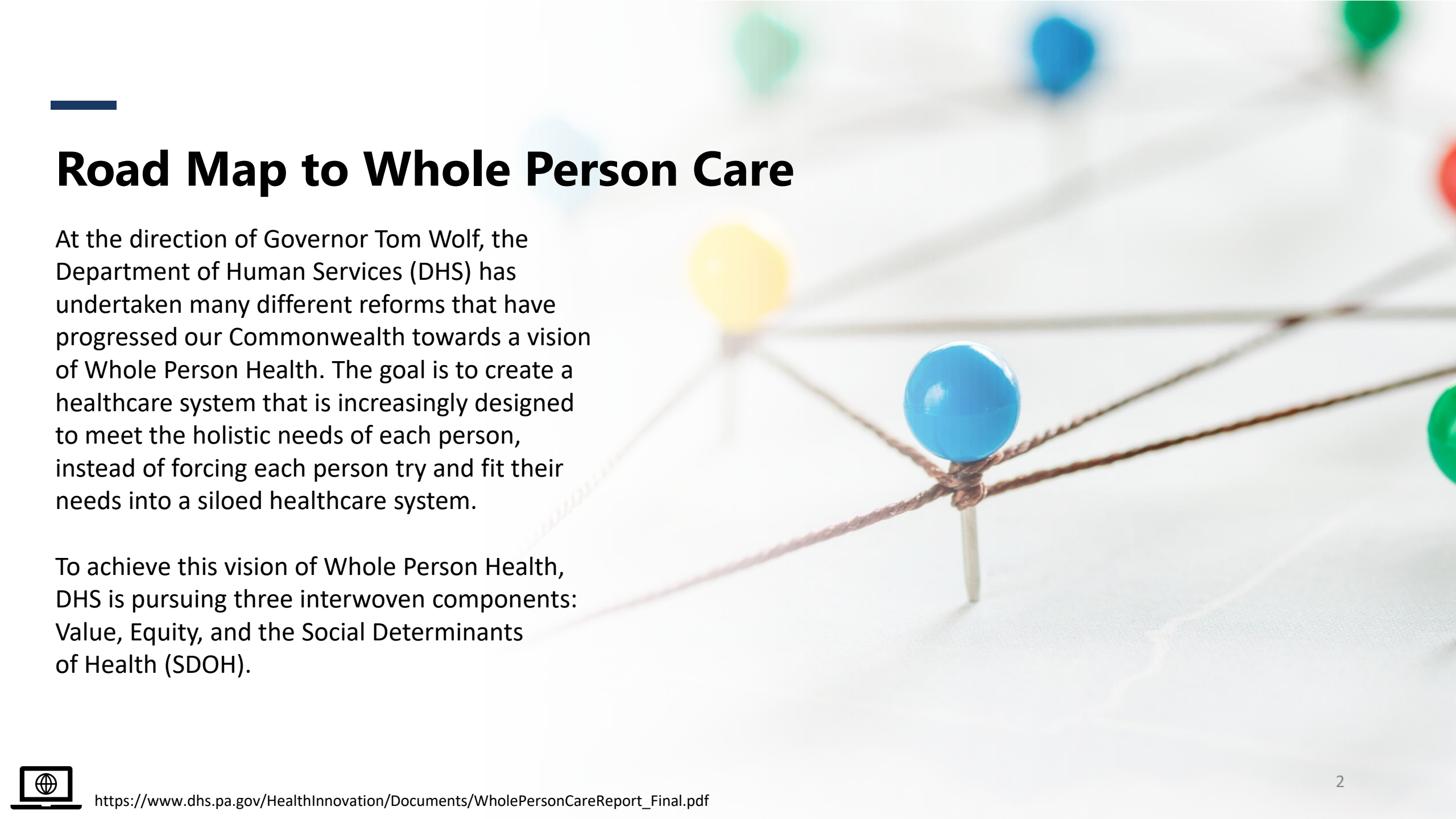
PCMH Learning Network: RAHC Program Introduction

February 2022

Road Map to Whole Person Care

At the direction of Governor Tom Wolf, the Department of Human Services (DHS) has undertaken many different reforms that have progressed our Commonwealth towards a vision of Whole Person Health. The goal is to create a healthcare system that is increasingly designed to meet the holistic needs of each person, instead of forcing each person try and fit their needs into a siloed healthcare system.

To achieve this vision of Whole Person Health, DHS is pursuing three interwoven components: Value, Equity, and the Social Determinants of Health (SDOH).

