Radical Care Transformation with Social Determinant Data

Session 266, March 8, 2018

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Conflict of Interest

Michelle Lehr O’Connell, MPA

Has no real or apparent conflicts of interest to report.
Conflict of Interest

Carlos Olivares

Has no real or apparent conflicts of interest to report.
Agenda

• Learning Objectives
• Care Transformation: An Iterative Approach
• Capturing Social Determinants of Health
• Building a Data Asset & Using the Data
• Organizing Care Teams & Delivering Care
• External Relationships & Care Outside the Clinic
• Lessons & Recommendations
• Questions?
Learning Objectives

• Describe an **iterative approach** to care transformation

• Formulate effective **methods of capturing social determinants** of health data

• Create necessary **data assets** and support **cultural initiatives** to analyze and use that data

• Discuss **non-traditional approaches to organizing care teams** and delivering care to a challenging population

• Explain how to influence **external relationships** to support and extend care outside the walls of a healthcare provider
Yakima Valley Farm Workers Clinic

- 57 unique locations
- 627,523 encounters
- 163,000 patients

In 2017

Rosewood Family Health Center

- Opened 2004
- Serves Southeast Portland
- 10,625 Patients
- 73% Adults
- 27% Pediatrics
- 12 Languages Spoken

Services include primary care, prenatal, behavioral health, psychiatry, social work, case management, and nutrition

Vulnerable patient population: low income and working poor, high incidence of trauma and substance use, complex biopsychosocial needs
Why has YVFWC taken on 106,000 lives at risk (52,000 in Oregon CCOs) and what will it take to succeed?
Care Transformation – An Iterative Approach

Radical

Rosewood
YVFWC Goals

- Improve Care Delivery
- Improve Patient Satisfaction
- Improve Staff & Provider Satisfaction
- Achieve Incentive Payments / Profitability

Rethinking Care at Rosewood

**How do we...**

- Demonstrate value
- Transform the **day-to-day model** of care
- Address the real barriers of health
- Leverage technology for more convenient care
- Provide true team-based care

Care Transformation – An Iterative Approach
Care Transformation – An Iterative Approach

Barriers to Transformation

- Traditional floor plan
- Siloed providers and staff
- Limited information about barriers to care & capacity to address them
- Limited technology infrastructure
Getting Radical

- **Redesigning work spaces** for care teams.
- Creating supportive, **integrated care teams**. Increasing **access** to deliver more timely and convenient care. Identifying barriers & assessing complexity. Finding **time in provider day** to structure care, not just deliver it.
- Implementing a **new EHR and analytics platform** for population health management.
- Building a **culture of innovation and improvement**, driven by teams & frontline staff. Providing better care because we have good data, new workflows, and space that supports team-based care.
Capturing Social Determinants of Health

Identifying Barriers to Care and Complexity

How do we effectively screen for, document and address social determinants of health?

How does screening improve overall utilization under a risk contract?

Why is it so complicated to implement in a primary care setting?
Case Study: Social Determinants and Hemoglobin A1c

As of 6/20/17 A1C = 7.0

Established Care after being without insurance or healthcare for 18 months. Met RD

Decreased self-management. Starts Diabetes Class

Met SW re: housing & unemployment

BHC for depression. RN education for insulin

Met CHW for BEST program

Neurosurgery & acute infections. Best friend starts dying process. Depressive symptoms

Met BHC for sleep and grief

SSRI

The graph shows the data in chronological order (8/21/2015 - 3/16/2017)
Data Capture Approaches

- National models did not meet needs of diverse local populations
- Investment in long R&D phase v. plug & play decision for data collection

“How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?”
Why didn’t we use a pre-existing model to capture social determinants of health data?

How did we select our questions?

How do we know these are the right questions?
Capturing Social Determinants of Health

Rosewood’s Plan for SoDH Data

**Structure**
What is our goal in asking these questions?

**Capture**
What method fits best with our workflows and population?

**Store**
How do we compile the information we are collecting?

**Make actionable by care team**
How do we ensure quick and easy access to data?

**Set up the point of care**
How do we ensure data can be effectively incorporated into care delivery?
Pragmatic, not Perfect

- Technology goal: **incremental investments**
- No perfect off-the-shelf solution
- Investment in vendor partnerships
- Take your time – avoid future road bumps
Survey results: Social determinants among Rosewood patients.

