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PRINCE GEORGE'S HEALTHCARE ALLIANCE, INC.

The Real Social "Influencers"

How Prince George's Healthcare Alliance is Breaking Down Barriers and Building Stronger Communities with SDoH

VBCExhibitHall.com

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Today's Presenters

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National Hunger & Homelessness Awareness Week

An annual program where people come together across the country to draw attention to the problems of hunger and homelessness

PGHA: What We Do

- **Prince George's Healthcare Alliance, Inc.,** is an award-winning 501 (c)(3), non-profit organization whose mission is to decrease over-utilization of health system resources and maximize quality-of-care coordination for high utilizers of healthcare resources.
- PGHA trains and deploys Community Health Workers (CHWs) to provide care coordination and deliver evidence-based interventions that address clinical, behavioral, and social determinants of health.

PGHA: Our Vision

Our vision is to help county residents change their health behaviors, to achieve their best health, and to optimize community health

PGHA Serves over 960,000 people, including:

- High-risk patients in poor control of their chronic illness
- High-risk patients needing connections to family and social services
- Patients with unmet behavioral health needs
- Patients in need of medication management
- Patients with no primary care physician (PCP)
- Patients who have not seen a PCP in >12 months
- Patients with no health insurance
- Patients with care gaps
- High-risk patients with a hospital readmission within 30-days for the same condition
- Very high-need patients who have 3 or more inpatient visits in one year
- Patients with multiple ED visits
- Patients with multiple 9-1-1 calls for non-emergent reasons

HealthEC's Tech-Enabled & Purpose-Driven Tool Streamlines Care Coordination

Social Determinants of Health (SDOH)

HealthEC's tech-enabled tool includes built-in assessments to document patient problems, goals, and barriers, and automatically schedules interventions to address positive social determinants.

- *Reduce hospital visits*
- *Cut hospital costs*
- *Provide care to underserved communities*
- *Improve community health outcomes*
- *Capture and track interventions*
- *Monitor care manager productivity*

Pathways to a Centralized PHM

1	Determine barriers	PGHA uses built-in SDOH assessment to auto-populate care gaps and Problems, Goals, Barriers, and Interventions.
2	Aggregate patient data	Data from siloed sources create a comprehensive care plan for PGHA that outlines patient medical, behavioral, and social needs.
3	Identify patterns	Tracking intervention timelines and completion status helps PCHA identify patterns in care delivery.
4	Design tactics to overcome implementation barriers	Care gap reporting, care manager contact tracking, and the intervention scheduler allow care managers to provide necessary oversight & schedule activities with daily reminders.
5	Collaborate with primary care networks	PGHA shares the care plan with the patient's care team and presents the care plan in case conferences.
6	Link to community resources	Referrals are recorded in the platform, allowing care managers to document resources and connections to CBOs, PCPs, specialists, behavioral health providers, and county agencies.

Community-based Population Health Model

Link to community resources

There is great value in connecting patients to community services, care coordinators, and communication services.

Improved health behaviors

Healthy behavior changes, including improvement in nutrition, exercise, sleep, hygiene, medications, etc., improve patient outcomes.

Care coordination technology platform

Unified view of clinical and operational data provides instant access to multiple facets of patient care and enables positive oversight.

Provide education

Education programs aligned with patient needs help to change health behaviors to optimize individual and community wellness.

Provider Engagement

Sharing comprehensive care plans with data from siloed sources enables providers to understand both the clinical and social aspects of their patients' care.

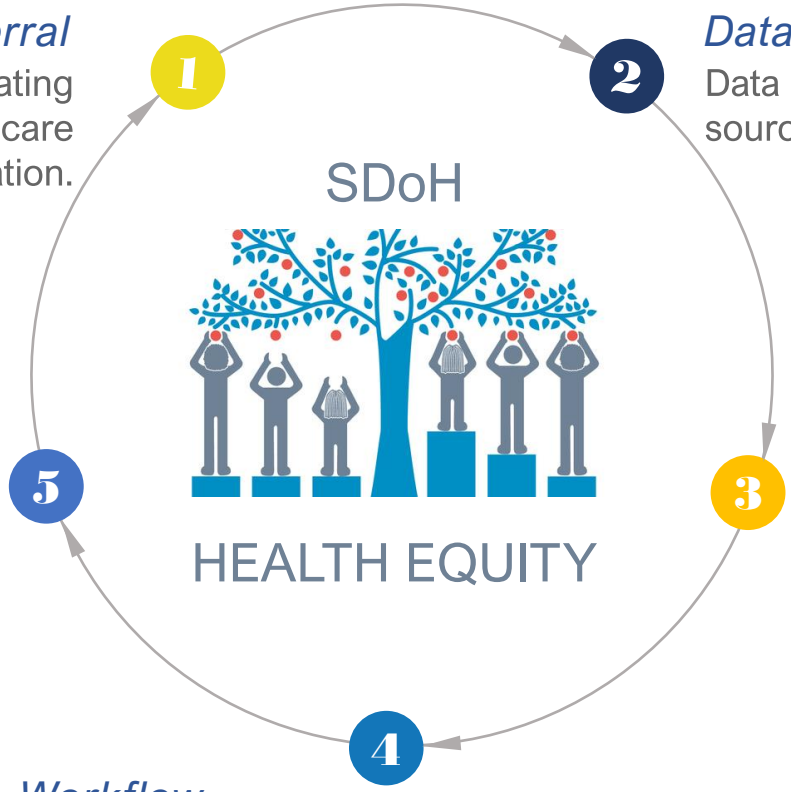
Collaborative SDoH Care Management

Referral

PGHA receives referrals from participating organizations for patients in need of care management coordination.