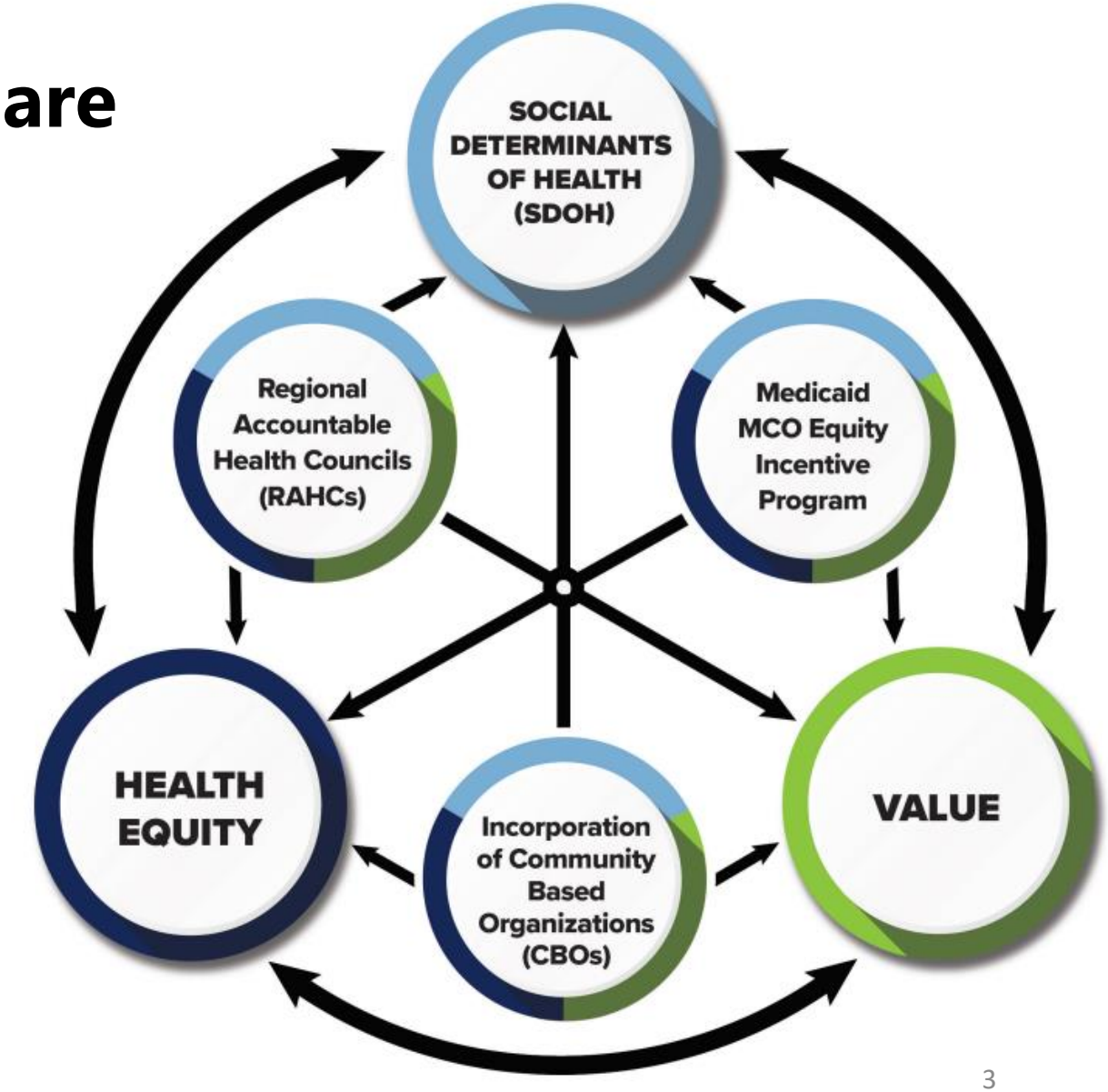


https://www.dhs.pa.gov/HealthInnovation/Documents/WholePersonCareReport_Final.pdf

Road Map to Whole Person Care

There are profound disparities across the Commonwealth based on the ZIP code where a person is born. Babies born in some ZIP codes are expected to live into their sixties, when just a few minutes or miles away, babies may live into their eighties.

