HEALTH DATAPALOOZA® 2016 HOSTED BY AcademyHealth

SESSION 5: SOCIAL DETERMINANTS AND WHAT TO DO WITH THEM: IMPROVING COST PROJECTIONS AND NAILING RESOURCE ALLOCATION

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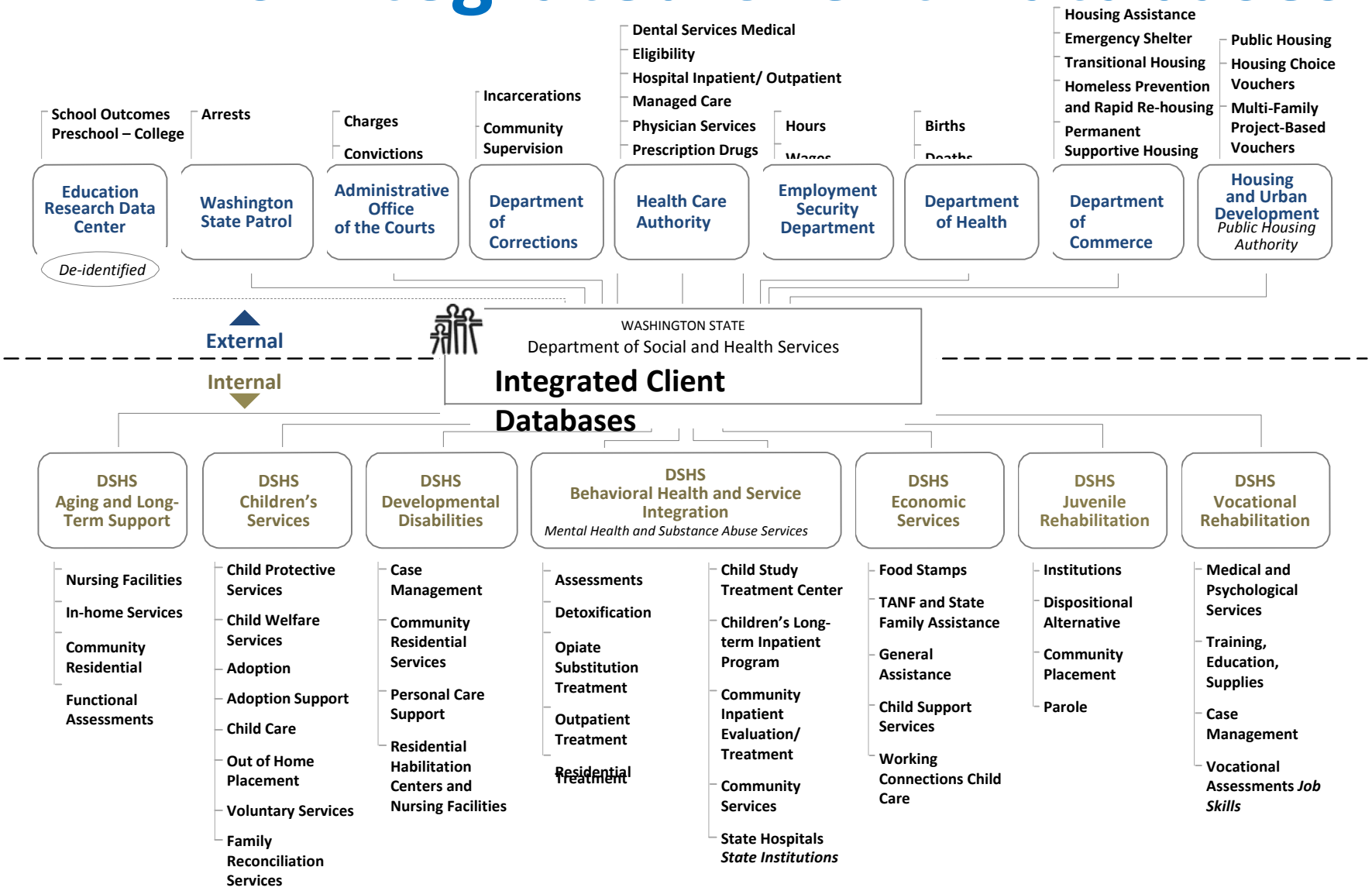
Putting Social Determinants into Practice

