cost of Care), including inpatient, outpatient, pharmacy, etc.

- **Condition-specific Payment**
  Payment for all care for a group with specific conditions or diseases (heart disease, transplants, mental illness).

Components of a Successful Value-based Program
Components of a Successful Value-based Payment Program

Data Action Outcome

Key Component: Data

- Data – what data? To whom? How often?
- Data Management Strategy – What to do with data once we have it?
- Patient Engagement Strategy – What data tells us if we are succeeding?
- Operational Strategy – What workflows are needed/how often to take action data trends?

Data Strategy Decisions

Where to get the biggest bang for the buck with the least investment?

- Saves the most money
- Produces measurable clinical improvement
- Simple (Excel vs. data warehouse/analytics platforms)
- Supports small, focused changes in clinical and back-office workflow
- Supports more proactive care models

Examples:

- Reducing inpatient utilization
- Improving immunization rates
Getting Started

- Identify gap or outlier to manage and monitor
  - Population (children, SMI, justice involved)
  - Pattern (utilization, gaps in care, no show)
  - Condition (diabetes, CHF, asthma)
  - What the health plan pays for

- Identify data sources that align with the target
  - Use more than one
  - Document limitations/qualifiers

Common Data Sources

<table>
<thead>
<tr>
<th>Source</th>
<th>Strengths/Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIE</td>
<td>- Frequency can be customized to provider need</td>
</tr>
<tr>
<td></td>
<td>- Comprehensive (all treating providers)</td>
</tr>
<tr>
<td></td>
<td>- Part 2 limitations for some providers &amp; services</td>
</tr>
<tr>
<td>EHR</td>
<td>- Provider services/data only</td>
</tr>
<tr>
<td>Claims</td>
<td>- Lagged</td>
</tr>
<tr>
<td></td>
<td>- Contingent on quality, completeness of coding</td>
</tr>
<tr>
<td></td>
<td>- Comprehensive (all treating providers)</td>
</tr>
<tr>
<td>Staff</td>
<td>- Anecdotal</td>
</tr>
<tr>
<td>Special Data Extracts</td>
<td>- Targeted</td>
</tr>
<tr>
<td>(ACO, health plan, CIN)</td>
<td>- May only be partial population</td>
</tr>
</tbody>
</table>
Data Management

• Establish a workflow for managing your data
  o Who receives/retrieves?
  o What is the expected action? Who do they share with?
  o How frequent is the follow-up?

• Agency considerations
  o Size of practice
  o Staff
  o Technology
  o Time

Data Management & Reports

Use a standardized reporting process and report format:
• Supports transparency across the company
• Supports confidence in the data
• Actionable focus
• Supports clinical strategic thinking
Considerations for Reports

- Data Displays
  - Normalized (per 1,000) vs. frequency-based
  - Aggregate vs. individual
  - Data vs. graphs
- Frequency – establish a rhythm (same report, same meeting, same time of month)
- Time Frame – multi-year trends vs. contract year trends
- Audience/Purpose – company-wide vs. site-specific
- Workflow – make data and report review a part of the regular clinical workflow
- Measure, monitor, re-measure – don’t forget to celebrate!

Operational Strategies

Develop workflows that turn data into clinical action:

- Point of contact for Alerts and reports
- Dissemination to care team or provider
- Clinical interventions applied
- Apply workflows company-wide
- Monitor use in the corporate office
- Find your champions
- Have backup point of contacts and care team personnel
- Have a workflow for every type of Alert
- Have a workflow for updating patient panels on regular time intervals
- Apply continuous quality improvement
HIE Value-based Use Cases

Use Case: Closing Gaps in Preventative Care

Goal:
Identifying patients with preventive health needs and conducting outreach campaigns to close gaps in care.

- Choose measure (e.g., child wellness visits, annual mammogram for age 40+)
- Build patient panel for routine visits or care gaps
- Dependent on the preventative measure (e.g., mammogram-aged females, child wellness age, etc.)
- Use HIE report services
  - Choose to receive report(s) weekly, monthly, quarterly, etc.
Use Case: Closing Gaps in Preventative Care

- **Design data workflow**
  - If your practice has a care management team or quality management (QM) team, the report can go directly to the care manager or QM specialist.
  - Reports can go to a provider's medical assistant (MA) or case manager.