As part of the whole-person health care reform package announced by Governor Wolf in October 2020, **Regional Accountable Health Councils (RAHCs)** were created through the Medical Assistance agreements between DHS and physical health MCOs, behavioral health primary contractors, and Community HealthChoices MCOs.



https://www.dhs.pa.gov/HealthInnovation/Documents/WholePersonCareReport_Final.pdf

RAHC Overview

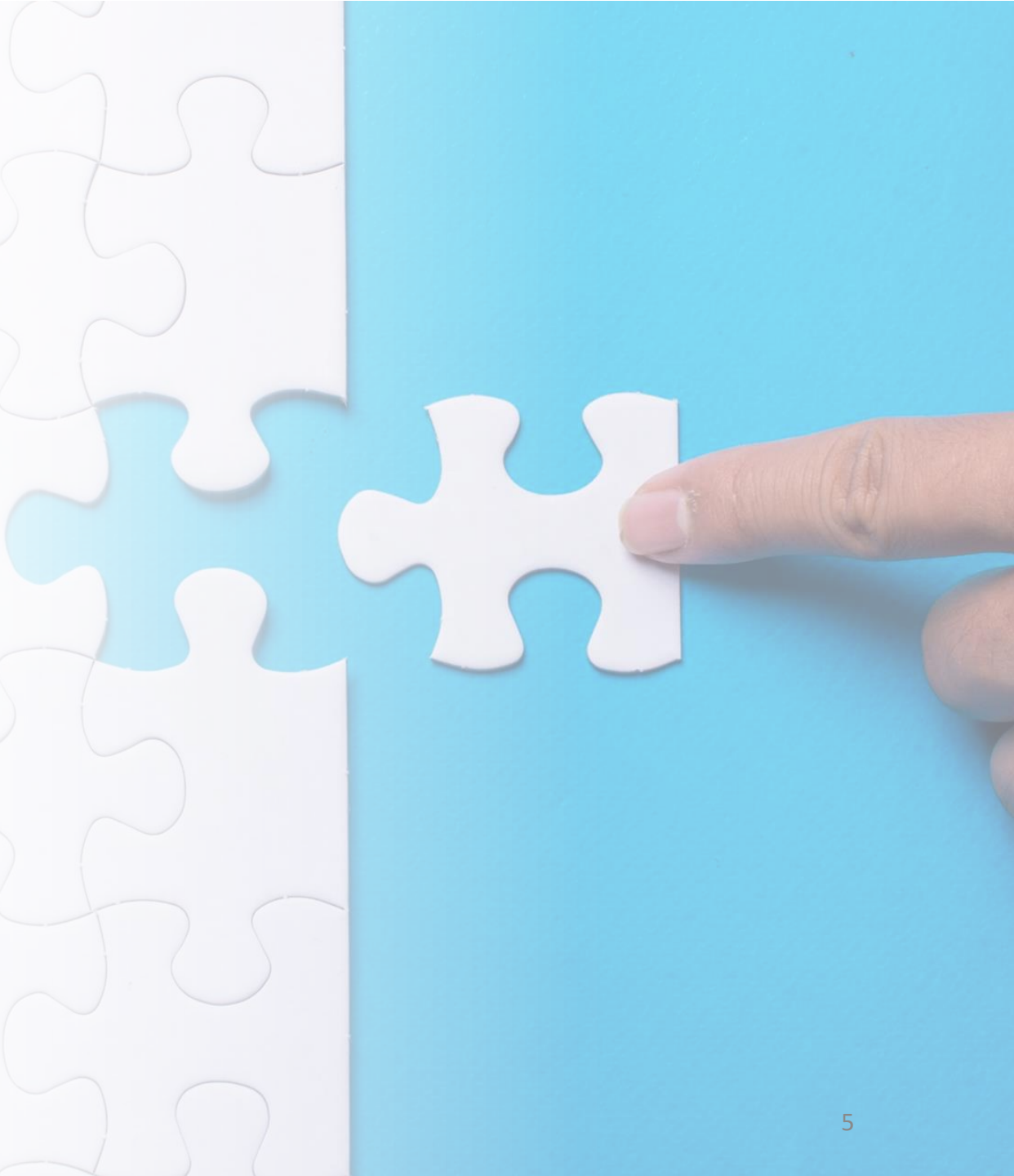
RAHCs provide a community-led approach to implement the planning and coordination of activities that address regional social determinants of health (SDOH) needs, reduce health disparities, and promote health equity and value in health care.

There are five RAHCs across the Commonwealth to represent the five physical HealthChoices (Medicaid) zones; Southwest, Northwest, Lehigh-Capital, Northeast, and Southeast.

RAHC Overview

The goals of the RAHC are to:

1. Promote health equity and eliminate health disparities
2. Identify and mitigate regional SDOH needs
3. Align value-based purchasing initiative to achieve better care and better health at lower costs
4. Support and steer population health improvement processes
5. Center health improvement efforts in the communities where needs exist



RAHC Progress

Since starting the RAHC work in February, the council has been able to make progress aligned to program goals as set by the Department of Human Services.

