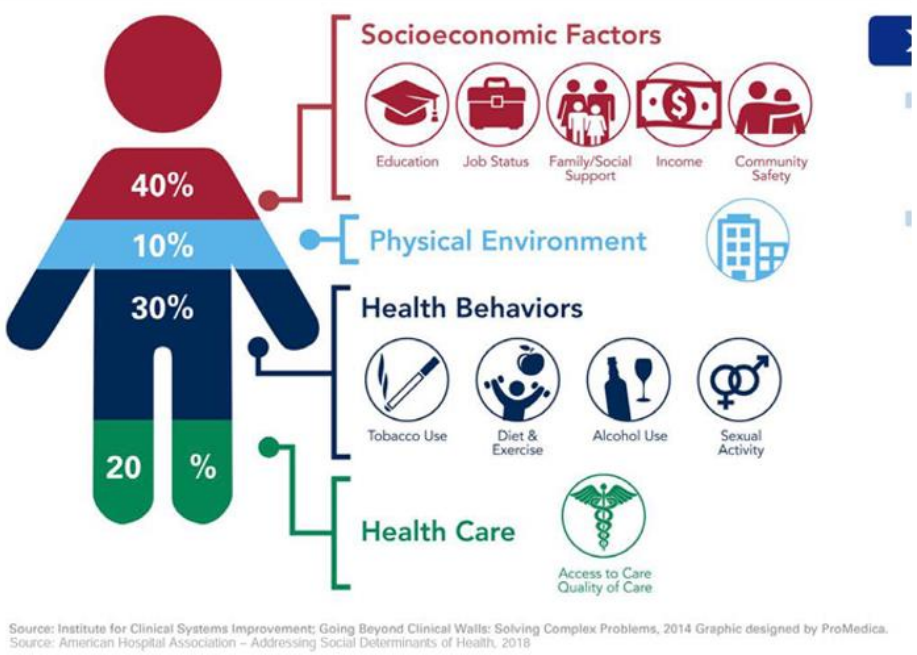
Powering the Business of Healthcare

PCMH Learning Collaborative

May 10, 2023

PA Navigate - SDOH Referral Platform Grant

- Goals:
  - Building a Statewide platform for connecting patients to social services
  - Making SDOH data as shareable as clinical data
  - Enabling a Population-level view of citizens' needs and CBO capacity to meet them
  - Help make Social Care sustainable



Evidence for SDOH Interventions

- Systematic review of 28 studies, half RCTs found evidence supporting changes in social needs and access to resources from referrals.
- A minority of studies evaluated effects on health outcomes (39%) or utilization/cost (32%), and findings were mixed.

Value - Tower Health/Reading Hospital Case Study

- Accountable Health Community survey showed a population that was food insecure, significant % low-income, immigrant, living in food desert

- Community Connection Project included providers, payers, CBOs (food banks/pantries)

- Used Wellsky for SDOH screening, referrals. Among food insecure patients, 85% referrals fulfilled, and 74% had food needs resolved within 1 year.

