OPTUMHealth Education

UNITEDHEALTH GROUP
Center for Clinician Advancement

# Social Determinants of Health: A Panel Discussion

**September 19, 2019**

# Learning Objectives

At the end of this educational activity, participants should be able to:

- Explore ways in which HCPs can understand the significance of SDOH on social and behavioral factors that impact health.
- Identify ways in which HCPs can recognize and address SDOH needs, and strategies to mitigate their impact on patients' outcomes.
- State ways in which family caregivers can be incorporated into health care teams.
- Provide examples of how the health care industry can address SDOH barriers.
- List examples of where the health care industry can facilitate industry thought-leadership on SDOH.

# Panelists

**Moderator**

**U. Michael Currie**

Senior Vice President and Health Equity Officer
UnitedHealth Group

**Panelist**

**Sheila Shapiro**

Senior Vice President, National Strategic Partnerships
UnitedHealthcare Clinical Services

**Panelist**

**Robyn Golden, LCSW**

Associate Vice President of Population Health and Aging
Rush University Medical Center

# Our Hypothesis

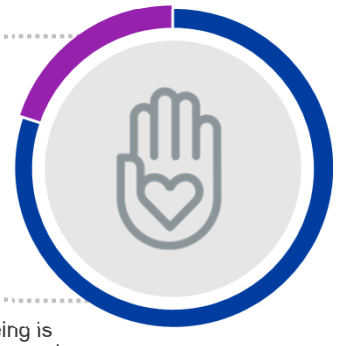
By building an infrastructure around social determinants of health, we can…

- Redefine health to consider the whole person – not just medical care
- Remove barriers that limit access to care and address health disparities
- Improve overall health and well being of all vulnerable populations

# Social Determinants of Health by the Numbers

**20%**

of health outcomes can be directly attributed to clinical care[1]



**80%**

of health and wellbeing is tied to social and economic factors, physical environment and health behaviors[1]

**91%**

of Medicaid plans report activities to address social determinants of health[2]

**19**

states require Medicaid managed care plans to screen for and/or provide referrals for social needs[2]

**85%**

of physicians report that unmet social needs lead to poorer health outcomes[3]

**20%**

of physicians are confident in their ability to address unmet social needs[3]

[1] Robert Wood Johnson Foundation, County Health Rankings, "Relationships between Determinant Factors and Health Outcomes"
[2] Kaiser Family Foundation, "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity"
[3] Robert Wood Johnson Foundation, "Health Care's Blind Side"



# Concurrent Happenings: Socioeconomic and Health Care

As we pursued our SDoH work, related findings/changes validated the need for SDoH inclusion in health care.

**40%** of Americans **can't** afford a **$400** financial **emergency**[1]

**$60K** is the median **household income** for commercial population[2]

**78%** of Americans live **paycheck to paycheck**[1]

CMS expands **supplemental benefits** definition/inclusions*

**80%** of health is determined by what happens **outside** of the **doctor's office**[3]

*2018
1 https://www.federalreserve.gov/publications/files/2017-report-economic-well-being-us-households-201805.pdf
2 Data USA; U.S. Census Bureau, 2017
3 Robert Wood Johnson Foundation, County Health Rankings, "Relationships between Determinant Factors and Health Outcomes"

# Social Investments = Clinical + Financial Results

Montefiore Health System's investment in housing in the Bronx reduced ER visits and unnecessary hospitalizations — for an **annual 300% ROI**

Through a community partnership, University of Illinois Hospital helped secure housing for recurring patients who were chronically homeless, and **costs dropped 61%**

CalvertHealth Medical Center brings its Mobile Health Center to residents who lack transportation, leading to a **9% reduction in readmission**

By implementing nutrition programs and screenings, within 6 months Advocate Health Care lowered costs by **$3,800 per patient**



## Social Valuation Tool

Social Valuation Tool represents the **value to the consumer** if they purchased the service out of pocket.