Data

Data on relevant patients received from siloed sources (HIE, providers, hospitals, etc.).



Follow-up

360-degree view of patient population facilitates data sharing with other entities tasked with providing care — pharmacy, behavior health, specialty care, etc.

Technology

Data warehouse and connectivity to quality measurement and reporting allow users to monitor utilization, compliance, and performance.

Workflow

- Embedded assessments address barriers to care and help connect beneficiaries to the services they need.
- Outreach, interventions, and outcomes are tracked.
- Data-driven collaboration between Medicaid agencies, payers, and providers is facilitated via shared reporting and care plans.

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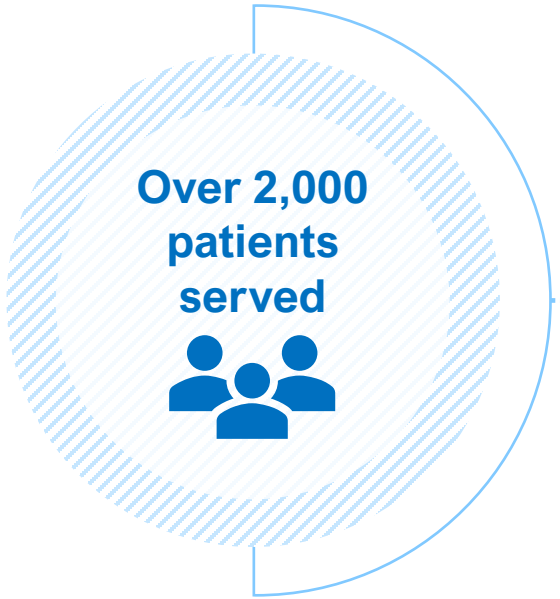
PGHA: Tech-Enabled Interventions

Using pre- and post-care management data reveals how addressing unmet social needs can improve outcomes and reduce costs.



Build Evidence-based Care Pathways

Care management was improved by creating and following evidence-based pathways.

Hospital Charges Per Patient Reduced By:

$11,138

The average reduction in hospital charges per patient went from **$18,929 to $8,699** six months after implementation.

Hospital Visits Per Patient Reduced By:

42%

Hospital visits per patient went from **3.55 to 2.05** six months after implementation.

Of the 2,000 patients that received SDoH screenings, 163 were enrolled in PGHA's Intensive Care Coordination Program.

PGHA sent 258 emails and texts and participated in 73 provider conferences on their patients' behalf, and 723 intervention pathways were created and completed.