- Used publicly available data to identify “Health Equity Zones” which are areas of profound disparity
- Completed a root cause analysis to identify social determinants of health that are impacting each zone
- Identified literature and evidence supporting the correlation between the poorly performing health outcomes and social determinants of health
- Held local discussions to align existing community-based efforts with potential interventions
- Established regional priorities and developed a strategic plan and business case for regional work and funding

Identification of Health Equity Zones (HEZs)

RAHCs will be responsible for analyzing the data and recommending zones to DHS that the RAHC believes to be areas of largest need. Several zip codes (ideally contiguous zip codes) may be combined to form a HEZ. Below are some examples of how a RAHC could prioritize HEZ selection:

- Bottom quartile of select data measures;
- Number of impacted Medicaid lives per HEZ;
- Community engagement in the proposed HEZ; and,
- Ability to impact change for root causes of the identified health disparities.

Data Analytics and Tools

Several different sources were used to determine areas of need and are publicly available.

- **Pennsylvania Health Equity Analysis Tool (PA HEAT):** Tool created by DHS to share data and mapping around population health, social determinants, environment, Medicaid outcomes, county statistics, food insecurity, and redlining.
- **Pennsylvania Languages Map *from the Department of Health*:** This map allows state agencies to identify the areas where foreign languages are spoked. By proactively overcoming language association barriers, the state will be able to provide faster and more equitable services to more than 1.2 million PA residents who speak a language other than English at home.
- **Area Deprivation Index (ADI):** Index measure created to identify neighborhoods of socioeconomic disadvantage. It includes measures around income, education, employment and housing quality.
- **Social Vulnerability Index (SVI):** This tool identifies and maps communities that are most likely to need support before, during, or after a hazardous event. It includes 15 social factors including poverty, lack of vehicle access, and crowded housing.

Demonstration of PA HEAT and Languages Map provided during live session

SDOH Needs and Interventions

Each Health Equity Zone went through a Root Cause Analysis to determine social determinants of health (SDOH) that are statistically poorly performing and potentially key drivers of health equity barriers. The key SDOH domains include:

- Housing
- Transportation
- Food
- Employment and Income

Differences in outcomes by race were also assessed to highlight inequities.

These SDOH/population health needs were then prioritized by local experts to achieve strongest impact on health inequities and health outcomes.

Regional Outcomes: Southwest

The Southwest Region when through an iterative process to identify areas of greatest need to be identified as "Health Equity Zones" (HEZs). To the left, you can see the map highlights the various areas that were considered and the averages metrics across the region. Below are the areas identified as being of great need:

East Allegheny

- Medicaid population within HEZ: **14,100**
- % age 65 or older: **18%** vs. 19% in PA
- % on Medicaid / other public insurance[1]: **21% vs.** 15% in PA
- % uninsured: **6% vs. 7% in PA**
- Zip codes: **15221, 15208, 15235, 15219**

South Allegheny

- Medicaid population: **14,800**
- % age 65 or older: **16%** vs. 19% in PA
- On Medicaid / other public insurance[1]: **34%** vs. 15% in PA
- Uninsured: **7%** in line with 7% in PA
- Zip codes: **15110, 15207, 15210, 15104, 15132**

Lawrence

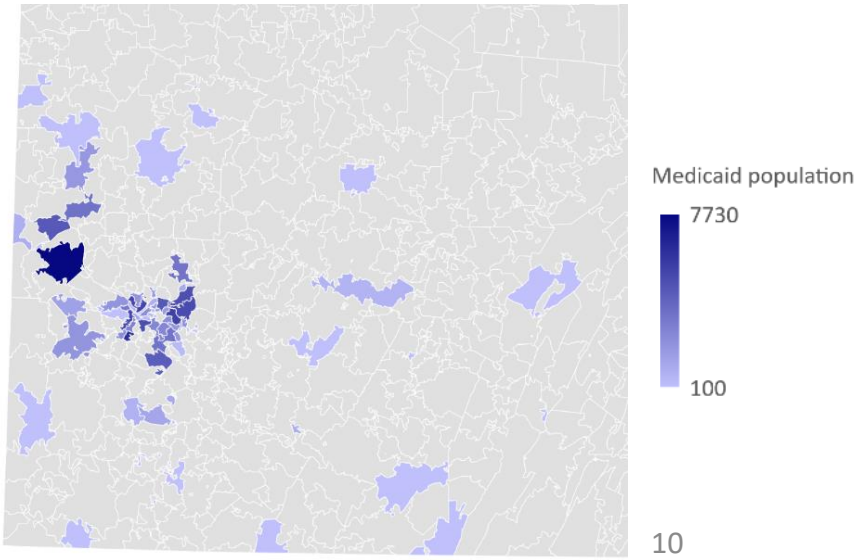
- Medicaid population: **10,240**
- % age 65 or older: **20%** vs. 19% in PA
- % on Medicaid / other public insurance[1]: **19%** vs. 15% in PA
- % uninsured: **5%** vs. 7% in PA
- Zip codes: **16101, 16102, 16117**