- **Design clinical workflow**
  - Use HIE Portal as part of pre-visit planning to review for recent encounters and active medications or identify needed tests.
  - Conduct outreach/pre-visit call and appointment reminder to complete pre-visit checklists or scheduled needed labs.

- **Update patient record**
  - If report or encounter is not already in your patient’s record, update it with this information.
  - If preventative measure not completed, contact patient to schedule.

- **Monitor the results at regular intervals to measure change from outreach campaign.**
**Use Case: Managing Chronic Conditions**

**Goal:**
Manage chronic conditions such as diabetes through Alerts, reports and clinical interventions.

- Choose condition or measure (e.g., diabetes)
  - Out-of-range/unmanaged?
  - Routine A1c

- Build panel of patients with diabetes
  - Real-time HIE alert for abnormal lab results (if panel size is manageable)
  - Monthly/quarterly HIE reports
  - Update panels monthly to add new patients or remove former patients

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**Use Case: Managing Chronic Conditions (Diabetes)**

- Design data workflow
  - Care manager or MA receives the Alert and consults with patient's provider for an order or applies clinical standing order
  - Reports reviewed for data aggregation and performance monitoring

- Design clinical workflow using evidence-based interventions, such as:
  - Diabetes Management: Team-Based Care for Patients with Type 2 Diabetes | Healthy People 2020
  - Best Practices Framework | American Diabetes Association
  - Diabetes-related Education | Diabetes Best Practices (ihs.gov)
  - Evidence-based diabetes care for older people with Type 2 diabetes: a critical review - PubMed (nih.gov)

- Monitor the results at regular intervals to measure change on overall diabetes register.
### Sample Diagnosis/Condition Agency-wide Performance Report

<table>
<thead>
<tr>
<th>Diagnosis/Condition</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer screening</td>
<td>73%</td>
<td>88%</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>73%</td>
<td>85%</td>
</tr>
<tr>
<td>Adult BMI assessment</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>30-day all cause readmissions</td>
<td>0%</td>
<td>27%</td>
</tr>
<tr>
<td>Diabetic eye exam</td>
<td>80%</td>
<td>88%</td>
</tr>
<tr>
<td>Kidney disease monitoring</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Med reconciliation post discharge</td>
<td>17%</td>
<td>45%</td>
</tr>
<tr>
<td>Diabetic med adherence</td>
<td>70%</td>
<td>94%</td>
</tr>
<tr>
<td>Hypertension med adherence</td>
<td>70%</td>
<td>90%</td>
</tr>
<tr>
<td>Cholesterol med adherence</td>
<td>77%</td>
<td>88%</td>
</tr>
<tr>
<td>Statin therapy diabetes</td>
<td>90%</td>
<td>92%</td>
</tr>
<tr>
<td>Overall Stars score</td>
<td>4.25</td>
<td>4.28</td>
</tr>
</tbody>
</table>

### Use Case: Overuse of Emergency Department (ED) Inpatient Facilities

**Goal:**
Reduce overutilization of ED and inpatient settings.

- Build panel of patients with out-of-range visit patterns
  - Establish criteria for High-Risk Registry (Example)
    - 6 or more ED Visits in 180 Days
    - 3 or more ED Visits in 30 Days
    - 3 or more Acute facilities in 90 days
- Use HIE Alert services
  - Choose real-time (for immediate coordination of care efforts)
  - Choose batch (for daily/weekly reports for aggregate clinical interventions)
Use Case: Overuse of Emergency Department (ED) Inpatient Facilities

- Design data workflow
  - Real-time Alerts – Who will take action at 3 a.m.?
  - Batch Alerts – Care manager, MA or case manager receives the alerts and consults with patient’s provider or care team.

