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THE POWER OF PARTNERSHIPS TO IMPROVE POPULATION HEALTH:
Improving the Quality of Health Care Outcomes One Member at a Time

Presented by: Jean Drummond, President, HCD International

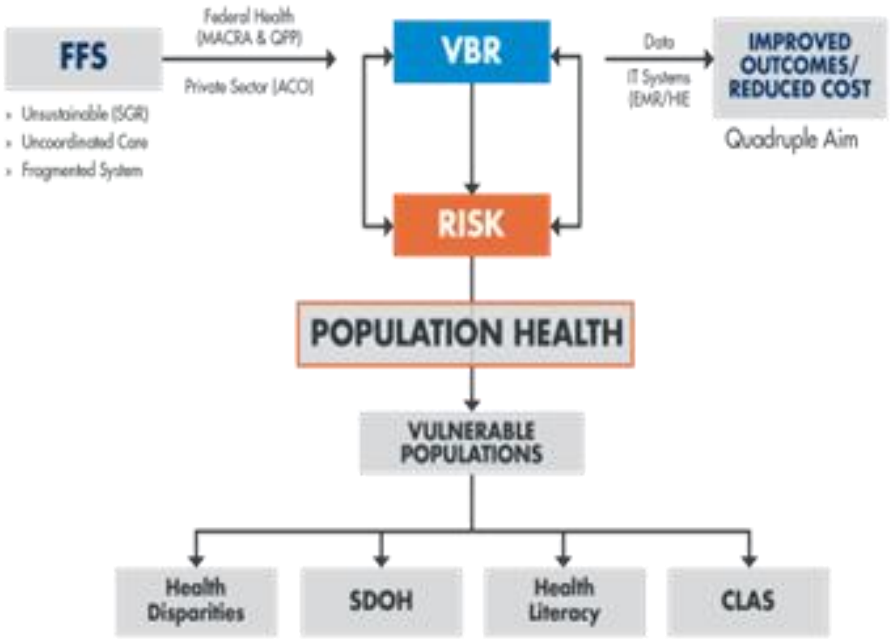
Date: December 5, 2019

Who: HCDI, UHC & MEMBERS

- **HealthCare Dynamics International** (HCDI) is a quality improvement and clinical transformation organization
- Founded and led by **primary care clinicians committed to innovative population health** solutions
- **18+** years supporting the **Centers for Medicare & Medicaid Services (CMS)** quality improvement and population health programs
- NICHE: **Policy to Practice Strategy** launched through the **PARACHUTE methodology**
- **Driven by Value Based Care and Payment for clinicians serving low resource communities**

Why?

What?



- Addressing HEDIS Gaps
  - Lead Screening
  - Diabetes
  - Breast Cancer Screening
  - Adolescent Well Child
  - Supplemental Security Income (SSI)
  - Other Measures
- Patient Engagement
- Provider Engagement
- Care Coordination
- Community Engagement

How?

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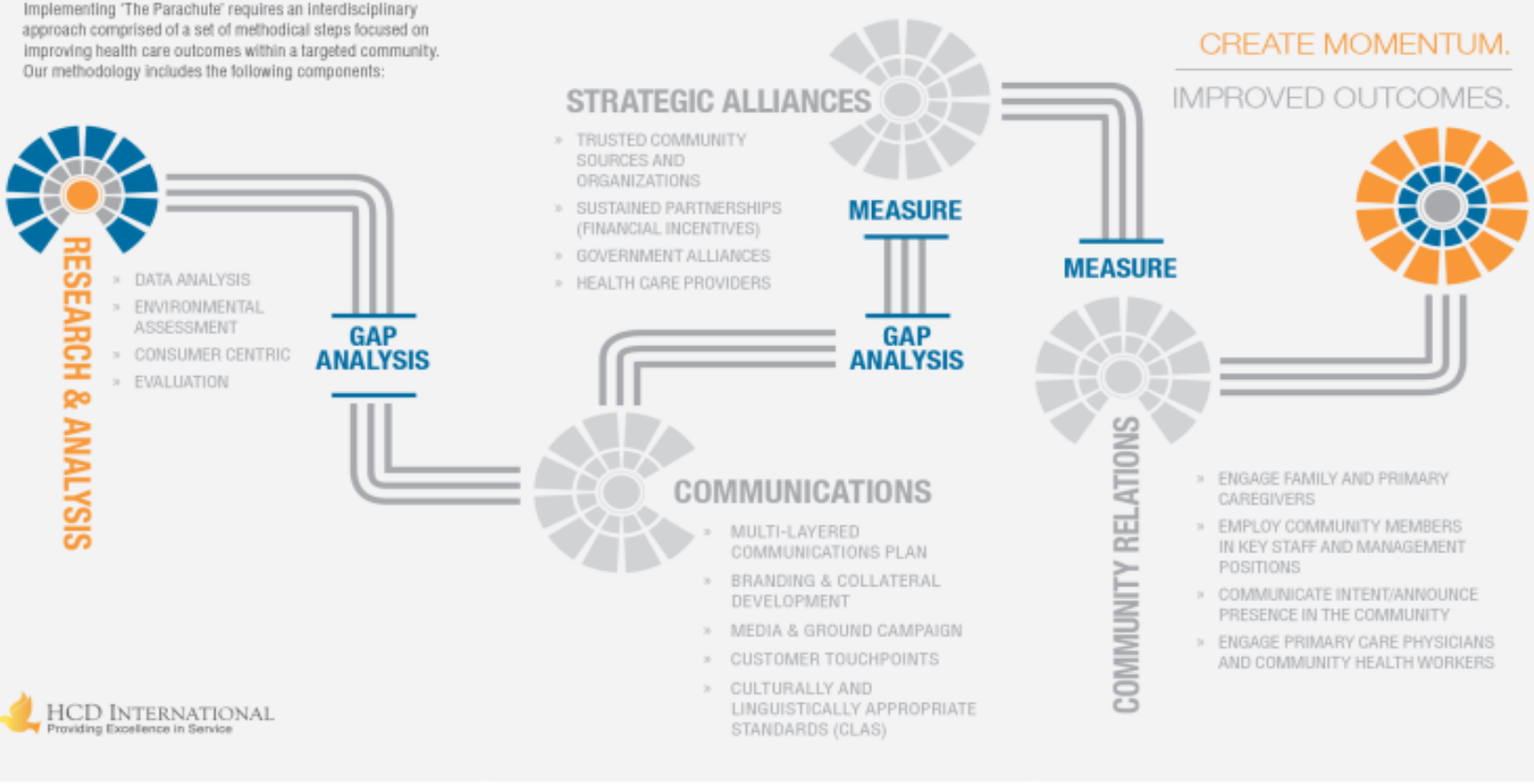
THE PARACHUTE