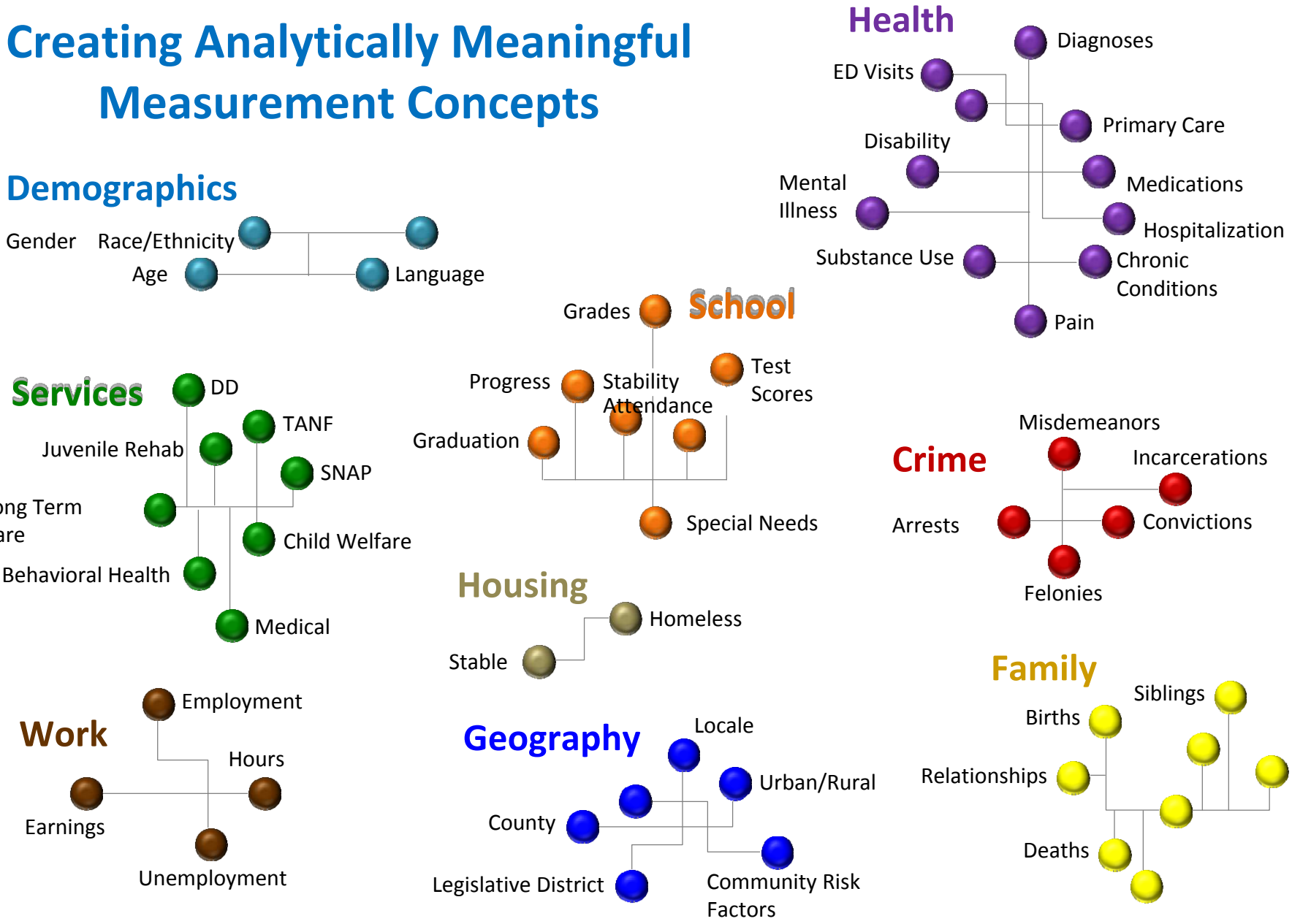
- Washington Medicaid
- Colorado Medicaid
- Rocky Mountain Health Plan

