CHCS Center for Health Care Strategies, Inc.

Advancing innovations in health care delivery for low-income Americans

Tracking and Measuring the Impact of SDOH Interventions

Texas MCO SDOH Learning Collaborative

June 11, 2021

12:00 pm -- 1:30pm PM CT

With support from the Episcopal Health Foundation

Rules of Engagement

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- Feel free to keep your camera off when you are not presenting, but please turn it on during group discussion.

Agenda

- Welcome and Introductions
- Health and Human Services Update
- Tracking and Measuring the Impact of SDOH Interventions
  - Dr. Salil Deshpande
  - Dr. Angie Hochhalter
  - Dr. Heidi Schwarzwald
  - John Wendling
- Group Discussion
- Wrap Up and Adjourn

Meet Today's Presenters

Matthew Ralls
Program Officer
Center for Health Care Strategies

Shao-Chee Sim
Vice President for Applied Research Episcopal Health Foundation

Andy Vasquez
Associate Commissioner, Quality and Program Improvement
Texas Health and Human Services Commission

Dr. Salil Deshpande
Chief Medical Officer
UnitedHealthcare Community Plan of Texas

Dr. Angie Hochhalter
Vice President of Quality
Scott and White Health Plan

Dr. Heidi Schwarzwald
Chief Medical Officer
Aetna Better Health of Texas

John Wendling
Chief Executive Officer
Parkland Community Health Plan

Tracking and Measuring the Impact of SDOH Interventions

Measuring and Tracking the Impact of SDOH Interventions: Context

- MCOs, providers, and HHSC recognize the importance of SDOH as key drivers to health outcomes/costs.
  - Identifying effective interventions can help stakeholders, including plans, with limited resources drive a series of high-impact, system-level approaches to improving care for Medicaid members.
- How do interested parties "make the case" that their interventions are making an impact?

Social Determinants of Health Strategies During the COVID-19 Pandemic

2020 Survey of Managed Care Organizations in Texas

Shao-Chee Sim, PhD, MPA
Vice President for Research, Innovation, and Evaluation
Episcopal Health Foundation
June 11th, 2021

Texas MCO Work to Address SDOH

SDOH Screening Tools

Social Service Referrals Platforms

MCO SDOH Strategies

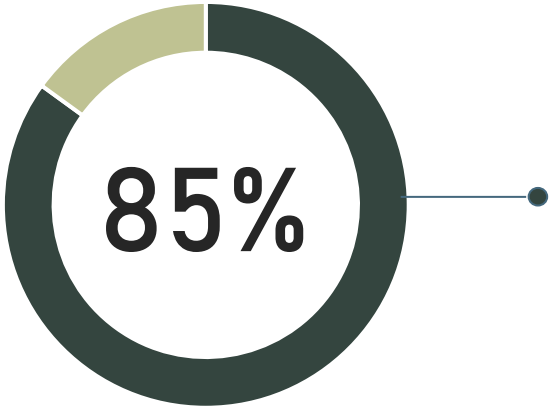
Provide **Navigators/ Community Health Workers**

Develop Specific **SDOH Interventions**

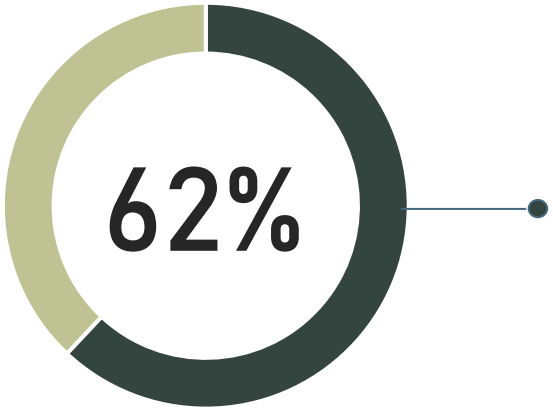
Invest in **Community Organizations**

Offer Directory of **Community-Based Resources**

Challenges and TA Needs of MCOs



of MCOs listed **effective interventions** as their **top concern**



of MCOs listed **effective interventions** as their top need for **technical assistance**

Key ROI Considerations for MCOs

01 What is the SDOH intervention? Be very clear

02 What is ROI? A concept around cost/resources and health outcomes

03 What are the metrics? Set-up metrics upfront and track over time

04 What is our design? Pre-post versus comparison group

05 Who can do the work? Internal versus external

06 How do we communicate and manage expectations?

Health and Human Services Commission

Andy Vasquez, Deputy Associate Commissioner, Quality and Program Improvement, Medicaid and CHIP Services, Texas Health and Human Services Commission (HHSC)

Dr. Salil Deshpande

Chief Medical Officer

UnitedHealthcare Community Plan of Texas

Social Determinants of Health

Salil Deshpande, M.D.
Chief Medical Officer
UnitedHealthcare Community Plan of Texas

June 2021

United Healthcare

Addressing SDoH is key to improving health and equity

- SDoH have bigger influence on health than clinical care: 60% of a person's health is driven by social, behavioral, and environmental factors like their education, income, and race/ethnicity.[1]
- Social and environmental factors drive health disparities: Unequitable access to education, employment, healthy environments, and healthcare are driven by structural biases including gender discrimination and racism[2]
- Unmet social needs are associated with higher utilization and cost: people reporting food insecurity or lack of transportation are more likely to report multiple ED visits (2.5x) and inpatient stays (2x).[3]
- More than 1 in 3 UHC Medicaid and Medicare members have unmet needs: 35% of 1.6 million members screened in 2020 had one or more unmet health-related social needs.
- Employers[4], state[5] and federal[6] governments, and our members[3] want our help.
- Addressing these factors represents our greatest opportunity to help people live healthier lives.

