Adirondack Health Institute

Lead • Empower • Innovate

Practice Transformation Workgroup
September 2020

PRESENTED BY:

Louann Villani, RN, AHI

Brenda Stiles, RN, Adirondacks ACO

Sept. 17, 2020

Agenda

I. Opening/Welcome – L. Villani

II. ADK Wellness Connections – V. Knierim (10 min.)

III. Prapare Tool – L. Tuggle (30 min.)

IV. SDoH: PCMH Program Requirements – J. Schwartzman (5 min.)

IV. Clear the Air in the Southern Adirondacks – L. Villani (5 min.)

V. October Topic: Reporting – L. Villani (5 min.)

VII. Open Forum (10 min.)

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ADK WELLNESS CONNECTIONS

PRESENTED BY:

Victoria Knierim

Community Engagement Facilitator, AHI

September 17, 2020

ADK Wellness Connections

- **A collaborative referral coordination and resource navigation network** comprised of service providers across the continuum of care in **Clinton**, **Franklin**, **Essex**, **Fulton**, **Hamilton**, **Saratoga**, **St. Lawrence**, **Warren**, and **Washington** counties to address **social** and **medical** needs.

ADK WELLNESS
CONNECTIONS

ADK Wellness Connections and Unite New York

ADK WELLNESS CONNECTIONS

UNITE NEW YORK

Healthy Together
Referral Network of Alliance for Better Health

CNY CARE COLLABORATIVE

ADKWC is integrated with Healthy Together, run by the Alliance for Better Health, and CNYCares, run by the CNY Care Collaborative, both Unite Us-based referral networks. This partnership is now part of the Unite New York network, which simply means you now have access to more resources in a larger geographic footprint of 19 counties.

ADK Wellness Connections Network Performance To Date

Since network launch on 10/15/18 through 08/16/20*:

***ADKWC data only – does not include Healthy Together or CNY Cares.**

2,818 needs referred.

122 ADKWC network partners, **179** sites.

371 Unite New York Network Partners

1,407 new clients added by ADKWC partners.

3 days on average for in-network referral acceptance.

47% of service episodes pertained to transportation.

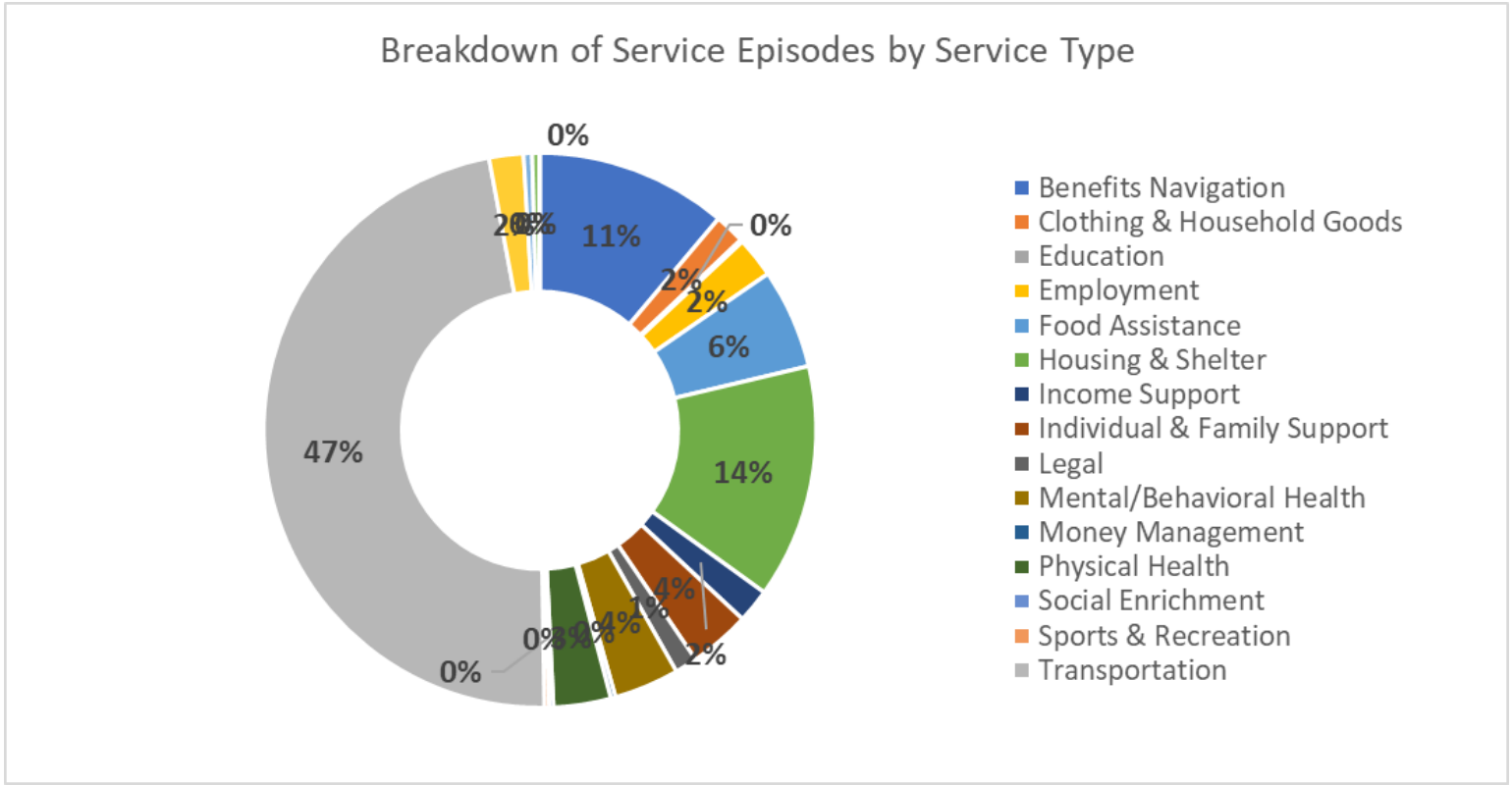
56% of cases closed with a positive outcome.

