New Efforts in Social Determinants of Health

Clinic to Community Linkage & Accountable Health Communities

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Jenn Kons, United Way of Greater Cleveland

11/16/2018
New Efforts in SDOH...Why Now?

- Focused attention on continued health disparities
  - First Year Cleveland focus on infant mortality
  - New data on pediatric asthma disparities

- Social inequalities continue
  - Cleveland ranks last in child poverty
  - Higher unemployment rates persist in Cleveland

- New opportunities available
  - Growing local and national interest in SDOH
  - More insured / more contact with health care
Example: Asthma Disparities

- Disparities exist in asthma exacerbation rates by income, race/ethnicity, and education.
Disparities by Combined Attributes

<table>
<thead>
<tr>
<th></th>
<th>Low Income, Medicaid, Non-Hispanic Black/African-American</th>
<th>All Children*</th>
<th>High/Middle Income, Commercial, Non-Hispanic White</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Obese or Overweight</td>
<td>8,129 / 21,642</td>
<td>77,325 / 230,787</td>
<td>27,271 / 96,291</td>
</tr>
<tr>
<td></td>
<td>37.6%</td>
<td>33.5%</td>
<td>28.3%</td>
</tr>
<tr>
<td>% with an asthma diagnosis</td>
<td>5,705 / 23,451</td>
<td>46,809 / 273,376</td>
<td>16,101 / 116,070</td>
</tr>
<tr>
<td></td>
<td>24.3%</td>
<td>17.1%</td>
<td>13.9%</td>
</tr>
<tr>
<td>% with asthma who had an in-system ED/Hosp/ICU visit</td>
<td>340 / 3,991</td>
<td>815 / 21,784</td>
<td>58 / 5,781</td>
</tr>
<tr>
<td></td>
<td>8.5%</td>
<td>3.7%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>
Project Goals

- Develop, test, and evaluate systemic approaches to addressing SDOH via better coordination between health care and social services.

- Develop large-scale policy and financing options to create sustainable solutions.
Problem: The Great Divide between Health and Other Human Services Providers

- Primary care providers attempt to provide comprehensive care to help patients thrive, but they are not well-positioned or equipped to make timely connections to community resources to address SDOH.
Solution: Clinic to Community Linkage (CCL)

- “Community-clinical linkages are connections between community and clinical sectors to improve population health.” (1)

- Develop a sustainable, scalable method for connecting patients seen in primary care practices to community resources via 2-1-1

- United Way 2-1-1 provides dedicated phone line and navigator to apply social service assessment, enhance medical referral outcomes and address identified social needs

CCL Overview

- Patient population: (initial conditions)
  - Adults with hypertension and elevated blood pressure
  - Children with asthma and/or overweight/obesity

- Pilot Clinics:
  - MetroHealth: J Glen Smith, Buckeye
  - UH Rainbow Babies & Children’s: Center for Women & Children
  - Care Alliance Health Center: Central Neighborhood Clinic

- Initial Targeted Neighborhoods: Buckeye-Shaker, Central, Glenville, Hough, Woodland Hills and Mt. Pleasant
CCL Referral Process

- Timely bi-directional referral and feedback system (interoperability) between United Way 2-1-1 and primary care clinics
Patient Brochure

Teaming up for health

Good health is more than just good health care

At MetroHealth, we want to do all we can to help you and your family be healthy.

We have partnered with United Way of Greater Cleveland to offer a special program for select J Glen Smith patients that can help you find resources in the community to improve your health.

United Way will find free or low-cost:
- Places for healthy food
- Places to exercise
- Workshops to improve blood pressure and improve your health
- Social services such as utility assistance, mental health and addiction treatment, and legal help

How does it work?

**STEP 1** Referral to United Way
A MetroHealth staff member may offer you a referral if your blood pressure is elevated.

**STEP 2** Talk to United Way Navigation Specialist
A trained dedicated expert will call you. They will help you find resources to manage your blood pressure and other services to help you and your family. You can also reach them by calling 1-833-225-2211.

**STEP 3** Navigation Specialist follow-up phone call
The 2-1-1 navigator will follow up to see how you are doing.
CCL Referral Process: EMR Referral Order

- Since September: 34 patients referred to UW211 (45% of eligible patients) from J Glenn, MetroHealth System
CCL Outcomes

- Data analysis and evaluation to include: referral data, health outcomes, and patient/provider experience
- Data will help inform the Accountable Health Communities Advisory Board plus providers, payers, policy makers of effect on health and social outcomes and any identifiable gaps in the community
- Create a culture change that bridges divide between health care and other sectors to achieve better health, social, educational and economic outcomes for all individuals
Next Steps

2018-2019:

- Build referral orders for childhood obesity/asthma
- Build electronic feedback loop from UW 2-1-1 to health system EHR
- Design workflows at 3 pediatric clinics, launch referrals and evaluate outcomes
- Evaluate, modify as needed, and scale to other neighborhoods, health systems, and populations/conditions
Accountable Health Communities