The COVID-19 pandemic has highlighted the health impacts of SDoH while simultaneously increasing social risk for millions of Americans.[7]

1. Schroeder, SA. NEJM 2007; 357: 1221-1228.
2. HHS. Healthy People 2030.
3. Insights from McKinsey's Consumer Social Determinants of Health Survey (2019).
4. Thomas, S. Large employers are on board with social determinants of health and virtual care strategies.
5. Artiga, S & Hinton E, 2018. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity.
6. CMS SHO# 21-001 RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health. Jan 7, 2021
7. CDC. COVID-19 Racial and Ethnic Health Disparities.

Solving social barriers has a direct impact on chronic disease management

Meal Delivery Programs Reduce the Use of Costly Health Care in Dually Eligible Medicare and Medicaid Beneficiaries:

Small Interventions, BIG Impact!

- 70% decrease in ED visits
- 52% decrease in inpatient admissions
- 71% fewer emergency transports
- Lower healthcare costs by 16%

Culture of Health, The ACA & More, Health Affairs vol. 37, no. 4: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0999

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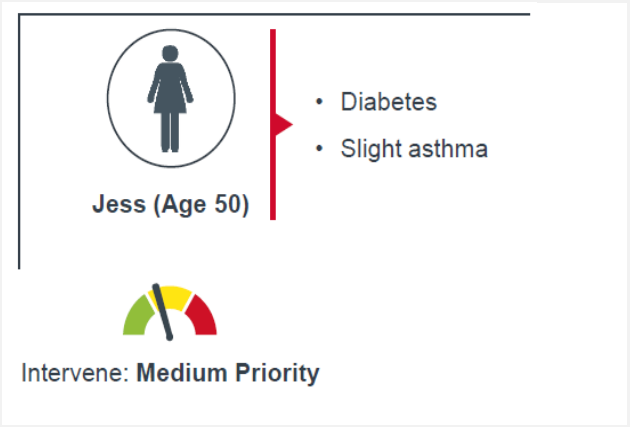
Inclusion of SDoH is a Better Way of Defining and Stratifying Risk

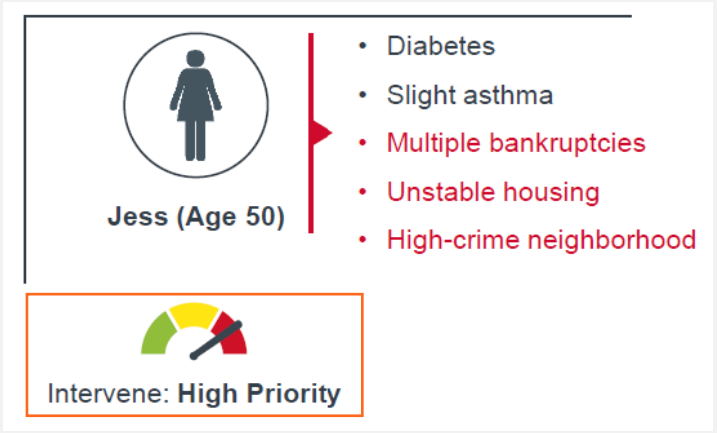
"Early evaluations of the Massachusetts model have found that adding social determinants and related variables to risk scores **strengthens the predictive power of risk adjustment** and yields **more accurate payments** to MCOs".[2]

Typical risk stratification



It is unlikely Jess will be identified for intervention until a likely unnecessary ED or inpatient event occurs.

Risk stratification inclusive of SDoH



After SDoH is added to risk stratification model, Jess is identified as a High Priority for intervention.

Figure 1[1]

1 Advisory Board interviews and analysis. "Social Determinants of Health Data, Educational Briefing for Non-IT Executives"
2 Deloitte Insights "Social determinants of health and Medicaid payments," Jim Jones, Sima Muller

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Combined Framework for Addressing SDoH

Health Plan Operational Approach –
Screening, Resource and Referral, Fulfillment

Community-Based Organization Strategy

Provider Alignment & Partnerships

Health Plan Operational Approach

Screening

Resource and Referral (R&R)

Fulfillment

- All Markets that do not have a state required screening tool use the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) screening tool to collect data on social barriers
- Markets with state required screening tool abide by requirements
- Screens will be conducted within the Resource & Referral platform to simplify the connection to local services and supports when screening identifies a social barrier or need