403 assistance requests (self-referrals)

ADK WELLNESS CONNECTIONS

ADK Wellness Connections Service Episodes by Service Type

Service Type	# of Service Episodes
Benefits Navigation	317
Clothing and Household Goods	50
Education	4
Employment	67
Food Assistance	165
Housing and Shelter	387
Income Support	56
Individual and Family Support	101
Legal	37
Mental/Behavioral Health	108
Money Management	8
Physical Health	95
Social Enrichment	7
Sports and Recreation	8
Transportation	1,340
Utilities	57
Wellness	14
Substance Use	12
Spiritual Enrichment	1
Grand Total	2,834



ADK Wellness Connections Coordination Centers

- **Family Service Association of Glens Falls** - Glens Falls PHN/Fulton PHN region (Fulton, Hamilton, Saratoga, Warren, and Washington counties).

- **Behavioral Health Services North (BHSN)** - Saranac PHN/Plattsburgh PHN region (Clinton, Essex, and Franklin counties).

- **St. Lawrence Health Initiative** - St. Lawrence PHN region (St. Lawrence County).

ADK Wellness Connections “Assistance Requests”

ADK Wellness Connections “Become A Network Partner”

ADK WELLNESS CONNECTIONS

ADK Wellness Connections is a **FREE** referral network sponsored by Adirondack Health Institute that helps **connect you to a wide range of resources in your area** to improve your health and well-being.

For more information about joining the network, please fill out the Partner Interest Survey!

Victoria Knierim

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adkwellconnects@ahihealth.org

a·H·I Adirondack Health Institute

PRAPARE

ADIRONDACK HEALTH
Better Health, Better Lives

HCC-RAF and Primary Care Risk Stratification

PCMH Measure CM 03 (NYS)

Per PCMH must include **entire** patient panel to identify and direct resources appropriately.

ADIRONDACK HEALTH
Better Health, Better Lives

Why are we focused on HCC coding and RAF scores?

All attributed patients of the primary care practice will be risk stratified using the HCC-RAF score.

The HCC-RAF score is generated within the EMR and scores risk based on:

- Complex chronic conditions;
- Behavioral health conditions;
- Social determinants of health.

