Social Determinants & Community Integration

Addressing Rural SDOH through Hospital-Community Partnerships

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Partners in Care Foundation
The Social Determinants Specialists.
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Our work serves as a bridge between medical care and what a person accomplishes in their own home. We manage the gaps in non-medical care that affect a person’s recovery and overall health. We represent a California network of community-based organizations (CBOs) and a national collection of similar networks providing evidence-based interventions. The result is happier, healthier people cared for at lower expense in their own homes and communities.

Changes We Want to See

• Integration of medical care and social services
• Enhanced self-management/empowerment of consumers
• Integration of behavioral health
  – Social and Behavioral Determinants of Health (SBDOH)
• Evidence-based interventions
• Community Agencies forming into regional delivery systems/networks, like IPAs
Factors in Premature Death, USA

Rural Hospitals & SDOH

- Community health – needs assessment & action plan
- Population health focus
- Address chronic diseases – health happens at home!!
- Reduce cycle of ED use (misuse)
- Move upstream to root causes of poor health
- Partnerships with community organizations
  - Volunteers for home visits, chores, telephonic support
  - Creative use of staff when census is lower
  - Apps, technology, care transitions – earlier discharge

What Community-Based Organizations Do to Address Patients’ Social Needs
Social & Behavioral Determinants

- **SDOH**: Systemic and hard to impact, e.g., Environment, Safe neighborhoods, Availability & affordability of housing

- Personal socioeconomic and behavioral challenges that affect health:
  - Family context—supportive, neutral, abusive, none
  - Health literacy, numeracy, language challenges
  - Nutrition—availability, affordability, taste, culture
  - Social isolation, loneliness
  - Access to public benefits and programs
  - Home safety, fall risk
  - Medication—understanding, affordability, adherence
  - Personal goals and motivation
  - Self-care & self-management—lack of control, knowledge
  - Barriers to exercise—time, motivation, pain, air quality, temperature
  - Physical & cognitive functioning—long term services & supports

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**Health Plan - All LOB (no Medicaid)**

<table>
<thead>
<tr>
<th>Home Safety Needs / Fall Risk Indicators</th>
<th>Psychological / Cognitive Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls within the last 6 Months</td>
<td>Possible Indication of Depression (PHQ-9)</td>
</tr>
<tr>
<td>Live Alone</td>
<td>Suicidal thoughts w/in past 2 weeks (PHQ-9)</td>
</tr>
<tr>
<td>Avg. # Home Safety Equip. Needs</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Grab Bars</td>
<td>Feeling Isolated/Lonely</td>
</tr>
<tr>
<td>Emergency Response System</td>
<td>No Direct, Emotional &amp;/or Social Support</td>
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<tr>
<td></td>
<td>Indication of Cognitive Impairment (SPMSQ)</td>
</tr>
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<td></td>
<td>Problems with Memory</td>
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<table>
<thead>
<tr>
<th>Physical Limitations</th>
<th>Legal / Financial Needs</th>
</tr>
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<tbody>
<tr>
<td>Experiencing Medium/High Pain</td>
<td>Power of Attorney (Financial)</td>
</tr>
<tr>
<td>Physical Impairments</td>
<td>Advance Directive</td>
</tr>
<tr>
<td>Vision</td>
<td>Problematic Expenses</td>
</tr>
<tr>
<td>Hearing</td>
<td>Medi-Cal</td>
</tr>
<tr>
<td>Unplanned Weight Loss/Gain last 6 mos.</td>
<td>Medicare</td>
</tr>
<tr>
<td>ADL (Assistance Needs)</td>
<td>VA Benefits</td>
</tr>
<tr>
<td>Laundry assistance needed</td>
<td>Social Security</td>
</tr>
<tr>
<td>Transportation assistance needed</td>
<td>SSI/SSDI</td>
</tr>
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**SBDOH in Rural Areas**

- Prevalence: About 2-3% points higher than the country as a whole (poverty, % duals, food insecurity, etc.)
- More older adults
  - Seniors need more services
  - Non-Medi-Cal out of pocket for LTSS/HCBS*
- Unique challenges
  - Distance and sparsity – need to drive
  - Rural areas have fewer services & providers, farther apart

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* LTSS=Long-Term Services & Supports; HCBS=Home- and Community-Based Services
Population Health Management to Address SDOH

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

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

What EHRs and Call Centers Don’t See
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