The Parachute is representative of a cadre of strategically applied, multi-disciplinary and integrated tactics to impact health care consumer behaviors of at-risk communities. Initially, it begins with a 'high-level' specific data driven goal that identifies a targeted population within a geographic location characterized by adverse health outcomes and associated high costs. As the parachute descends, great attention is given to identify community assets that serve as trusted sources and support systems for the targeted audience. As the parachute touches ground, the strategy evolves into a set of results driven consumer engagement activities. The canopy, covering the ground, symbolizes inclusiveness, and a personalized touch designed to cover the consumer and their community. The Parachute Model takes into account a broad macro-level strategy, yet focuses on a specific patient population to improve health outcomes and lower cost.

Implementing 'The Parachute' requires an interdisciplinary approach comprised of a set of methodical steps focused on improving health care outcomes within a targeted community. Our methodology includes the following components:



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Value of our Community Health Staff

HCDI embraces a core set of values that promotes 'inclusiveness'

- Builds trusted relationships with patients and families
- Provides culturally and linguistically appropriate services
- Represents multiple cultures, ethnicities and religions
- Understands the policy drivers and economic impact of value based care
- Utilizes motivational interviewing, teach back and encourage self-activation
- Demonstrates patience. Express empathy. Remain persistent.
- Knowledgeable of local health, community and social service networks
- Strengthen community partnerships to support social needs of patients
- Respect community norms and demonstrate commitment to health education
- Identifies and addresses SDoH that impact patients and communities