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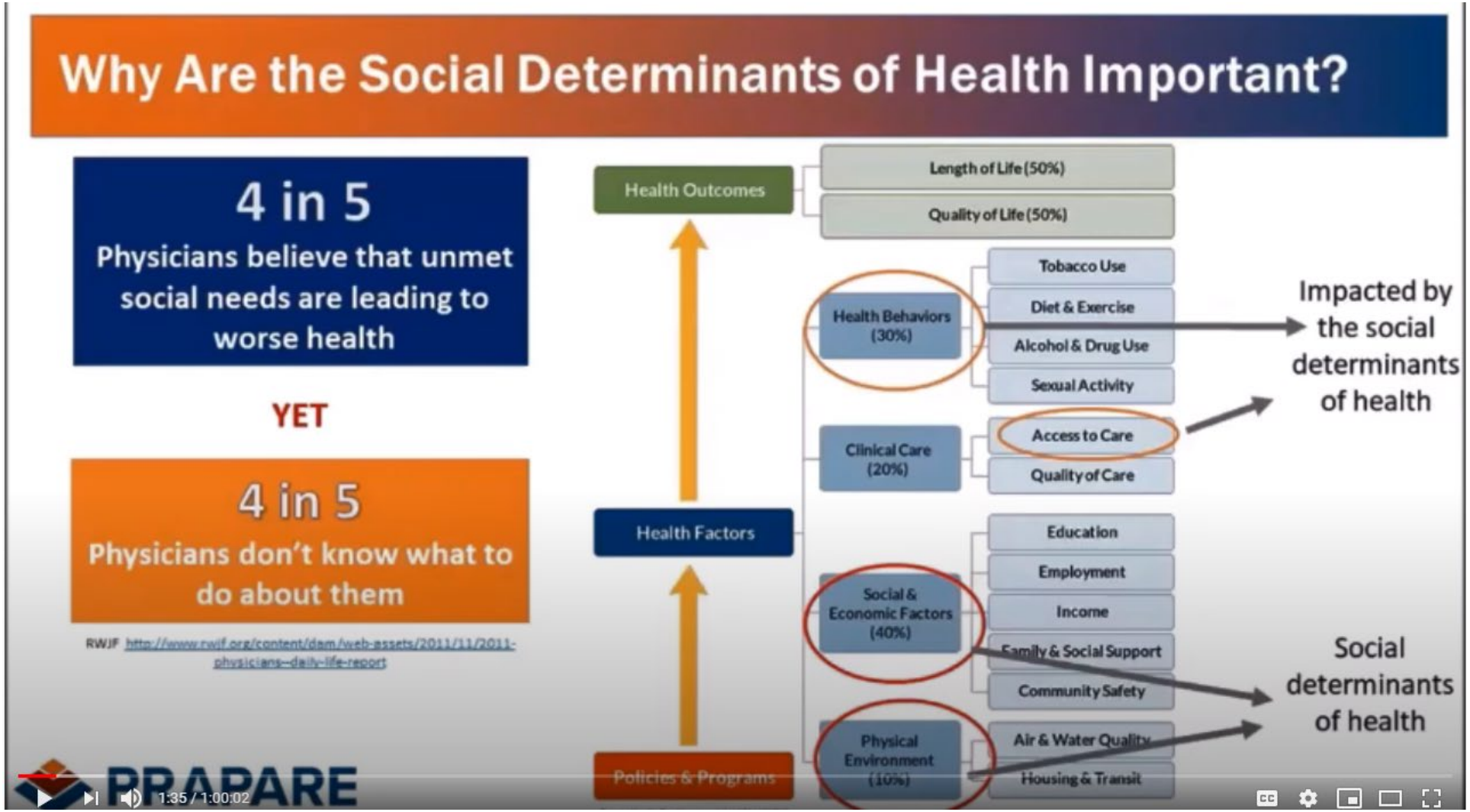
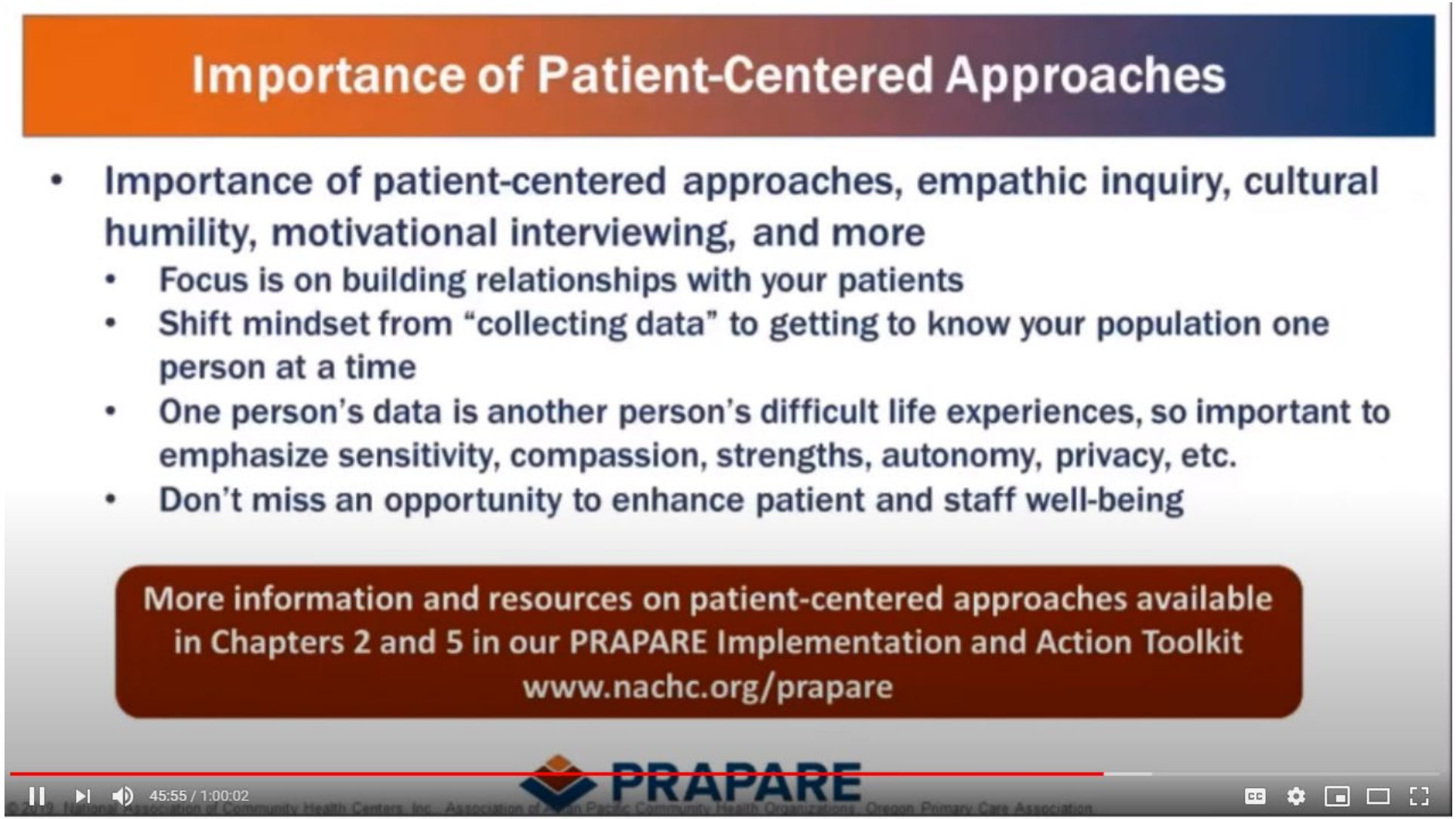
Hierarchical Condition Category (HCC) Coding: Improving Risk Identification

- How does HCC Coding work?
  - Ranks diagnoses into categories that represent conditions with similar cost patterns.
  - Higher HCC categories represent higher predicted healthcare costs, resulting in higher risk scores
  - Acute illnesses and injuries will not fall in HCC risk because they are not reliably predictive of ongoing healthcare costs
  - Risk adjustment based on medical record documentation from a face-to-face encounter; documented at **least once a year** and coded accordingly to the ICD-10 guidelines
- What does this mean?
  - The more comprehensive you code diagnoses the more accurate the HCC ranking will be for predicting the cost associated with care.


Why Are the Social Determinants of Health Important?
4 in 5
Physicians believe that unmet social needs are leading to worse health
YET
4 in 5
Physicians don't know what to do about them
RWJF http://www.rwjf.org/content/dam/web-assets/2011/11/2011-physicians--daily-life-report
Health Outcomes
Length of Life (50%)
Quality of Life (50%)
Health Behaviors (30%)
Tobacco Use
Diet & Exercise
Alcohol & Drug Use
Sexual Activity
Clinical Care (20%)
Access to Care
Quality of Care
Health Factors
Social & Economic Factors (40%)
Education
Employment
Income
Family & Social Support
Community Safety
Physical Environment (10%)
Air & Water Quality
Housing & Transit
Policies & Programs
Impacted by the social determinants of health
Social determinants of health
PRAPARE
1:35 / 1:00:02


Importance of Patient-Centered Approaches
Importance of patient-centered approaches, empathic inquiry, cultural humility, motivational interviewing, and more
Focus is on building relationships with your patients
Shift mindset from "collecting data" to getting to know your population one person at a time
One person's data is another person's difficult life experiences, so important to emphasize sensitivity, compassion, strengths, autonomy, privacy, etc.
Don't miss an opportunity to enhance patient and staff well-being
More information and resources on patient-centered approaches available in Chapters 2 and 5 in our PRAPARE Implementation and Action Toolkit
www.nachc.org/prapare
PRAPARE
45:55 / 1:00:02

The PREPARE form is used to collect social determinants of health data.

