Using a State Innovation Model Award to Address Health Equity: DC’s Approach

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Bridging the Gap between Health Care and Health Equity
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What I Will Cover

• Landscape view of DC: Demographics, Divides and Disparities

• DC Residents in Medicaid Program

• DC’s State Innovation Model Design Year: Focus on Reducing Health Disparities and Achieving Health Equity

• Next steps
Landscape View of DC: Demographics, Divides and Disparities
Framing the Issue

• DC has one of the highest health insurance coverage rates in the nation

• However, when compared among states, DC has not achieved widespread improvement in population health---
  – 50th in mortality amenable to health care
  – 51st in breast cancer death rates
  – 42nd in children who are overweight or obese

• Additionally, in key metrics for how DC compares among states in prevention and treatment---
  – 51st in hospital discharge instruction for home recovery
  – 51st patient-centered hospital care¹

• The impact of social determinates of health is apparent on the well-being of DC residents

2. Kaiser Family Foundation Health Facts (2015). . Downloaded from the World Wide Web on September 15, 2016 http://kff.org/other/state-indicator/poverty-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%22,%22sort%22:%22desc%22%7D
DC is Organized by Wards; Most Health Disparities are in Eastern DC
DC is Segregated by Race: Most African-Americans are in Eastern DC

- Eastern Census tracks of DC are mostly black residents
- Western Census tracks of DC are mostly white residents
- Several tracks in SE DC have less than 2% white residents
- Many tracks in western DC have less than 5% black, Hispanic or Asian-American residents

Source: The Washington Post; June 19, 2015; By Aaron Blake
15% of Residents Experience Food Insecurity

Grocery Store Location by Census Tract by Change in White/Black Resident Ratio from 2000-2012

Legend
- Grocery Store Location
- Change in White/Black Ratio
- Real Change

Data Sources: American Factfinder (2012 ACS 5-Year Merge File and 2000 Census Summary File), Census Bureau TIGER Shape Files, data.dc.gov
Unemployment is Highest in Eastern DC

Unemployment

<table>
<thead>
<tr>
<th>Ward</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 7</td>
<td>9.4%</td>
</tr>
<tr>
<td>Ward 8</td>
<td>11.3%</td>
</tr>
<tr>
<td>Ward 3</td>
<td>3.3%</td>
</tr>
<tr>
<td>City</td>
<td>5.8%</td>
</tr>
</tbody>
</table>

Updated May 2016
DC Dept. of Employment Services
DC Residents in Medicaid Program
More Than 4 in 10 DC Residents are Either Enrolled in Medicaid (or DC’s Local-Funded Program [Alliance])

*Total Residents  672,228

Source: District population estimate from United States Census Bureau. Medicaid and Alliance data reported from DHCF’s Medicaid Management Information System (MMIS).
Note: These data exclude District residents who are not United States Citizens and thus the percent of residents on publicly funded health care may be slightly overstated.
Fee-For-Service Beneficiaries are Responsible for a Disproportionate Share of Medicaid Spending

Is Beneficiary In Fee-For-Service Program?

- Yes → 26%
- No → 74%

N = 228,644

*Medicaid Recipients

Total Medicaid Expenditures

- 75%
- 25%

$2,296,649,398

Source: Data from DHCF MMIS system.
*Only persons with 12 months of continuous eligibility in CY2015 are included in this analysis.
DC’s State Innovation Model Design Year: Focus on Reducing Health Disparities and Achieving Health Equity
DC’s 5 Health Care Transformation Aims

Within five years (2017 – 2021)—

1. 100% of chronically-ill DC residents enrolled in Medicaid will have access to a care coordination entity, that is primarily responsible for all aspects of care (2018)

2. 15% reduction in non-emergent ED visits for all DC residents (2020)

3. 10% reduction in preventable hospital readmission rates for all District residents; 15% reduction for residents enrolled in Medicaid (2020)

4. Develop and implement a plan to reinvest savings achieved through system redesign to promote prevention and health equity (2021)

5. 85% of Medicaid payments will be linked to quality; 50% will be tied to an APM (2021)
Three ‘Pillars’ & Four ‘Enablers’ for Health Care Transformation
Envisioned DC Health Care Landscape

Accountable entity takes responsibility for the patient’s ‘whole’ health

Exchange of Actionable Data
Potential Data Flow for Patient Care Profile

- eCQM Tool & Dshbrd.
- Prenatal Registry
- Patient Pop. Dashbrd.