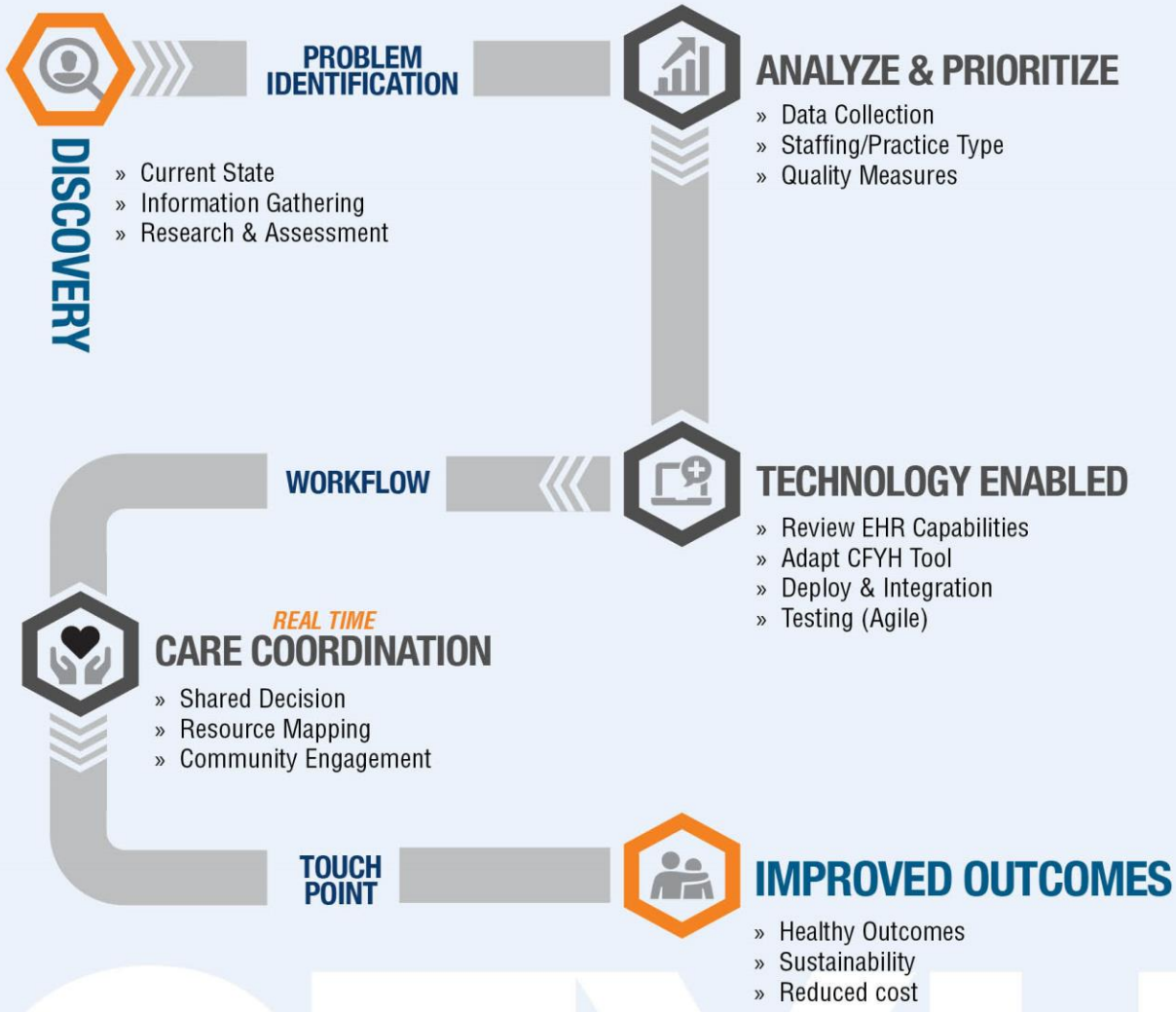
CARING FOR YOUR HEALTH

Social Determinants Indicator Tool (CFYH Tool)

HealthCare Dynamics International (HCDI) is delighted to share the 'Caring for Your Health' Social Determinants Indicator Tool (CFYH Tool). HCDI developed this tool in response to clinician concerns regarding the social factors affecting their patient population, the impact of these factors on clinical outcomes, and the subsequent negative adjustment that can result from value-based payment model. These social factors affect the patient's ability to self-manage and adhere to their shared decisions. This brief questionnaire is patient facing and provides real-time, up-to-date information to the provider, while creating an opportunity for shared decision-making to identify patient preferences to improve the quality of their care. HCDI provides free training and technical assistance to effectively integrate this tool into your already established work flow processes.

The 'Caring for Your Health' Social Determinants Indicator Tool is both a patient level and population health management tool that:

- Provides real-time opportunities to identify socio-economic factors that can affect the patient's clinical outcomes
- Assists in patient risk stratification
- Allows for documentation of the patient case complexity
- Aids in development of early interventions
- Promotes health equity



‘Caring For Your Health’™ SDoH Indicator e-Tool

- Patient-facing social determinants assessment
- Very EASY 3-4 minute user-friendly, low-literacy tool
- Immediate results to provider/practice
- Based on nationally recognized, validated resources
- Captures demographic, REaL, SDoH and clinical data
- Facilitates real-time person centered care coordination
- Successfully implemented in rural, urban and suburban settings
- Customized HL7/FHIR EMR integration
- Integrates person and family engagement principles
- Patient, provider, practice, payor, and population reporting capabilities
- Incorporates and tracks ICD-10 Z codes
- Multiple workflow integration options

CFYH Data Collection Elements

Demographics

- Name
- Age
- Zip Code
- Gender

REaL

- Race
- Ethnicity
- Language

Clinical Data*

- Diabetes
- HgA1c Value

SDoH

- Food
- Housing
- Economics
- Education
- Medications
- Transportation
- Loneliness
- Utilities
- Employment
- Insurance status
- Rodent Infestation

*CFYH can be customized to include additional chronic conditions and behavioral health screening questions.

Actionable, Real-Time Patient Level Report

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Jane Doe

Details | FHIR

First Name:	Jane	**Skips Meds for Food:**	**Yes**
Last Name:	Doe	**Skips Meds to Save Money:**	**Yes**
Year of Birth:	1990	**Need Help Reading Paperwork:**	**Yes**
Zip Code:	20743	**Lacks Transportation for Care:**	No
Gender:	Female	**Looking for work over a week:**	**Yes**
Race & Ethnicity:	White/Caucasian, African/	**Feels Lonely:**	**Sometimes**
Marital Status:	Married	**Has Bug Infestation:**	No
Education:	High School graduate	**Has Mold:**	**Yes**
Health Insurance Status:	Self-Pay	**Has Lead Paint/Pipes:**	**Yes**
No Money for Food:	**Often**	**Smoke Detectors not working:**	No
Might Become Homeless:	**Yes**	**Needs Assistance with:**	Getting dressed
Electricity May Shutoff:	Yes	**Cared for at Hospital Since Last Visit:**	**Yes**
Gas May Shutoff:	Yes		
Oil May Shutoff:	Yes	**Has Diabetes:**	Yes
Water May Shutoff:	Yes	**Knows HbA1c?:**	Yes
Can't See Doctor Because of Money:	**Yes**	**Eye Exam in 12 months:**	Yes
		Foot exam in 12 months:	Yes