Community-Based Services & Risk Stratifications

Who Delivers SBDOH Interventions

• Alternative workforce for non-medical in-home interventions
  – Experienced coach/navigator with a Bachelor’s degree in human services
• Serve as the “eyes and ears” in the home
  – Gather data and information that patients don’t share in a medical setting or encounter
  – Able to pay close attention to members and caregivers in their home setting, leading to proactive interventions
  – Trust and knowledge of local communities and available resources
  – Cultural/linguistic fit/competence
Community-Based Organizations (CBOs)

Eyes and Ears in the Home

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Partners in Care Foundation’s Models

- Partners at Home – California Statewide Network of community-based organizations for home visits, care transitions, and evidence-based self-management workshops
- Care Transition Choices (Contracts with Providence, Arrowhead MC)
  - Coleman CTI plus HomeMeds; or
  - Bridge Telephonic Social Work (Rush University Medical Center)
- A Matter of Balance – Fall prevention workshops, often used in Trauma Centers
  - https://www.cantonmercy.org/trauma/
- Chronic Disease (or Pain or Diabetes) Self-Management workshops
- HomeMedsPlus (Contracts with Blue Shield of California & UCLA)
- Consulting and providing tools for addressing SBOH

Criteria for Identifying Readmission Risk

High-risk patients must have 2+ of the following:

- Two or more readmissions in last 12 months
- Two or more ED visits in last 6 months
- Length of stay greater than 10 days
- 8+ medications at discharge
- Limited caregiver support at home
- Two or more chronic conditions
- Depression as a secondary diagnosis
Dr. Coleman’s CTI

- Develop patient/family skills for self-care and connecting with community resources
- Hospital visit to introduce program and gain consent.
- Home visit by coach (social worker or CHW) within 72-hours of discharge:
  - Review red flags for disease exacerbation
  - Plan what to do if signs/symptoms get worse
  - Patient activation for self-care and self-management
  - Instruct on use of Personal Health Record, including medication list
  - Reminders and coaching to schedule follow-up medical appointments, with transportation if needed
  - HomeMeds medication risk screening & pharmacist intervention can be added
  - Ensure DME, prescriptions, diet-compliant meals, etc. available as ordered
- Telephonic follow-up for 30-days

Rush Medical Center’s Bridge

- Transitional support through intensive service coordination that starts in the hospital and continues after discharge to minimize the risk of complications
  - Hospital visit to introduce program and determine needs
  - Telephonic service coordination by social worker
  - Address caregiver issues and arrange for services and follow-up appointments as needed after discharge
  - Refer to longer term self-management programs as appropriate.
  - Follow-up for 30-days
**CCTP DEMONSTRATION**

32,000 Patients - $16 Million Saved

![Chart showing results by CCTP Site](chart.png)

- Westside (3 Hospitals): 21.5%, 15.4%, 20.2%
- Glendale (3 Hospitals): 11.4%, 14.4%, 15.7%
- Kern (5 Hospitals): 12.5%, 12.5%

*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

**Partners’ HomeMeds**

Supports Health Coach/alternative workforce

- Inventory all meds being taken: out of system meds, drugs from other countries, borrowed, and DTOC
- Assess for potential adverse effects, e.g., BP, pulse, falls, dizziness, confusion
- Document adherence issues
- Algorithm identifies targeted potential medication-related problems (MRPs)
- Pharmacist reviews potential MRPs & makes recommendations for resolution, contacts provider and/or patient

**Adherence Inquiry:**

1. Why do you take this (purpose)?
2. How much do you take at one time?
3. How often do you take it?
4. How long have you been taking the medication (months or years)?

**Medication Non-Adherence:** Accounts for 30% to 50% of Treatment Failures

- Increases Hospital admissions by 40%
- 89,000 premature deaths could be avoided with proper adherence

Source: National Council Medical Director Institute, September 2018

**National Data – 27,516 clients**

Average age: 75.5; Avg. # meds: 11.7

![National Data Chart](chart.png)
Pharmacist Judgment of Potential Impact of HomeMeds℠ Intervention

<table>
<thead>
<tr>
<th># of patient records reviewed by PharmD</th>
<th>ER Visit Avoidance</th>
<th>Hospitalization Avoidance</th>
<th>Physician Visit Avoidance</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2,927</td>
<td>1,178</td>
<td>102</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>839</td>
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</table>

