SDoH, Social Risk Factors, Social Needs

October 30th, 2019
Agenda

Welcome

SDoH, Social Risk Factors, Social Needs: A Framework to Align Terminology

Panel Presentations:

• Atrius Health

• Kaiser Permanente

• Anthem

Q&A session
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Q&A session
Speakers

Dan Slater, MD
Chair of Pediatrics and Chief Medical Officer of MassHealth ACO

Sarita Mohanty, MD
Vice President of Care Coordination for Medicaid and Vulnerable Populations

Merrill Friedman
Senior Director of Disability Policy Engagement
Established in 2014, the **Health Care Transformation Task Force** is a multi-sector industry consortium comprised of Providers, Payers, Purchasers, and Patients committed to advancing delivery system transformation that drives rapid, measurable change for ourselves and our country.
Our members aspire to have **75%** of their respective businesses operating under **value-based payment arrangements** by the end of 2020.
HCTTF continues to progress towards our goal of 75% of business in value-based payment arrangements by the end of 2020.
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A Framework to Align Terminology

**Social determinants of health (SDoH):** The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life including economic policies and systems, development agendas, social norms, social policies, and political systems. SDOH impact everyone; they are not something an individual can have or not have, and they are not positive or negative.

**Social risk factors:** Specific adverse social conditions such as food insecurity and housing instability that are associated with poor health. A person may have numerous risk factors, but have fewer immediate social needs, as defined below.

**Social needs:** The individual’s immediate non-medical needs (e.g., food and housing need). For example, an intervention to provide fresh produce to patients in need does not address the underlying systemic issues that cause food insecurity, but rather mitigates an immediate individual need.
Examples of interventions across the continuum of SDoH, social risk factors, & social needs

**Economic stability**: Advocate for policy that promotes housing stability including affordability, quality, support services to protect tenancy and availability; and food security (e.g., supporting federal nutrition programs, advocating for the expansion of healthy food access and nutrition education programs).

**Food and housing insecurity**: Implement housing and food insecurity screening tools in provider settings.

**Food and housing need**: Refer individuals to community health workers, social workers, or housing advocates to help people in need complete SNAP/WIC/housing applications and/or collaborate with community-based organizations that can provide needed resources.
SDoH, Social Risk Factors, Social Needs: A Framework to Align Terminology

Although it is clear that social determinants of health (SDoH) contribute to personal health status, the term is often used imprecisely and conflated with similar, yet distinct, terms. To address this reality, the HCTTF developed a precise framework that defines SDoH, social risk factors, and social needs.

Social determinants of health

The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life including economic policies and systems, development agendas, social norms, social policies, and political systems (World Health Organization). SDoH impact everyone; they are not something an individual can have or not have, and they are not positive or negative.

Social risk factors

Value-based care is a powerful lever to encourage the health care system to account for the impact of SDoH, social risk factors, and social needs.

While health care organizations can help to screen for social risk factors and address unmet social needs, cross-sector collaboration is essential to tackle upstream social conditions.

Specific adverse social conditions such as food insecurity and housing instability that are associated with poor health. A person may have numerous risk factors, but have fewer immediate social needs.

Social needs

The individual’s immediate non-medical needs (e.g., food and housing need).

Examples of Health Care Interventions

SDoH

- Economic Stability: Advocate for policy change that promotes housing stability; advocate for robust federal and state nutrition programs

Social Risk Factors

- Food & housing insecurity: Implement housing and food insecurity screening tools in provider settings

Social Needs

- Food & housing need: Refer individuals to community health workers, social workers, or housing advocates to help people in need and/or collaborate with CBOs that can provide needed resources
When Talking About Social Determinants, Precision Matters

Katie Green, Megan Zook

OCTOBER 29, 2019  DOI: 10.1377/hblog20191025.776011

Public health experts have aptly expressed concern about the health care industry’s characterization of interventions as addressing “the social determinants of health” and have pointed out the limitations of over-medicalizing individuals’ social needs rather than
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Q&A session
Integrating Social Determinants of Health to Optimize Value-Based Care
A Presentation to the Health Care Transformation Task Force