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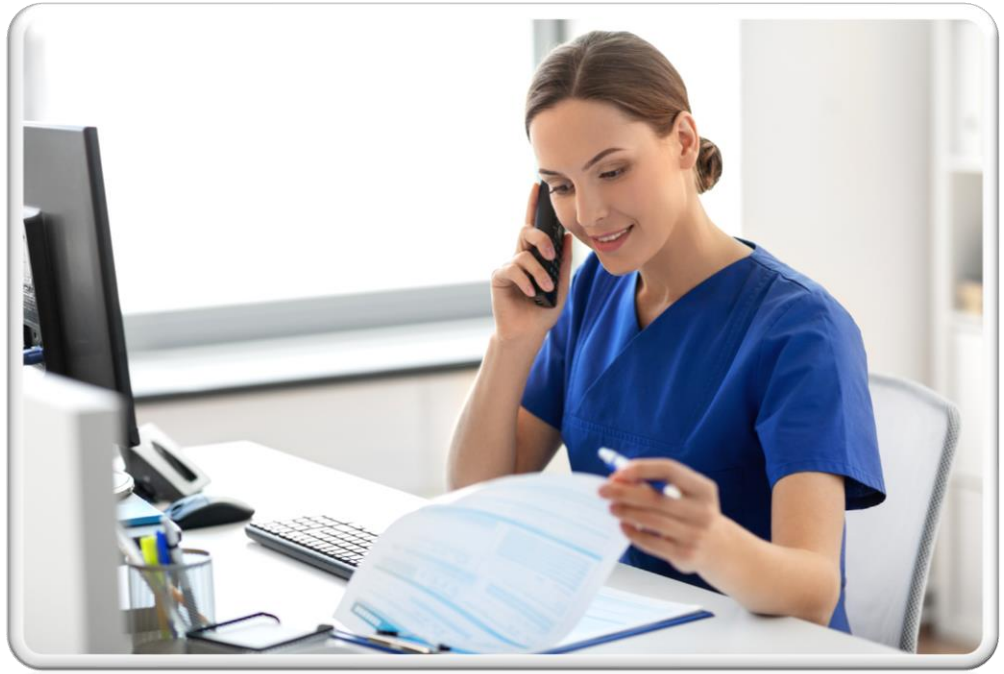
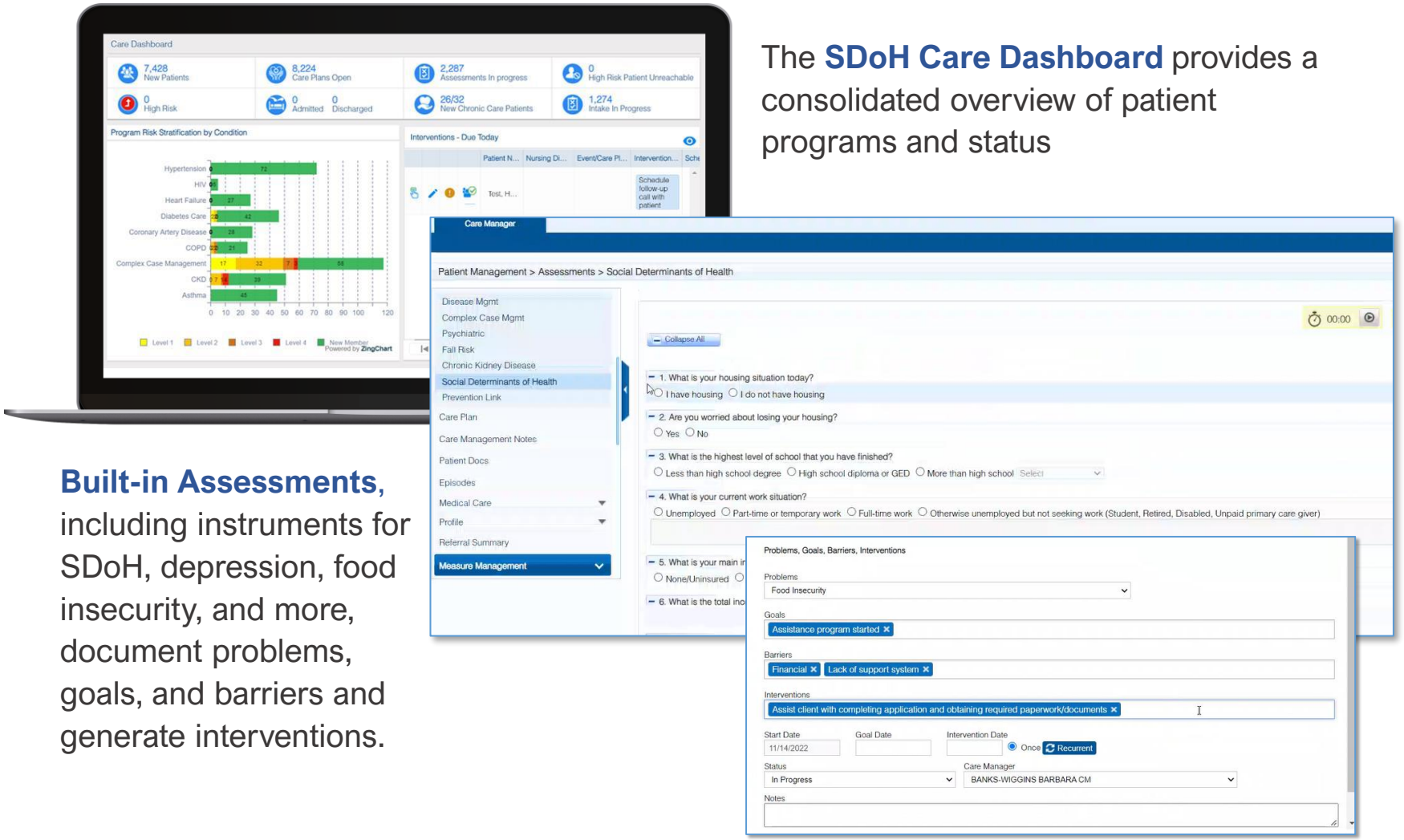
PGHA: Tech-enabled Outcomes