Will need to code SDOH conditions captured by Z codes.

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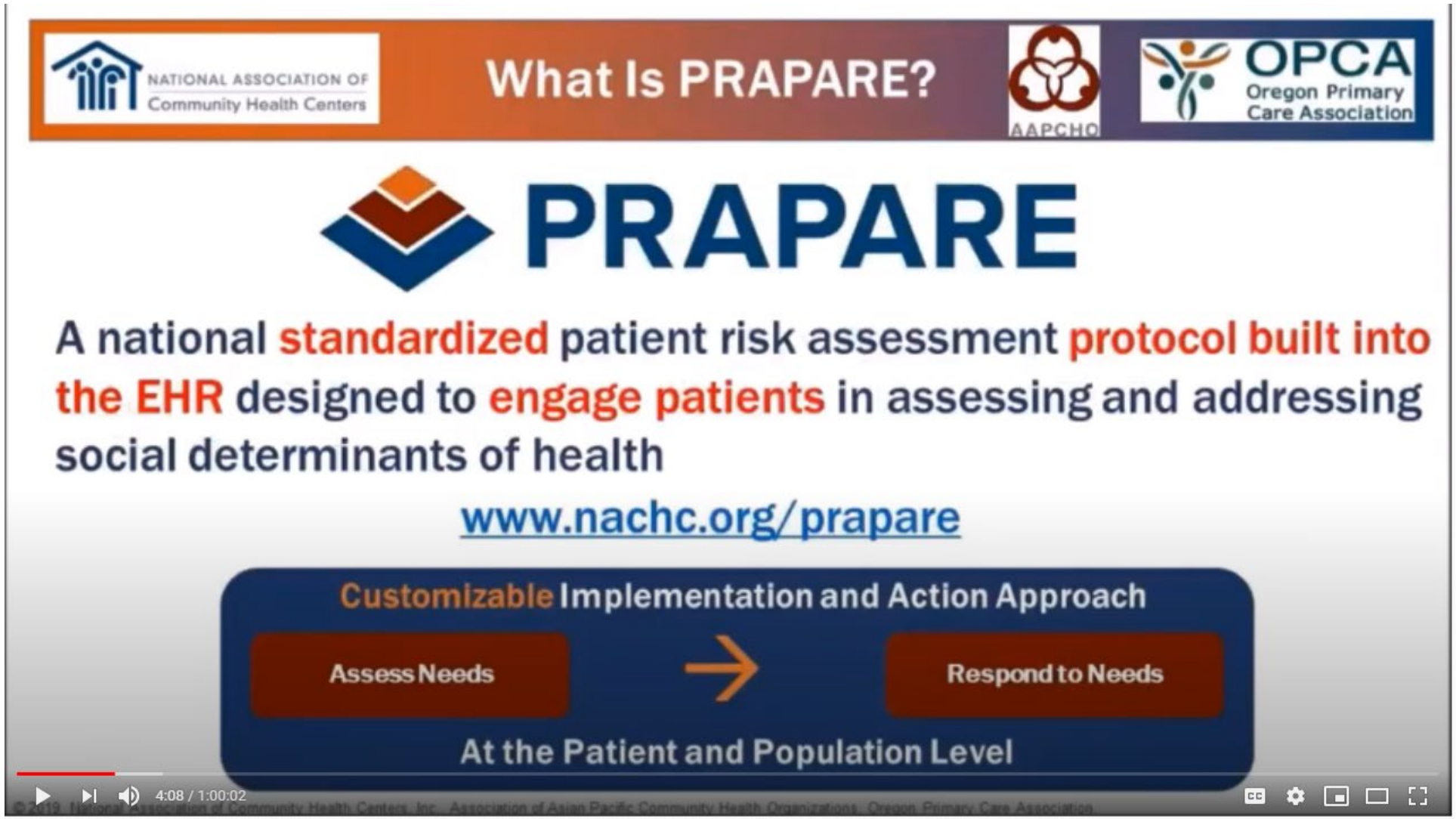
NATIONAL ASSOCIATION OF Community Health Centers
What Is PRAPARE?
AAPCHO
OPCA Oregon Primary Care Association
PRAPARE
A national standardized patient risk assessment protocol built into the EHR designed to engage patients in assessing and addressing social determinants of health
www.nachc.org/prapare
Customizable Implementation and Action Approach
Assess Needs
Respond to Needs
At the Patient and Population Level
4:08 / 1:00:02
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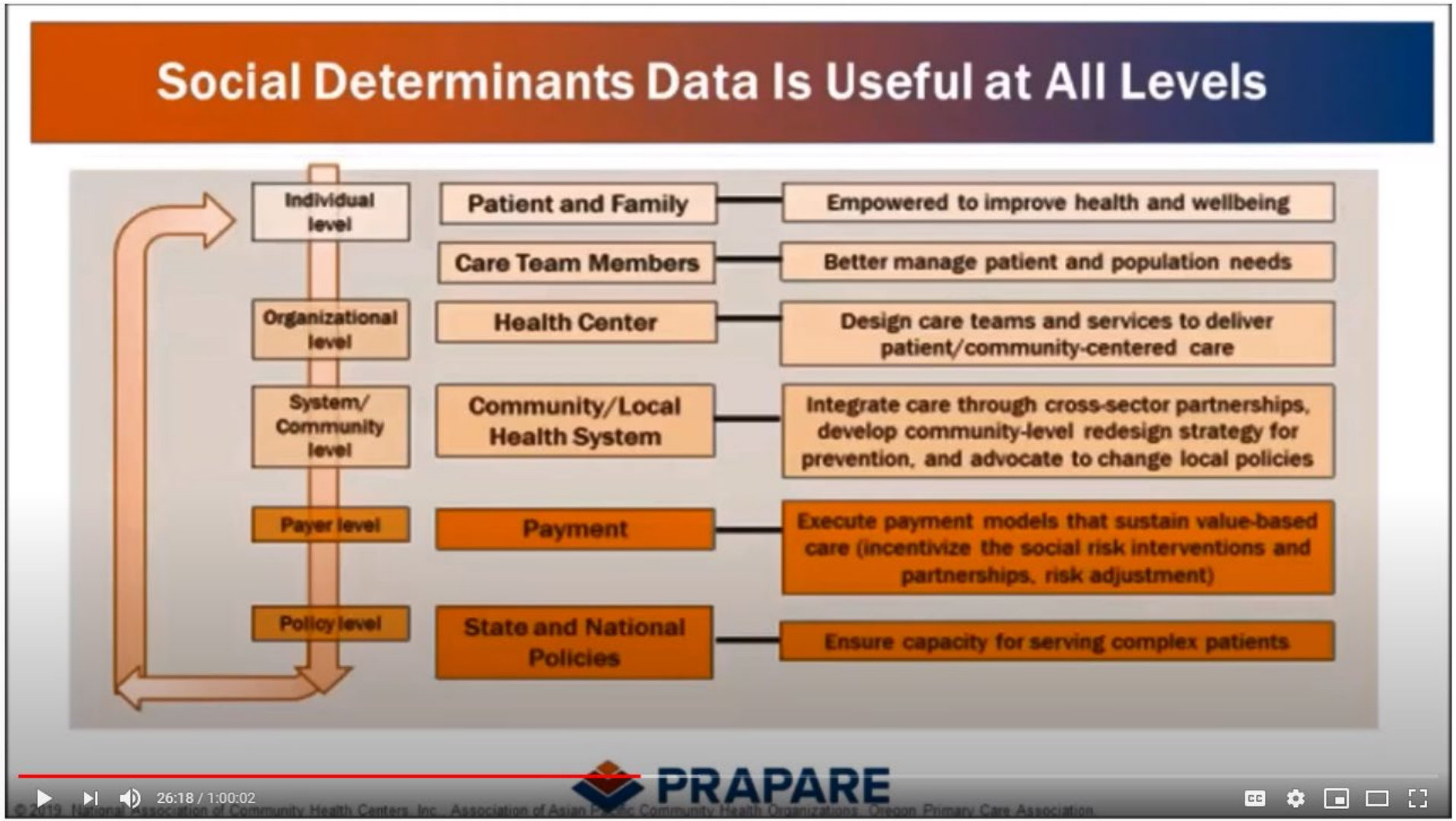
Social Determinants Data Is Useful at All Levels
Individual level
Patient and Family
Empowered to improve health and wellbeing
Care Team Members
Better manage patient and population needs
Organizational level
Health Center
Design care teams and services to deliver patient/community-centered care
System/ Community level
Community/Local Health System
Integrate care through cross-sector partnerships, develop community-level redesign strategy for prevention, and advocate to change local policies
Payer level
Payment
Execute payment models that sustain value-based care (incentivize the social risk interventions and partnerships, risk adjustment)
Policy level
State and National Policies
Ensure capacity for serving complex patients
PRAPARE
26:18 / 1:00:02
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WHAT QUESTIONS ARE IN PRAPARE?