Dan Slater, MD
Chair, Pediatrics, Atrius Health
Medical Director, MassHealth ACO, Atrius Health
Assistant Professor of Pediatrics, Harvard Medical School
Multi-Specialty Ambulatory Practice
Employees: 5300
Physicians: 715 Physicians
Patients: 745,000
Office Visits: 2.3 million annually
70% of patients covered by risk contracts
Clinical Locations: 31 throughout Eastern MA
Revenue: 1.9 Billion
Our Patient-Centered Medical Home is the Foundation

The Community

PCP TEAM

School

Hospitals

Specialists

Community Based Services

Insurers

Roster Review

Registry Management

Care Facilitator

- Case Management Review
- Referrals
  - Behavioral Health
  - Social Work

Care Plan
Our Toolbox:
Proactive, Data-Driven, High Touch Care

- Proactive
  - Social Determinant Screening
  - Specialty Involvement
  - Clinical Pharmacy

- Data Driven
  - Registry Development
  - Historic Utilization
  - Predictive Analytics
  - Roster Review

- High Touch
  - Expanded Care Facilitation
  - Community Health Workers
  - Performance Excellence Support
  - Case Management

Quadruple Aim (Value)
Social Determinant Screening Timeline

Jan 2018: SDoH Charter Created

Feb 2018: PRAPARE Tool Selected

March – July 2018: Review of PRAPARE at practice sites, community database reviews, build process

July 2018: Pediatric Pilot on paper

Dec 2018: IM Pilot

Dec 2018: Pediatric Pilot at 2 Pediatric Sites

Jan – July 2019: Spread of electronic screening throughout Pediatrics

Dec 2018: Electronic Pilot at 2 Pediatric Sites
PRAPARE: Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences

• Identify and address patients’ social needs.
• Define and document the increased complexity of our patients
• Integrate healthcare with services and community partnerships to meet patient needs
• Evaluate socioeconomic drivers of poor outcomes and higher costs.
  – Ex. Low healthcare confidence
Social Determinants of Health Survey Response Rates

All Payer SDoH Response Rates
- 48438, 72%
- 15304, 23%
- 3605, 5%

MassHealth ACO SDoH Response Rates
- 5388, 64%
- 1775, 21%
- 1311, 15%

Social Needs
As a Percent of All-Payer Positive Screens

Social Needs
As a Percent of MassHealth ACO Positive Screens

Note: Findings include electronic screening results, December 2018 – September 2019, in Pediatrics and Internal Medicine departments
Social Determinants Tip Sheets

**FOOD**

- Information and referral service to individuals and Breads can connect you to resources for a **free hot food**

**Housing**

- Resources for homeless individuals and families
  - Shelter for individuals
  - Emergency Family Shelter Assistance for pregnant individuals or families with a child under 21
  - Greater Boston Family Shelters for families not eligible for emergency assistance

**Utility**

- Emergency Heating Assistance
  - The Salvation Army: (617) 645-8333

**Housing**

- Resources for individuals and families who are not currently homeless

**Utilities**

- Lifeline Phone Service
  - Low cost home or cell phone service for individuals who have specified programs

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### A Family Story

- 6 yo child screened at Well Child Visit found to have positive PRAPARE screen
- Needs: Utilities, Clothing, Medicine & Phone.
- Family referred to CHW who met with mother in her home following an intake phone call
- Mom 36 yo with diabetes and cancer
- 4 children at home as well as oldest son’s 2 year old
- Mom has not had her diabetes medications for more than a week due to difficulty navigating system and lack of phone
- Children have developmental, neurologic and psychiatric disorders
- In addition to identified needs, family experiencing housing and food instability.

### The Interventions

- **Medication Support:**
  - office contact, authorization support, prescriptions filled
- **Housing Support:**
  - Application to assist in eviction prevention
- **Food Support:**
  - SNAP Double Bucks
  - Fresh Truck
  - Fair Foods
  - Project Bread Hotline
- **Utilities Support:**
  - Phone Support: coaching in budgeting to assure bill paid
  - LIHEAP: fuel assistance and payment plan
- **Clothing Support:**
  - Rosies Place
- **Self Efficacy:**
  - Autism Supports, Vocational Training, Father’s Uplift
Barriers & Learnings

• Barriers
  – Competing priorities
  – Technologic challenges
  – “Don’t ask for information I can’t address”
  – “Respect for patient autonomy needs to inform clinician actions when well intentioned financial incentives may encourage a “screen-and-refer” approach”

