Colorado Community Health Network's Use of PRAPARE Data Visualization to Inform Population Health Management and Payment Reform Efforts

The Colorado Community Health Network (CCHN) partnered with Colorado Community Managed Care Network (CCMCN) to implement PRAPARE with three participating health centers. The team consisted of a staff member from CCHN's quality and policy division and a data analyst and project manager of CCMCN. Staff spent a significant amount of time developing and delivering PRAPARE training curriculum for their health centers after attending PRAPARE Train the Trainer Academy learning sessions. CCHN and CCMCN then hosted an all-clinic PRAPARE discussion to encourage clinics to align behind one population of interest to more easily standardize and analyze PRAPARE data. Due to the alignment between different value-based payment arrangements and other quality initiatives, the group selected patients with uncontrolled diabetes (defined as patients with HcA1c scores greater than nine). CCHN's future plans include possible statewide target population, particularly related to payment reform and the exploration of opportunities for a referral management system.

Curriculum Planning

CCMCN and CCHN met with participating health centers to understand and customize best PRAPARE implementation strategies for each health center. Implementation strategies included:

- Unique visits with care managers to ask the PRAPARE questions
- Potential use of tablets for PRAPARE screening
- Phone call PRAPARE screenings
- Administering PRAPARE during one-on-one visits with the patient during their regularly scheduled appointments

CCMCN and CCHN then spent time with each health center to develop detailed workflow plans to document how, when, and who is conducting PRAPARE screening using the strategies health centers identified.

Colorado's participation in PRAPARE implementation was well timed due to Medicaid changes happening within the state. PRAPARE has allowed the PCA and its health centers to align with SD efforts under payment reform.

Successful Data Strategies

CCMCN serves as the data warehouse for health centers and uses Tableau's Business Intelligence (BI) platform for reporting. In this platform, data can be imported from various channels including text files and Excel spreadsheets. Tableau has the ability to display social determinants of health data collected by health centers in a manner that engages clinic leadership to have dynamic conversations regarding the impact of social determinants in their community, improvements for workflow implementation, and solutions to implementation challenges and barriers. This engagement created buy-in from both the executive level teams and the care management teams in understanding the importance of the PRAPARE tool.

Next Steps: Supporting Health Centers in Data Collection to Further Discussions on Risk Stratification

As these health centers progress, additional health centers will join the PRAPARE movement. The plan moving forward is for health centers to meet every three months to review PRAPARE social determinants data and refine the data collection process as they share lessons learned.

Additionally, CCHN is meeting with Regional Accountable Entities (RAEs-Medicaid regional contracts responsible for the management of the Medicaid behavioral health capitation and aspects of physical health) to share how health centers have applied their social determinants of health data to inform care and population health management. These discussions have been positive to show health center value and influence some REAs to consider PRAPARE as they draft plans for risk stratification of patients for care coordination.