Our pioneering, patent-pending tool provides an **estimated market value** for social services that **can be used to....**

- Show financial value of social referrals to members
- Support the triple aim through the lowering of costs and improvement of quality through holistic interventions
- Serve as the gold standard for social determinant of health valuation
- Create reporting for providers and social organizations as to their value on social referrals



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# ICD-10 Code Expansion to Address Social Determinants

On March 6, 2019, we submitted **23 new codes** to add to the ICD-10-CM code set.

### Strong Support from Industry Partners

AMA
NCQA Measuring quality. Improving health care.
AHCCCS Arizona Health Care Cost Containment System
NATIONAL ASSOCIATION OF Community Health Centers

### ICD-10 Committee Timeline

- **April/May 2019:** Two-month comment period
- **November 2019:** Committee decision, next steps
- **November 2020:** If approved, new codes available for adoption and use



# Next Steps - What You Can Do

On February 18, 2018, the ICD-10-CM Cooperating Parties approved and the AHA Coding Clinic published advice that allows the reporting of codes from categories Z55-Z65, based on information documented by ***all clinicians* involved in the care of the patient***.

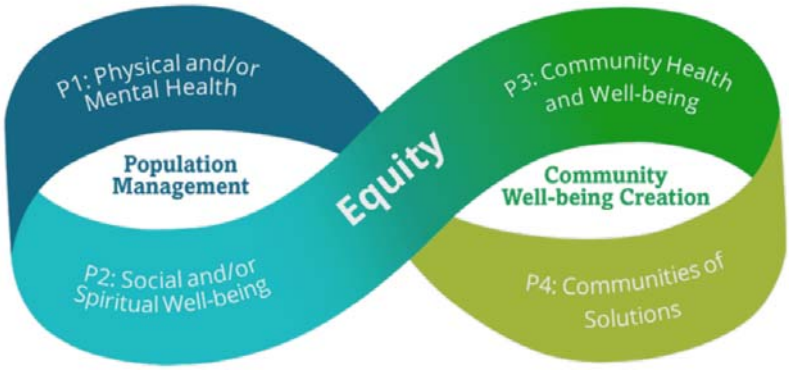
- Support the use of self-reported data-AHA Coding Clinic will be recommending use to the ICD-10 Committee in August, 2019
- Document known Social Determinants of Health
- Communicate this change to your organizations and to your billing staff

. *clinicians have been loosely defined according to the AHA



UnitedHealthcare

# Pathways to Population Health: Making it Happen On the Ground




**Source:** Pathways to Population Health: An Invitation to Health Care Change Agents. October 2018. http://pathways2pophealth.org/files/Pathways-to-Population-Health-Framework_102218.pdf

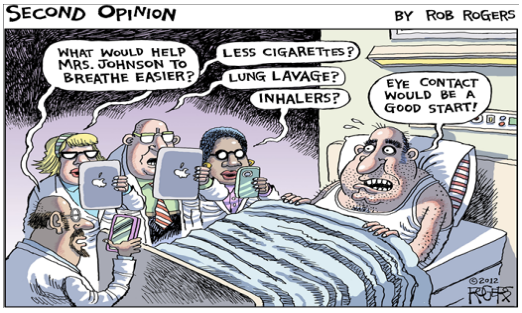
# Population Health Management in Practice

| | |
|---|---|
| **Patient Identification and Screening:** | •Which patient population will you target and how will you assess their social needs? |
| **Resource Navigation & Care Management:** | •For which specific social needs will you offer support?<br>•What level and type of support?<br>•Short-term vs. long-term care management? |
| **Team and Workflow:** | •Who will provide resource support for patients?<br>•How will this integrate with broader clinical processes? |
| **Data and Evaluation:** | •How will you know how much to invest in social supports in the long run?<br>•How will you know how to maximize the impact of this investment? |
| **Community Partnerships:** | •What community-based organizations are critical to the health of your members?<br>•How will you partner with them to continually improve access to resources? |
| **Leadership and Change Management:** | •Have you identified a social needs champion with the ability to allocate resources?<br>•Do you have the necessary buy-in from key stakeholders? |