Health Plan Operational Approach

Screening

Resource and Referral (R&R)

Fulfillment

- All Markets that do not have a state required R&R platform will have access to **Aunt Bertha**
- Markets where states mandate the use of a R&R platform, or those who have been selected as a local market for a state-specific platform will align with that platform.
- C&S and Government Programs will be testing the following R&R platforms at the state level:
  - **Unite Us**
  - **Healthify**
  - **NowPow**

Health Plan Operational Approach

Screening

Resource and Referral (R&R)

Fulfillment

- All SDoH referrals can be fulfilled in various ways:
  - CBO documents in referral tool
  - Care Manager documents
  - Call Center Representative documents
  - Provider file on SDoH provides fulfillment details
- For all noted referrals that are not closed out, a call is made to the member to attempt to close the loop and to ask about the members satisfaction with the services provided.

Community-Based Organization Strategy

Goal**: Develop and implement a strategy with CBOs to support **community resource expansion, community partner engagement,** and **community capacity.

Support Navigation Tool

Align with CBO tool of choice to encourage utilization

Value Based Contracting

Assist with a valued resource and confirm that social needs are met

Quantify Value

Quantify work to allow CBOs to socialize work or as a metric to use for grant writing

Identify/Establish CBO Networks

Demonstrates the collective work CBOs do for our members and in the community

Provider Alignment and Partnerships

***Goal**: Develop and implement provider partnerships and health system engagement opportunities focused on the **integration of health equity and SDoH strategies** into the clinical workflow.*

Data Sharing

Share SDoH data through expanded provider screenings with actionable and bidirectional data flow

Value Based Contracting

Drive SDoH collaboration opportunities and deliver better clinical outcomes

Coding Standardization

Promote the adoption & expansion of ICD-10 SDoH industry standard coding

Health Equity

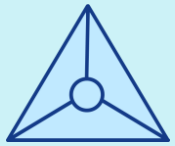
Implement health equity driven prioritization and outreach strategies using provider screening data

Imputed Market Price™ Valuation Tool

The Imputed Market Price™ (IMP™) 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 CBOs as to their value on social referrals

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Provider Pilot and Learning Collaborative

Goals

- Leverage provider capacity in assessing and addressing SDoH barriers
- UHC provides patient referral support and assistance, as well as access to UHC's SDoH Data Visualization Library
- Strive for confirmation of all CBO referrals
- Providers share electronic data with UHC using secure connection
- Use Imputed Market Price™ to estimate value
- Share emerging data and best practices with provider partners to inform and collaborate on the ongoing design of SDoH models
- Develop proof of concept for a value based contracting model for evaluation by TX HHSC, and consideration for a future benefit waiver (e.g., DSRIP transformation)

Analysis

- Hospital Admissions per 1000 members
- Inpatient Days per 1000 members
- 30-Day Readmission Rate
- Emergency Room Visits per 1000 members
- Percent of Avoidable Emergency Room Visits
- Financial value of the CBO referrals received
- Total SDoH Barrier Reductions

Dr. Angie Hochhalter

Vice President of Quality

Scott and White Health Plan

Scott&White HEALTH PLAN

Part of
BaylorScott&White HEALTH

Scott and White Health Plan
Community Resource Hub

11 June, 2021

Texas MCO SDOH Learning Collaborative

Program Goals

- Reduce negative impact of non-medical needs on member health
- Reduce avoidable ER visits
- Reduce avoidable hospital admissions
- Engage members who may not be connected to health plan services
- Understand member and community needs
- Enhance family resilience

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

Program Process

Provider office, ER

Targeted outreach calls from MCO

Care Manager

Member and navigator identify needs, set goals, collaborate to engage local resources