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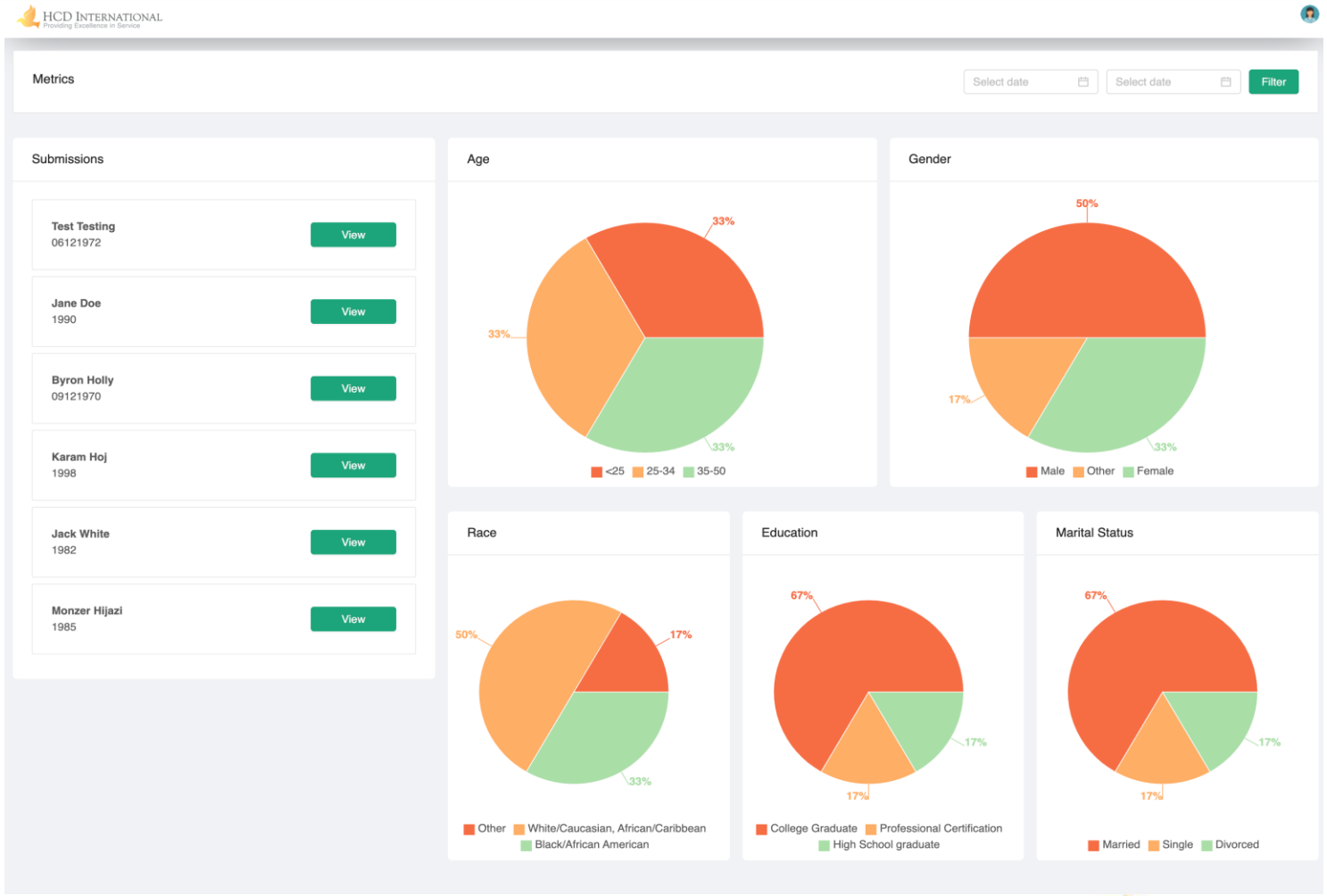
Actionable Practice/Community Based Organization Level Report



Breast Cancer Screening - HEDIS Measure

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MEMBER COUNT
19,530

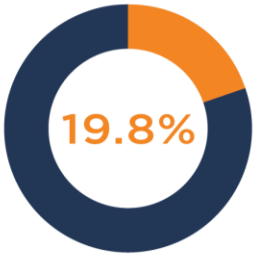
TOTAL CONTACT ATTEMPTS
30,718

TOTAL OUTREACH CONDUCTED
4,421

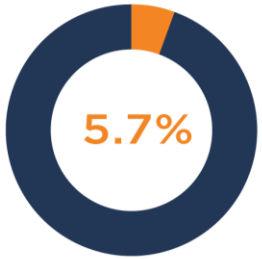
TOTAL TOUCHES
35,139

ESTIMATED COST SAVINGS
$63,812,424

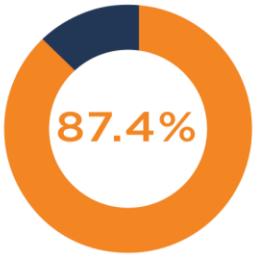
LIVES SAVED
1,170



GAP CLOSED RATES



REFUSAL RATES



TELEPHONIC CONTACT RATE

OUTREACH CONTACT RATE

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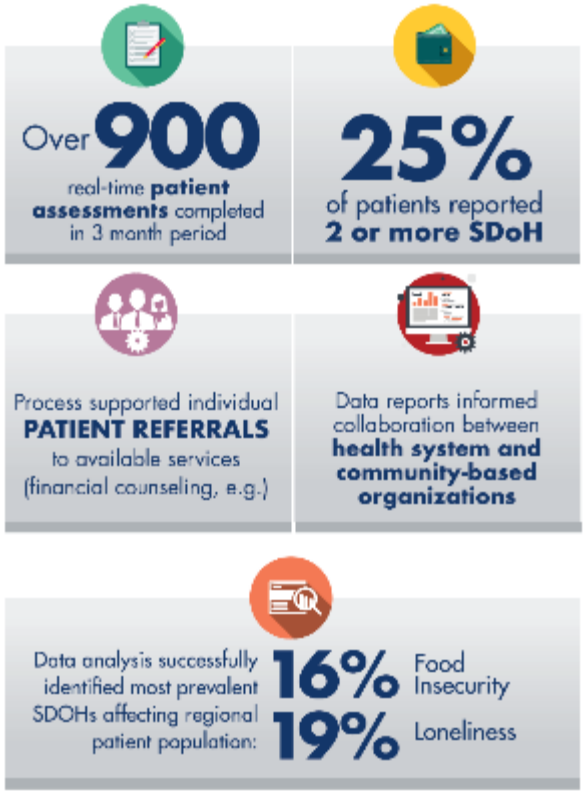
Results & Intervention

HCDI's advanced implementation model demonstrates that full SDoH integration and individualized patient responses are indeed possible.