**Source**: Essential Needs Roadmap. Health Leads. https://healthleadsusa.org/resource-library/roadmap/

# Characteristics of Effective Care Management

- Using empathic language and gestures
- Anticipating the patient's needs to support self-care
- Providing actionable information
- Minimal handoffs
- Frequent touch points
- Person-specific, tailored interventions
- Ability to effectively link individuals to services
- Trusting care team relationships




Sources: 1. Mitchell, Suzanne E., et al. "Care transitions from patient and caregiver perspectives." *The Annals of Family Medicine* 16.3 (2018): 225-231.
2. Boutwell, Amy E., Marian B. Johnson, and Ralph Watkins. "Analysis of a social work–based model of transitional care to reduce hospital readmissions: Preliminary data." *Journal of the American Geriatrics Society* 64.5 (2016): 1104-1107
3. Kirst, Maritt et al. "What works in implementation of integrated care programs for older adults with complex needs? A realist review" *International journal for quality in health care : journal of the International Society for Quality in Health Care* vol. 29,5 (2017): 612-624.

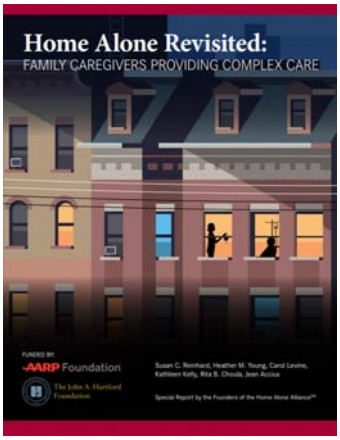
# Relationship-Centered Care

**"I've learned that people will forget what you *said*, people will forget what you *did*, but people will never forget *how you made them feel*."**

- Maya Angelou

# A Focus on Family Caregiving

- Availability of family caregivers for supporting patients is another critical area for healthcare to attend to
- We assume that they are "ready, willing, and able"
- Yet, they're not always – and caregiving brings with it serious implications on their own health and wellbeing
  - Caregivers who are socially isolated or have no choice about care provision are at greater risk for difficulties with complex care




Home Alone Revisited: Family Caregivers Providing Complex Care (AARP, 2019) https://www.aarp.org/content/dam/aarp/ppi/2019/04/home-alone-revisited-family-caregivers-providing-complex-care.pdf

# The CARE Act


Source: AARP, Updated on 4/10/19

- Law in 40 states
- Stipulates that family caregivers:
  - Get noted in the hospital electronic medical record
  - Get notified prior to a discharge from the hospital to any location
  - Receive training on the care to be provided at home prior to the patient's discharge
- Promises to spur awareness of caregiver needs and the importance of addressing them

# How Can Health Plans Help Family Caregivers?

1. The medical record and service plan can **identify family caregivers**.
2. Family caregivers are **assessed for their own needs** and well-being.
3. Family caregivers can **participate in care planning**.
4. Family caregivers and care coordinators can **have each others' contact information.**
5. Care coordinator can **refer them to training to learn caregiving skills** such as administering meds and wound care.
6. Care coordinator can **refer them to respite care** and other needed services such as evidence-based caregiver support services, especially for dementia.
7. Consumers and family caregivers are on **advisory committees**.