Washington

- Medicaid population: **2,930**
- % age 65 or older: **20%** vs. 19% in PA
- % on Medicaid / other public insurance[1]: **24%** vs. 15% in PA
- % uninsured: **5%** vs. 7% in PA
- Zip codes: **15314, 15022, 15033**

Key Stats for the SW RAHC[1]

- Medicaid population: **563,000**
- Medicaid % in RAHC: **17% vs. 21%** in PA
- Persons below poverty: **17%**
- Area Deprivation index: **6.86**
- Medicaid outcome index: **0.01**
- Minority population: **31% vs. 16%** in PA
- Rural zip codes: **18%**



1. Health Equity Analysis Tool (HEAT) app of Pennsylvania

Pilot Intervention: Southwest

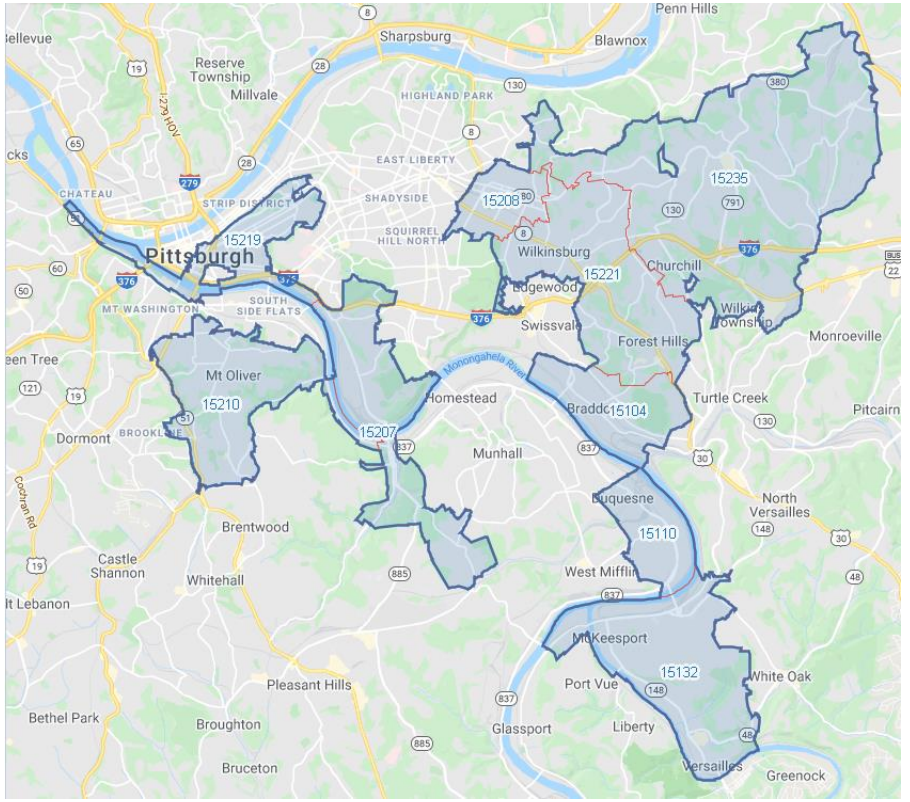
Southwest RHTP 12.29.pdf

Health Equity Zones: East Allegheny, South Allegheny
Zip codes: 15221, 15208, 15235, 15219, 15110, 15207, 15210, 15104, 15132
Medicaid Population: 28,900
SDOH Domain: Transportation
Intervention: Improve ride share and other transportation alternatives to fixed route transportation for medical and non-medical needs, with a focus on the diabetic population.

This intervention is focused on improving the access to both medical and non-medical resources through methods outside of traditional fixed route transportation (i.e. ride share services, free public transportation, community van, mobile resource vehicle). Intent to improve access to food, exercise, nutrition programs.