Data Sources/ Mini HIEs
- CRISP
- HMIS
- DOH Systems
- MMIS
- Capital Partners in Care

Data Points
- Primary Care
- Specialty Care
- Meds
- Demo
- Immunizations
- Acute & Post-Acute Care
- Housing
- Human Services
- Transpo.
- Physical Safety
- Employment
- Food Security

Upcoming HIE Tools
**Patient Care Profile**

**PATIENT DEMOGRAPHICS**
- Name: John X. Smith
- DOB: 04/09/1954
- Address: 3700 Massachusetts Ave NW, Washington DC, 20016
- Phone #1: 202-444-7777
- Phone #2: 202-555-3232

**RISK STRATIFICATION**
- Redmission: 51 - Medium - Bread for the City - Dr. X - 2025556688
- Re-ED visit: 70 - High - MFA - Dr. O - 2025679876

**CARE MANAGEMENT PROGRAM(S)**
- Care Plan available: Yes, click HERE to view
- Organization: Trusted Health Plan
- Care Manager: Ms. Mary Von
- Phone Number: 443-410-4100
- Email: mvon@hcc.org
- Type: Diabetes control
- Short / Long term: Long term
- Start Date: 2/1/2014
- End Date: 2/1/2016

**CHRONIC CONDITIONS**
- Diabetes: 8/22/1982
- COPD: 3/21/2008

**IMMUNIZATIONS**
- MMR: 6/6/2015

**HOUSING STATUS**
- Status: Permanent Supportive Housing
- Date: 10/10/2010

**ENCOUNTER NOTIFICATION(S)**
- ER VISIT(S) [LAST 120 DAYS]
  - Date: 6/15/2014
  - Facility: MFA
  - Visit Type: ER
  - Date: 7/2/2015
  - Facility: Bread for the City
  - Visit Type: ER

**HOSPITAL VISIT(S) [LAST 120 DAYS]**
- Date: 6/15/2014
- Facility: Providence Hospital
- Visit Type: Inpatient
- Date: 7/2/2015
- Facility: Howard University Hospital
- Visit Type: OBV

**MEDICAID CLAIMS DATA FROM LAST 12 MONTHS**

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**Hasan**
New & Upcoming Initiatives that Will Impact Health Equity

1. My DC Health Home- Jan 2016
   • Beneficiaries with Severe Mental Illness
   • Community mental health providers receive monthly PMPM rate to integrate full array of services for attributed panel
   • Standard health assessment that gathers social data
   • Performance tracked and shared with providers quarterly
New & Upcoming Initiatives that Will Impact Health Equity (cont.)

2. My Health GPS – April 2017

- Beneficiaries with 3 or more chronic conditions—mostly physical
- Primary Care providers receive monthly PMPM rate to integrate full array of services for attributed panel
- Peer Navigator/Community Health Worker is a required member of team
- Performance tracked and shared with providers quarterly
- Pay-for-performance (P4P)
3. FQHC Pay-for-Performance Program - Fall 2017

- Must submit to participate:
  - HRSA-approved quality improvement plan
  - Access to clinical advise 24 hours, 7 days a week
  - Proof of National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Level 2 recognition

- Exploring socially-driven measures to track performance
Next Steps
Keep Momentum Going

1. Explore **adding homelessness as a risk-factor** for Health Home model

2. **Leverage HIEs** to design and implement Patient Care Profile

3. **Expand access to claims** data through upcoming Medicaid Data Warehouse

4. Use existing and new methods to **engage stakeholders** in ways to reduce health disparities—especially in eastern DC.