# Our Real-World Experience at Rush


**An Integrated Health System Serving the South and West Sides of Chicago**

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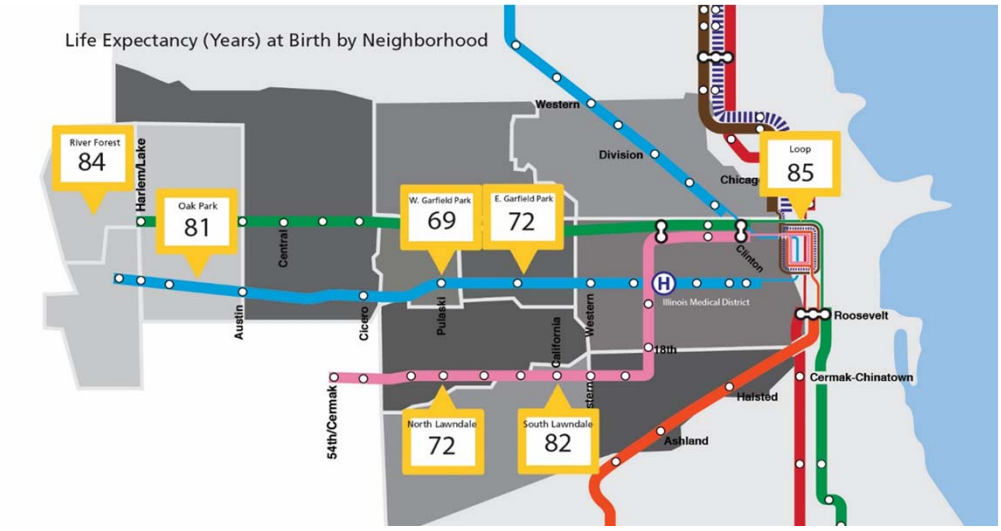
# Complex and Structural Issues Affect People's Health



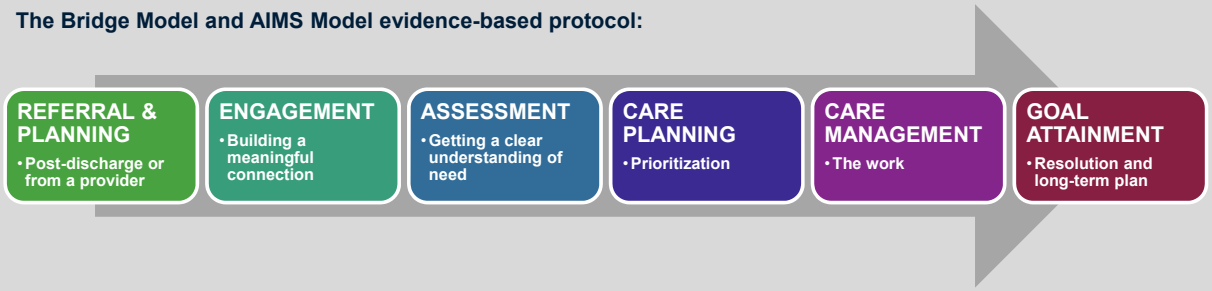

# Rush's Multi-Pronged Approach

- Anchor and equity mission
- Community coalitions
- SDOH screening and targeted initiatives
- Ambulatory care management
- Health promotion and support groups

# Ambulatory care management – at Rush and beyond

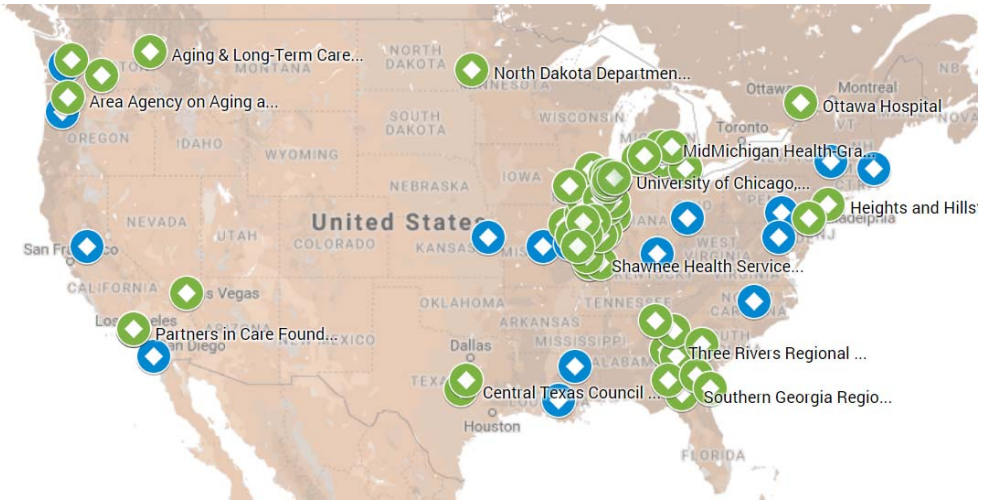
- **The Bridge Model** supports patients & families following hospital discharge
- **AIMS (Ambulatory Integration of the Medical and Social)** supports those in need of social work services in outpatient or community settings
- **Collaborative care team** for supporting those with depressive symptoms
- **Triad model** for managing patient panels under value-based (ACO) arrangements

**The Bridge Model and AIMS Model evidence-based protocol:**




The Center for Health and Social Care Integration (CHaSCI), based at Rush, offers training and technical assistance on the Bridge and AIMS Models. Visit www.chasci.org or email Robyn to learn more.