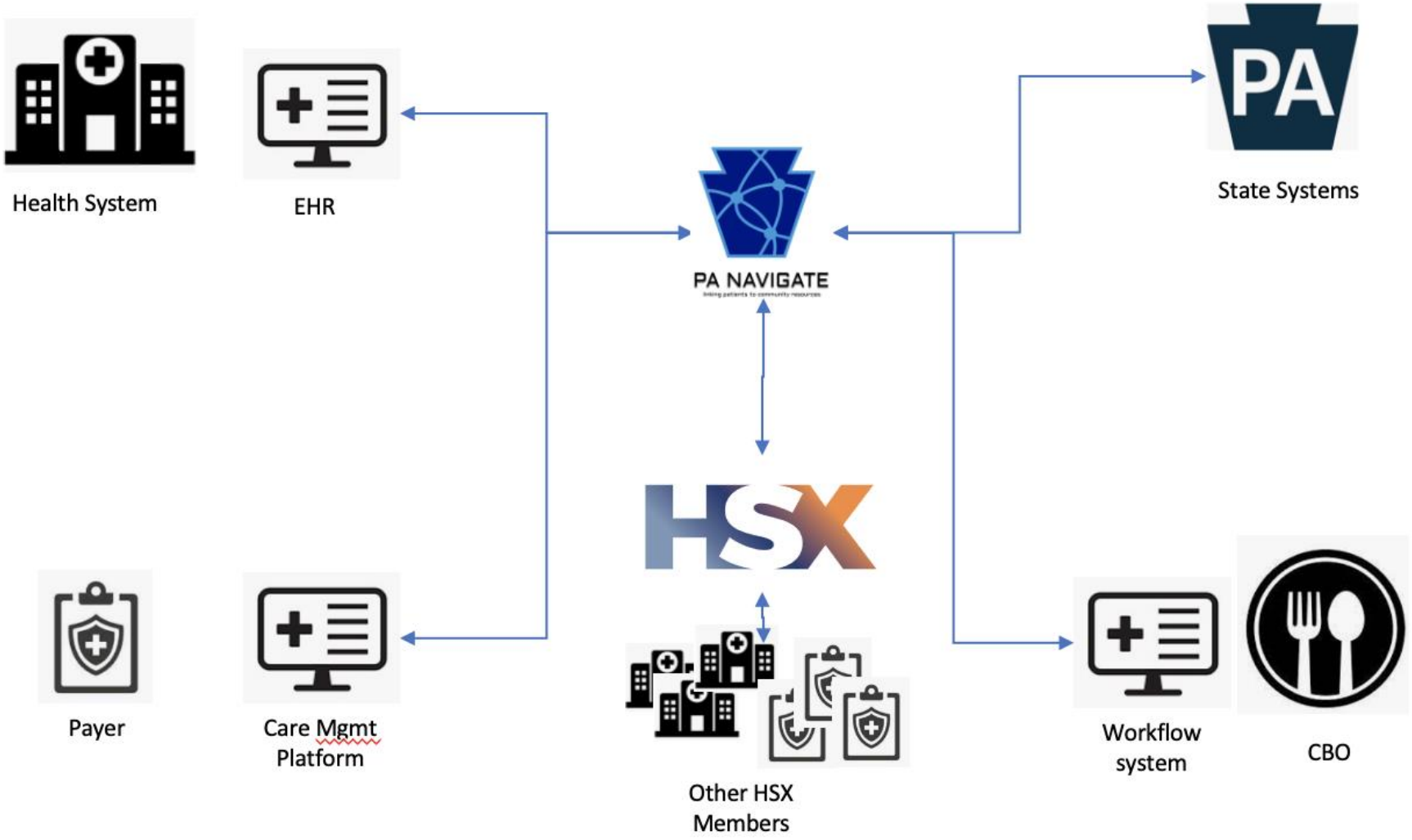
- Results: Among patients whose food needs resolved:
  - ✓ 32% fewer ED visits
  - ✓ 32% fewer hospital admissions
  - ✓ 30% fewer readmissions
  - ✓ 31% reduced hospital costs

Source: Wellsky/Tower Health. Impacting SDOH through cross-sector collaboration.

