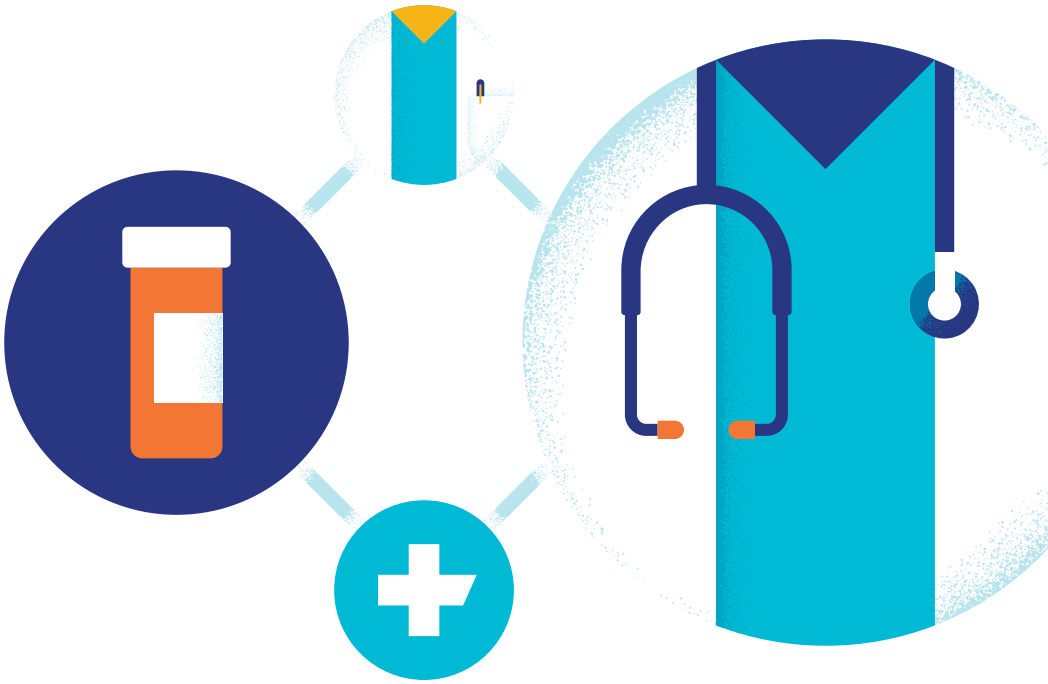

Advancing access to care and population health outcomes in Washington

In its mission to help people live healthier lives, UnitedHealthcare Community Plan of Washington seeks to enhance the performance of the health care system and to collaborate with providers and partners to expand access to high-quality health care. Advancements in access to care and population health outcomes are achieved not only by improving care for patients showing up for their appointments but by the efforts made to provide care for those who are not able to.

As the Medicaid health care environment shifts focus from acute care of individuals to a value-based, population-health focused model of care, there is a need to bridge the historical disconnect between clinical care and population health outcomes.[1] Closing that gap requires integrating clinical care with non-clinical social drivers of health (SDOH) and alignment with the quadruple aim of enhancing patient experience, supporting population health, reducing cost of care, and improving the work life of providers.[2]

Primary Care Providers (PCPs) play a pivotal role in the care of patients receiving Medicaid. Access to high-quality primary care is associated with improved health outcomes and higher patient satisfaction.[3] Access to primary care also lowers health care costs by decreasing utilization of more expensive hospital and emergency department services.[4] Medicaid members often face barriers to accessing and effectively utilizing primary care, including transportation, language barriers, appointment availability, and challenges navigating the health care system.[5] Barriers related to SDOH needs are often exacerbated for people of color and people living in rural communities.[6]

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6556001/
[2] https://pubmed.ncbi.nlm.nih.gov/25384822/
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6527832/
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5309146/
[6] https://health.gov/healthypeople/priority-areas/social-determinants-health

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Patients unable to make their appointment experience worsened health conditions and costly, avoidable emergency department usage.

Providers treat those who arrive at their appointments, rather than those patients who were unable to make their appointment and often need the most care and support. Despite providers' best efforts, their bandwidth to conduct personalized outreach and social services coordination is often limited due to capacity and the number of patients they serve. As a result, patients who may be at the greatest risk for poor health outcomes remain disconnected from primary care, and experience worsened health conditions and costly, avoidable emergency department usage.

UnitedHealthcare Community Plan of Washington is committed to addressing the gap between clinical care, SDOH needs and population health outcomes. The health plan is collaborating with Waymark, a public benefit company that utilizes technology-enabled, community-based care to improve access to and quality of care for people enrolled in Medicaid.

The intervention launched in January 2023 to serve 15,000 members with multidisciplinary support teams providing wraparound services through primary care providers. The teams include local community health workers (CHWs), care coordinators and licensed therapists who deliver data-driven outreach, care coordination and social services support. The collaboration aims to accelerate access to primary care and further drive the health care system in Washington toward a value-based model of care by strengthening connections between clinical care and population health outcomes.

