Partnerships to address social determinants of health

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Partners in Care Foundation

The Social Determinants Specialists

Changing the Shape of Health Care

- Partners is a think-tank and a proving ground.
- High-impact, innovative
- Integrating clinical and social services
- Test, measure, refine and replicate
- Consulting, evidence-based tools and training
- Direct services across all of California

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Changes We Want to See

- Integration of medical care and social services
- Enhanced self-management/empowerment of consumers
- Integration of behavioral health
- Evidence-based interventions
- Community-Based Organizations (CBOs) working as regional delivery systems/networks, like IPAs

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What CBOs do to Address Patients' Social Needs

How??

- ***Partner*** with hospitals, physicians & heath plans
- ***Focus*** – The home
- ***Payers*** – Medicaid
  – Medicare
  – Exchange
  – Commercial

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Population Health Management to Address SDOH

- Risk ***Stratification*** — Active screening and targeting
- Continual ***Monitoring*** for "trigger events" that could change a risk category
- Build partnerships with **community based organizations** as part of the delivery system for population health

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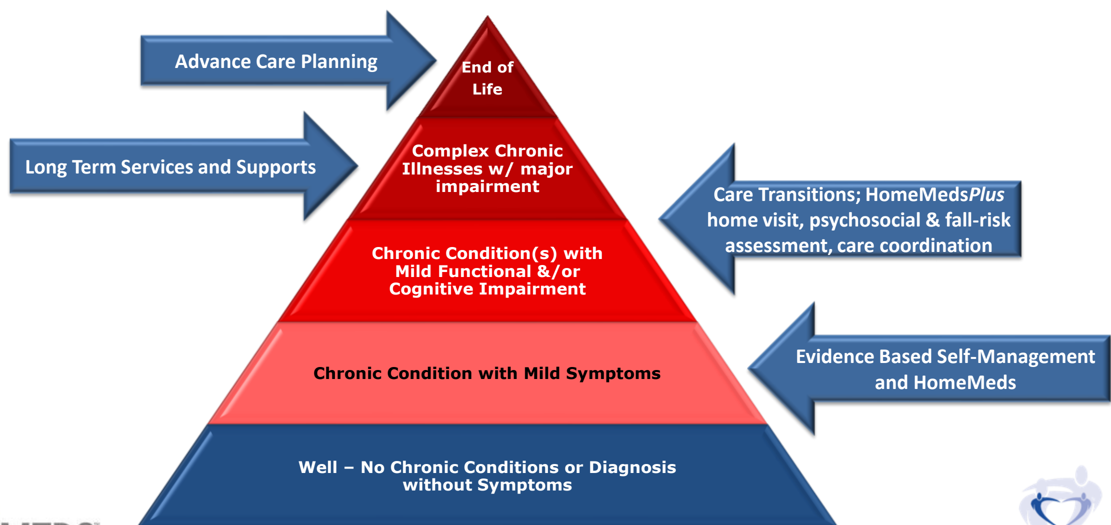
Community-based services for risk strata



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CBOs: Bridge to the Home

- CBOs improve health/functioning at home for decades
- Local trust, history and community support
- Know the lay of the land — quality of services
  - Not a call center approach — local employees
- Mobility and flexibility— responsive, nearby
- Health coaches, navigators, social workers, community health workers - an alternative and affordable workforce
- Culturally and linguistically matched

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Community-Based Organizations (CBOs): Your Eyes and Ears in the Home

- Gather data and information typically not shared in a medical setting or encounter:
  - Comprehensive psychosocial and functional assessment
  - Home safety and fall-risk evaluation
  - Link medication issues with evidence-based pharmacist intervention
  - Advance directives
- Service coordination and connection to benefits/discounts
- Attention to caregivers — education/training, support, respite
- Evidence-based health self-management and fall-prevention workshops

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CBO Home Visits Find what EHRs and Call Centers Can't See

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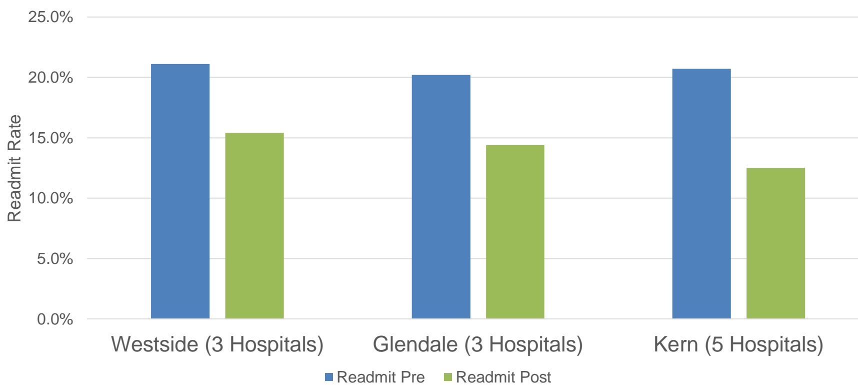
CMS DEMONSTRATION

32,000 Patients - $16 Million Saved by CMS

Care Transitions: Dr. Eric Coleman's Coaching & Rush University Bridge Models



UCLA further study found significantly reduced:
-30, 60 & 90-day readmissions
-ED use