Initial needs met

Coaching as needed

Relationship continues

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

Initial Program Launch

Launch, 2019

United Way of Central Texas

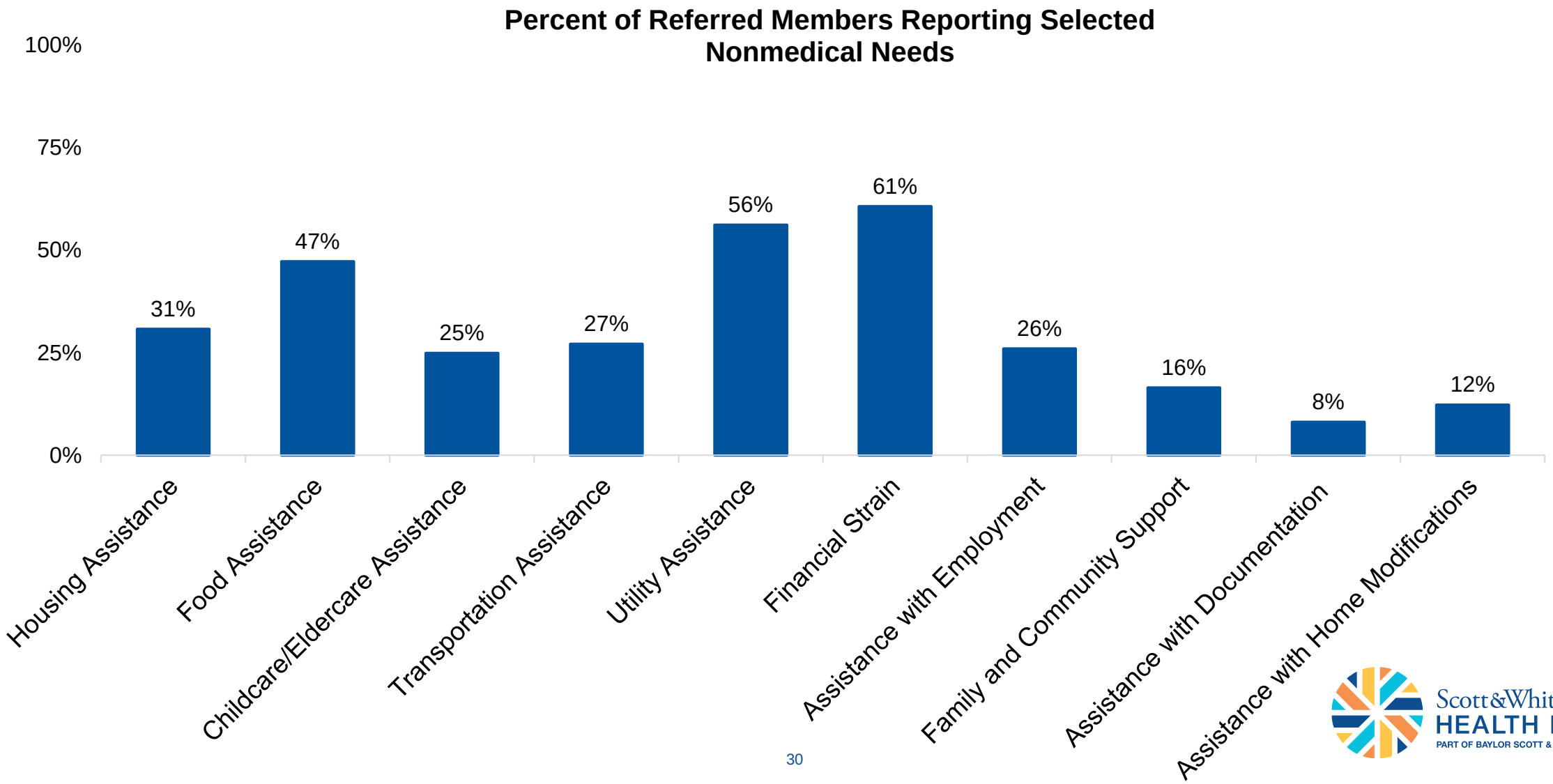
Available to health plan members in 7 counties:

- Bell
- Coryell
- Hamilton
- Lampasas
- Milam
- Mills
- San Saba

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

United Way of Central Texas

381 referrals through May 2021



Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

Support Examples

COVID-19, Winter Storms

- Connections to funding through local COVID-19 Recovery Fund, FEMA, other specific funds
- Help with rent, utilities, replenishing food, and other needs during recovery

Home Eviction

- Connections to legal aid, rental assistance, unemployment benefits, and food support
- Ongoing coaching and support to complete applications, access benefits, and look for employment

Multiple Needs

- Coaching to prioritize needs, step-by-step support to meet multiple challenges and achieve goal
- Example: Identify affordable and safe childcare on the bus route to/from work to maintain employment schedule

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

Program Impact

ED Visits and Hospital Admissions per 1000 Member Months are higher before referral than they are after (330 Members Referred)

	Change from 90 Days Before to 90 Days After Referral	Incidence Rate Ratio [90% Confidence Interval]
ED Visits	-21.92 per 1000 Member Months	0.824 [0.658 - 1.032]
Hospital Admissions	-27.02 per 1000 Member Months	**0.461 [0.301 - 0.704]**

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

Program Expansion

Launch, 2019

United Way of Central Texas

Expansion, 2021

prosperwaco


HEALTH AFFAIRS BLOG

RELATED TOPICS:
COVID-19 | PUBLIC GOOD | NONPROFIT STATUS | SYSTEMS OF CARE | COSTS AND SPENDING | HEALTH PHILANTHROPY

Collaborative Approach To Public Goods Investments (CAPGI): Lessons Learned From A Feasibility Study

Len Nichols, Lauren Taylor, Paul Hughes-Cromwick, George Miller, Ani Turner, Corwin Rhyan, Richard Hamrick