Care Productivity



HealthEC's CareConnect Platform



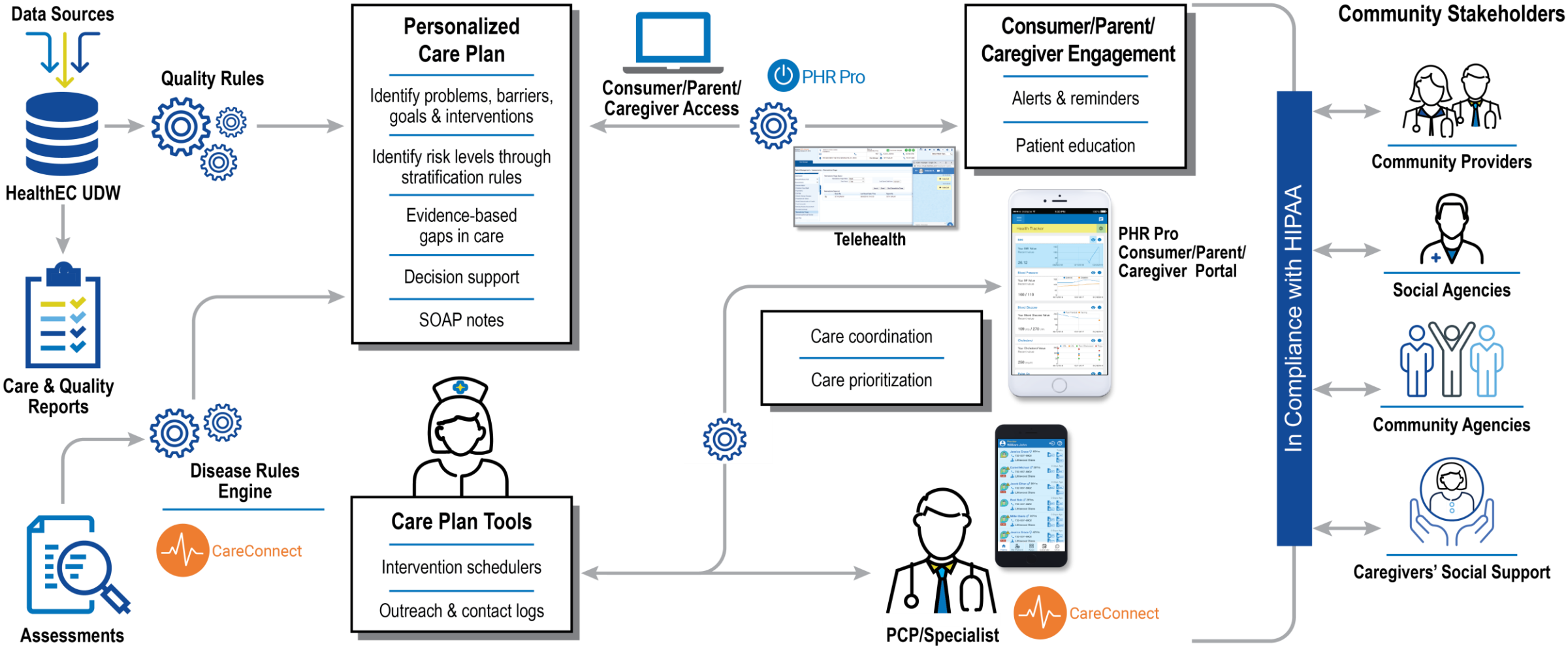
The **SDoH Care Dashboard** provides a consolidated overview of patient programs and status

Built-in Assessments, including instruments for SDoH, depression, food insecurity, and more, document problems, goals, and barriers and generate interventions.

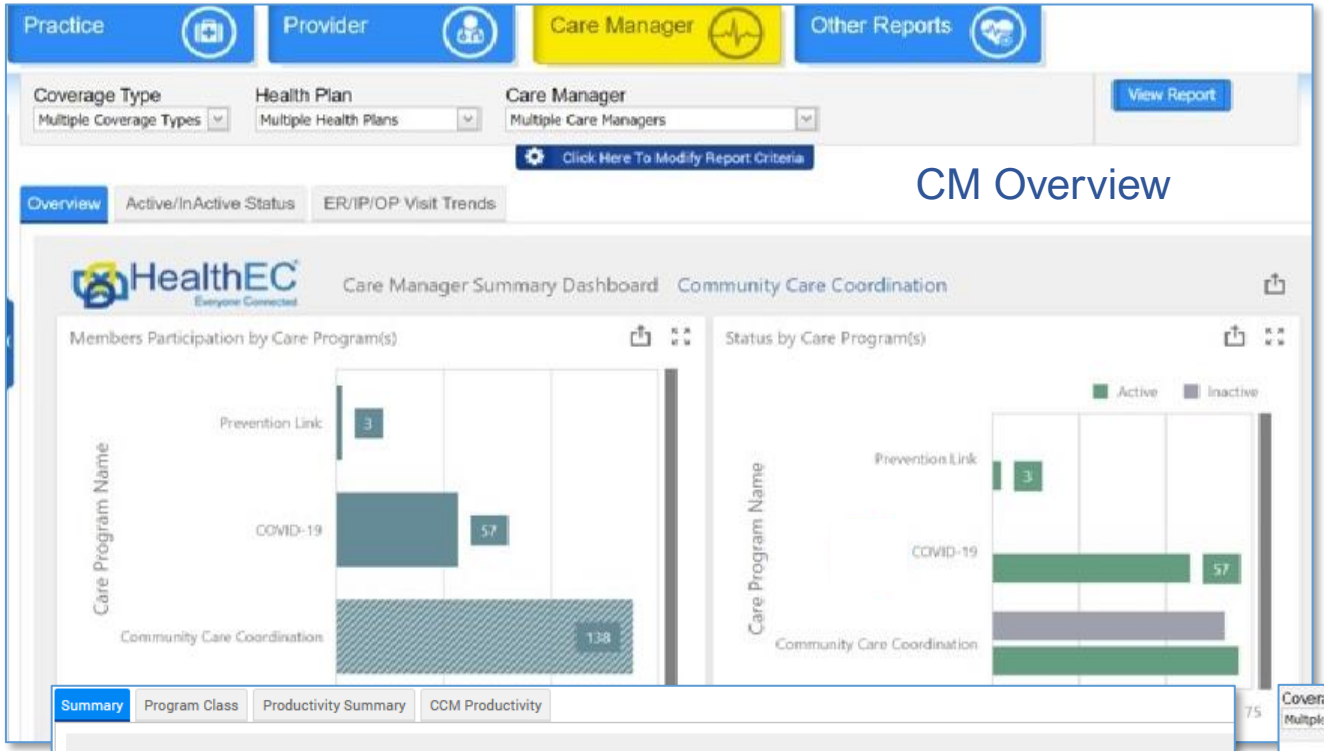
HealthEC's Best In KLAS population healthcare coordination platform provides:

- Built-in assessments with smart technology that creates documentation of patient's problems, goals, barriers, and interventions
- Guides intervention steps and scheduling
- Creates comprehensive care plans, snapshot views of client cases
- Tracks patient contacts
- Captures productivity

