Northeast Valley Health Corporation

PHLN Year 2 Project Aim

1. Utilize and evaluate the Counting Chronic Conditions tool to stratify patients with Diabetes (DM) at Pacoima Health Center
2. Incorporate SDOH into Risk Stratification Model
3. Develop DM Care Coordination Model and define/refine team member roles

Measures for Success

1. Number of DM patients stratified into risk tiers by HbA1c (controlled and uncontrolled) and by site
2. % DM patients in Tier 3 & Tier 4 with a completed PRAPARE
3. Identify care coordination services per risk tier based on current resources and capacity
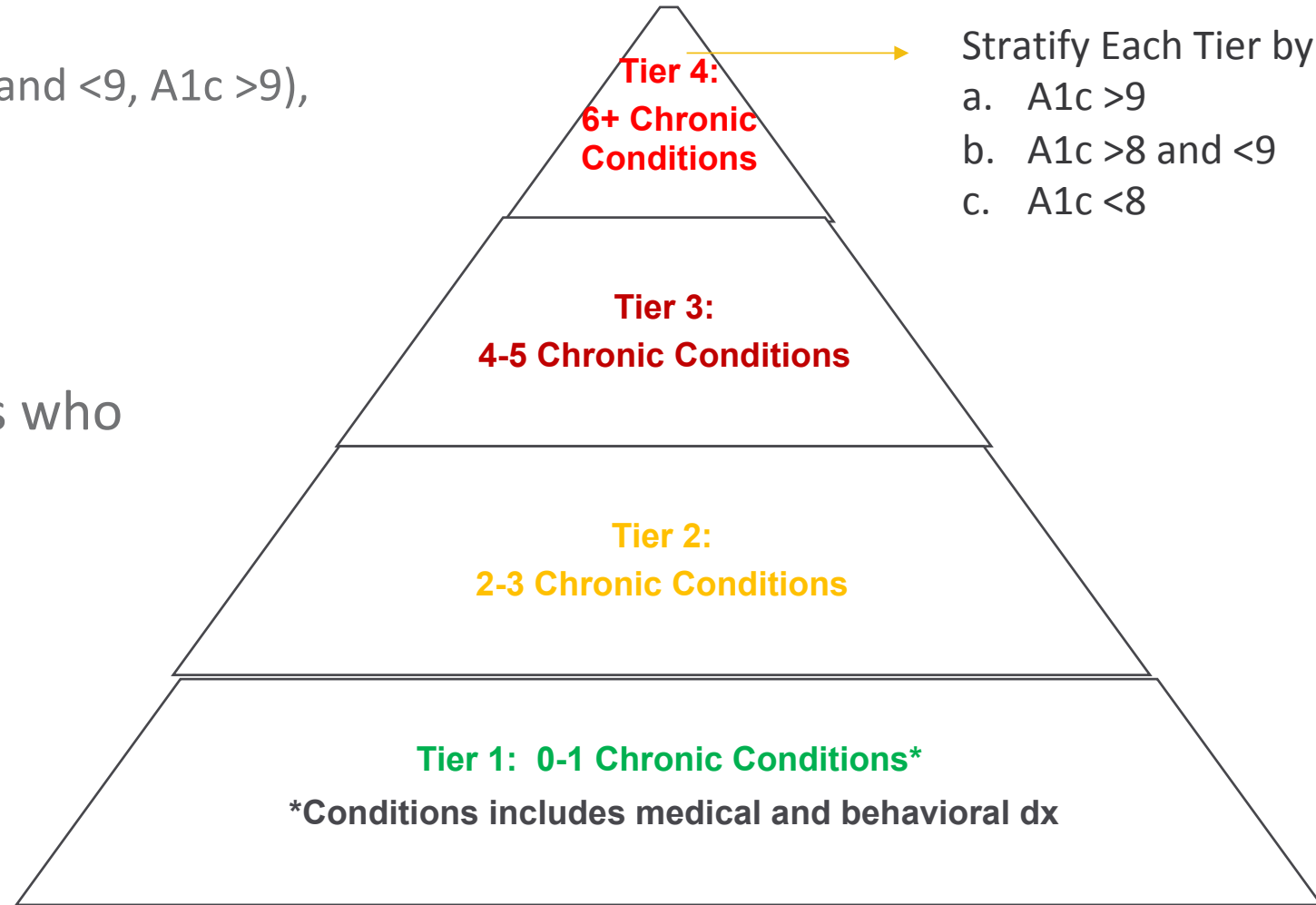
Changes