Grant Details – PA Navigate

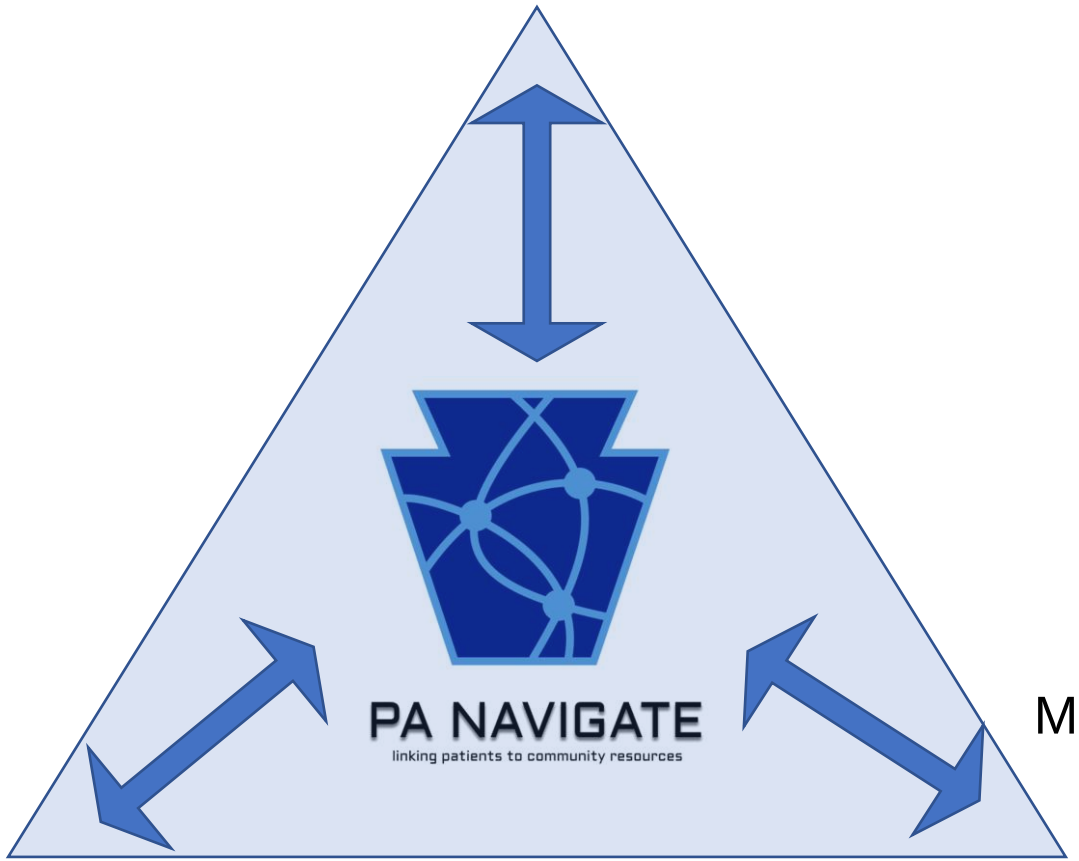
- PA Rise Rebranded PA Navigate
- PA HIEs collaborating to Select Single Vendor for State
- PA DHS Funding: Up to $18M across four HIEs;
  - $4.83M to HSX
  - HSX To Stand Up 50% of All CBOs Across State
  - HSX Share - Fixed Amount - $900K – Same as Other HIEs
- Grant period: Aug 31, 2022 - Jan 31, 2025
- Timeline:
  - Complete Vendor Procurement - Q2 2023
  - Member Integrations Completed through 2024
  - Procurement Envisions 5-Year Period of Performance

Simplified Architecture



Multiple Forms of Integration

Coalition Sharing
within PA Navigate



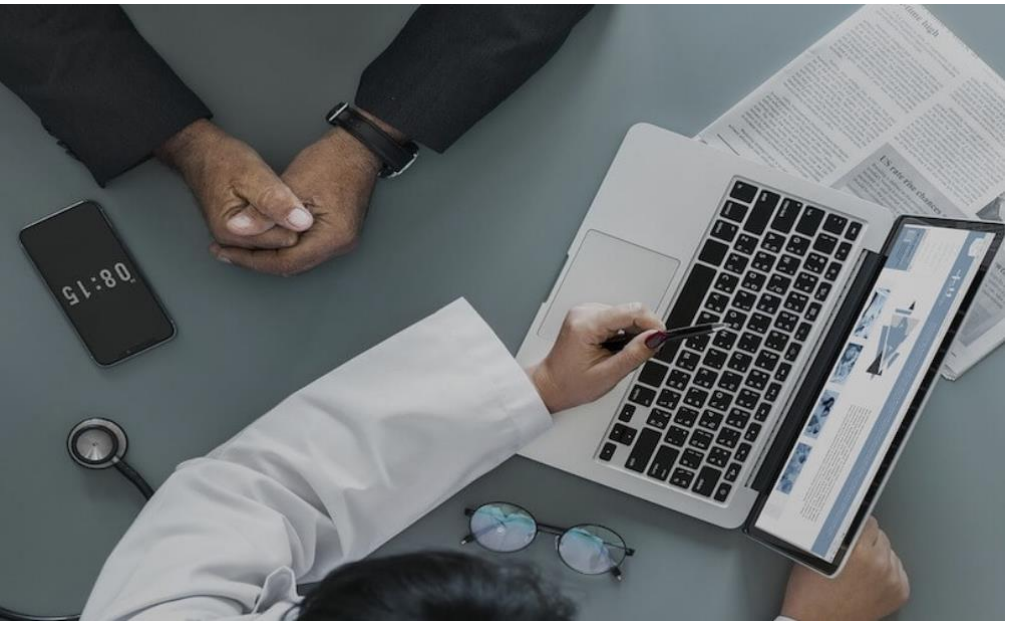
Data sharing
through HIEs

EMR/Case
Mgmt/Workflow
Integrations

EMR/Case Mgmt/Workflow Systems

- Depth of integration depends on vendor & version
- Levels of integration:
  - SSO (no separate login)
  - SSO + Patient Context
  - Referral/Screening Initiation from System of Record
  - System of Record Writeback
- Technical mechanisms:
  - APIs
  - FHIR/SMART on FHIR
  - Native app integrations (e.g., Epic)

What does this mean for me (providers/payers)?