Core	
1. Race*	10. Education
2. Ethnicity*	11. Employment
3. Veteran Status*	12. Material Security
4. Farmworker Status*	13. Social Isolation
5. English Proficiency*	14. Stress
6. Income*	15. Transportation
7. Insurance*	16. Housing Stability
8. Neighborhood*	
9. Housing Status*	

Optional	
1. Incarceration History	3. Domestic Violence
2. Safety	4. Refugee Status

Optional Granular	
1. Employment: How many hours worked per week	3. Insurance: Do you get insurance through your job?
2. Employment: # of jobs worked	4. Social Support: Who is your support network?

* UDS measures are automatically populated into PRAPARE EHR templates. You do NOT need to ask those questions multiple times!

10 translations of PRAPARE now available! 16 more on the way!

Find the tool at www.nachc.org/prapare

PRAPARE

Chapter 21 of the International Classification of Diseases, Tenth Revision (ICD 10) covers factors influencing health status and contact with health services. This chapter is referred to as the "z-codes" Z00-99. For SDH coding, *Z55-65 Persons with potential health hazards related to socioeconomic and psychosocial circumstances* is the most relevant section.

PRAPARE Question	PRAPARE Response	ICD-10 z-code
What is your housing situation today?	I have housing	
	I do not have housing (staying with others, in a hotel, on the street, in a shelter)	**Z59.0 Homelessness**
What is the highest level of school that you have finished?	Less than high school degree	**Z55.3 Underachievement in school**
	High school diploma or GED	
	More than high school	
What is your current work situation?	Unemployed and seeking work	**Z56.0 Unemployment, unspecified**
	Part-time work	
	Full-time work	
	Otherwise unemployed but not seeking work	
Percent of federal poverty level (FPL) (PRAPARE automatically calculates household size and income questions)	100% or below	**Z59.5 Extreme poverty**
	101-150%	**Z59.6 Low-income**
	151-200%	**Z59.6 Low-income**
	Over 200%	
	Unknown	
In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? (Check all that apply.)	Food	**Z59.4 Lack of adequate food**
	Clothing	
	Utilities	
	Childcare	
	Medicine or any health care	
	Phone	
	Other	

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Example of PRAPARE in progress note

Subjective:

Chief Complaints:

1. TEST PRAPARE.

ROS:

CONSTITUTIONAL:

no Recent illness. weight gain No. insomnia yes. no weight loss. weakness yes. no loss of appetite. fatigue yes. sweats yes. chills yes.

