Paving the Way for Value-Based Pay

DCPCA Annual Summit
Megan Loucks - DCPCA, Donna Ramos-Johnson - DCPCA, Noah Smith - DHCF
5/16/2019
Session Overview

Past

• VBP Readiness Assessment
• DCPCA Support via QI, Policy, and HIT

Present

• HIT to support VBP service delivery

Future

• DHCF’s vision to support VBP
Where we were

READINESS ASSESSMENT FOR VBP
Outcomes versus health spending

Health Outcomes

Health Spending Per Capita

Sources: The Economist Intelligence Unit; World Health Organisation.
Value-Based Health Care

**PATIENTS**
- Lower Costs & better outcomes

**PROVIDERS**
- Higher Patient Satisfaction Rates & Better Care Efficiencies

**PAYERS**
- Stronger Cost Controls & Reduced Risks

**SUPPLIERS**
- Alignment of Prices with Patient Outcomes

**SOCIETY**
- Reduced Healthcare Spending & Better Overall Health

NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society
The Movement to Value-Based Payment

Provider Financial Risk

Provider Accountability and Integration

- Fee-for-service
- Performance-based payments
- Primary care incentives
- Performance-based contracts
- Bundles and episodes of care payment
- Condition or service line programs
- Shared savings
- Shared risk
- Capitation

Accountable care organizations
Assessing Value-Based Readiness

• The Value-Based Payment Readiness Assessment Tool was developed by HMA and CohnReznick, in partnership with the DCPCA

• In 2015, 7 DCPCA member health centers participated in the assessment.

https://www.healthmanagement.com/vbp-survey/
Core Elements of Value-Based Care

• Financial Readiness
• Organizational Readiness and Partnerships

• Service Delivery:
  – Population Health Management
  – Care Coordination & Management
  – Patient-Centeredness & Engagement
<table>
<thead>
<tr>
<th>Category</th>
<th>Core Element (Essential for VBP)</th>
</tr>
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<tbody>
<tr>
<td>Population Health Management</td>
<td>Technology to support retrieving, storing, calculating, and reporting on clinical quality metrics.</td>
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<tr>
<td></td>
<td>Real-time communication and alerts, including proactive alerts for ER and hospital use.</td>
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<td></td>
<td>Integrated historical and real-time data to inform patient outreach.</td>
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<td>Actionable patient registry.</td>
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<tr>
<td>Care Coordination &amp; Management</td>
<td>Offer transitions of care.</td>
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<td>“Whole person” care coordination services in a system linked to social service agencies.</td>
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<td>Conduct patient assessments (including risk assessments) and capture results in structured data.</td>
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<td>Use care plans for care coordination.</td>
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<tr>
<td></td>
<td>Strategy to outreach and engage attributed managed care members, as well as “super utilizers” and high risk.</td>
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<tr>
<td></td>
<td>Behavioral health integration: team-based care and shared medical record.</td>
</tr>
<tr>
<td>Patient-Centeredness &amp; Engagement</td>
<td>Same-day appointments for patients who need them.</td>
</tr>
<tr>
<td></td>
<td>Offer enhanced access (e.g., evening/weekend hours, telemedicine &amp; e-consults, self-measured devices, remote access to health information/patient portal).</td>
</tr>
<tr>
<td></td>
<td>Assess and address patients’ linguistic and cultural needs.</td>
</tr>
</tbody>
</table>
Population Health Management

2015 Assessment

• Technology to support retrieving, storing, calculating, and reporting on clinical quality metrics.

• Integrated historical and real-time data to inform patient outreach.

• Real-time communication and alerts, including proactive alerts for ER and hospital use.
  – Only 29% get proactive alerts in the EHR when patients use the ED or are admitted to the hospital.

• Actionable patient registry.
  – 57% have and use an actionable “registry” that contains patient data; None create a list of “super utilizers”.
Care Coordination
2015 Assessment

• Offer care coordination services in a system linked to SSAs.
• Conduct patient assessments (including risk assessments) and capture results in structured data.
  – 43% conduct risk assessments and capture results as structured data.
• Use care plans for care coordination.
  – Rare use of care plan for coordination of services. 57% employ care teams.
• Strategy to outreach and engage attributed managed care members, as well as “super utilizers” and high risk.
  – 29% have a strategy in place to engage attributed members.
• Behavioral health integration: team-based care and shared medical record.
  – High levels of clinical integration, but significant barriers to information sharing.
Patient-Centeredness & Engagement
2015 Assessment

• Assess and address patients’ linguistic and cultural needs.