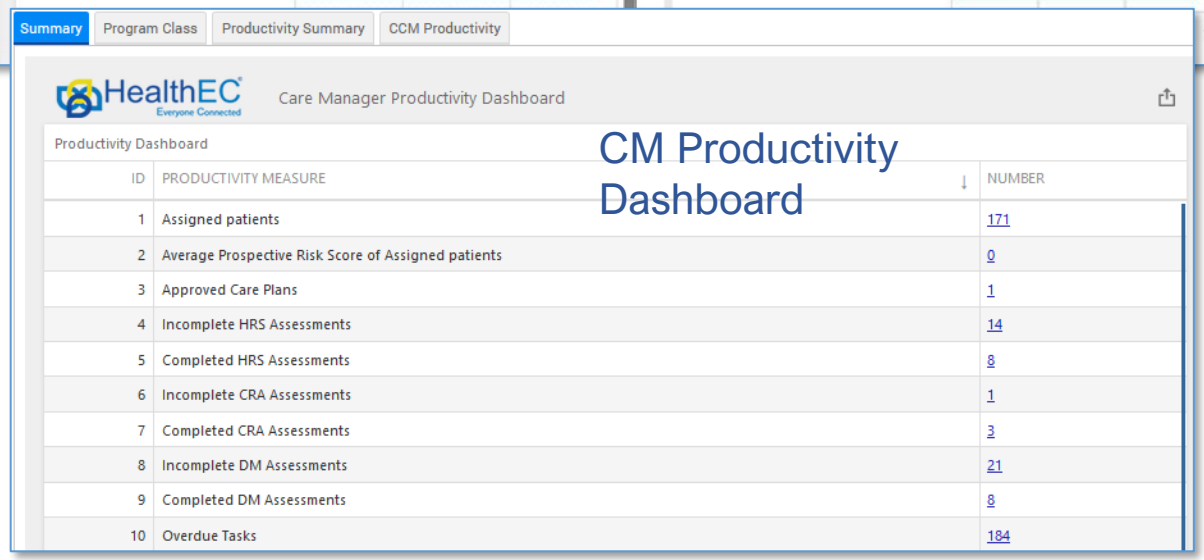
Workflow


Data Sources
HealthEC UDW
Quality Rules
Care & Quality Reports
Assessments
Disease Rules Engine
CareConnect
Personalized Care Plan
Identify problems, barriers, goals & interventions
Identify risk levels through stratification rules
Evidence-based gaps in care
Decision support
SOAP notes
Care Plan Tools
Intervention schedulers
Outreach & contact logs
Consumer/Parent/ Caregiver Access
PHR Pro
Telehealth
Care coordination
Care prioritization
PCP/Specialist
CareConnect
Consumer/Parent/ Caregiver Engagement
Alerts & reminders
Patient education
PHR Pro Consumer/Parent/ Caregiver Portal
In Compliance with HIPAA
Community Stakeholders
Community Providers
Social Agencies
Community Agencies
Caregivers' Social Support