HomeMeds℠ Plus
Home Visit Care Coordination Model

- Psychosocial assessment including:
  - Evaluate functional capacity (Activities of Daily Living) & coordinate access to DME
  - Screen for depression and cognitive impairment
  - Assess home safety, cleanliness, & maintenance
  - Observe for evidence of abuse, odors, inadequate food, caregiver issues
  - Flag potential fall risks from medications, trip hazards or poor lighting
- 30-day follow-up to help the patient implement the care/service plan
- Provide and encourage use of Advance Directives
- Coach to prepare for physician follow-up appointments
- Coordinate transportation assistance to appointments

Outcomes HomeMedsPlus UCLA Health

Over 1,000 Medicare Advantage/Medical Group patients paid by UCLA
>60% reduction in pre-post readmission rate within high-risk group

"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."
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

Care Transition Choices with UCLA Health

>8,300 patients @ 2 hospitals helped by Partners in CMS-funded Community-based Care Transitions Program
- Average 34% reduction in readmission rate vs. baseline
- New propensity-score-matched study found substantial & significant decreases in 30, 60 and 90-day readmissions and 30-day ED use
- Innovative partnership between health coach and UCLA MyMeds Pharmacists using Partners' nationally recognized HomeMeds program

Providence Year 1 Outcomes

- Care Transition Choices Began October 2017
- Coach access to EPIC
- Results through June 2018

Data files provided to Health Services Advisory Group (HSAG) by the Centers for Medicare & Medicaid Services (CMS) were used for analysis in this report. The data files include Part-A claims for Medicare Fee-for-Service beneficiaries.
Now is the Time!
CMS: Financial and Policy Alignment

Medicare FFS Physician Fee Schedule
– Transitional Care Management (TCM)
– Chronic Care Management (CCM)
– Dementia Assessment and Care Plan
– Behavioral Health Care Management

CHRONIC Care Act
– Authorizes Medicare Advantage Plans paying for community services and special supplemental benefits like meals, care transitions
– Increased flexibility for TELEHEALTH
– Payment for Remote Patient Monitoring

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

Why a CBO Network?
• Health plans and hospital systems have large service areas.
• Offer variety of skills, ethnicities, languages.
• Shared accreditation, IT, sales, billing, contract negotiation, compliance, quality.
  – Members focus on service provision.
Partners at Home
A Statewide SDOH Network

Starting on the SDOH path?
We can help!

• Planning and consultation about SDOH and CBO services
• Toolkits, Training, designing 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 license and training
• Measurement – value-based outcomes

SDOH Resources

• Rural Aging in Place Toolkit: https://www.ruralhealthinfo.org/toolkits/aging
• Older Americans Act Services – Area Agencies on Aging
  - Meals, employment, emergency response system, evidence-based health and wellness, caregiver support, financial counseling, etc.
  - https://www.ageca.org/Programs/Providers/AAA/AAA_Listing.aspx
• Multipurpose Senior Services Program (Medi-Cal, Age 65+, nursing home eligible, ADL/ADL impaired) – Waiting list: https://www.aging.ca.gov/ProgramsProviders/MSSP/Contacts/
• Home & Community-Based Alternatives Waiver (Medi-Cal, all ages, nursing home or subacute level of care) – Waiting List: https://www.dhcs.ca.gov/services/LTC/Pages/Home-and-Community-Based-Services-Alternatives-Waiver.aspx
• Centers for Independent Living (disability services): https://www.calsilc.ca.gov/independent-locator
• To find benefits for which people may qualify: www.benefitscheckup.org
Other Rural SDOH Models/Innovations

- Online Self-Management Classes – https://www.selfmanagementresource.com/programs/online.programs
- Living at Home/Block Nurse Program - Minnesota
- Caregiver support via smartphone apps, webinars/video, web forum, etc.
  https://caregiveraction.org/family-caregiver-toolbox
- Postal Service Carrier Alert Program
- Community Health Workers – Northeast Oregon Network (NEON) Pathways Community Hub.
  https://www.neonoregon.org/pathways
- Integrated Care Management in Rural Communities.
- Social workers & community health teams
  https://blueprintforhealth.vermont.gov/about-blueprint/blueprint-community-health-teams

Questions?

Raise your hand or submit questions at
www.menti.com and enter code 69 32 61

Thank You!

Feel free to follow up for more information with:

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The Social Determinants Specialists