• Learnings
  – Completion rates are strong
  – Patients are receptive to being asked about their social needs
  – Health-related social needs are common across payers
  – Multiple sectors are needed to meet family needs
  – We have more resources to assist our patients than we believe, and we can help more than we think we can
THANK YOU
Unmet social needs are a barrier to health for many Americans

**SOCIAL NEEDS**

Americans view social needs as an integral part of overall health

55% say transportation, housing, balanced meals, and supportive social relationships are all very or extremely important to health care

55%

**SELF-EFFICACY**

One third of Americans say they are not confident in their ability to access resources to address their social needs

35% lack confidence that they could identify the best resource to meet their need

35%

**CONNECTION**

Americans want their medical providers to ask about social needs and connect them with resources

97% of Americans feel that their medical provider should ask about social needs during visits

97%

Source: Kaiser Permanente Social Needs In America Survey, 2019
Addressing social needs can improve health outcomes

In fact, one third of all Americans experience stress relating to social needs

1 in 4 AMERICANS have had an unmet social need they say was a barrier to health in the past year

21% FUNDS 21% prioritized paying for food or rent over seeing a doctor and/or paying for medication

17% TRANSPORT 17% couldn’t go to the doctor / pick up medication because they lacked transportation

9% HOUSING 9% couldn’t see a doctor regularly because they lacked stable housing

Source: Kaiser Permanente Social Needs In America Survey, 2019
Thrive Local
Thrive Local is at the core of KP’s solution to address social health needs

**Identification**
Social needs identified by KP staff, providers, patients, caregivers, or community partners

**Connection**
Using the Thrive Local network, health or social service providers can locate the appropriate community, government, or health care systems resources to meet social needs

**Information**
Thrive Local provides information on community resources and tracks referrals with community partners

**Optimization**
Information from the Thrive Local network is used by Kaiser Permanente and community partners to better understand social needs, identify community wide social care gaps, and improve community conditions for health
Thrive Local will support KP’s ability to address members’ total health needs and support improved health in the communities in which we operate

**VISION**

To support the Total Health of our members and the communities we serve by connecting those with identified social needs to community resources

**MISSION**

To implement an enterprise-wide resource locator, undertake community outreach, and build community partner networks to help address the social needs of our KP members, caregivers, family members, and the community

**OBJECTIVES**

Develop a shared enterprise tool for reliable referral of KP members and the general public to community services

Develop collaborative and accountable community networks

Enable KP to be a leader in understanding and supporting the social needs of its members and community

Improve health outcomes, member experience and provider satisfaction

Support existing care delivery, population health and affordability initiatives
Thrive Local consists of three components:

**Resource Directory**
Online platform allows users to search and filter for community resources.
Resources updated regularly by contracted vendor.

**Community Partner Networks**
Community Based Organizations (CBOs) outside of KP use vendor platform.
KP users send and track referral to Community Partner Network.

**Technology Platform**
Closed loop referrals.
Bidirectional exchange of information between KP and Community Partner Network.
Integration of KP HealthConnect and kp.org.

Together, these components provide integrated clinical and social care, supported by data integration and partnerships with the community.
## Developing a Business Case

### Information Technology (IT) Expenses
- Vendor Fees
- Program Management
- Technology Security & Risk
- Architecture & Solution Design
- Integrations
- Data Solution
- Contingency
- Include investment and ongoing expenses

### Business / Non-IT Expenses
- Program Management
- Training
- Evaluation
- Analytics
- Redeployment of Staff
- Contingency
- Include investment and ongoing expenses

### Soft Benefits
- Increase staff/clinician efficiency
- Alignment with regulatory requirements
- Avoid duplicative solutions across organization
- Increase staff/clinician satisfaction
- Increase patient satisfaction

### Hard Benefits
- Difficult to project because little research and evidence
- Assumed a reduction in PMPM costs for low income population if at least 1 need met.
- Phase in the benefit realization
**Thrive Local benefits communities, patients, and health care systems**