AUGUST 13, 2020 10.1377/hblog20200811.667525

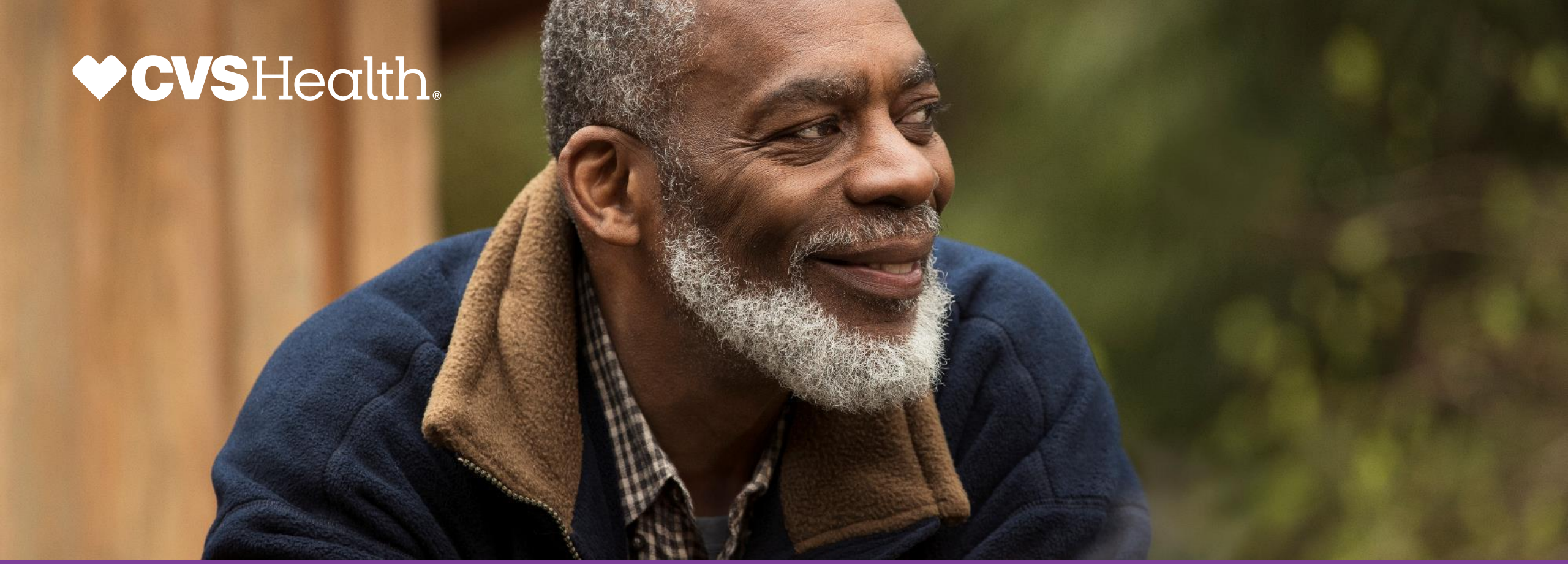
ADD TO FAVORITES SHARE

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

Dr. Heidi Schwarzwald

Chief Medical Officer

Aetna Better Health of Texas



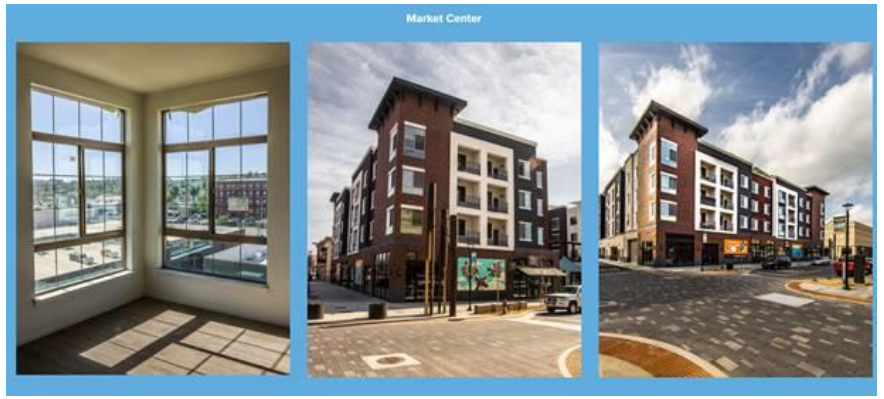
Aetna/CVS Health Affordable Housing Investments

Heidi Schwarzwald MD MPH
CMO, Aetna Better Health of Texas

June 2021

What are affordable housing investments?

- Impact Investments
- Low-income housing tax credit equity or loans
- Facilitate construction or rehabilitation
- Rent restrictions based on income levels
- Often units are reserved for seniors, veterans, at-risk youth, 2nd chance participants, those experiencing homeless, etc.
- Supportive services are provided free of charge to tenants