Washington - Improving Service Delivery Through Administrative Data Integration and Analytics

RDA's Integrated Client Databases



Creating Analytically Meaningful Measurement Concepts



PRISM: Rapid-Cycle Predictive Modeling and Data Integration in a Clinical Decision Support Web Application

- Data sources
  - Medical, mental health and LTSS services from multiple IT systems
  - Medicare Parts A/B/D data integration for dual eligibles
  - LTSS functional assessments
  - Housing status (including some local jail stay data) from the State's eligibility data system
- Data refreshed on a weekly basis for the entire Medicaid population
- Dynamic alignment of patients to health plans and care coordination organizations, with global patient look-up capability for providers
- 1,000 currently authorized users
- 700,000 page views in past 12 months

Selected PRISM Uses

- Triaging high-risk populations through predictive modeling to more efficiently allocate scarce care management resources
  - Informing care planning and care coordination for clinically and socially complex persons through integrated and intuitive display of risk factors, service utilization and treating providers
  - Identification of child health risk indicators including mental health crises, substance abuse, excessive ED use, and nutrition problems

Colorado's Accountable Care Collaborative: Medicare-Medicaid Program (ACC:MMP)

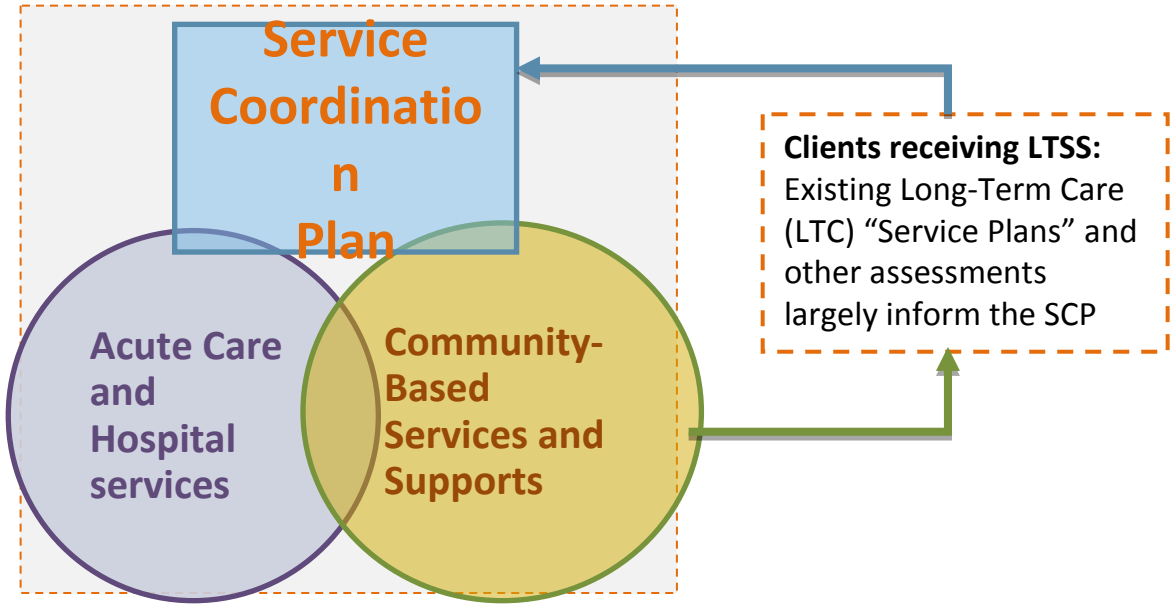
Service Coordination Plan

Making Medicare and Medicaid work better together for our clients

New System for MME's

Coordination of Primary Care, Acute, Sub-Acute, and Specialty Care

RCCO Coordinates **both** acute and community-based services for **ALL** enrolled clients



Clients receiving LTSS: Existing Long-Term Care (LTC) "Service Plans" and other assessments largely inform the SCP

Service Coordination Plan

- **Single, comprehensive** view of all elements needed to coordinate client's physical, behavioral and social health care services and supports
- Promotes **communication and coordination** across delivery systems and among providers
- **Completed w/client, capturing their needs and wants**

What other Assessments/Care Plans May Exist?