Rationale:

- South and East Allegheny zones are neighboring and therefore a collaborative intervention is feasible
- Transportation is a priority in these zones
- Existing resources are available to support and share lessons learned
- Emphasis on non-medical transportation to improve access to everyday resources and community involvement



Potential Partners:

- Traveler's Aid of Pittsburgh
- AgeWell Pittsburgh
- FQHCs
- Ways to Work
- ANR Transportation
- And more

Regional Outcomes: Northwest

The Northwest Region when through an iterative process to identify areas of greatest need to be identified as "Health Equity Zones" (HEZs). To the left, you can see the map highlights the various areas that were considered and the averages metrics across the region. Below are the areas identified as being of great need:

Erie (Urban Core)

- Medicaid population within HEZ: **6,700**
- % age 65 or older: **15% vs. 19% in PA**
- % on Medicaid / other public insurance[5]: **45% vs. 15% in PA**
- % uninsured: **9% vs. 7% in PA**
- Zip codes: **16501, 16503, 16507**

Sharon, Farrell (Shenango Valley)

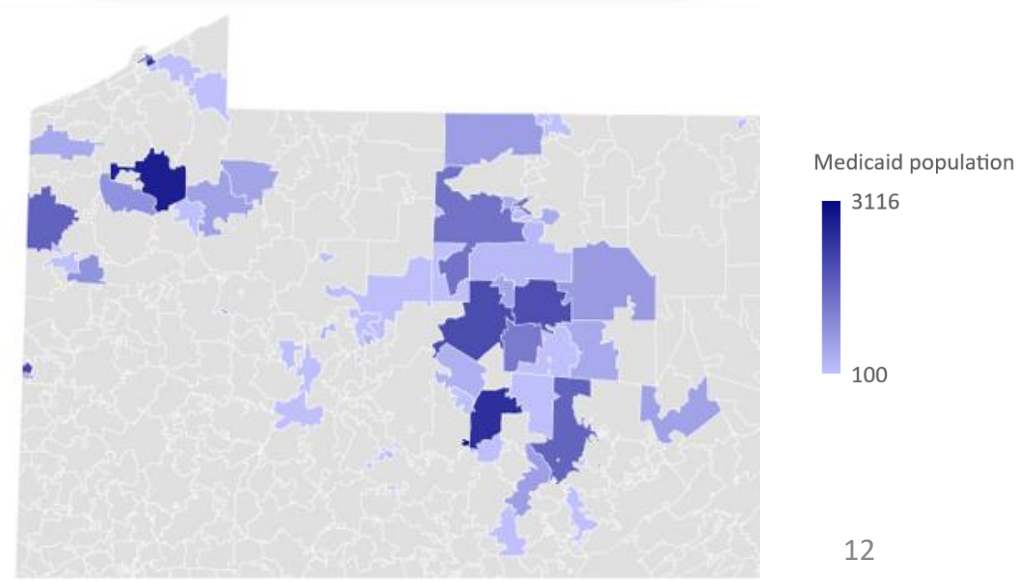
- Medicaid population: **2,650**
- % age 65 or older: **19% vs 19% in PA**
- % on Medicaid / other public insurance[5]: **34% vs 15% in PA**
- % uninsured: **8% vs 7% in PA**
- Zip codes: **16121, 16146**

Kane, Mt. Jewett, Lewis Run (Kane)

- Medicaid population: **2,500**
- % age 65 or older: **16% vs 19% in PA**
- % on Medicaid / other public insurance[5]: **18% vs 15% in PA**
- % uninsured: **5% vs. 7% in PA**
- Zip codes: **16735, 16738, 16740**

Key Stats for the NW RAHC[1]

- Medicaid population: **168,500**
- Medicaid % in RAHC: **21% vs. 21%** in PA
- Persons below poverty: **14%**
- Area Deprivation index: **7.45**
- Medicaid outcome index: **-0.18**
- Minority population: **7% vs. 16%** in PA
- Rural zip codes: **70%**