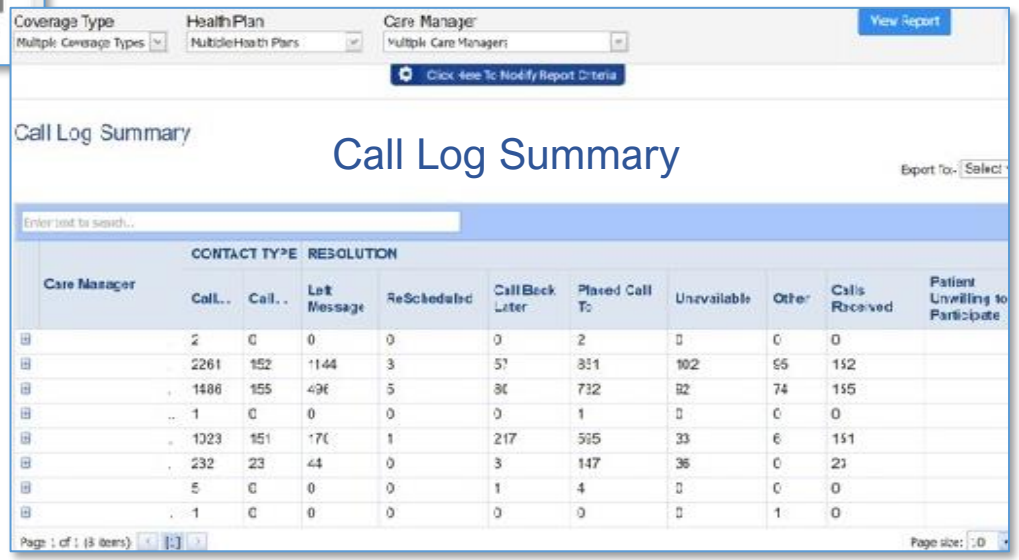
Care Manager Reports – Measuring Impact



CM Overview

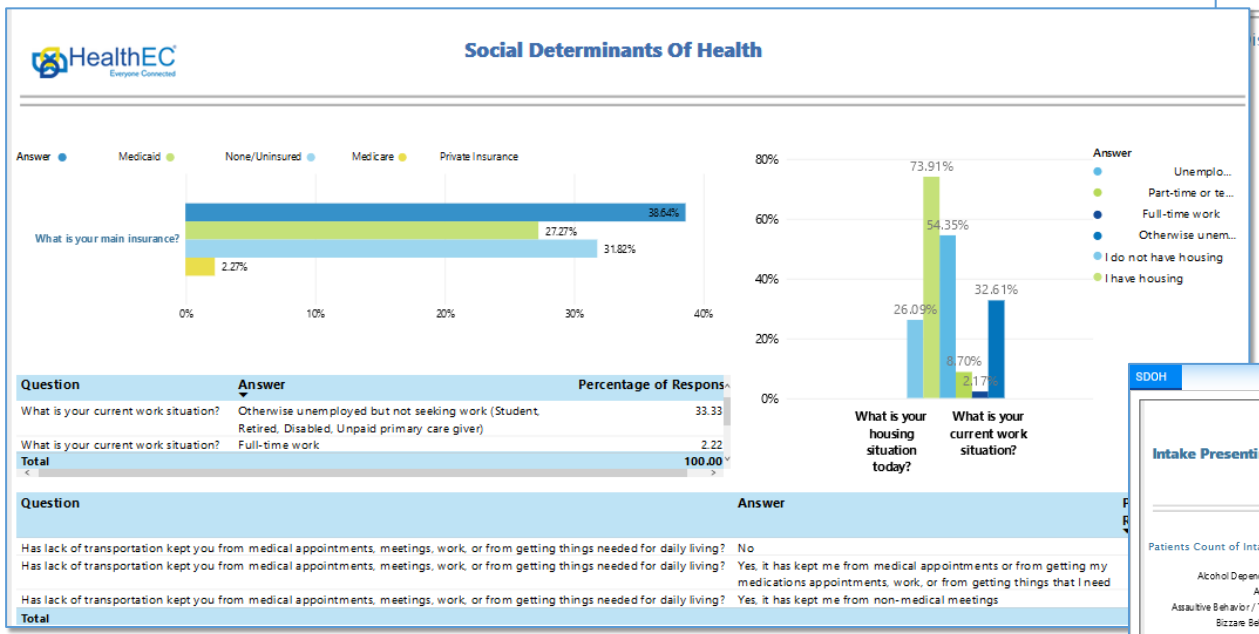


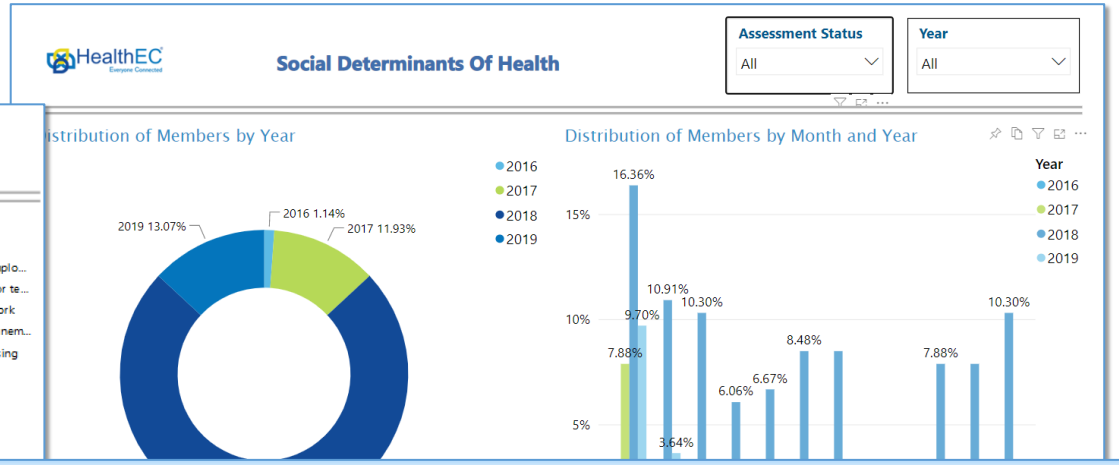
CM Productivity Dashboard

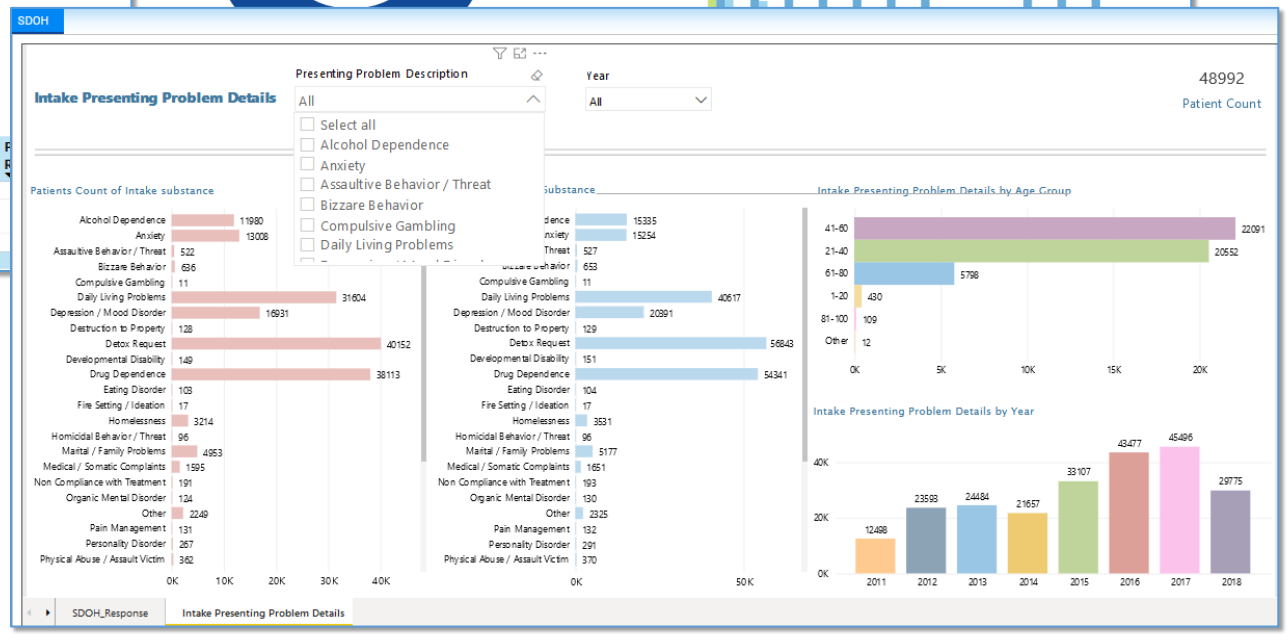


Call Log Summary

Assessment Dashboards







> We recognize that social determinants of health are responsible for about 80% of health outcomes — and while we can't fix them all, we can do our part.