• Same-day appointments for patients who need them.
  – 71% offer same-day appointments, yet challenges in wait times and throughput.

• Offer enhanced access (e.g., evening/weekend hours, telemedicine & e-consults, self-measured devices, remote access to health information/patient portal).
  – 43% clinical nurse triage. 20% after hours triage. 43% offer weekend hours every weekend.
Highlights

DCPCA SUPPORT OF VBP SERVICE DELIVERY
DCPCA’s Support of Key Elements via Policy

- “Whole person” care coordination services in a system linked to social service agencies.
  - DCPACT

- Behavioral health integration. Key milestones:
  - Provision for payment of same-day behavioral and physical health services
  - Inclusion of Certified Addiction Counselors in the FQHC payment rule
  - MCO payment for FQHC office-based substance use disorder treatment
  - Training and resources to build FQHCs’ capacity to provide Medication Assisted Treatment (MAT)
  - Removal of prior authorization requirements for MAT
DCPCA’s Support of Key Elements via QI

Population Health Management
- Quality metrics preparation, validation, comparison, reporting, and visualization.

Care Coordination & Management
- Care Management Learning Collaborative.
- Care coordination for cardiovascular disease and diabetes.

Patient-Centeredness & Engagement
- Team-based Care and PCMH.
- Trauma-informed care.
- Health literacy.
- Self-measured devices.
- Remote access/patient portal.

QI Infrastructure
- Act as a hub to accelerate innovation.
- Provide training on QI methodology, tools, and culture.
DCPCA’s Support of Key Elements via HIT

2006-2009
- Implemented eCW electronic health records for 6 community health centers
- $5.0 million in funding from DC DOH

2012-2014
- Implemented the CPC-HIE
- $900K in CMS CCIN funding through Mary’s Center

2016-2018
- Implemented the HealthEC Population Health Management System
- $780K funding from United Health Foundation

2017-2021
- Offer technical assistance and outreach services for Meaningful Use attestation and HIE tools adoption
- $6.0 million in contract funding from DHCF

2008-2011
- Implemented DC RHIO Health Information Exchange
- $6.0 million in funding from DC DOH

2014-2016
- Enhanced CPC-HIE functionality and expanded participation
- $1.6 million in CMS PAH funding through GWU

2017-2018
- Implemented enhanced HIE tools in conjunction with CRISP, including expanded Population Health Analytics capabilities
- $967K in CMS funding through DHCF
Where we are

CURRENT HIT/HIE TO SUPPORT VBP
# HIT/HIE Support for VBP Service Delivery

<table>
<thead>
<tr>
<th>Available Tools</th>
<th>Population Health Management</th>
<th>Care Coordination</th>
<th>Patient-Centeredness &amp; Engagement</th>
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<tr>
<td><strong>Health Information Technology (HIT)</strong></td>
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</tr>
<tr>
<td>• EHR Patient Health Record/Progress Note</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>• DIRECT Messaging</td>
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<td>X</td>
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<tr>
<td>• Patient Portal</td>
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<tr>
<td><strong>Health Information Exchange (HIE)</strong></td>
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<tr>
<td>• Patient Care Snapshot</td>
<td>X</td>
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<tr>
<td>• Query Portal</td>
<td>X</td>
<td></td>
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<tr>
<td>• CRISP ENS Prompt/Notification Service</td>
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<tr>
<td>• CAliPhr eCQM</td>
<td></td>
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<tr>
<td>• Population Health Analytics Dashboard</td>
<td>X</td>
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</tbody>
</table>
Population Health Management

- Real-time communication and alerts, including proactive alerts for ER and hospital use.
  - **CRISP ENS Prompt**: offers real-time access to hospital/ER admissions and discharge information
  - **CRISP ENS Notification Service**: delivers hospital/ER admissions and discharge reports to providers for subscribed patient panels
- Integrated historical and real-time data to inform patient monitoring and outreach.
  - **Patient Care Snapshot**: provides real-time access to patient clinical data including patient demographics, care team information, medication fill history, clinical documents, lab results, and encounter history
  - **CRISP Query Portal**: offers real-time access to a longitudinal view of a patient’s clinical records from all contributing providers
Patient Snapshot

Patient Name: Gilbert Grape  Gender: Male  Date of Birth: 01-01-1984

Patient Demographics

- Gilbert Grape
- 4145 EARL C ADKINS DR. River, WV 26000
- Gender: Male
- D.O.B.: 01-01-1984
- Phone: 11111111