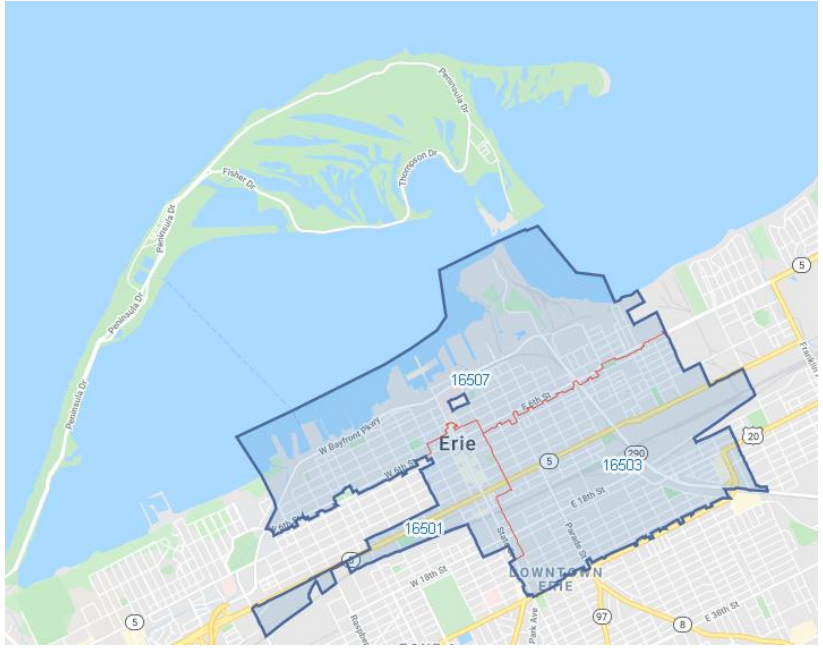
1. Health Equity Analysis Tool (HEAT) app of Pennsylvania

Pilot Intervention: Northwest

Northwest RHTP 12.29.pdf

Health Equity Zone: Erie (Urban Core)
Zip codes: 16507, 16503, 16501
Medicaid Population: 6,700
SDOH Domain: Food
Intervention: Improved food distribution through coordination with the regional food pantries and utilization of Primary Care screenings to provide food boxes and refer individuals to SNAP application services.

This intervention is focused on improving health of individuals through food and improved access to primary care. The benefits of attending a primary care will be exemplified through food security screening and supports. This type of intervention has also shown an increase in trust from the community.



Rationale:

- Erie is the largest of the three Northwest zones
- Infrastructure for intervention roll out
- Food insecurity was highlighted as a need in this region, in addition to the need to improve Primary Care engagement and education
- This intervention creates an environment that has proven successful in other regions

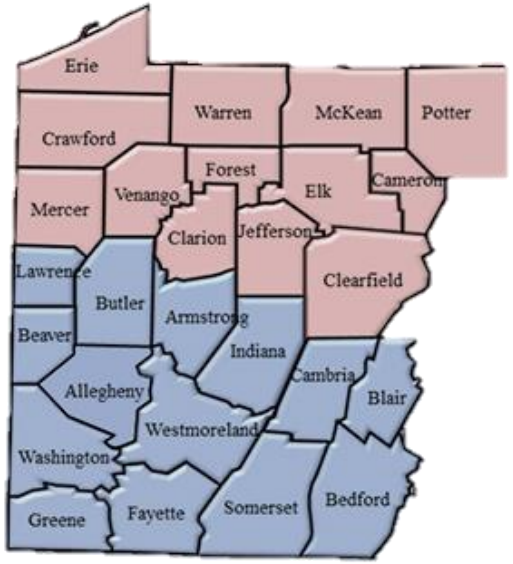
Potential Partners:

- Community Health Network
- Primary Health Network
- Second Harvest Food Bank
- ANR Transportation
- AHN St. Vincent
- UPMC Hamot
- And more

How to Get Involved

There are two Regional Accountable Health Councils in the West Region, Northwest and Southwest.

Both councils have various workgroups that will be meeting regularly throughout 2022 to further develop regional SDOH interventions. Quarterly council update meetings are also available to the public.



To get involved, please complete the [Expression of Interest form] and indicate the level of engagement you would like to have (i.e. workgroup participation, program updates via email, invitation to quarterly updates).