HCDI partnered with a local multi-practice provider to use the CFYH Tool. Food insecurity was identified as a SDoH. HCDI worked with the practice to implement a clinical food pantry to address this critical social need.

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HCD International IMPACT

$37,131,546
Reduction in Hospitalizations
HCDI Supported Cost Savings

60,000 +
Patient touches related to HEDIS

13,419
Outreach conducted for HEDIS

2500 +
Clinicians Trained and Tracking SDoH, CLAS, and Evidence Based Diabetes Tools

160,217
Social Determinant of Health (SDoH) Data Elements Captured via CFYH

17,200 +
Race, Ethnicity and Language (REaL) Data Elements Captured

500
Patient SDoH Gaps Closed
HCDI Lead Programs and Partnerships

277
Patient SDoH Food Insecurities Identified (Diabetic Population)
HCDI Lead Programs and Partnerships

Better Health | **Improved Care** | **Lower Cost**

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THANK YOU FOR YOUR TIME AND INTEREST IN HCDI

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Achieving Care for the Whole Person through Community Partnerships

Maryland Department of Health's 16th Health Equity Conference

December 5, 2019

UnitedHealthcare
Community Plan

UnitedHealthcare Community Plan of Maryland

UnitedHealthcare Community Plan

Mission

Helping people live healthier lives and helping make the health system work better for everyone.

Vision

Be the most trusted name in health care.

- UnitedHealthcare Community Plan of Maryland provides services and coverage for over 145,000 Medicaid HealthChoice members.
- Across Maryland under three core lines of business, UnitedHealthcare serves 830,000 members.
- UnitedHealth Group is the proud employer of over 300,000 Marylanders.

Complex Needs Addressed in Siloed Systems

UnitedHealthcare Community Plan

Medical

Diabetes
Heart Failure
Kidney Failure
Pain Syndromes

Behavioral

Schizophrenia
Bipolar Disorder
Factitious Disorder
Borderline Personality Disorder

Social

Homeless
Hungry
Unemployed
Disabled
Criminal Record
No Transportation

Substance Use

Alcohol
Heroin
Cocaine
Prescription Medication

Age & Frailty

Hospice
Life Expectancy
Palliative Care

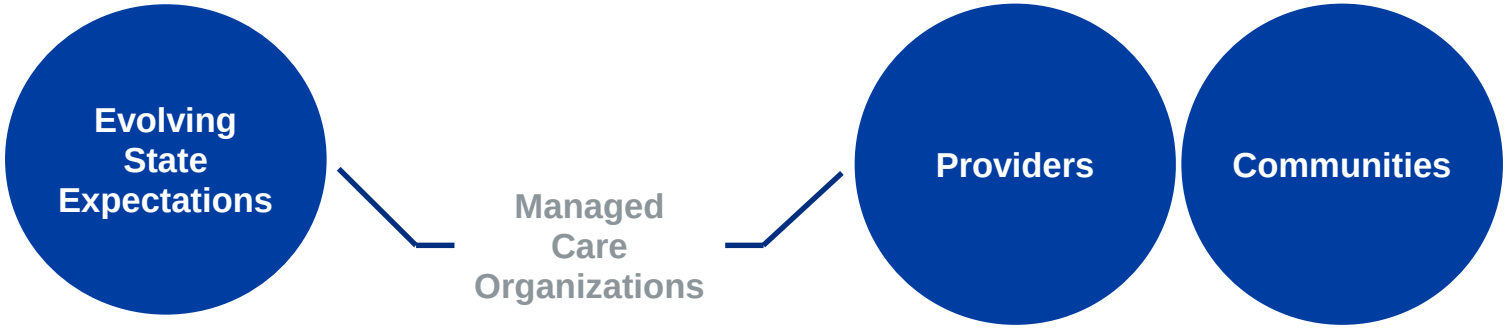
Functional Status

Eating
Bathing
Dressing
Personal Hygiene
Toileting
Transferring From Bed or Chair