Medical History:

Social History:

General:

Advanced Directive

Reflections Referral Offered *Accepted*

Social Determinants:

PRAPARE

Date Completed/Updated: *07/13/2020*

What is your current housing situation? *I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, or in a park)*

Are you worried about losing your housing? *Yes*

What is the highest level of school that you have finished? *More than high school*

What is your current work situation? *Full time work*

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply *Child care*

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? *Yes, it has kept me from medical appointments or from getting my medications*

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings) *I choose not to answer this question*

How stressed are you? Stress is when someone feels tense, nervous, anxious, or cant sleep at night because their mind is troubled *A little bit*

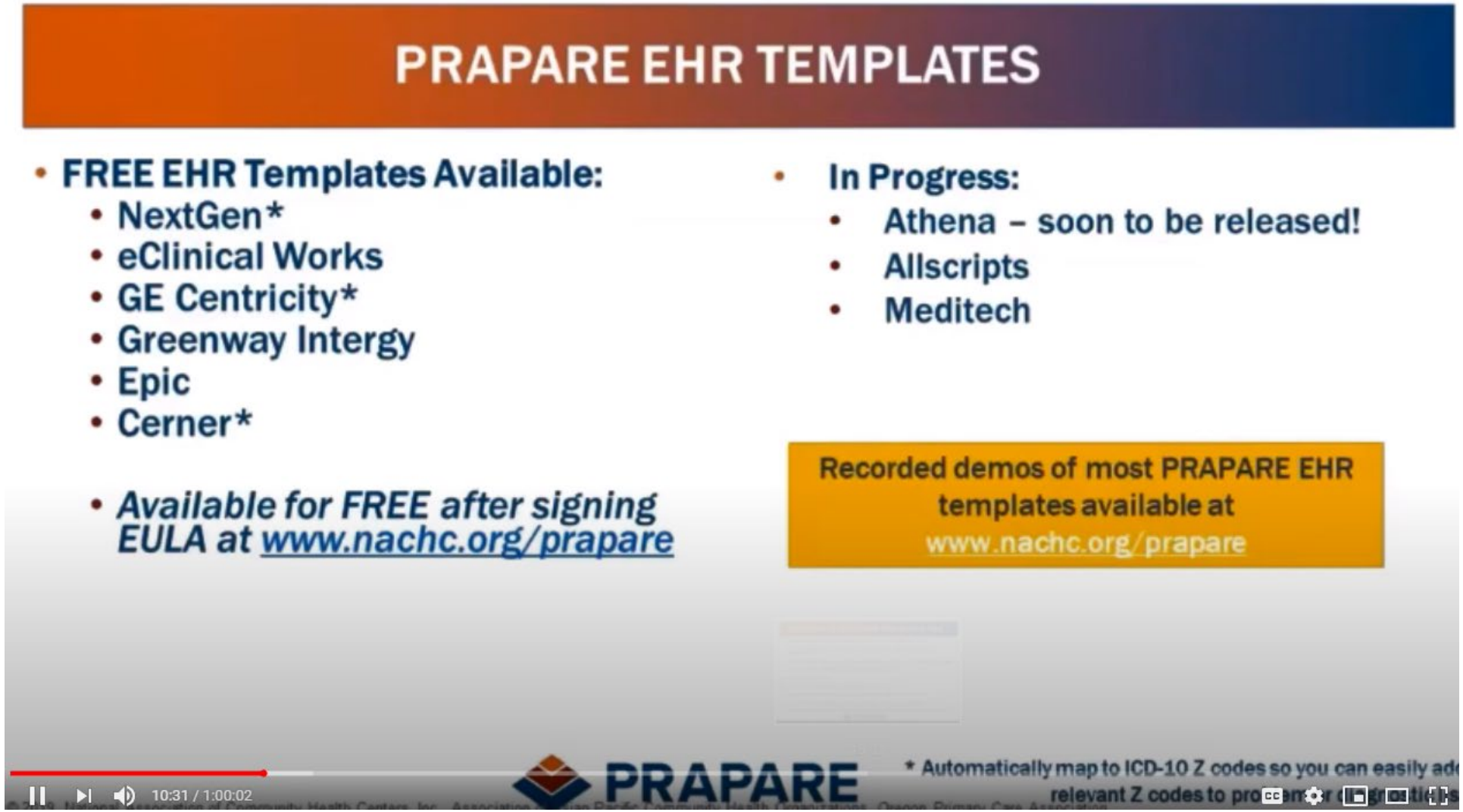
In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility? *No*