Questions

Program Contact:
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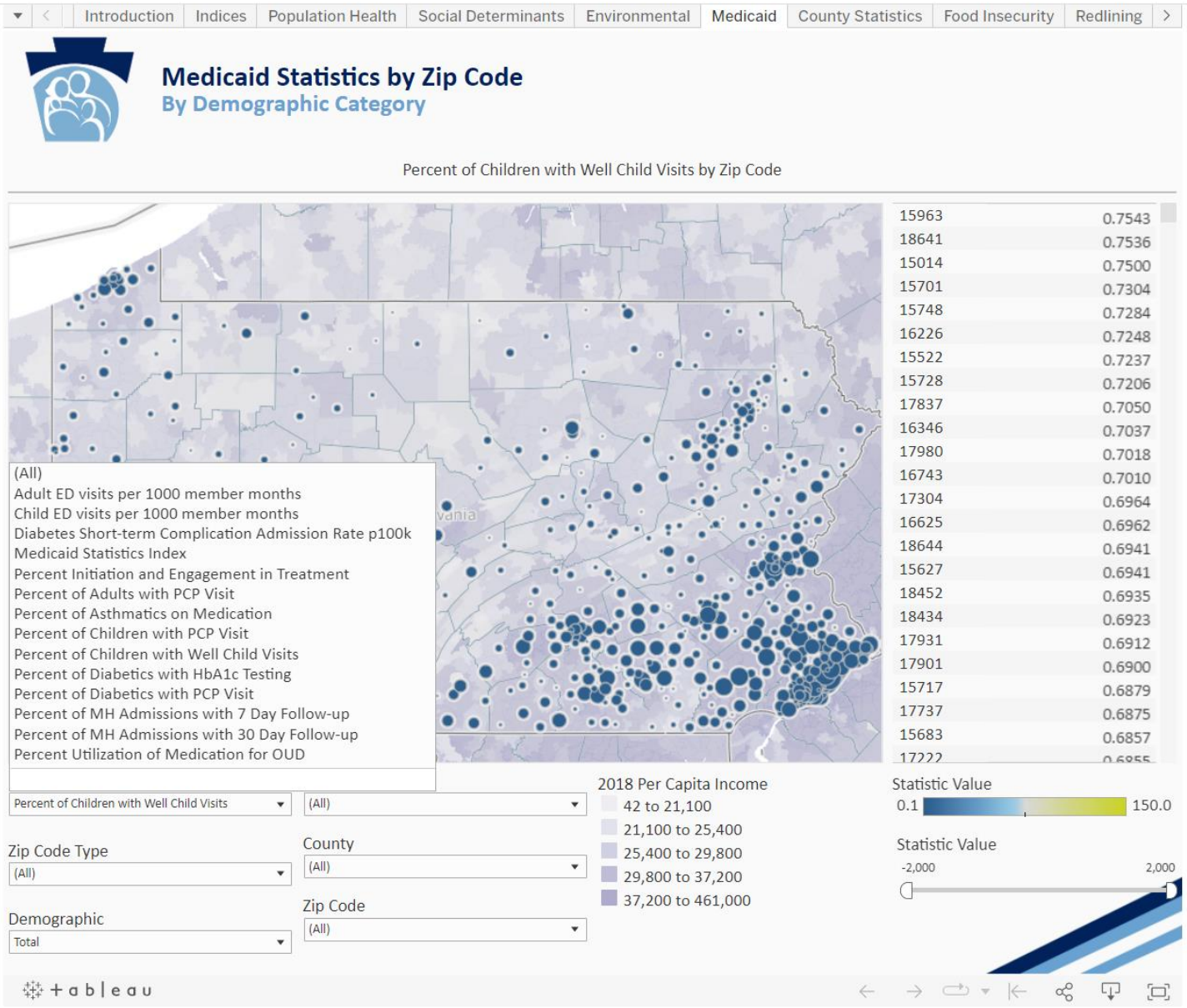
For more information:
Regional Accountable Health Council Resources

Appendix

Participants: Allegheny County

- Regional Managed Care Organizations
- UPMC
- Allegheny Health Network
- Allegheny Health Choices
- Community Care HUB
- Neighborhood Resilience Project
- Greater Pittsburgh Community Food Bank
- United Way of Pittsburgh
- Urban League of Greater Pittsburgh
- Allegheny County Department of Human Services
- Mental Health America of Southwestern PA
- NAMI
- Family Links
- Allegheny Family Network
- Healthcare Council of Western PA
- South Hills Interfaith Movement
- Women for a Health Environment
- Eastern Area Adult Services
- Alliance for Nonprofit Resources

PA HEAT



The Pennsylvania Health Equity Analysis Tool (PA HEAT) was utilized for several data needs in RAHC assessments. For example, various Medicaid measures were assessed to understand poorly performing metrics for each HEZ. To learn more about some of the mapping and data available, use the PA Heat User Guide.

Social Determinants of Health (SDOH)

Health outcomes are determined as much by non-health related factors as they are by healthcare and health behaviors. **All the discussed interventions for the RAHC are focused on social determinants of health.**

50-80%

Of health outcomes are driven by non-health related factors, such as physical environment or socioeconomic factors

20-50%

Of health outcomes are affected by health care services and health behaviors

1. Solving Complex Problems – Institute for Clinical Systems Improvement, |2. HealthyPeople. Gov