Tested Changes

- Counting Chronic Conditions (CCC) Tool

  - Compared to NACHC Clinical and Behavioral Health Risk national model "draft"

- PRAPARE Risk Score (Tallied Method)

- Developed a Diabetes Care Coordination Model a.k.a. a "Menu of Services" per risk tier

Implemented Changes
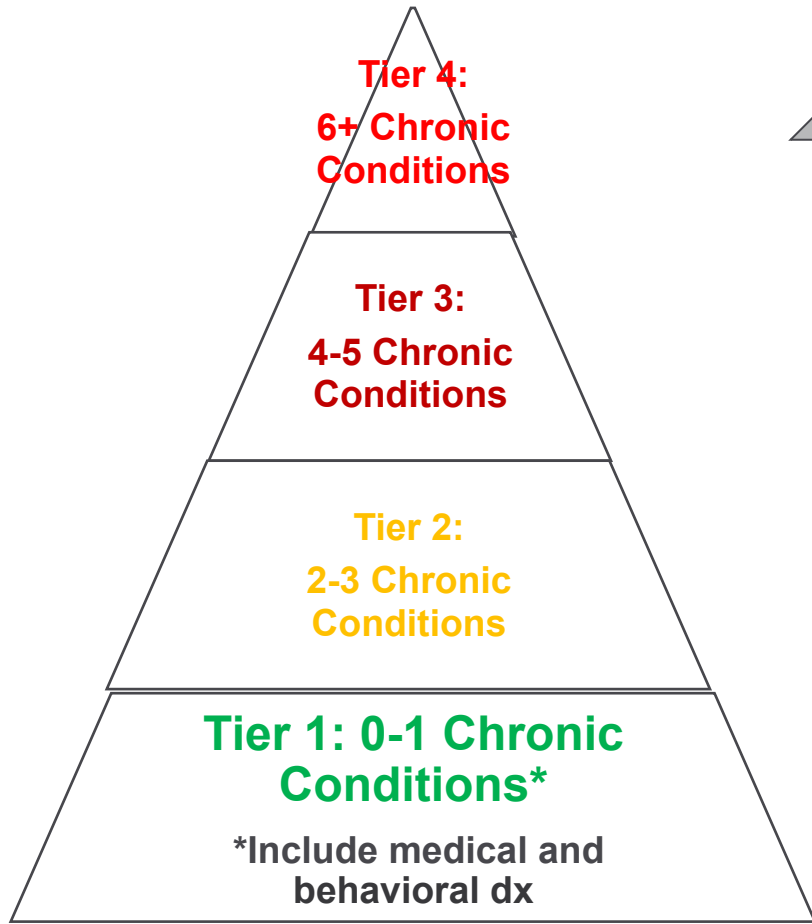
- CCC Risk Score Available on Clinical Decision Support Tool
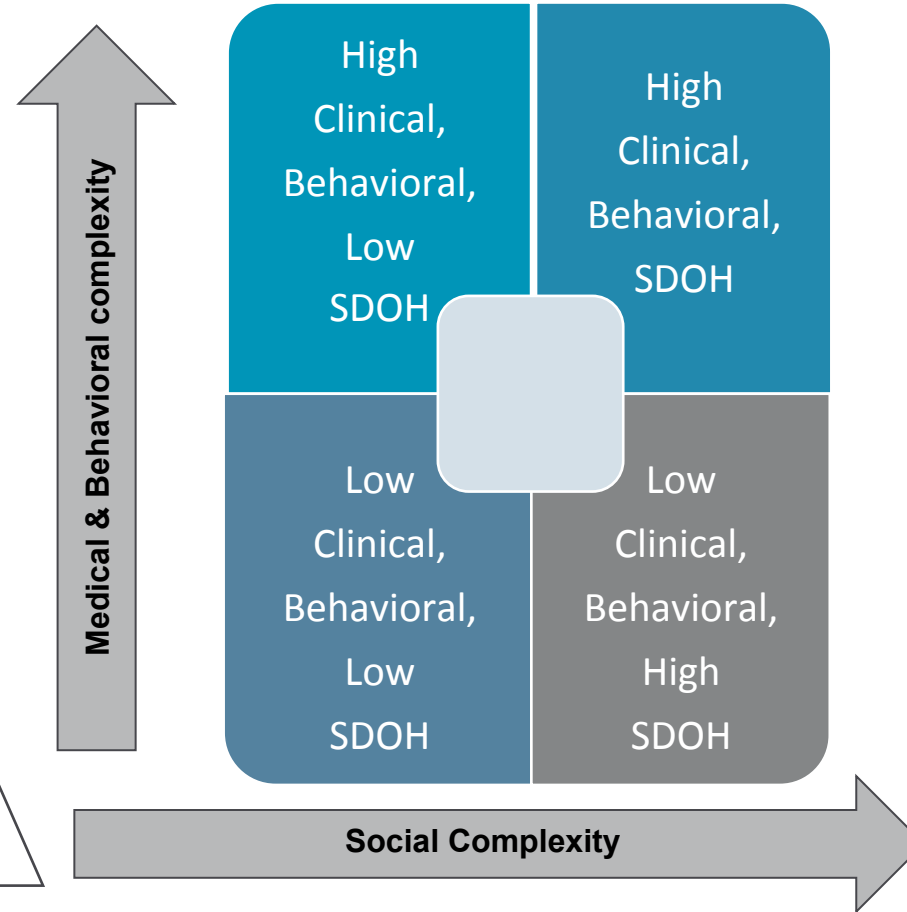
Using Data for Improvement