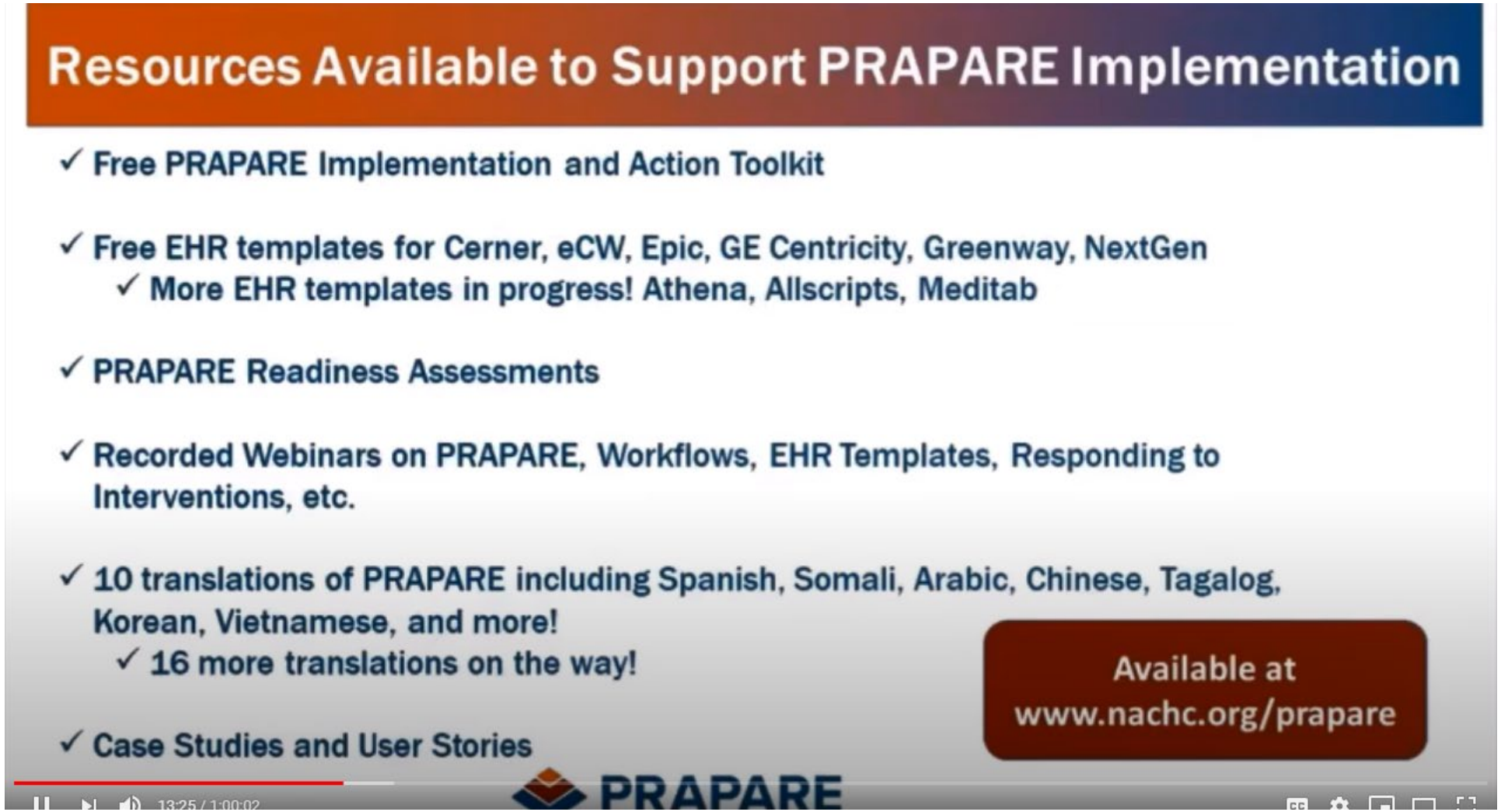
Do you feel physically and emotionally safe where you currently live? *Yes*

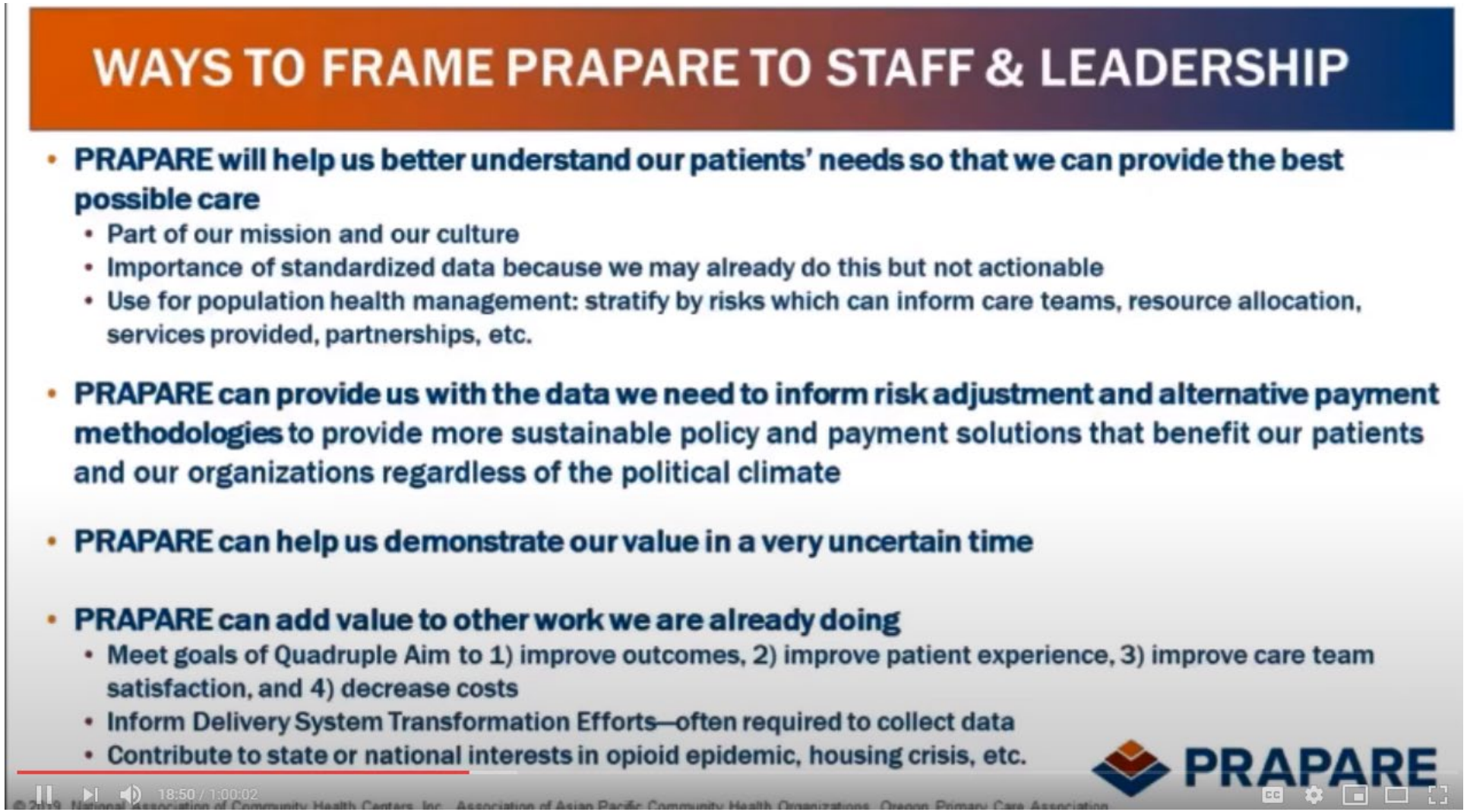
In the past year, have you been afraid of your partner or ex-partner? *No*