Investment Considerations

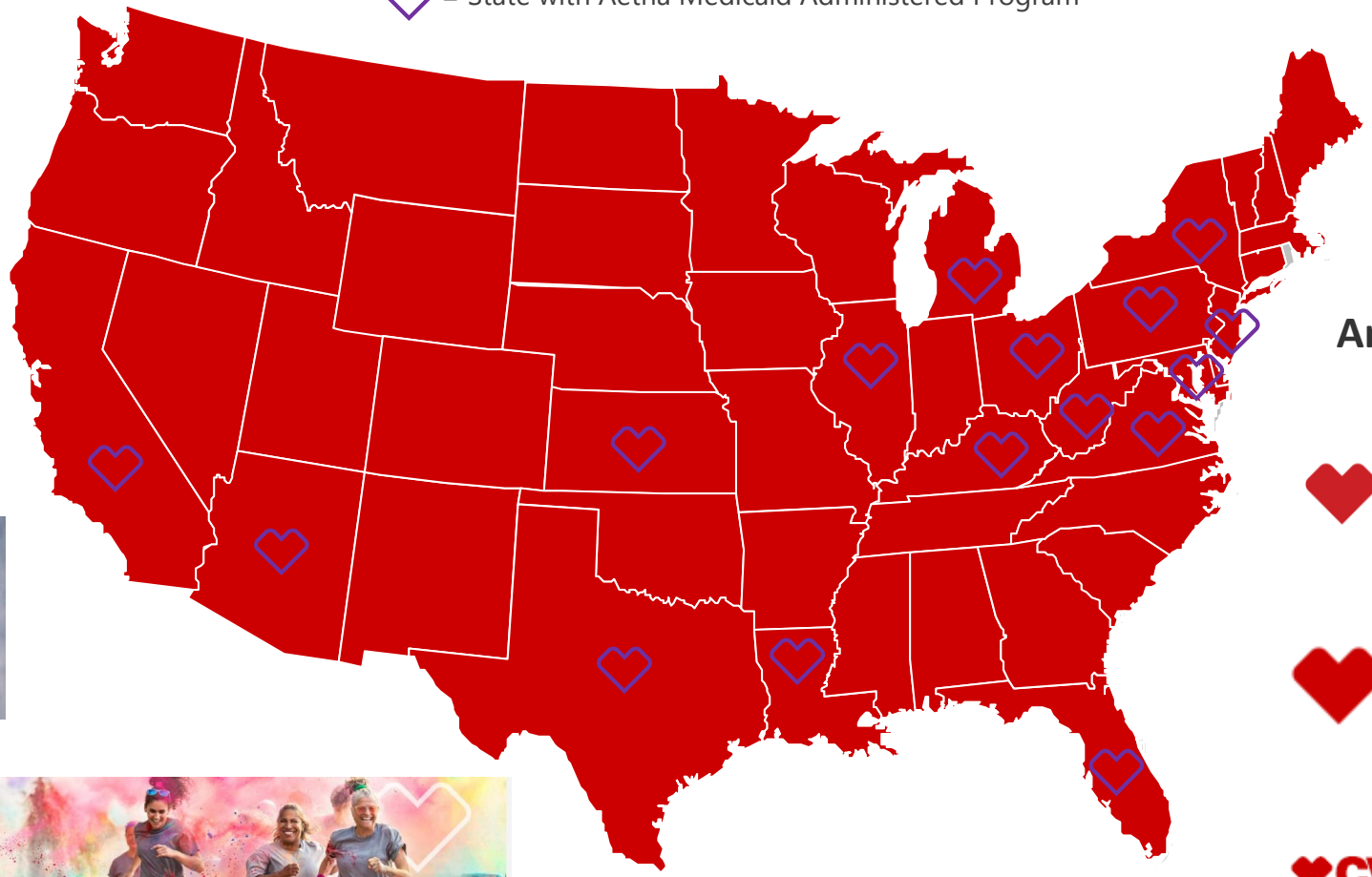
CVS pharmacy

aetna Aetna Better Health®

DestinationHealth

Health HUB

= State with Aetna Medicaid Administered Program



Project Health

aetna Commercial and Medicare

CVS minute clinic

Analyze Rethink Transform (ART)

CVS caremark®

Diversity & Workforce Initiatives

CVS pharmacy y más

CVS Health FOUNDATION

Omnicare® a CVS Health company

CVS kidney care™

Texas Affordable Housing Investments

Totals since inception (2000-2020):

$88.2M
Total Equity Invested

11,122
Affordable Units Created/Rehabilitated

42
Counties

Recent Investments (2019-2020):