QIO found reduced mortality, too

*Program to Date through Jul 2016
[1] Baseline (Pre): All-Cause, All-Condition, Medicare FFS: Westside & Glendale = Jan – Dec 2012; Kern = Apr 2012-Mar 2013
[2] CCTP (Post): Medicare High-Risk FFS Population, Readmission Rate to Date (Westside= May 2013 – Jul 2016; Glendale = May 2013-Mar 2016; Kern = Nov 2013 – Jul 2016

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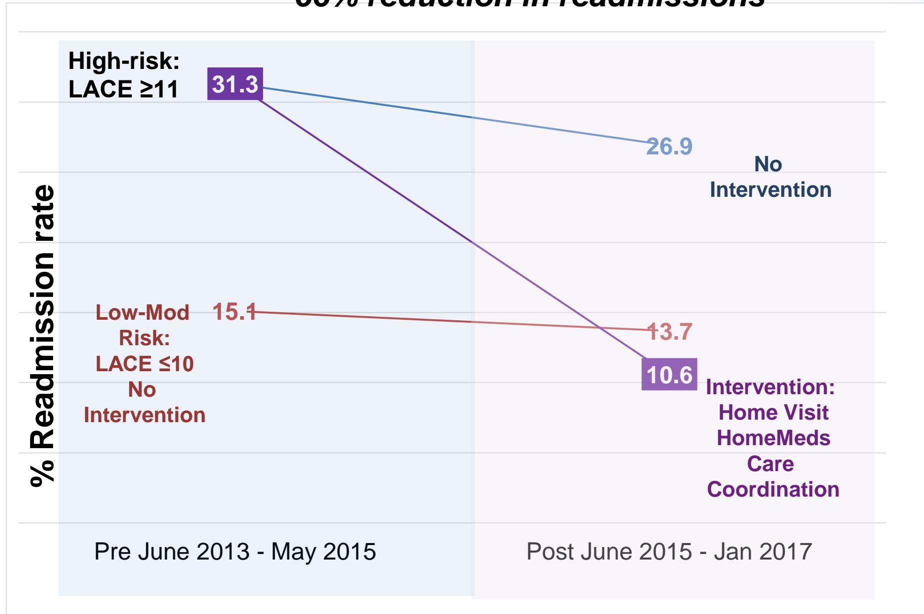
HomeMeds*PLUS*: Population-level Outcomes in Med Group/MA
66% reduction in readmissions



"Concerning the 10 cases that you pulled of the Medicare Advantage intervention: this appears to be the sort of post-discharge intervention that a high-risk patient should receive."
UCLA MD/Researcher

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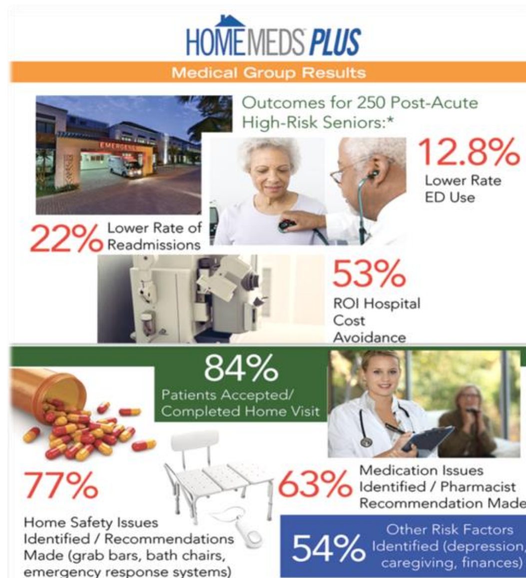
Evidence-Based Programs and Services

Impressive results for 250 post-acute high-risk seniors in a large SoCal Medical Group



*Compared to patients who did not receive a home visit

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Chronic Disease Self-Management Program (CDSMP) – Clinical Outcomes

- **Outcomes c**ompared to baseline, after 12 months
  - Self-rated health good or excellent: 32% pre & 60% post
  - BMI ↓
  - A1C ↓
  - Systolic BP ↓
  - Depression score ↓
  - Self-rated pain ↓
  - ↑ aerobic exercise
  - ↑ stretching/strength exercise

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Value Proposition

- Improves quality outcomes/HEDIS measures
- Improves after-discharge patient satisfaction
- Manages ED/inpatient throughput
- Improves patient mix — tertiary & quaternary rather than chronic
- Enhances interprofessional alliances and partnerships

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Recognition Growing … Adoption is Slow

- These are "foreign" approaches – especially going into homes
- Adoption is occurring – mostly pilot programs
- True proof of impact requires significant populations
- Too small an intervention group won't impact population outcomes as fully as needed

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Why a CBO Network?

- Health plans and providers have large service areas.
- Offer variety of skills, ethnicities, languages.
- Shared accreditation, IT, sales, billing, contract negotiation, compliance, quality.
  - Members focus on service provision.

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Starting on the SDOH path…how we can help

- Planning and consultation about SDOH and CBO services
- Toolkits, e.g., workflows, job descriptions
- Targeting criteria
- Evidence-based assessment of patients' non-medical needs:
  - socioeconomic factors,
  - home safety,
  - medication safety,
  - functioning,
  - cognition/depression/anxiety,
  - health behaviors
- HomeMeds
- Measurement – value-based outcomes

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Thank You!

Feel free to follow up for more information with:

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