- # DM patients

  - By HbA1 (A1c <8, A1c >8 and <9, A1c >9),

  - By risk tier, and

  - By site

- Tiers 3 & 4: % patients who completed PRAPARE

Stratify Each Tier by A1c
a. A1c >9
b. A1c >8 and <9
c. A1c <8

Tier 4:
6+ Chronic Conditions

Tier 3:
4-5 Chronic Conditions

Tier 2:
2-3 Chronic Conditions

Tier 1: 0-1 Chronic Conditions*

***Conditions includes medical and behavioral dx**

Current State

Near Future

Long Term

Tier 4:
6+ Chronic Conditions

Tier 3:
4-5 Chronic Conditions

Tier 2:
2-3 Chronic Conditions

Tier 1: 0-1 Chronic Conditions*

***Include medical and behavioral dx**

Medical & Behavioral complexity

| High Clinical, Behavioral, Low SDOH | High Clinical, Behavioral, SDOH |
| Low Clinical, Behavioral, Low SDOH | Low Clinical, Behavioral, High SDOH |

Social Complexity

Behavioral Risk Score

Social Risk Score

Clinical Risk Score

Cost/ Utilization Risk Score

1 Overarching Risk Score

Strategies for Success

1 Core Team Inclusive of Different Care Team Members

2 Share Ideas Early and Often: Internally and Externally

3 Narrow Down Population and Drill Down the Data

4 Align with Other Organizational Priorities/Projects (Health Homes)

Key Tools & Resources

Population Health Management Software with CCC Score and clinical decision support tool.

Patient Navigators assess and respond to patients' social needs identified by PRAPARE.

Care Coordination "menu of services" is based on patient risk tier to maximize and standardize resource allocation across the organization.

Next Steps

Spreading

- Develop a SDOH Risk Score (testing a weighted score for positive responses vs. counting SDOH positive responses)

- Increase PRAPARE Screening

- Utilize two risk scores
  - Counting Chronic Conditions
  - PRAPARE

- Add Cost/Utilization Score when available

- Develop a method to adjust based on provider/ care team input

Sustaining

- Health Homes Program Patient Navigators for Health Homes eligible patients

- Family Medicine Care Coordinators for DM patients

- Continue to work with NACHC Risk Stratification learning collaborative to test alternative risk stratification methods

- Apply for grant funding to test and evaluate scoring, model, and ROI.

Current Challenges or Barriers

1 Collecting SDOH data to inform risk tier on all patients. Integrate cost, and utilization data on managed care patients and collect and integrate data on uninsured patients.

2 Technological solution for tracking care coordination; i.e., which services are recommended, offered, and status.