Source: https://www.northwell.edu/katz-institute-for-womens-health/articles/healthcare-inequalities-putting-nation-at-risk?utm_source=native&utm_medium=display&utm_campaign=kiwh_2020

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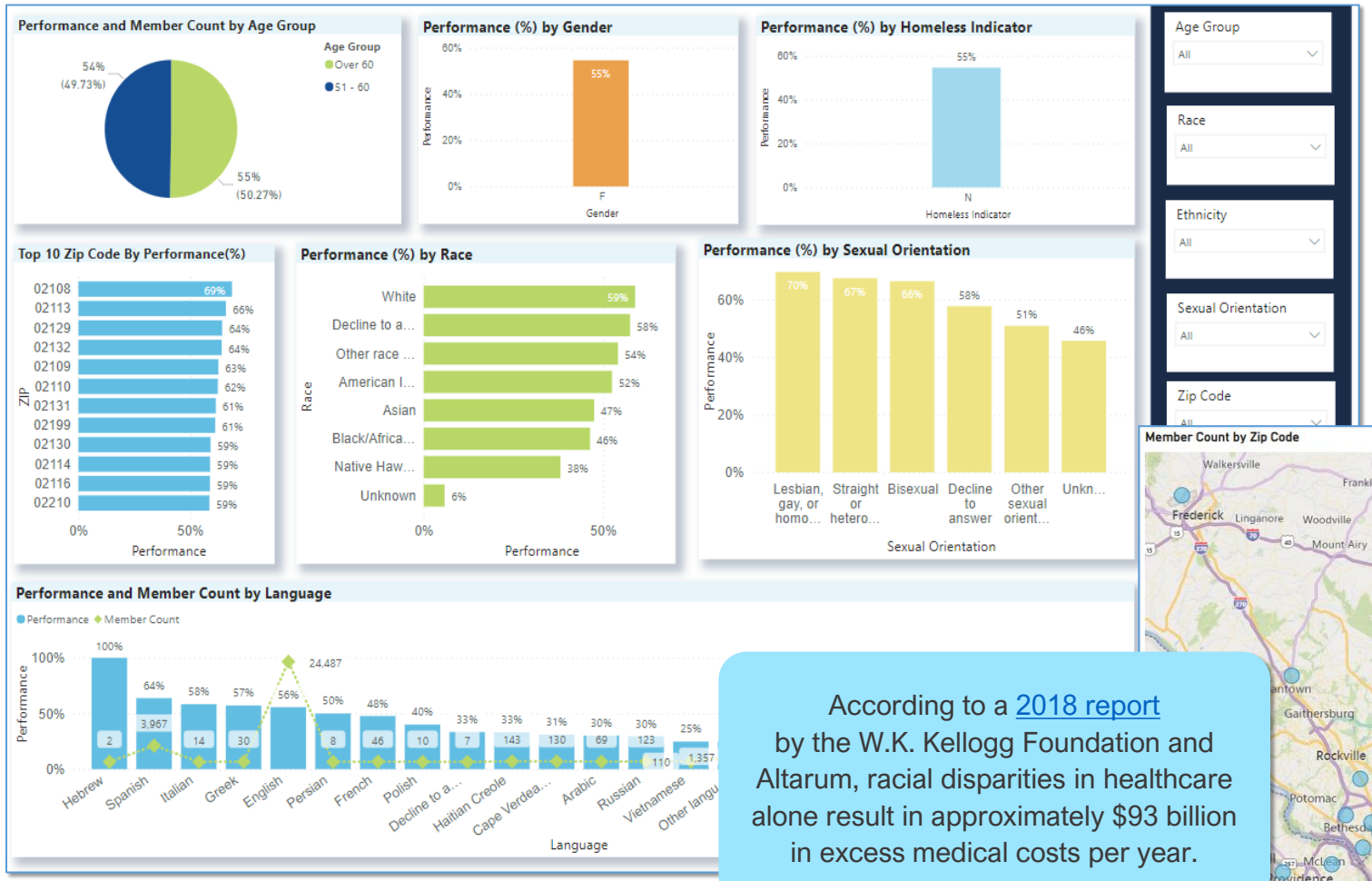
Health Equity Dashboard & Geo-mapping



- Patient and performance data can be viewed/filtered by demographics such as gender, age group, race, ethnicity, sexual orientation, ZIP code, and more.
- Health equity data can also be geo-mapped by ZIP code and filtered by various demographics to reveal location-based barriers to care.