Clinical Documents

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Source</th>
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<tbody>
<tr>
<td>09/04/2018</td>
<td>Summary of Care</td>
<td>Meritus</td>
</tr>
<tr>
<td>08/28/2018</td>
<td>Summary of Care</td>
<td>Meritus</td>
</tr>
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<td>Summary of Care</td>
<td>Meritus</td>
</tr>
<tr>
<td>08/20/2018</td>
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</tr>
<tr>
<td>08/20/2018</td>
<td>Summary of Care</td>
<td>Meritus</td>
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Encounters From ADT

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<th>Reason</th>
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<td>Outpatient A04</td>
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<td>08/20/2018</td>
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<tr>
<td>03/19/2018</td>
<td>Inpatient A03</td>
<td>CRISP TESTING PATIENT</td>
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<tr>
<td>03/13/2018</td>
<td>Inpatient A01</td>
<td>CRISP TESTING PATIENT</td>
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Care Alerts

<table>
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<tr>
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<th>Source</th>
<th>Description</th>
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<tbody>
<tr>
<td>04/04/2019</td>
<td>ENS_ABGBL TWL</td>
<td>Please help us help you! We have been trying to reach this patient, who has been referred to us by their health insurance company. We are AbsoluteCARE, a local primary care office specializing in adults with a history of frequent ED/hospital usage. We provide care management, social work, behavioral health services, and transportation in addition to advanced primary care services. Help get this patient enrolled in AbsoluteCARE by calling one of us (Monday–Friday between the office hours of 8am - 5pm), and we will send you an NPI number.</td>
</tr>
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</table>

Care Team
The information contained in this system is protected as Health Information (PHI) and may be subject to protection under the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and is intended for use only by the entity to whom it is addressed. If you are not the intended recipient, you are advised that disseminating, distributing, printing or copying the contents of the mailing to anyone other than the intended recipient may be prohibited by law. If you receive this message in error, please notify the sender immediately by clicking the report an issue button.

- **TERRY BURKE (335657900)**
  - Mount Sinai Hospital
  - 7/28/16 4:34 PM
  - ER Transfer
  - FUZ Stomach Pain VIW PAIN ON BOTH SIDES

- **STEPHAN WELLS (361826393)**
  - Shouldice Hospital
  - 7/28/16 3:30 PM
  - ER Discharge
  - PEC2 HEAD INJ FAX967 LT LEG PAIN/FOOTBALL

- **DARLA STARK (440925517)**
Population Health Management

• Clinical quality and utilization measures to guide clinical program improvements.
  – CRISP CAliPhr (eCQM) Tool: uploads clinical data from progress notes maintained in a provider’s EMR to calculate a range of CMS clinical quality measures.

• Actionable registries for patient management and determining preventive measures.
  – HealthEC Population Health Management (PHM) Dashboard: produces Medicaid claims-based registry reports for patients attributed to a provider organization, including total cost of care, ER utilization, medication adherence, hospital admissions and hospital readmissions reports.
### Practice - PCP Followup within 7 days of Discharge

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>TIN</th>
<th>Member Panel</th>
<th>Total Admissions</th>
<th>PCP Followup within 7 days</th>
<th>PCP Followup Incomplete</th>
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<td></td>
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<td>52</td>
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<td>6021</td>
<td>251</td>
<td>99</td>
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<td><strong>Total</strong></td>
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<td><strong>9,688</strong></td>
<td><strong>374</strong></td>
<td><strong>156</strong></td>
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Click here to modify report criteria.
Care Coordination

• Risk assessments and risk stratification.
  – **Provider EMR**: offers initial health screening and assessment tools to support care management decision-making.
  – **HealthEC PHM**: produces patient risk stratification and assessment reports for determination of appropriate care management strategies.

• Care management services.
  – **Patient Care Snapshot and Query Portal**: provide access to patient care team and prior clinical encounter information to inform care decisions.
  – **HealthEC PHM**: produces high utilizer and non utilizer lists to facilitate patient outreach efforts.
  – **CRISP Care Management Registry**: maintain listings of care management programs offered by providers and support care management program reporting.
HealthEC – Risk Assessment & Stratification