A Transforming Health Care System

UnitedHealthcare Community Plan

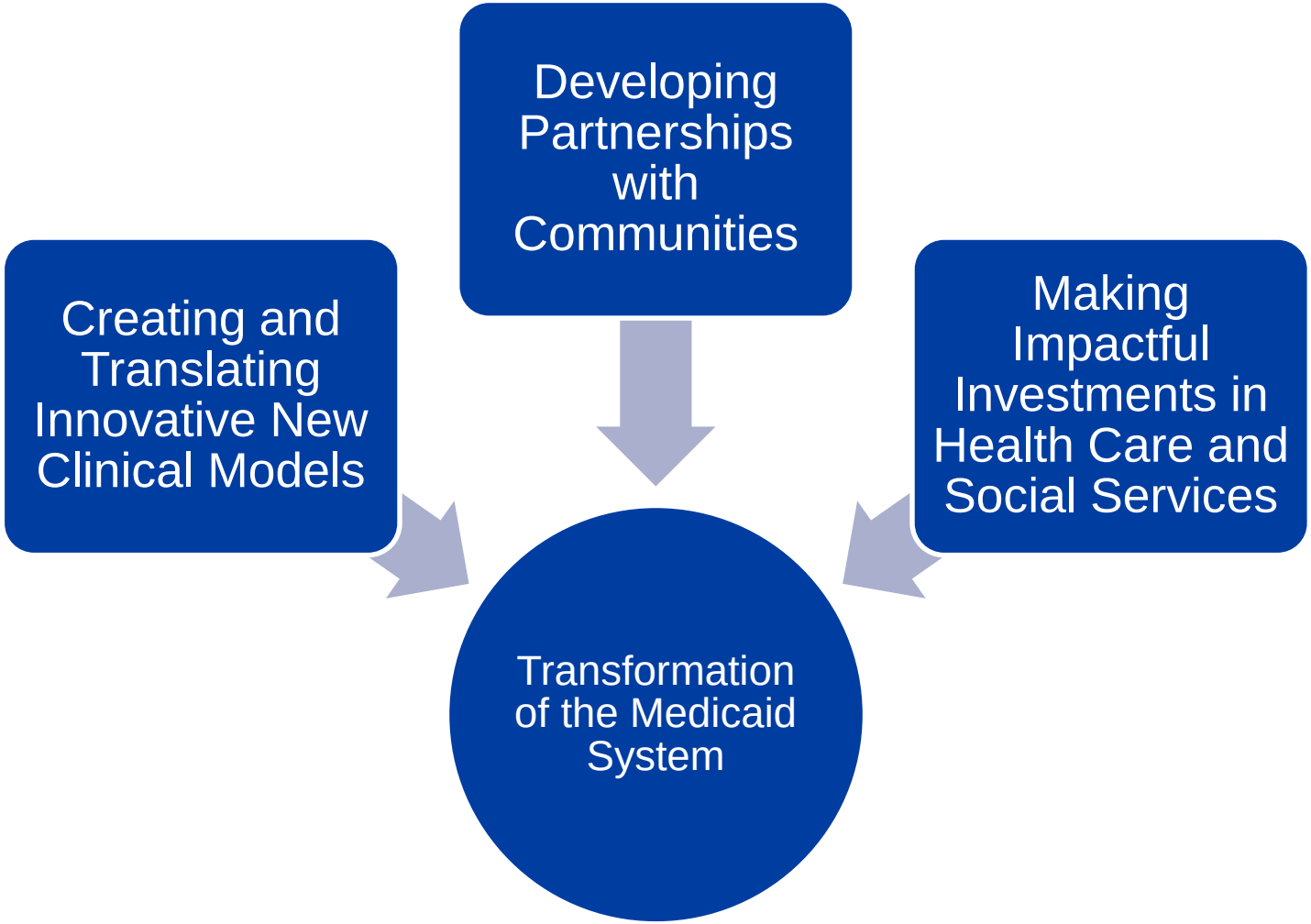
States are requiring providers and organizations to improve quality, reduce costs, and deliver impact while meeting both the health AND social needs of Medicaid members.



Managed Care Organizations are in position to bridge the gap between these evolving states requirements and the ability of providers and capacities of communities to meet them.

UnitedHealthcare's approach to bridging the gap for providers and communities

UnitedHealthcare Community Plan



Transforming Care for Medicaid Members: Creating and Translating Innovative New Clinical Models

UnitedHealthcare
Community Plan

What is Whole Person Care?

UnitedHealthcare Community Plan

1. Member-centric care model

- Integrated care coordination team (medical, behavioral, social, specialty)
- Single point of contact to coordinate overall care
- Incorporation of provider and specialists

2. Single technology platform for Case Management

- Strategic use of additional data platforms and tools [CRISP]

3. Expanded identification stratification into Emerging Risk population

- Identifies the **impactable** members **predicted** to likely be in the top 15% of costs unless an intervention is made

4. Supports all identified populations under a single leadership and oversight structure including:

- *Persistent Super Utilizers* - Highest cost members and/or individuals with chronic and/or complex illnesses
- *Emerging Risk* – expanded, newly managed population
- *Transition Case Management* – Medical and Behavioral health
- *Direct Referrals* – from Clinical Continuum Team
- *Maternity/Healthy First Steps*