# Bridge and AIMS Informing Health and Social Care Integration Across the Country

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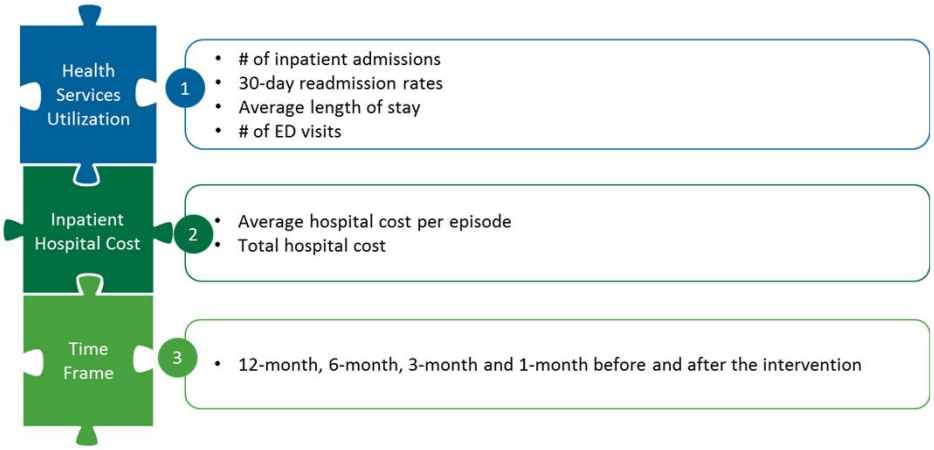
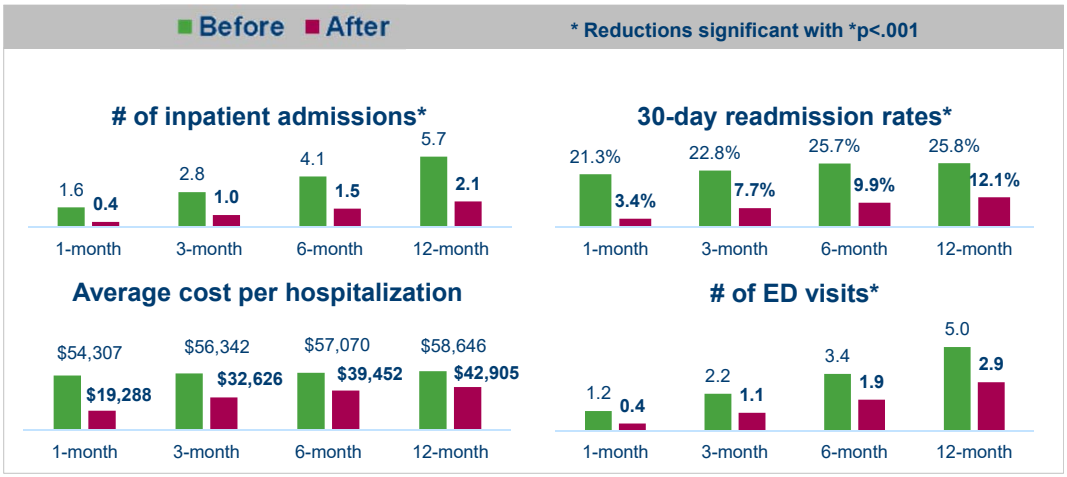
# A Look at Bridge's Impact with High-Utilizers

**A retrospective study for patients with 5+ hospitalizations in last 12 months; N=423, 2015-2016**




Source: Xiang, X., Zuverink, A., Rosenberg, W., & Mahmoudi, E. (accepted). Social work-based transitional care intervention for super utilizers of medical care: A retrospective analysis of the Bridge Model for Super Utilizers. Social Work and Health Care, "Social Workers in Integrated Healthcare: Improving Care throughout the Life Course" Special Issue.