Plan of Care or Assessment	Who Receives this?	Who Assesses?
ULTC 100.2	Any Medicaid client seeking waiver benefits	Single Entry Point (SEP) or Community Centered Board (CCB) Case Manager
Long Term Care "Service Plan"	All Medicaid clients receiving Long Term Supports and Services and ALL HCBS waiver clients	Single Entry Point (SEP) or Community Centered Board (CCB) Case Manager
Developmental Disability Section Service Plan *Not required	clients on HCBS-SLS, HCBS-DD, or HCBS-CES waiver	Community Centered Board (CCB) Case Manager
Supports Intensity Scale (SIS)	clients on HCBS-SLS, HCBS-DD waiver	Community Centered Board (CCB) Case Manager
Intake / Initial Assessment For Behavioral Health Services	Clients seeking or receiving behavioral health services	Behavioral Health Organizations (BHOs) or Community Mental Health Centers (CMHCs)

d. TRANSPORTATION REQUIREMENTS OR PREFERENCES ☐N/A

i. ☐ Fixed route bus	iv. ☐ Paratransit/demand response eligibility	vii. ☐ Taxi
ii. ☐ Personal vehicle	v. ☐ Non-Medical transportation to Day Program	viii. ☐ Medical transportation
iii. ☒ Family or Friends	vi. ☐ Door-to-Door Attendant	ix. ☐ Other:

Barriers To Care/Access: Friends/family are not reliable during inclement weather.

e. TRANSPORTATION ASSISTANCE NEEDED ☐N/A

i. ☐ Travel training	v. ☐ Orientation and mobility instruction	viii. ☐ Escort
ii. ☒ Para transit scheduling	vi. ☐ Non-medical transportation	ix. ☐ Medical transportation
iii. ☐ Vehicle transfer	vii. ☐ Training for fixed-route bus	x. ☐ Other:

iv. ☒ Eligibility establishment for paratransit/demand response use

Barriers To Care/Access:

f. EMPLOYMENT/SCHOOL INFORMATION Unemployed. Discussed work prep courses offered by local CMHC. Daisy expresses no desire to pursue at this time but would like to revisit this in the future when health improves and she does not feel so sad.

Barriers To Care/Access:

g. PHYSICAL DISABILITY ☒ N/A

i. ☐ Mobility	Describe:
ii. ☐ Physical	Describe:
iii. ☐ Hearing	Describe:
iv. ☐ Vision	Describe:
v. ☐ Multiple Disabilities	Describe:
vi. ☐ Specific Disability	Describe:

h. INTELLECTUAL DISABILITY, INCLUDING DELIRIUM AND DEMENTIA none stated

i. ASSISTIVE TECHNOLOGY NEEDS ☒N/A

i. ☐ Mobility appliances	v. ☐ Shower bench	ix. ☐ Lifting chair
ii. ☐ Shower chair	vi. ☐ Transfer equipment	x. ☐ Home modifications
iii. ☐ Cane, walker, crutch	vii. ☐ Power wheelchair	Describe: _____
iv. ☐ Manual wheelchair	viii. ☐ Brace(s) or Prosthetic(s)	xi. ☐ Other

Client Still Needs: Describe: _____

Barriers To Care/Access:

j. EXISTING MENTAL HEALTH/SUBSTANCE USE DISORDER

Daisy states that she has recurrent depression symptoms (sadness, hopelessness, crying, and loneliness). She would like assistance to connect with mental health services.

Barriers To Care/Access:

k. PREFERENCE FOR LIVING ARRANGEMENT (identify any housing concerns)

Daisy lives alone in a rental apartment. She doesn't wish to change her living arrangement at this time.