For orgs using an existing SDOH referral platform

- Potentially get better pricing thru PA Navigate
- See referrals/assessments for your patients/members from other orgs
- Close the referral loop with CBOs more often
- Link SDOH data with clinical data through HSX
- Integration to streamline data sharing with DHS & partner orgs

What does this mean for me (providers/payers)?

For orgs without an existing SDOH referral platform

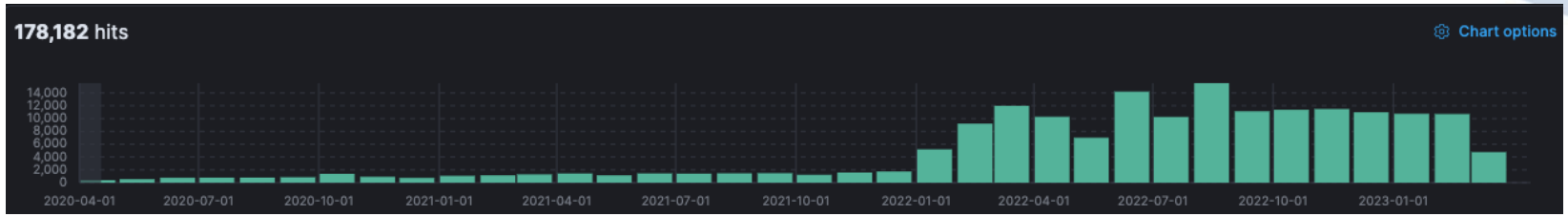
- Everything above, plus…
- Streamline workflows with electronic referrals, tracking followup
- Aggregate data to assess impact of your care management efforts
- Monitor/reward responsiveness of your CBO partners
- Share referral activity with the PA Navigate network

PCMH SDOH Contractual Requirements

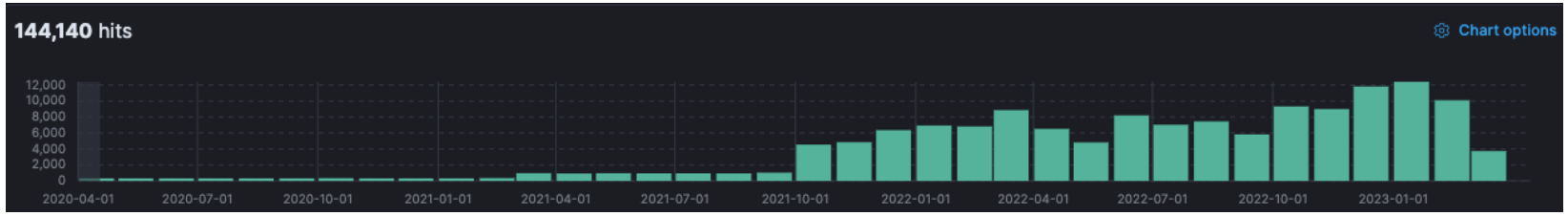
- [PCMH practices] Will **complete a Social Determinants of Health assessment**, at least annually and more frequent for patients who screen positive, using a Nationally recognized tool focusing on the following domains: food insecurity; health care/medical access/affordability; housing; transportation; childcare; employment; utilities; clothing and financial strain and **submit ICD-10 diagnostic codes for all patients with identified needs**.
- For patients with identified needs, the PCMH must **assist the member with obtaining the needed services** and monitor the outcome of the referral. The PCMH must **track referrals and outcomes** and be able to submit to the PH-MCO via claims submission the outcome of every Social Determinants of Health assessment performed using the HCPCS codes of G9919 (positive screening result) or G9920 (negative screening result) as well as **providing the PH-MCO and Department a report of the SDOH assessment outcomes** as may be requested.