Key Takeaways

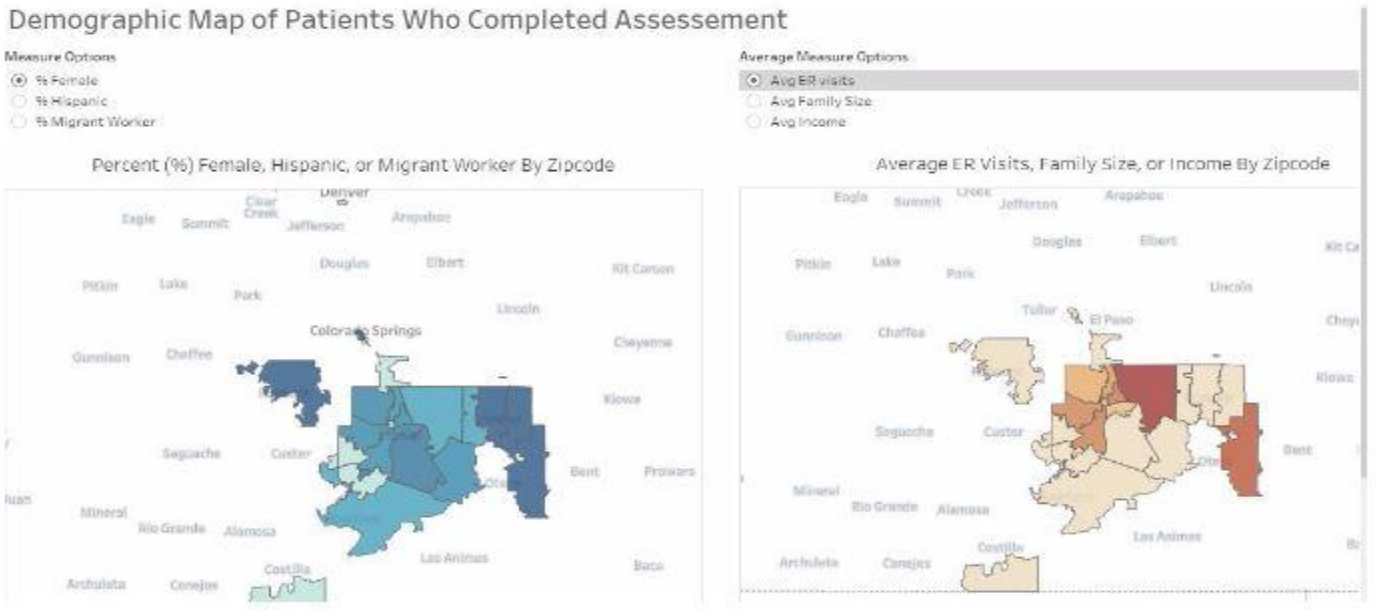
- **Data Speaks Loudly:** Investing in a data reporting software and staff capacity to analyze data makes a great impact in engaging leaders and partners to invest in and respond to the social determinant needs found in their communities. CCHN found that visualizing the PRAPARE data collected by their health centers using a dashboard not only cemented the participating health centers' interest and resolve in collecting this information, but it also really helped garner interest from other health centers not currently using PRAPARE. Visualizing the data helped clinic staff and leadership see just how complex their patients were and how the data could be applied to inform clinic care, population health management, and payment reform efforts.

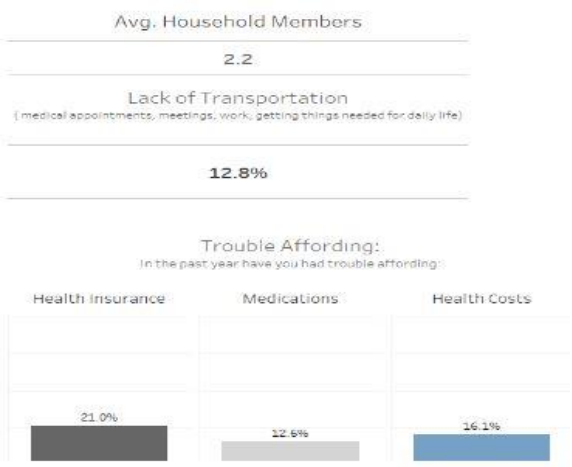
- **Create clinic synergy:** Aligning behind a goal, metric, or population amplifies the collective impact and value of work across health centers and helps to facilitate shared learning across health centers.

Health Center-Level Changes as a Result of PRAPARE Implementation

- Pueblo Community Health Center is in a unique situation in Colorado as CCMCN hosts their EHR for them. This means that CCMCN has had access to their data since the beginning of the project and has been working to develop reporting mechanisms with Pueblo's data. Several months into the Academy, CCMCN met with Pueblo staff, including the care managers responsible for completing the assessment, and showed them their data. CCMCN staff observed that reviewing the data during a formal meeting made care managers feel validated for the work they are doing and gave them a way to message the needs of patients. Additionally, Pueblo has launched a partnership with their county health department to utilize the data in future work together that will be further defined over time.

- Metro Community Provider Network (MCPN) has utilized PRAPARE as their initial screening tool by Patient Navigators as one of the ways to determine if a patient needs a referral for care coordination. The Patient Navigators are collocated with the care team and are able to utilize time before and after medical visits in the exam room to complete the screening tool with patients. Based on the results of the screen, they can provide resources that day as needed, and also identify if the patient is in need of more intensive services and assistance, which can be provided by the care coordinators. Additionally, MCPN is working to develop an internal risk-stratification model to identify patients for care coordination. To ensure the stratification accounts for the whole person, they are equally weighing medical diagnosis, behavioral health diagnosis, and social determinants in the stratification model.





Graphics from CCMCN's Tableau demo to visualize their social determinants data collected by Colorado health centers