*Greater Cleveland Consortium*

11/16/2018
AHC Overview

- Innovation Project through Centers for Medicare and Medicaid (CMS)
- Systematically identify screen and address SDOH.
- Measure impacts on cost, utilization and outcomes.
- Screen 75,000 individuals annually at participating sites.
- Navigate 3,000 individuals annually.
- May 2017 – Nov 2018: planning and pilot
- Dec 2018: implementation

<table>
<thead>
<tr>
<th>Health System</th>
<th>Location</th>
<th>Clinical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleveland Clinic</td>
<td>South Pointe Hospital</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>MetroHealth</td>
<td>Main Campus</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td></td>
<td>Main Campus</td>
<td>Heart &amp; Vascular</td>
</tr>
<tr>
<td></td>
<td>Main Campus</td>
<td>Labor &amp; Delivery</td>
</tr>
<tr>
<td>Sisters of Charity</td>
<td>St. Vincent Charity</td>
<td>Inpatient Psychiatric Care</td>
</tr>
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Cleveland is 1 of 31 AHC projects nationwide.
AHC Intervention

Consent
- AHC brochure to eligible patients
- Document opt in/out in EHR

Screening
- Patient completes a screening booklet with 14 questions on social service needs.

Referral
- During the visit, 2-1-1 creates referrals based on screening.
- Copy given to patient after visit.

Navigation
- Patients with needs and ≥ 2 ED visits in year offered Navigation. If accepted, 2-1-1 to follow up for 12 months.
AHC Screening Tool

CMS-mandated, validated survey on select SDOHs

- 14 questions
  - Living Situation
  - Food Security
  - Transportation Access
  - Utilities
  - Personal Safety
- Demographic questions on income, education, race/ethnicity
- Risk level / Number of Emergency Department visits
- Not geared toward disease-specific subpopulations
## AHC Pilot Screening Results

### 545 screens

<table>
<thead>
<tr>
<th>Domain</th>
<th>Question Content</th>
<th># of Resp.</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>Worried food would run out</td>
<td>372</td>
<td>70%</td>
</tr>
<tr>
<td>Food</td>
<td>Food you bought just didn’t last</td>
<td>256</td>
<td>67%</td>
</tr>
<tr>
<td>Living Situation</td>
<td>Pests, mold, lead paint or pipes, lack of heat, over/stove not working, no working smoke detectors, water leaks</td>
<td>235</td>
<td>44%</td>
</tr>
<tr>
<td>Transportation</td>
<td>Lack of reliable transportation keeping you from daily living activities</td>
<td>225</td>
<td>42%</td>
</tr>
<tr>
<td>Utilities</td>
<td>Electric, gas, oil or water threatened or shut off</td>
<td>211</td>
<td>40%</td>
</tr>
<tr>
<td>Living Situation</td>
<td>Do not have steady place to live or worried about losing housing</td>
<td>193</td>
<td>36%</td>
</tr>
<tr>
<td>Safety</td>
<td>Insulted or talked down to you</td>
<td>130</td>
<td>24%</td>
</tr>
<tr>
<td>Safety</td>
<td>Screamed or cursed at you</td>
<td>111</td>
<td>21%</td>
</tr>
<tr>
<td>Safety</td>
<td>Threatened you with harm</td>
<td>44</td>
<td>8%</td>
</tr>
<tr>
<td>Safety</td>
<td>Physically hurt you</td>
<td>34</td>
<td>3%</td>
</tr>
<tr>
<td>No positive domains</td>
<td></td>
<td>44</td>
<td>8%</td>
</tr>
</tbody>
</table>
AHC Advisory Board

1. Identify gaps in needed social services
2. Assess equity of the intervention
3. Address gaps in services & guide community plan
   - AHC Clinical Partners
   - Social Service Providers
   - Ohio Department of Medicaid & Managed Care Plans
   - Researchers
   - Government
   - Foundations
   - Community Advocates
   - Medicare and Medicaid Beneficiaries
Gap Analysis & Community QI Plan

Gap Analysis:

• Annual assessment of community needs and available resources
• Based on results of screenings, assessments, and referral summaries. Informed by Navigation.
• Opportunity to inform local funding priorities

Quality Improvement Plan

• Developed in response to the Gap Analysis
• Goal is to improve system efficiency and accountability
Advisory Board Subcommittees

- Convened to “go deeper” on Gap Analysis and Community Quality Improvement Plan
- Members will do research that improves the Gap Analysis, and come up with possible projects for the Advisory Board to pilot through the QI Plan
- The subcommittee will take these project proposals, and the Gap Analysis, to the larger Advisory Board for approval
Evidence Exists for Various Integration Models

Source: Lauren Taylor, MDiv, MPH
Presented to Cleveland AHC Advisory Board, 10/25/18
Summary: Both CCL and AHC . . .

- Working to find the most efficient ways to **identify needs** and **provide community resources** to patients so they can have an equitable chance for health and well being

- Require **improved local collaboration** between health and human services sectors

- Aim to **reduce system costs** while **improving outcomes** in health and quality of life
Questions?

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