- **36%** experience food insecurity
- **66%** have experienced a lot of or moderate stress
- **38%** have experienced an event in their lives that has led to emotional trauma
- **20%** unemployed & seeking work
- **11%** experience housing insecurity
- **16%** often or always feel isolated
- **51%** experience financial insecurity
EHR Selection & Optimization

Selection for population health management strategy

Optimization ongoing, iterative investment to meet care delivery needs
Building a Data Asset & Using the Data

EHR Data Storage

Historical
No social determinant data in systems

Current
Some paper, but some engaged providers store data using Z-codes

Planned
Fully integrated into analytics platform and workflows

Z59.5 – Extreme poverty
Z60.3 – Acculturation difficulty
Building a Data Asset & Using the Data

DATA SOURCES

Clinical
Full clinical extracts from YVFWC & 3 additional CHCs with overlapping patient populations (nightly)

Plan
Claims and eligibility feeds from 5 health plans in OR & WA

ANALYTICS ARCHITECTURE

Master Patient Index → Centralized Data Warehouse → Web Portal

REPORTS & TOOLS

- Performance Improvement
- Utilization Analysis
- Patient Registries
- Member Alignment Reports

DATA STRATEGY: Trust, speed, and completeness.
Building a Data Asset & Using the Data

**QUALITY IMPROVEMENT**
- Monitor quality metrics as our risk contract measures them
- Target and close care gaps
- Support best practices in documentation

**RISK ADJUSTMENT**
- See what the plan sees proactively
- Highlight opportunities for submission
- Give providers opportunities for intervention at point of care

**UTILIZATION MANAGEMENT**
- View events and cost outside of your system
- Assign patients correctly
- Identify high or rising cost and risk populations
- Incorporate quality and outcomes data for targeted prioritization of outreach and access to care

**PATIENT OUTCOMES**
- Track outcomes / quality measures / medical loss ratios
- Complement and support other sources like patient satisfaction
- Understand the outcomes of your population and what drives them
Pulling it all together to achieve cultural adoption of transformation & innovation.
Redesigning physical space.

Organizing Care Teams & Delivering Care
Creating integrated teams.

**Primary Care Team**
- Primary Care Providers (MD, PA)
- Registered Nurse
- Medical Assistants
- Clinical Support Staff

**Support Team**
- Psychiatric NP
- Behavioral Health Consultant
- Medical Social Worker
- Registered Dietitian
- Community Health Workers

**Expanded Team**
- Intake Nurse
- Triage Nurse
- Call Center
- Patient Benefits Coordinators
- Receptionists
Integrated providers supporting primary care teams.

- Specialty services physically integrated with primary care
- Brief, targeted interventions
- Same day access
- Warm handoffs
- Curbside consultation
- Coordination of care & care management
**Timely, more convenient & planned care.**

### Family Practice Physician with Obstetrics - Schedule Example

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**Organizing Care Teams & Delivering Care**

![HIMSS18 Logo](https://via.placeholder.com/150)

**HIMSS18** The leading health information and technology conference

WHERE THE WORLD CONNECTS FOR HEALTH
Getting results.

Patient Satisfaction

97.7%

“loyalty intentions” score

Provider Satisfaction

2017 scores average 4-4.5 out of 5 stars
Colorectal cancer screening rate

Maintained or increased surplus under Medicaid risk-based contracts during transformation

% of diabetic patients with controlled a1c

Cervical cancer screening rate

Getting results: Teams + Technology = Transformation
External Relationships & Care Outside of the Clinic

Community Partners

- Supportive Services
- Comprehensive Care
- Data
- Long-term Support
- Network Resources
- Data on Program Impacts

YVFWC

CCO

Primary Care
Behavioral Health
Psychiatry
Social Work
Nutrition Services

Care Navigators
Diabetes Class:
A partnership between YVFWC/Rosewood, Oregon Food Bank, Portland Open Bible Church & FamilyCare

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<td>We worried whether our food would run out before we got money to buy more</td>
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- Pre-Class
- Post-Class
Lessons and Recommendations

1. Plan your infrastructure first – but not too much.
2. Initiate cultural and technical changes in tandem.
3. Tailor your approach to your population.
4. Partner with a managed care plan.
5. Break down traditional hierarchies and barriers to form data-driven, creative teams.
Please remember to complete the online session evaluation!