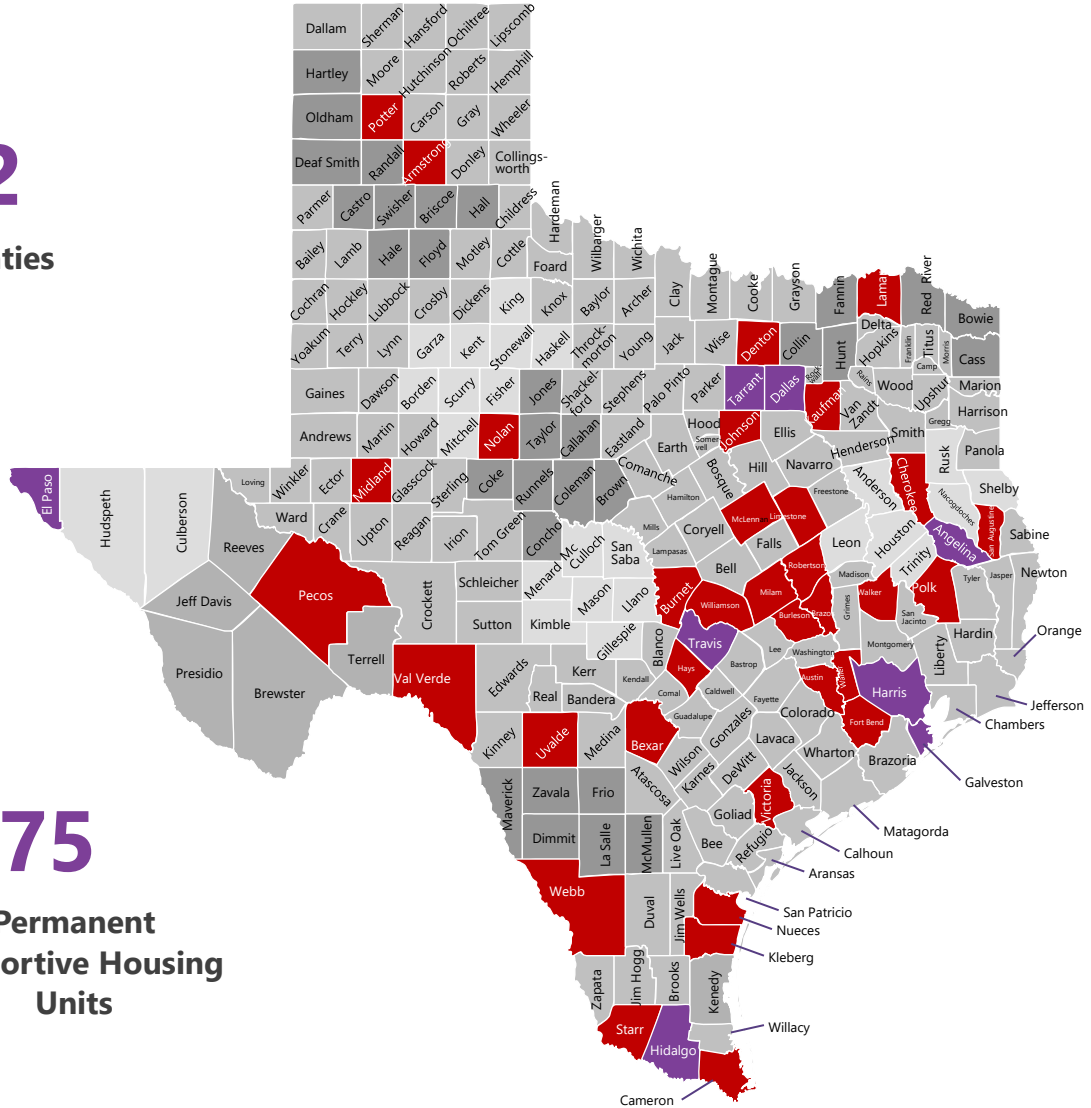
$16.2M
Equity Invested

754
Affordable Units Created/Rehabilitated

29%
Senior Housing Units

76
Extremely Low Income "ELI" Units <30% Area Median Income

75
Permanent Supportive Housing Units



Going Beyond The Investment
Aetna/CVS Health Programs & Initiatives

Enterprise Focus on Addressing SDoH and Supporting Social Justice & Equity Commitments

- Vaccine Equity (In-Store, Community & Pop-Up Clinics)
- Project Health (In-store & Mobile Clinics)
- Workforce Initiatives (Veterans, Seniors, At-Risk Youth, 2nd Chance, Abilities in Abundance, etc.)
  - Apprenticeships
  - High School Programs
  - On-the job training
  - Workforce Innovation & Talent Centers
- Food Insecurity Programs
- Senior Programs
- Health & Wellness Programs
- Mixed-use Developments
- Outcome Measurement

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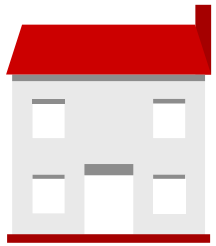
Benefits of Housing Combined with Services





Housing Stability

- Housing for vulnerable populations
- Reduced overcrowding
- Decreased risk of teen pregnancy, early drug use, and depression

Health Outcomes

- Better access to healthcare and nutritious foods
- Increased use of primary care services
- Positive mental and behavioral health outcomes

Economic Security

- Fewer overburdened renters
- Increased school attendance & performance
- Higher community employment rates

Lower Health Expenditures

- Fewer emergency room visits
- Better chronic disease management
- Lowered physical and behavioral service costs

Community Benefits

- Community revitalization
- Advances health, income, education and social equity
- Reduced crime and poverty rates

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Measuring Outcomes of AHI combined with Supportive Services

Data Analytics Team Focus

- Housing Stability
  - Time in stable housing
  - Reduction in overcrowding
  - Housed youths aging out of foster care
  - Reductions in homelessness and housing shortages

- Health Outcomes
  - Increased PCP utilization
  - Better prescription adherence
  - Improved chronic disease management
  - Reduced infant mortality
  - Increased in life expectancy
  - Improvements in mental, behavior and emotional health
  - YOY change in BMI, blood pressure, glucose and total cholesterol