<table>
<thead>
<tr>
<th>Health Plan: FFS</th>
<th>COPD</th>
<th>DM</th>
<th>CHF</th>
<th>ESRD</th>
<th>SNF</th>
<th>ACTIVE CCM</th>
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<table>
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<th>Health Plan: FFS MH GPS TIER1-Eligible</th>
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<th>DM</th>
<th>CHF</th>
<th>ESRD</th>
<th>SNF</th>
<th>ACTIVE CCM</th>
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<td>N</td>
<td>N</td>
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<tr>
<td>Wellness/Prevention</td>
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<table>
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<td>N</td>
<td>N</td>
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Patient-Centeredness & Engagement

- Technical assistance for EHR Meaningful Use.
  - *Patient Education materials.*
  - *Patient Portal access for provider communications and access to health records.*
  - *Secure messaging for patient referrals.*
- Telemedicine pilots to facilitate patient access to remote care delivery.
  - *Tested various care delivery models and access to HIT/HIE tools.*
- Community Resource Inventory (CRI) needs assessment and technical design for capturing SDOH patient data.
  - *Review available assessment and referral tools.*
  - *Evaluate service provider workflows and document data collection needs.*
  - *Produce a technical design for a CRI data capture and exchange platform that will leverage existing processes and tools.*
Hi Jimmy (pt portal),

Whitman-Walker Health welcomes you to our Patient Portal!

¡Whitman-Walker Health le da la bienvenida a nuestro portal paciente!

Appropriate Use of the Patient Portal:

--Clinical summaries for recent visits, along with lab results, are available via the Patient Portal.

### Messages

- **3** unread
- **View All**

**Healow is here Book Your Medical Appointments Online!!**

10/15/2018

Dear Patient, Whitman-Walker is excited to ann...

**testing**

09/14/2018

Testing sending a secured message to patient thru ...

**Test**

11/10/2017

Test...

### Current Medication

- **6** taking
- **View All**

**Selzentry**

**Abilify**

15 MG

Once a day

**Oxycodone HCl**

30 MG

every 6 hrs

**Request Refill**

### Latest Lab Results

- **19** new
- **View All**

**17-Hydroxypregnenolone**

04/13/2018

**IgG-Urine Pregnancy Test**

Negative

08/10/2017

**CBC With Differential**

03/27/2017

### Latest Statement

Please check your latest statement. If payment is pending check details.

**Bill Date:** 12/27/2012

**See Statement Details**

**Your account Balance:** $30.00

**Pay this bill**

### Recent Referrals

- **View All**

**S Abbott**

screening mammogram

08/10/2018

**FU**

08/12/2014

**mammo**

08/12/2015

### Medical Records

Personal Health Record can be requested by clicking on the Request PHR below

**Request PHR**
Where we are heading

DHCF VISION TO SUPPORT VBP
Hi, I’m Noah

• Experience shows us that value-based purchasing is a journey
• Patient and panel information is foundational to your success
• We’re here to help! DHCF is investing in new tools to help you communicate with colleagues and provide whole-person care
The District’s Health Care System is Disconnected

- **Patients** are often not meaningfully connected to their multiple providers
- **Providers** are not connected to other care partners and payers
- **Payers** are not connected to clinical information
- **Government** agencies are not connected to public health information
While caring for a patient in the emergency department with a chronic lower extremity wound I found myself with limited information on her condition and the patient had limited details.

The only records in our system were almost a decade old, yet the patient stated that she had recently been seen in another healthcare system.

Using the CRISP access built into our EHR, with one-click I was able to access her records in CRISP where I not only saw her recent visit to another ED, but that she had a follow up wound care appointment in 2 days and that she had a care alert.

The alert provided her social worker’s name with a direct phone number and I was able to notify the social worker that the patient was being seen in our ED and to help coordinate her care.
Value-based Incentives and Health Information Exchange Together Help Connect a Disconnected System

Facilitate Innovation Practice and Sustainable VBP

Expand Useful Health IT Uptake and Information Exchange

Delivery System Redesign & Practice Transformation

Create and test new delivery system and payment models

Quality Measurement & Improvement Strategies

Funder: Citywide Health Information Exchange Projects

Strategic Leader: Coordinate public input through the HIE Policy Board

Administrator: Health IT and HIE adoption (EHR Incentive Program – MEIP)

Steward: Medicaid Claims Data

Regulator: HIE entities to set privacy, security, access and use requirements

A system of integrated care connected through information

Health system reforms dependent on access to information

Continuous access to quality information
Aligning Measures Across Programs; Primary Focus on Outcomes