<table>
<thead>
<tr>
<th>For Communities</th>
<th>For Patients</th>
<th>For Health Care Systems</th>
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</thead>
<tbody>
<tr>
<td>Community-wide asset created through free access to the Thrive Local platform for community health centers and community-based organizations</td>
<td>Referral volume and proof of impact may lead to increased partnership opportunities</td>
<td>Increased organizational capacity through more targeted referrals and connections among community-based organizations</td>
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<tr>
<td>Referral volume and proof of impact may lead to increased partnership opportunities</td>
<td>Community-wide analysis to inform policy, investment decisions and community advocacy</td>
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<tr>
<td>Improved experience of care due to built-in capabilities for referral and feedback</td>
<td>Improved health and well-being</td>
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<tr>
<td>Reliable referrals to organizations that can address patients’ most pressing needs</td>
<td>Help navigating complex systems</td>
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<td>Improved satisfaction among frontline providers</td>
<td>Improved performance on health outcomes and patient well-being</td>
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<td>Reduced utilization and total cost of care</td>
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<td>Adoption of community-wide social health networks that address patients’ needs</td>
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Thrive Local will facilitate comprehensive, coordinated services in our communities

Thrive Local is a partnership between Kaiser Permanente and Unite Us.

Thrive Local will...

Connect health care and social services providers to deliver integrated care

Empower organizations across communities to work together through a shared technology platform that connects individuals to an array of services

Be fully implemented in 3 years

In 3 years Thrive Local aims to be available to all 12.3 million KP members and 68 million people in the communities KP serves
KP is partnering with Unite Us to implement Thrive Local

Unite Us offers an **outcome-focused software platform** with a community engagement team that **builds coordinated networks** to address **social needs**

Unite Us…

- Connects health care and social services into one **accountable, coordinated ecosystem**

- Provides a **flexible** and **scalable** platform and helps all network partners track referrals during the patient's total health journey

- Ensures successful implementation by **deploying a team in each community to work directly** with all partners that choose to join the platform
We will measure Thrive Local’s impact and success

<table>
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<tr>
<th>Desired outcomes</th>
<th>Sample indicators</th>
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<tbody>
<tr>
<td>Closure of social care gaps</td>
<td>• Number of referrals to community-based organizations</td>
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<tr>
<td></td>
<td>• Number of social needs met</td>
</tr>
<tr>
<td>Improved clinical outcomes</td>
<td>• Reduced HgA1c for food insecure diabetics</td>
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<tr>
<td></td>
<td>• Reduced depression, functional impairment for socially isolated seniors</td>
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<tr>
<td></td>
<td>• Improved asthma control for people living in poor quality housing</td>
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<tr>
<td>Improved personal health and well-being</td>
<td>• Improved member experience and satisfaction</td>
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<tr>
<td></td>
<td>• Improved health-related quality of life</td>
</tr>
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<td></td>
<td>• Improved overall well-being</td>
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<tr>
<td>Enhanced system performance</td>
<td>• Reduced inpatient and ED utilization and total cost of care</td>
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<tr>
<td></td>
<td>• Reduced duplicative solutions across regions and business units</td>
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<td></td>
<td>• Improved provider satisfaction and retention, increased joy in work</td>
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<tr>
<td>Improved community health</td>
<td>• Improved neighborhood-level measures of health</td>
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<tr>
<td></td>
<td>• Reduction in health inequities</td>
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<td></td>
<td>• Improved performance, financial health of community-based organizations</td>
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</table>
Kaiser Permanente - Community Health Initiatives

- **Food for Life** - Connect households with CalFresh and design medically tailored meal delivery options to increase access to affordable, healthy food.

- **Housing**
  - Thriving Communities Fund – focused on affordable housing. First ‘impact investment’ will be in Oakland, CA
  - KP joined the Mayors and CEOs for U.S. Housing Investment coalition – dedicated to advancing long-term solutions to the nation’s housing crisis
  - **Challenge Sprint**
    - Goal is to end chronic homelessness by 2019 for the more than 500 people over the age of 50 who are currently living unsheltered in Oakland
    - Uses real-time data and analytics to inform our efforts and accelerate reductions in homelessness that are attainable and lasting

- **Resilience In Schools Environments (RISE)** - implements policies, practices and trainings to help the school students and staff adapt to and deal with challenges, trauma and emotionally charged experiences.
Drivers of Health @ Anthem

Health Care Transformation Task Force Webinar

Merrill Friedman, Federal Affairs

October 30, 2019
Estimates of how drivers of health contribute to population health

http://www.cdc.gov/nchhstp/socialdeterminants/faq.html#c
Drivers of Health are key factors impacting high healthcare utilization and costs and poor health outcomes.