- Design clinical workflow
  - Contact ED for real-time coordination of care and if appropriate to avoid inpatient stay.
  - Engage care team to review records/HIE portal. Discuss with patient’s provider team and determine next steps/new plan of care.
  - Patient to schedule visit to discuss clinical needs and discuss appropriate use of services/how to contact practice after hours.

- Use regular reports (monthly/quarterly)
  - To measure improvement with workflow applied.
  - Compare location to location or team to team.

ED Utilization June 2019 – June 2020
Use Case: COVID-19 Test Results

Goal:
Identify COVID positive patients before a visit to schedule telehealth if needed and ensure adequate supplies of PPE.

- Use alerts for most efficient method of receiving COVID-19 test results for notifying patients and the knowledge of staff.
- Build panel of patients
  - All scheduled visits or procedures for a set period (week, month)
  - All patients
- Receive HIE COVID-19 positive test results real-time or batch Alerts or use Dynamic Alerts for use at time of registration in EDs, Urgent Cares and other acute settings.

Use Case: COVID-19 Test Results

- Design data workflow
  - Care manager, MA or case manager receives alerts directly
  - QM or pop health team distributes daily report

- Design clinical workflow
  - Notify team/provider of patient's test status
  - Obtain provider orders and contact patient with instructions
  - Consider telehealth appointment
  - Ensure available PPE
The Future is Here:
Social Determinants of Health (SDOH) Referral System
Incorporating Social Determinants of Health

Social determinants of health (SDOH) are the conditions in the environments where people are born, grow, live, learn, work, play and age that affect a wide range of health, well-being, functioning, and quality-of-life outcomes and risks.

Research shows expenditure reductions associated with SDOH referral programs.

(Zachary Pruitt, 2018)

Taking Action on SDOH – The Evidence Base

Housing

• There is strong evidence that providing people who are homeless, or at risk of becoming homeless, with supportive housing can significantly lower expensive forms of healthcare, thereby reducing costs.
• Consistent findings that housing reduces ED visits, admissions and inpatient days and results in large decreases in healthcare costs.
• One study estimated an ROI of $2,249 per person, per month.
• For every $1 spent, it's a savings of $1.57 by providing housing.

Taking Action on SDOH – The Evidence Base

**Nutrition**

- There is strong evidence that ensuring people have access to healthy food can significantly lower healthcare utilization and costs.
- Home-delivered, medically tailored meals for those with chronic conditions or nutritional risk have been found to significantly lower inpatient utilizations, 30-day readmissions and overall medical costs.
- Meals on Wheels program for Medicare beneficiaries resulted in reduced hospitalizations, ED visits and declines in overall healthcare costs.
- Medically tailored meals resulted in a larger ROI than nontailored meals: $220 per participant, compared to $10 per participant.


**Transportation**

- There is moderate evidence that providing non-emergency medical transportation (NEMT) to low-income people, those with certain chronic conditions or dually eligible enrollees can increase the receipt of outpatient, preventive care, prevent expensive forms of care and produce an ROI.
- One study found an ROI of $3,423 per person, per month for dialysis patients and $792 for diabetes wound care patients.

AHCCCS Whole Person Care Initiative (WPCI)

- Officially launched the Whole Person Health Initiative in November 2019.
- Focused on role social risk factors play in influencing individual health outcomes.
- Exploring options for advancing WPCI through maximization of AHCCCS’s current benefit package.

(AHCCCS Whole Person Care Initiative (WPCI), 2021)
Arizona SDOH Referral System Features

- Referral directory
- “No Wrong Door”
- Evidenced-based screening (PRAPARE)
- Referrals tailored to individual needs
- Alerts and communications
- Data dashboards, analytics and outcomes
- Client portal

Arizona SDOH Program Timeline

2020 – 2021

1 – 3/2020
Form Work Group & Market Analysis

4 – 8/2020
Define Requirements, Develop RFP

3 – 5/2021
Implementation Planning

6 – 9/2021
Early Adopters Implementation

9/2020 – 3/2021
Vendor Selection, Contracting

Fall 2021
General Rollout Begins
Questions?

More Information

Health Current Website: healthcurrent.org

Contact:

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References