5. Standardized solution across states provides:

- Scalability, Consistency, and Improved Quality

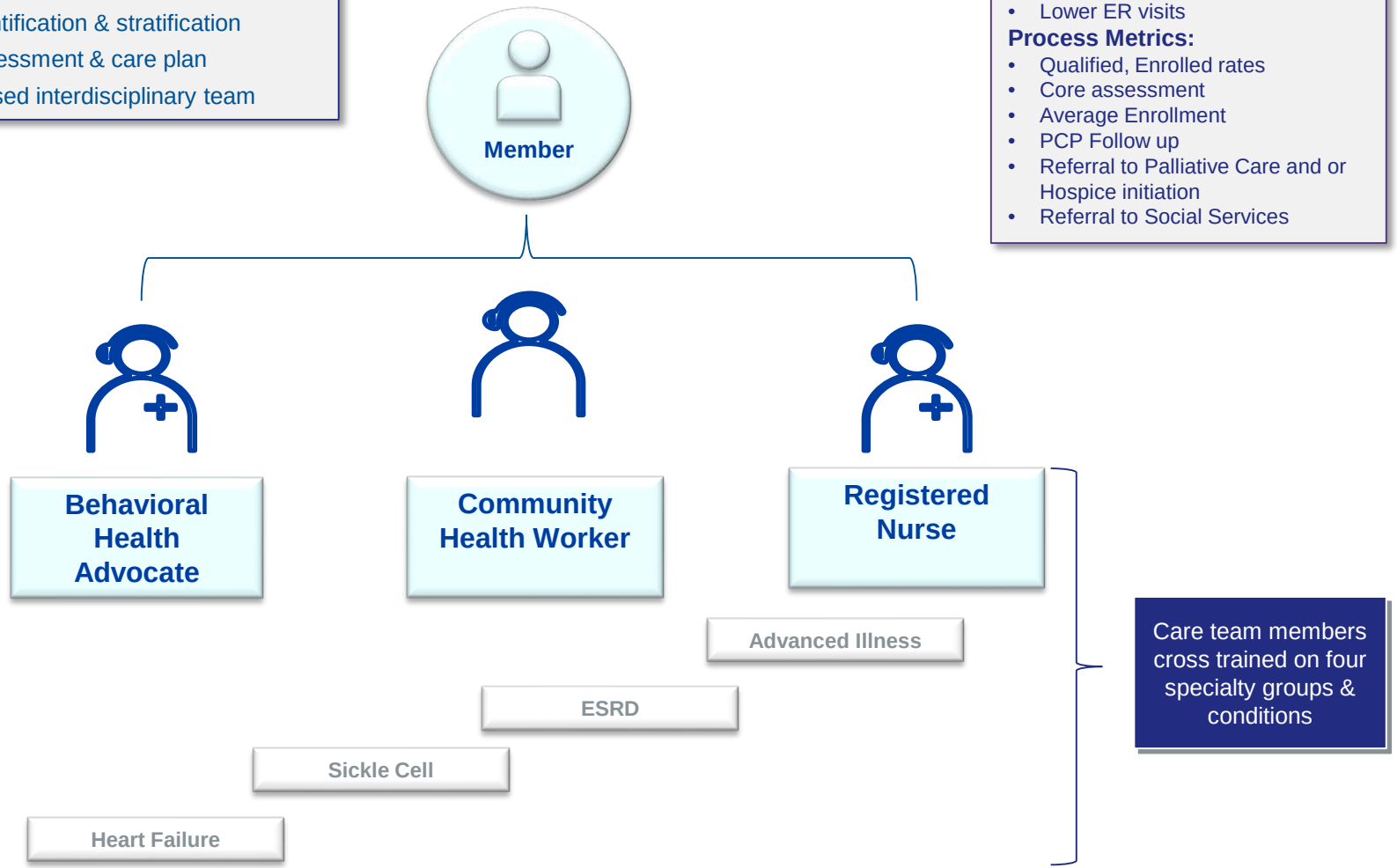
Whole Person Care Clinical Design

UnitedHealthcare Community Plan

- **Components of the Whole Person Care Model**
- Single point of contact
- Single identification & stratification
- Single assessment & care plan
- Locally based interdisciplinary team

Targeted Outcome:
- Increased Provider visits
- Lower Impatient Admits
- Lower ER visits

Process Metrics:
- Qualified, Enrolled rates
- Core assessment
- Average Enrollment
- PCP Follow up
- Referral to Palliative Care and or Hospice initiation
- Referral to Social Services



The Internal Care Team

UnitedHealthcare Community Plan

Clinical

- **Registered Nurse (RN)** Clinical Consultant for all medical clinical issues referred by the whole person care team. Primary case owner on medically intensive cases charged with developing a member centric, clinical plan of care.
- **Behavioral Health Advocate (BHA)** Clinical Consultant for all behavioral clinical issues referred by the whole person care team. Primary case owner on behavioral intensive cases charged with developing a member centric, clinical plan of care.
- **Medical Director** Physician support on case consult and case rounds
- **Pharmacist** Review and assessment of history, safety and cost effectiveness. Case rounds participation and case consult support

Non-Clinical

- **Field Community Health Worker (FCHW)** locally based non clinical care coordinator tasked to help members navigate the health system and gain access and coordinate the services required by the clinical plan of care agreed upon with their care provider
- **Virtual Community Health Worker (VCHW)** Virtual (telephonic) non clinical care coordinator tasked to help members navigate the health system and gain access to the services required by the clinical plan of care agreed upon with their care provider

How are members identified? Hotspotting

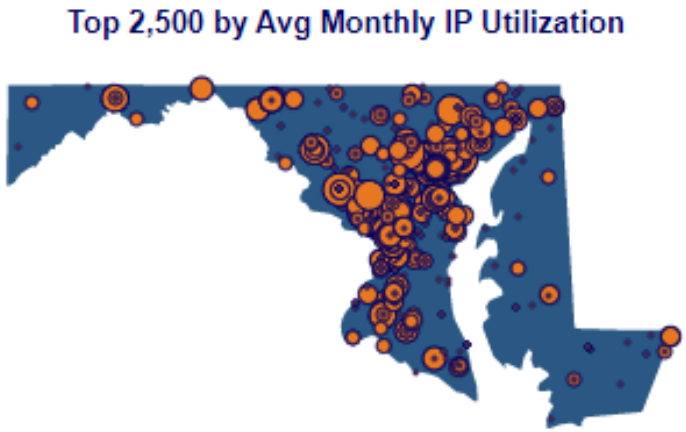
UnitedHealthcare Community Plan

METR PMPM | METR Spend | IP Admits/K | ER Visits/K | METR BCR | Members

A strategic use of data to identify high risk, high cost individuals in order to better address their complex needs, improve their quality of care, and reduce spend through a team based model of care.