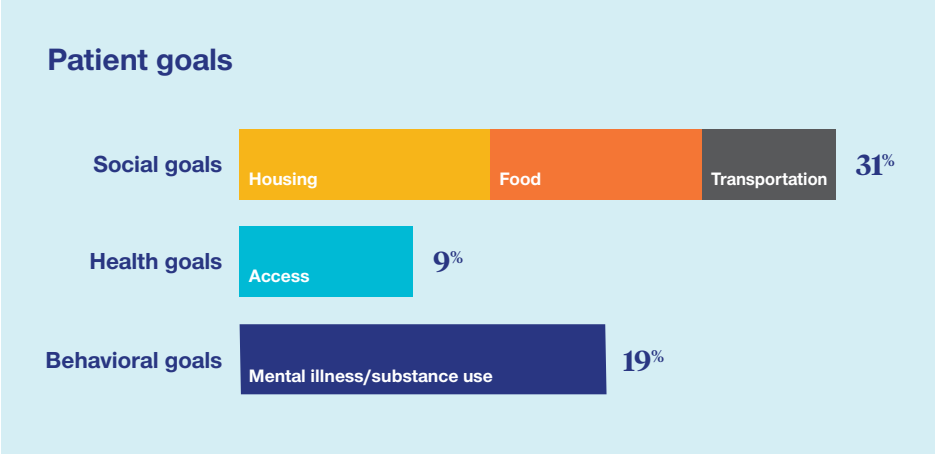
The Waymark model is rooted in an evidence-based approach to care management that uses proprietary predictive technology to proactively identify patients at the greatest risk of poor health outcomes or avoidable emergency room usage. The predictive model incorporates de-identified utilization data from the national Medicaid claims dataset, called the Transformed Medicaid Statistical Information System. The technology guides care teams consisting of CHWs, behavioral health therapists and care coordinators. The care teams are provided information regarding which patients to contact, the best time and method for outreach and most effective interventions based on that individual's unique needs. The approach aims to supplement primary care efforts with community-based, whole-person care services spanning physical health, behavioral health and SDOH needs while improving members' health outcomes and experiences.

Evidence demonstrates that these workflows can reduce inpatient admissions, hospital length of stay and total cost of care among Medicaid patients compared to a randomized control group. Specialized workflows also target Healthcare Effectiveness Data and Information Set (HEDIS®) measures that evaluate health plan performance. A specialized maternity and pediatrics pathway utilized by Waymark has demonstrated improvements in HEDIS gaps in care, reductions in maternal mortality, and decreased cost of care primarily led by fewer NICU admissions.[7,8] The results of the Waymark model stand in contrast to CHW-only programs without technology enablement and multidisciplinary support.[9]

The collaboration in Washington is serving 15,000 UnitedHealthcare Community Plan of Washington members through wraparound care teams. To date, results parallel the trials that form the basis for Waymark's workflows and technologies. A pre-post analysis (90 days before and after enrollment) demonstrated a 20% reduction in non-emergent ED visits as defined by the NYU Emergency Department algorithm and a 10% reduction in inpatient admissions.[10] The program has also had early success with HEDIS metric improvement, meeting annual targets in June for improving antidepressant medication management, asthma medication ratio and follow-up rates after hospitalization for mental illness.

[7] https://pubmed.ncbi.nlm.nih.gov/28682317/
[8] https://pubmed.ncbi.nlm.nih.gov/15786855/
[9] https://pubmed.ncbi.nlm.nih.gov/28874487/
[10] https://pubmed.ncbi.nlm.nih.gov/28726238/

A key outcome of the collaboration includes achievement of patient-identified goals related to social, health and behavioral outcomes. An assessment of the UnitedHealthcare and Waymark program found that 89% of enrolled patients identified one or more goals. 54% of those patients achieved at least one of those goals as of July 2023. Social goals included help with housing (requested by 13% of patients), food (11%) and transportation (7%). Health goals included support accessing primary care (9%) and other care services. Goals related to mental illness or substance use were typically addressed by Waymark behavioral health therapists (19%).



Patient experience was measured through a customer satisfaction (CSAT) questionnaire. The program achieved a 90% patient satisfaction score within the first six months of rollout. Local knowledge around resources, services and supports that are available at a community level is critical for meeting patients' SDOH needs. Patient use cases include supporting transportation and childcare needs for a patient with a chronic health condition who had previously missed appointments, and addressing SDOH needs specific to patients with diabetes and for individuals who have recently been released from incarceration.

From the perspective of participating providers, the program offers a local team proactively engaging with patients who may be hard to reach and addressing SDOH needs that impact engagement and health outcomes. The availability of wraparound services creates increased capacity for patient engagement, coordination and SDOH support, enabling providers to focus on delivering high-quality care that aligns with a value-based, population-health focused model.

At clinics like Country Doctor Community Health Center, a Federally Qualified Health Center in Seattle, Waymark care coordinators directly document in the provider's patient records, enabling rapid and coordinated care across the same platform. Additionally, Waymark CHWs often accompany members who request assistance to primary care visits, reducing the number of faxes, emails, direct mail or inbox messages that providers have to sift through to organize and coordinate care across multiple service providers.

"We chose to partner with Waymark because their local, community-based, multidisciplinary care model aligns not only with the evidence of what works in Medicaid, but also our own mission and values," said Matthew Logalbo, MD and Medical Director, CDCHC. "We have worked hard to develop services tailored to the needs of our patients (e.g. our low barrier addiction treatment clinic, peer support specialists, re-entry CHWs, and healthcare for the homeless services), but we can't meet the level of demand that exists alone. Waymark provides us with more capacity outside the clinic setting to engage and support patients, bring them into care, and connect them to our programs and other resources in the community that can address patients' social determinants of health."

UnitedHealthcare Community Plan of Washington's collaboration with Waymark has demonstrated that combining community-based care teams with evidence-based predictive technologies can improve patient experiences, advance population health goals, and move towards a value-based model of care. The first six months of the program have demonstrated strong patient and provider satisfaction, a reduction of non-emergent ED visits, and improvements in HEDIS metrics. The program is continuing to work toward its aim of improving access to high-quality care, supporting primary care providers, and closing the gap between clinical care and population health outcomes.

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