In order to best meet members’ needs, we need to understand their needs and the barriers they face.

Traditional health plan approaches are not sufficient to address these non-clinical impacts on health.

We need access to new data.

We need to develop cross-sector collaborative relationships with a variety of nonprofit and public partners.

We will need to use data to not only improve the care of individual members but also to drive population-level initiatives and improvements.
Critical Success Factors

- Assessment tools
- Individualized service plans
- Partnerships with community-based organizations to deliver the social supports
- Care coordination and care management
- Peer support and community engagement
Nearly all of Anthem’s State Medicaid Programs have at least one Housing Initiative Being Implemented.

Anthem customizes its approach based on a variety of factors:

- State & Community Needs/Resources
- Meetings w/Housing Leaders, CoCs, Providers (etc.)
- Presence of 1115 Waiver
- Member Needs / Data Driven Analysis
- Access to Partnerships and Data

States with Housing Programs
## Blue Triangle Overview

### BLUE TRIANGLE PROGRAM Structure

- 53 Efficiency Units (Studio Apartments)
- 2 ADA compliant units
- On-site Support Services Staff
- Laundry & Computers
- Overnight Security
- Only Anthem Medicaid Members

### BLUE TRIANGLE PROGRAM Philosophy

- Low Barrier
- Transitional/Safe Haven
- Harm Reduction Approach
- Social Determinant of Health Focus
- Service Connection
- Meet People Where They Are

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**Blue Triangle follows housing first philosophy; first provide housing, then surround members with support services.**
Blue Triangle Members & Health Conditions

Health Conditions

- MH: 87%
- High Blood Pressure: 55%
- SUD: 91%
- COPD: 39%
- Diabetes: 24%
- Intellectual Disability: 2%
- TBI: 5%
- Seizures: 14%
Blue Triangle Program Outcome Measures

Outcomes

<table>
<thead>
<tr>
<th>CHANGE UTILIZATION</th>
<th>IP Mental Health</th>
<th>IP Physical Health</th>
<th>Nursing Facility</th>
<th>OP ER</th>
<th>OP Other</th>
<th>OP Surgical</th>
<th>Primary Care</th>
<th>RX</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-61%</td>
<td>-55%</td>
<td>-82%</td>
<td>-49%</td>
<td>-3%</td>
<td>90%</td>
<td>37%</td>
<td>22%</td>
</tr>
</tbody>
</table>

*Based on admits/1000 member months for inpatient and visits/1000 member months for outpatient services.

Members connected with permanent housing 57%

Reduction in per member per month spend for program participants $337
Project SEARCH

Employment for each Project SEARCH intern either at the health plan or another competitive job in the community

- 16+ hours a week
- More than minimum wage
- Integrated employment site
- Not seasonal work
- A REAL JOB!
Project SEARCH National Impact

**REACH**
- 600+ programs
- 47 states
- 10 countries

**EMPLOYMENT**
- 33% employed by the host site
- 67% employed elsewhere in the community

**DATA**
- 94% of sites entered data
- 75.5% of graduates employed
- Average hourly wage: $9.61
- Average hours worked: 25.4/week

**STATISTICS**
- 600+ programs
- 10 countries
- 47 states
Healthy Corner Stores and Heart Smarts

In many urban and rural communities, convenience stores are the only food retailer for consumers, many of whom are lower-income and rely on Supplemental Nutrition Assistance Program (SNAP) and Women, Infants and Children Program (WIC) benefits to purchase food.
The Food Trust is implementing this Healthy Corner Stores initiative in three communities: Cleveland, Indianapolis and San Jose.

In each community, 6-10 small stores have partnered to install new refrigerator cases, signs, lights and labeling to make fresh food appealing and easy to access.

Whenever possible, stores are stocked by local farms and community gardens.
Early Results

All three sites are showing promising early results. One store had 78 customers for the Heart Smarts lessons.

Heart Smarts regulars are bringing their neighbors.

Customers include new mothers, people with disabilities, people with limited English proficiency.

Traffic and revenue at the stores has increased.

Understanding What’s Beneath the Surface
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