Data filters can further be refined by:

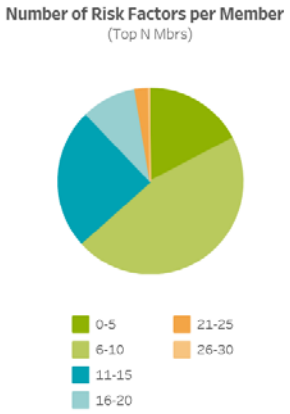
- **Diagnosis cohorts**
- **Social determinants**
- **Health care utilization**
- **Geographic location**

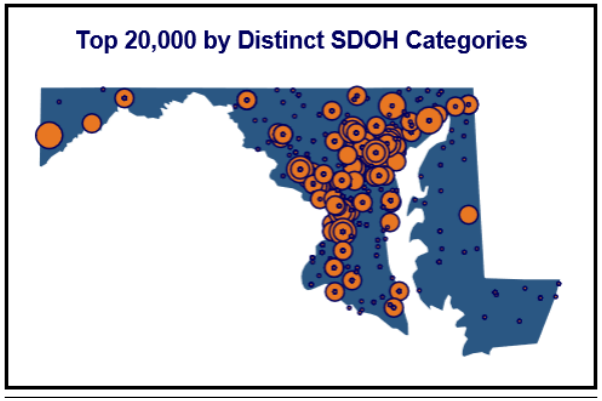


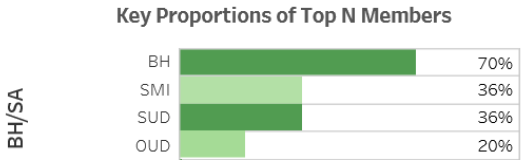
Hotspotting: Filtering perspectives

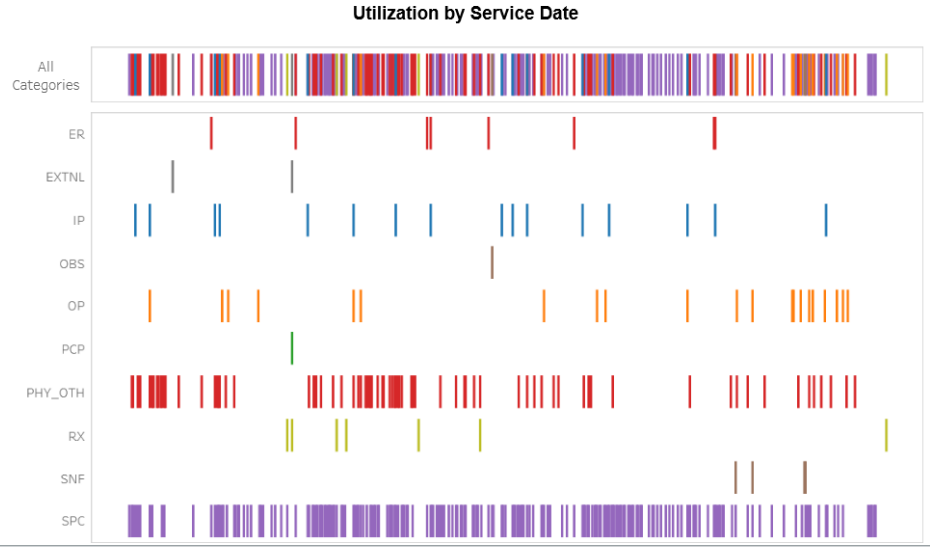
UnitedHealthcare Community Plan

For example, a data filter of the top 20,000 members filtering by distinct SDOH categories reveals that 70% also may have a behavioral health diagnosis and > 6 risk factors









Primary Risk Factor Rank by Member Count
(Top N Mbrs)

1	Substance Abuse	233
2	Other neurology	194
3	COPD, including asthma	160
4	Diabetes	132
5	Orthopedic trauma, fracture or dislocatio	92
6	Joint degeneration/inflammation	83
7	Epilepsy	78
8	Psychotic/schizophrenic disorders	76
9	Mood disorder, bipolar	69
10	Other cardiology	69

Mary's Journey

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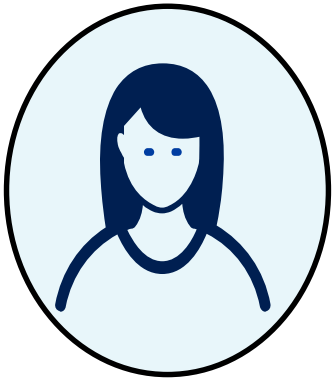

Medicaid Member

Medical and Social Needs Assessment:

- Cardiovascular disease
- Neurogenic Bladder
- Anxiety
- Depression
- Unemployed
- Housing Need

Connected with PCP and BH Services

Assisted member with Housing Application

Member was identified January 2019, however
Member at first was not interested in engaging
Successful Engagement began in March 2019-Present with CHW

	Pre-intervention 7 Months	Post-intervention 7 Months
Avg. Monthly Cost of Care	$21,500	$8,000
ER Visits	9	5
Inpatient Admits	6	2
Inpatient Days	18	17

Member-Centered Plan Created:

- Purpose-centered case management with goal planning
- Monthly care coordination (primary and specialty) to ensure compliance , understanding and follow through.
- Assisted member in finding community resources based on need identified
- Educated Member on preparation for provider visits (i.e.: medication list, questions)

Transforming Care for Medicaid Members: The Power of Partnerships

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