Are you a refugee? *No*

What country are you from? *United States*


PRAPARE EHR TEMPLATES
FREE EHR Templates Available:
NextGen*
eClinical Works
GE Centricity*
Greenway Intergy
Epic
Cerner*
Available for FREE after signing EULA at www.nachc.org/prapare
In Progress:
Athena – soon to be released!
Allscripts
Meditech
Recorded demos of most PRAPARE EHR templates available at www.nachc.org/prapare
10:31 / 1:00:02
PRAPARE
* Automatically map to ICD-10 Z codes so you can easily ad
relevant Z codes to pro


Resources Available to Support PRAPARE Implementation
✓ Free PRAPARE Implementation and Action Toolkit
✓ Free EHR templates for Cerner, eCW, Epic, GE Centricity, Greenway, NextGen
✓ More EHR templates in progress! Athena, Allscripts, Meditab
✓ PRAPARE Readiness Assessments
✓ Recorded Webinars on PRAPARE, Workflows, EHR Templates, Responding to Interventions, etc.
✓ 10 translations of PRAPARE including Spanish, Somali, Arabic, Chinese, Tagalog, Korean, Vietnamese, and more!
✓ 16 more translations on the way!
✓ Case Studies and User Stories
Available at
www.nachc.org/prapare
PRAPARE
13:25 / 1:00:02


WAYS TO FRAME PRAPARE TO STAFF & LEADERSHIP
PRAPARE will help us better understand our patients' needs so that we can provide the best possible care
Part of our mission and our culture
Importance of standardized data because we may already do this but not actionable
Use for population health management: stratify by risks which can inform care teams, resource allocation, services provided, partnerships, etc.
PRAPARE can provide us with the data we need to inform risk adjustment and alternative payment methodologies to provide more sustainable policy and payment solutions that benefit our patients and our organizations regardless of the political climate
PRAPARE can help us demonstrate our value in a very uncertain time
PRAPARE can add value to other work we are already doing
Meet goals of Quadruple Aim to 1) improve outcomes, 2) improve patient experience, 3) improve care team satisfaction, and 4) decrease costs
Inform Delivery System Transformation Efforts—often required to collect data
Contribute to state or national interests in opioid epidemic, housing crisis, etc.
PRAPARE
18:50 / 1:00:02

Questions?

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SDOH in PCMH

- What are Social Determinants of Health?

  As defined by the WHO (2020), "social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."

- Why are Social Determinants of Health important?

  Social determinants of health include access to resources to meet a person's needs. Their presence or absence can contribute greatly to health inequities.

SDOH within the PCMH program

(NCQA 2020)

Criteria	Core, Elective, NYS	Description	SDOH Impact
KM02	C	Comprehensive Health Assessment	The practice conducts a comprehensive health assessment that includes SDOH
KM07	E	Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.	After the practice collects information on social determinants of health, it demonstrates the ability to assess data and address identified gaps using community partnerships, self-management resources or other tools to serve the ongoing needs of its population
KM11A	NYS	Identifies a disparity in care related to a vulnerable population	SDOH data can be used to identify a disparity or vulnerable population.
KM12	C	Proactive Outreach	Can be used to close gaps identified in KM11A

SDOH in PCMH

Criteria	Core, Elective, NYS	Description	SDOH impact
KM21/KM26/ KM27	C/E/E	Community Resource Needs	The practice identifies needed resources by assessing collected population information which may include Social Determinants. The practice keeps a list of community resources to help address social needs and evaluates the usefulness of the resources by obtaining patient feedback.
AC09	E	Equity of access	The practice may utilize data related to SDOH to assess and improve equity of access. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health (NCQA 2020).
CM01/CM03	C/NYS	Care Management Criteria/Risk Stratification	Care Management Criteria must include at least 3 of the following: A. Behavioral health conditions. B. High cost/high utilization. C. Poorly controlled or complex conditions. D. Social determinants of health. E. Referrals by outside organizations

SDOH in PCMH

Criteria	Core, Elective, NYS	Description	SDOH Impact
CM07	E	Identifies barriers to goals	SDOH information may be a useful way to identify barriers to goals
Informational questions in QPASS	NA	NCQA has a series of questions for annual reporting practices included as part of the submission process. The questions do not impact the practice's score, but they must be completed in order to submit	Provides insight to NCQA regarding practice's current state of adoption of SDOH concepts

Clear the Air in the Southern Adirondacks (CASA)

The NYS Smokers' Quitline is offering **up to three months of FREE nicotine gum** while supplies last.

Individuals can reach out to 1-866-NY-QUITS (1-866-697-8487) or visit *nysmokefree.com* to apply.

CASA currently has *free* posters available and other electronic resources for healthcare providers. If you would like receive posters or would like more information, please contact:

CLEAR THE AIR
IN THE SOUTHERN ADIRONDACKS

Joey Boswell,
CASA Community Engagement Specialist
jboswell@ahihealth.org

October Topic: Reporting

- What are the pain points with your EHR? Do you use a report module from your EHR?
- Do you have Hixny integrated into your EHR? Have you seen the reports in Hixny? Are they helpful? Have you seen the patient dashboards?
- How are you doing with coding?
- How many organization are you using any z-codes for SDoH?
- Are they utilizing CPT 2 codes for HTN, depression screening and poor A1C control?
- Forever diagnosis?
- Risk Coding (Nov. topic)?

PCMH & Tracker Grid

- All practices with due date from April 2020 on must submit by 11/30/2020.
- Reminder sent on first Monday of the month.
- QPASS updated 9/14/2020. Check to see any documents checked in are still there!
- If you need assistance, contact us!

Additional Resources

- AHI website: https://ahihealth.org/

  *recordings and slides from meeting are there

- AHI COVID newsletter – Monday afternoons

- Adirondacks ACO newsletter

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