# Bridge's Impact with High Utilizers: Reductions in Utilization and Cost of care

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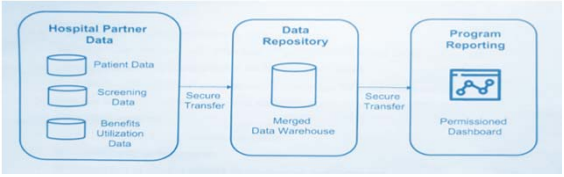
## Engaging More Individuals: Screening for Unmet Social and Economic Needs

- In 2016, decided to expand efforts to capture need beyond waiting for a referral or hospitalization
- Began process of screening universally for unmet social determinant of health needs:

| | |
|---|---|
| **Access to Care** | Do you have a doctor (primary care physician) or nurse that you see regularly? |
| | Do you have health insurance or a medical card? |
| **Food Insecurity** | Are you worried that your food will run out before you have money to buy more? |
| | In the last twelve months, have you run out of food that you bought and didn't have money to get more? |
| **Utilities** | In the last two months, have you had difficulty paying your electric, gas or water bill? |
| **Transportation** | Do you have a hard time finding transportation to and from your medical appointments? |
| **Housing Instability** | Do you currently have a place to stay/live? |
| | In the next two months, will you have a place to stay/live? |

## Rolling Out the SDOH Screenings

- Across care settings
  - Primary care
  - Emergency department
  - Inpatient
  - Community
- Various pilots on implementation and operationalization
  - Workflow variations and training needs
  - Data warehouses and workflow




- Of 7,000+ screens to date, ~1/3 have reported unmet needs

# Addressing Reported SDOH Needs

- For scalability, built out tiered way to respond to reported needs:


**Utilities**
- Pilot with CEDA (emergency energy assistance program)

**Hunger**
- Give food (Top Box, on-site food pantry)
- Referral to Greater Chicago Food Depository

**Transportation**
- Rides to medical appointments
- PACE connection

**Housing**
- Medical legal partnership
- Housing high-utilizer pilot
- Social work escalation

**Access to care**
- Benefits counseling
- Transitional care clinic and CommunityHealth partnership

**2+ or complex needs →** social worker for ambulatory care management (AIMS)

# Supporting Family Caregivers at Rush: AIMS and Bridge as One Route to Identify Need

☐ Home health / Homemakers
- Do you have a home health nurse who visits you? Any other in-home health care providers?
- Do you have a homemaker? (someone provided through aging or disability services or private pay, who helps you with things like laundry, housework, and meal preparation)
- Who else provides help to you at home if or when you need it (i.e. informal supports - family or church)?

☐ Social support / community support
- Who do you receive support from socially and in the community? (e.g., partner/spouse, family, faith community/organization, friends, other)

☐ Advance directives
- Do you have a living will, power of attorney, POLST, or other advance directive on file with your provider?

☐ Others involved in patient's care
- Who else is involved in your care? (e.g., family, friends, paid caregiver, faith community, etc.)

☐ Patient involved in care of someone else
- Are you involved in caring for someone else? (e.g., spouse, parent, child, friend)

☐ Relationship status
- Are you in a long-term relationship? (e.g., single, married, widowed, separated, etc.)

Screenshots from part of the CHaSCI Assessment template provided to Bridge and AIMS replication sites

## A More Comprehensive Solution: Rush's New Caregiver Health and Wellness Initiative

- Family caregiver identified in EHR
- Referral to initiative from interprofessional team members
- Initial assessment with family caregiver
- If warranted, more thorough assessment (built on AIMS & Bridge)
- Determine recommendations and consult with care team as needed
- Care planning and interventions with family caregiver

## Looking Ahead and Coalescing the Field

# Discussion

# Q & A

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## Thank You!

If you have any questions or concerns please contact OptumHealth Education at moreinfo@optumhealtheducation.com.