According to a 2018 report by the W.K. Kellogg Foundation and Altarum, racial disparities in healthcare alone result in approximately $93 billion in excess medical costs per year.

Provider Testimonials

"The Healthcare Alliance are experts on CHW integration into team-based service delivery settings, and they have consistently provided this expertise in development of COVID Care Response Plans for the county. Prior to these efforts, the Alliance's CHW team implemented health education and patient navigation interventions that decreased hospital readmissions and frequent ED visits for high-risk patients. They have proven to be a premier non-profit care coordination program in the state."

"We love our partnership with the Healthcare Alliance."

"With HealthEC's services, we were able to achieve our desired outcomes for our value-based programs and overall organization integration."

"They have done a really nice job and have supported us. They keep our goals and interests in mind."

"HealthEC has worked hand in hand with us throughout the whole process. We have created dashboards with our member practices, and we use the data to guide them through the analytics process and to identify where to focus our efforts."

"The strength of our partnership with HealthEC is very high."

Challenges and Best Practices

Challenges	Best Practices
Practices may not be aware of screening tools and may not have staff available to focus on screenings.	Provide practices with guidance on how to identify possible SDoH-positive patients for referrals for care management coordination service.
Practices are uncomfortable screening their patients for SDoH because they may not have the resources to coordinate a response.	Develop an optimized list of services to which patients can be referred to better track and monitor follow-up.
Lack of data exchange capabilities between Health and Human Services and healthcare/community organizations contributes to care barriers.	Find a technology partner that understands SDoH and can provide the appropriate built-in assessments and support for reporting and data integration.
Practices may not realize the value that addressing positive SDoH brings to care management and outcomes.	Identify quality measures that can be tied to addressing SDoH as a way to evaluate and demonstrate ROI.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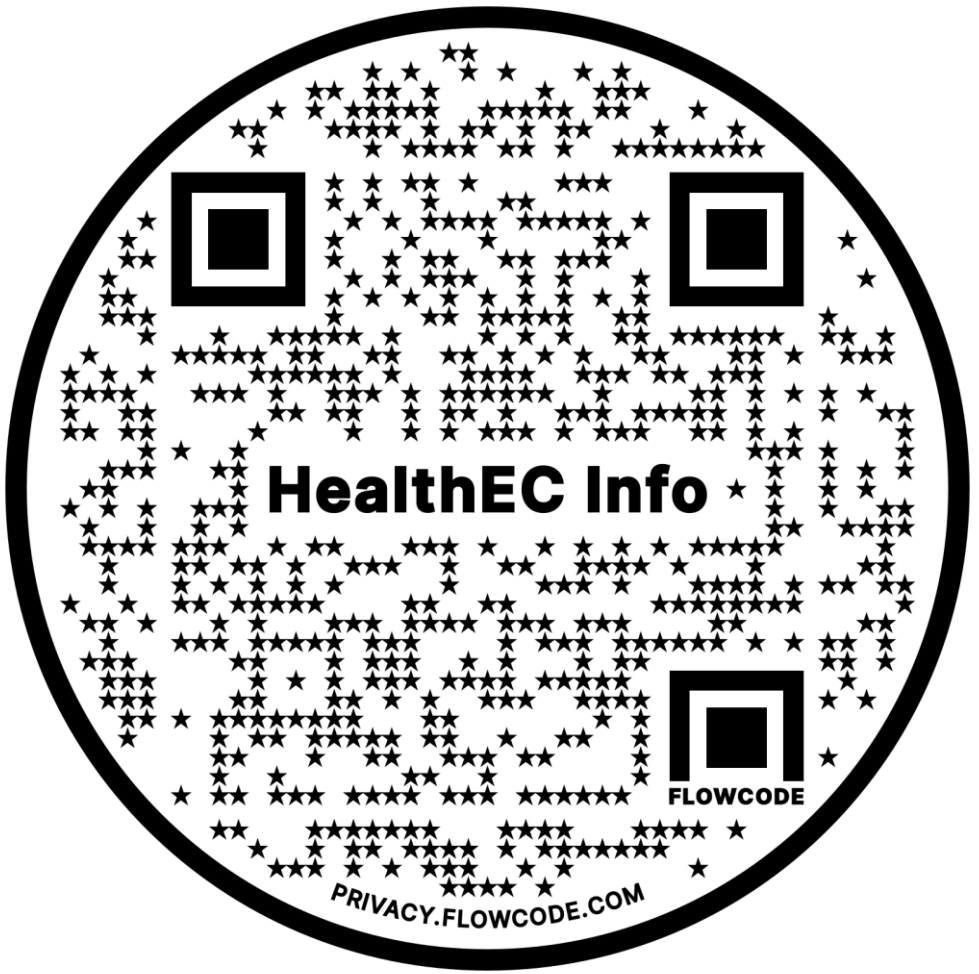

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