SDOH Code Use (Past 3 Years)

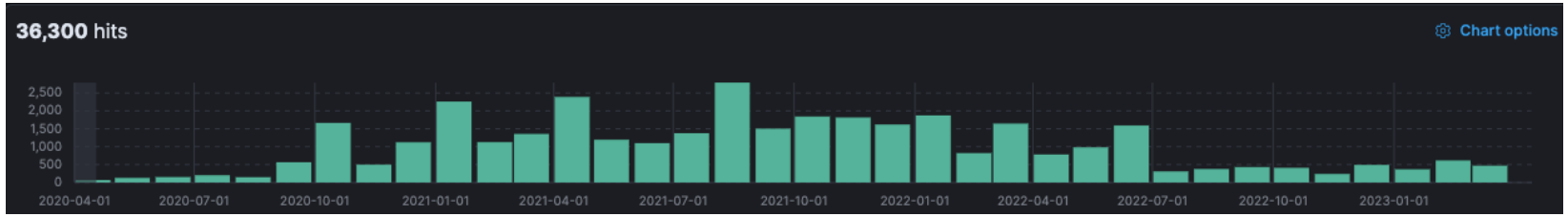
Food Insecurity



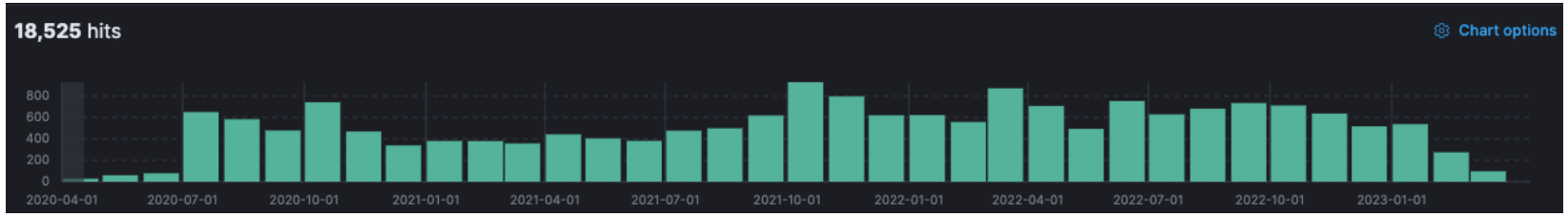
Housing Insecurity/ Homelessness



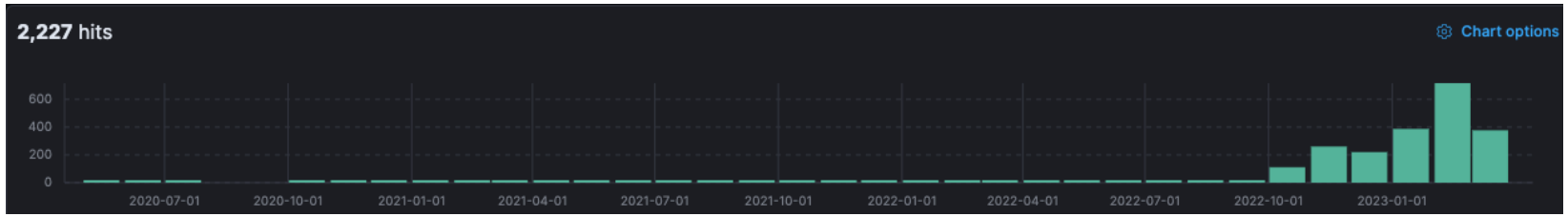
Social Isolation



Employment Insecurity



Transportation Insecurity



What does this mean for me (CBOs)?

- Demonstrate your impact to partner orgs & current/potential funders
- More impact/funding → more people you can assist
- Financial incentives for closing the loop
- Analytics to better understand your operations
- Consolidate referral sources on a common platform
- Integrate with your existing system to streamline workflow

Benefits to the Commonwealth

- Public-facing self-serve option for citizens
- Better coverage of SDOH needs = better outcomes
- Population health monitoring for social needs
- Uncovering areas of unmet need/capacity
- Demonstrating the value of addressing social needs in terms of improved health outcomes
- Attracting more Medicaid funding to PA

Discussion / Questions?

Who can I call?

HSX (Philadelphia)

Jennifer Natale, Advisor, Special Projects
jennifer.natale@healthshareexchange.org
570-441-4241

Bill Marella, VP Value Based Care & Analytics
Bill.marella@healthshareexchange.org
610-745-7605

Central PA Connect (Lancaster)

Keith Cromwell, HIE Program Director
Keith.Cromwell@pennmedicine.upenn.edu
717-544-5269

Clinical Connect (Pittsburgh)

Phyllis Szymanski, President
szymanskipd@clinicalconnecthie.com
412-628-0179

KeyHIE (Danville)

Mary Honicker, IT Program Director
mhonicker@geisinger.edu
570-214-9438

Thank You!

Simplified Architecture