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measures</th>
<th>FQHC P4P</th>
<th>My Health GPS P4P</th>
<th>MCO P4P</th>
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<tr>
<td>Outcomes</td>
<td>Inappropriate ED Visits</td>
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<td>Readmissions</td>
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<td>Preventable Hospitalizations</td>
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<td>Process</td>
<td>Follow-Up after Discharge (Mental Illness)</td>
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<td>Access</td>
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<td>24/7 Access Policy</td>
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<td>Adults' Access to Preventive/Ambulatory Health Services</td>
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</table>
* Alternative Payment Model (APM) categories are based on the 2017 Update to the Health Care Payment Learning and Action Network Framework (LAN). In essence, category 1 is fee for service (FFS) with no link to quality; category 2 is FFS with a link to quality such as pay for reporting or a bonus payment for quality outcomes; category 3 is an APM built on a fee for service architecture (e.g. shared savings, or shared savings with downside risk; and category 4 is population-based payment for populations or conditions.
Regional Health Information Exchange (HIE) is Expanding to Improve Communication and Coordination

- All acute care hospitals have access and contribute to HIE (CRISP DC)
- All FQHCs have access to health information exchange (CPC)
- More than 4 in 10 high-volume Medicaid providers (100+ claims) already participate in HIE
- Approximately 490,000 DC patients see providers who receive real-time hospital alerts from CRISP DC
- Most nursing facilities participate; increasing participation by behavioral health providers
- KP and CareFirst participating in CRISP DC and Maryland
Patients Are Treated by Care Teams Across Organizations Who Want to Communicate More Effectively

- DHCF and CRISP are building a regional electronic Provider Directory to help hospitals, health systems, and providers communicate.
- Leveraging HIE to send secure emails and referrals
- Developing shared goals to improve timeliness and completeness of specialty referrals
DCHA Collaborative Aims to Improve Timely Hospital Discharge and Reduce Readmissions

Pilot a discharge planning process to ensure information on hospitalization and follow-up care is available within 24 hours of discharge, including:

- Identifying key information to exchange in a common discharge planning form, using HIE
- Piloting new processes with technical assistance, including workflow redesign to better utilize technology and team-based models;
- Assessing the model for adoption across the District and disseminating an implementation guide.
Strong Provider Support for Telehealth to Enhance Access to Primary Care, Especially in Wards 7/8

- Current fee-for-service telehealth model follows ‘hub-and-spoke’ approach
- My Health GPS Providers currently most likely to bill for telehealth
- 2018/2019 telemedicine pilots demonstrate providers prepared to implement PCP models, kiosks, especially for specialty care
  - Medical Home Development Group; Unity Health Care; Accent on Health; GW MFA; Urgent Wellness
- For future: interest in home visiting; remote patient monitoring; partnerships with faith-based and community organizations.
Community Input Led to Focus on Social Determinants of Health

Beginning April 2017, DHCF held a series of discussions on social needs of District residents

• Explored District efforts to collect and use SDOH data
• Generated a set of strategies and tactics to improve health outcomes
• Held 80+ person meeting with national experts “level-set” current work and shared priorities
• Hosted 20-person workshop on strategies to address collection and use of social need data
Two-Phase Approach Will Enable Screening and eReferrals for Social Needs via Health Information Exchange

Phase 1 (2019): CRI (AWARDED TO DCPCA)
Community Resource Inventory Grant*

- Develop Standardized Screening Tool
- Design and Develop Community Resource Inventory
- Gather Technical Requirements for Community Resource Information Exchange Technical Solution

Phase 2 (2019-2021): CoRIE
Community Resource Information Exchange (CoRIE) Grant

- Develop and Implement Technical Solution with the following capabilities:
  - Implement Standardized Screening Tool to assess social needs
  - Utility to exchange screening results with other providers
  - Utilize Community Resource Inventory
  - Referral Function allows providers to make referrals to social service providers
  - Close-Loop Function enables notification to referring providers when patient is seen
Is Health Information Exchange in DC ready for prime time?

• **Governance**: DHCF is proposing rulemaking to regulate the exchange of health information in DC to 1) protect the privacy of patient’s data, 2) ensure it is secure, 3) restrict access to approved parties, and 4) limit its use

• **Long-term Funding**: DHCF has funded a 5-year grant to CRISP DC to build and maintain *Core HIE Capabilities* for all District providers

• **VBP Alignment**: HIE capabilities and use cases are directly aligned with value-based purchasing requirements and will continue to be

• **DHCF Staff**: Dedicated health reform and health IT staff aligning programs – you are the customer!

• **Community Driven**: Guidance provided by the HIE Policy Board

Yes!