Barriers To Care/Access:

l. COMMUNITY RESOURCES USED

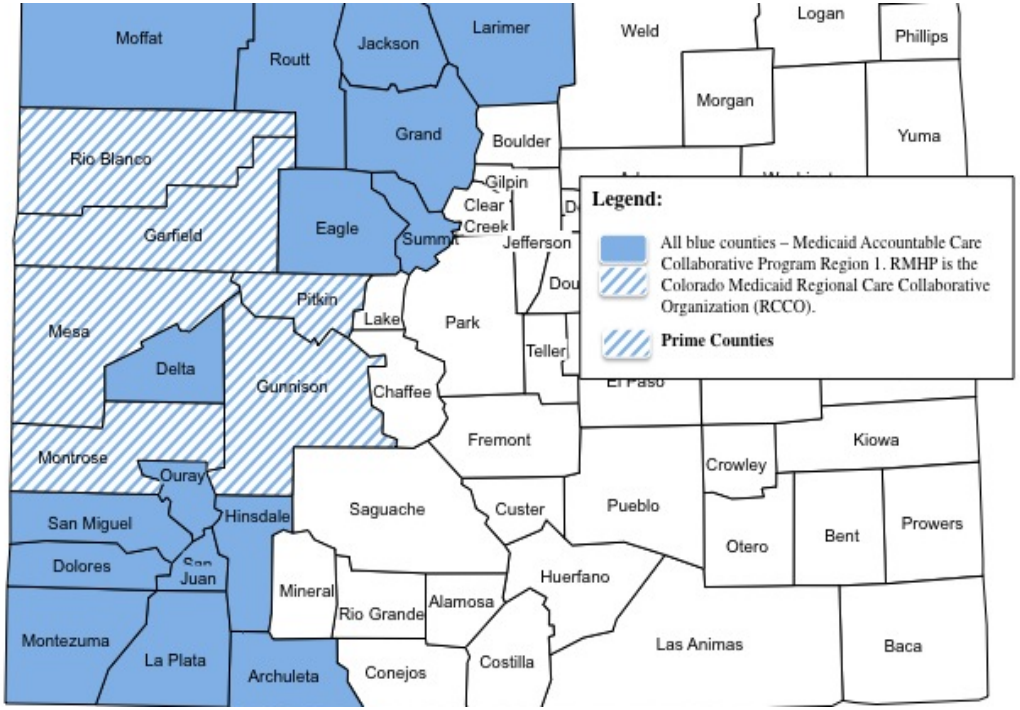
Daisy and I discussed available resources. She plans to look into a local class on nutrition at the rec center around the corner. I suggested she may also obtain information about exercise classes, when the time is right. She then said she thought they may also have a board game night, which she thought she might enjoy.

Barriers To Care/Access:

m. FOOD

Rocky Mountain Health Plan

Who is Rocky Mountain Health Plans?



- Independent, 501c(4)
- Serving 350,000 people
- All types of health coverage – group, individual, self-funded, ACA, Medicare, and Medicaid
- Focused on Western Colorado
- Committed to health equity

A Phased Approach

How it started Convened organizations responsible for care coordination, care management and case management including:

- Primary care offices
- Community Mental Health Center
- County Public Health and Human Services Departments
- Home Health
- Hospice
- RMHP Care Coordinators
- Hospital discharge coordinators
- Assisted living and LTACs
- ILCs
- …and others

Social

SOCIAL

Living Status:

- ☐ Home
  - ☐ Alone
  - ☐ Caregiver _____
    - ☐ Partial Support
    - ☐ Full Support
- ☐ Nursing Home
  - ☐ Rehab / Skilled _____
  - ☐ Long-Term _____
- ☐ Assisted Living Facility _____
- ☐ Residential Supported Living _____
- ☐ Homeless
- ☐ Long-Term Care Support Services / Providers _____
- ☐ Other _____

Social Barriers:

- ☐ Transportation _____
- ☐ Financial _____
- ☐ Housing _____
- ☐ Diet / Access to Food _____

Other: _____

Thank You!

Dr. Kevin Fitzgerald, CMO, Rocky Mountain Health Plan

David Mancuso, Ph.D., Director, Research and Data Analysis Division, WDSHS

Pamme Taylor, VP, Advocacy and Community Based Programs, Wellcare

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Lesley Reeder, Principal, Steadman Group

Dr. Kevin Park, National Medical Director, Molina Healthcare