- Economic Security
  - Lowered # of overburdened renters
  - Increased employment rates
  - Improved educational outcomes
  - Less food insecurity
  - Earlier detection of health issues

- Lowered Healthcare Expenditure
  - Costs for chronic disease management
  - ER visits/hospital bed days/readmissions
  - Impatient/Outpatient stays
  - Nursing home days
  - # of vaccine distributions
  - Benefits of “Aging in Place” efforts

- Community Benefits
  - Reduction in crime, recidivism & poverty rates
  - Increase in community space and parks
  - Decease in social isolation

- Employer Cost Savings & Productivity
  - Decreased absenteeism
  - Fewer replacement workers
  - Decreased medical and administrative costs
  - Better quality control
  - Improved safety and moral

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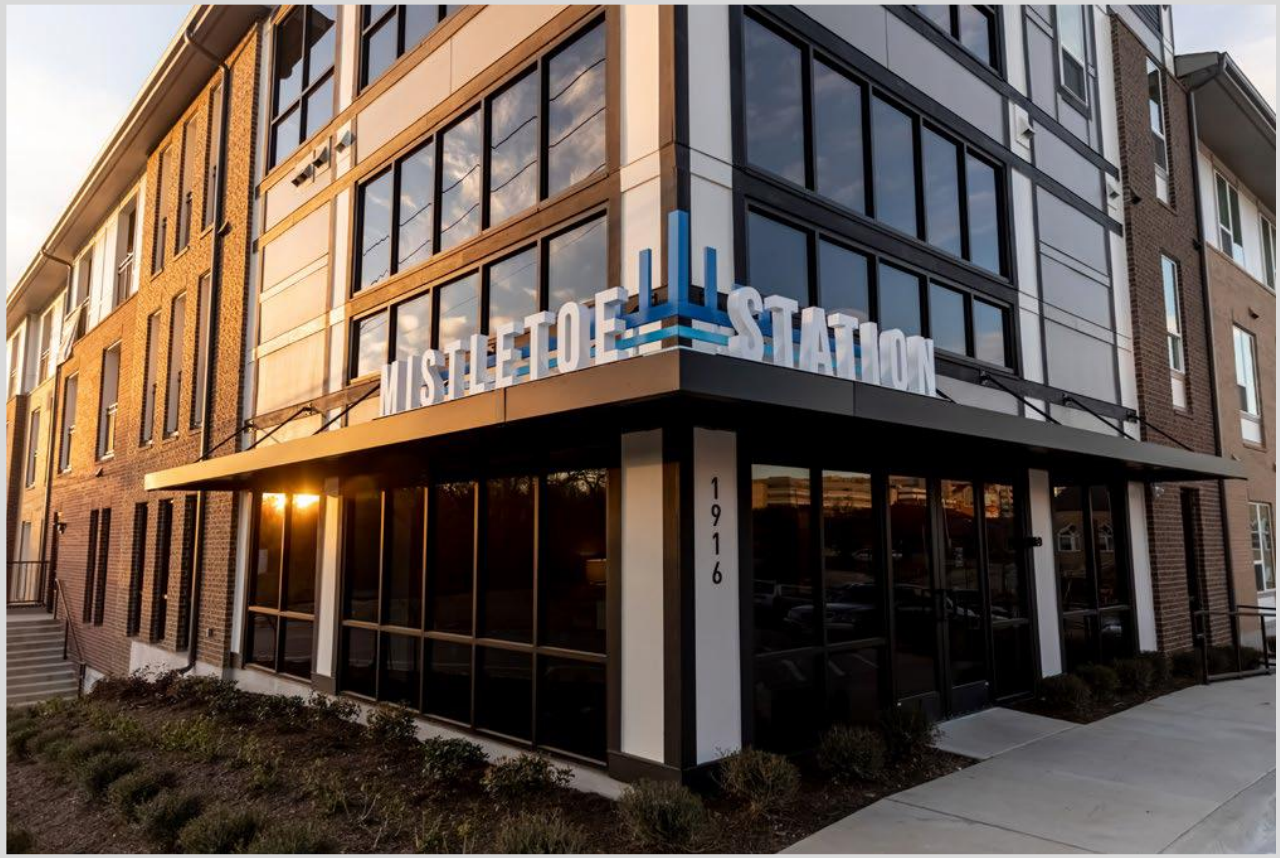
Preliminary Outcomes

- 71 Active ABH TX members in supportive housing today
- 42% decrease in PMPM costs
- 400% increase in Mental Health outpatient visits*
- 20% decrease in ER PMPM



“

It's changed everything to have a place to live. I was ready to give up.

— KEVIN DUVALL, NEW RESIDENT AT SEQUOIA COMMONS

After years of homelessness and food insecurity, 59-year-old Kevin Duvall still feels overwhelmed and grateful knowing he can cook his own food, pour a clean glass of water and enjoy the privacy and safety of his own home.

John Wendling

Chief Executive Officer

Parkland Community Health Plan

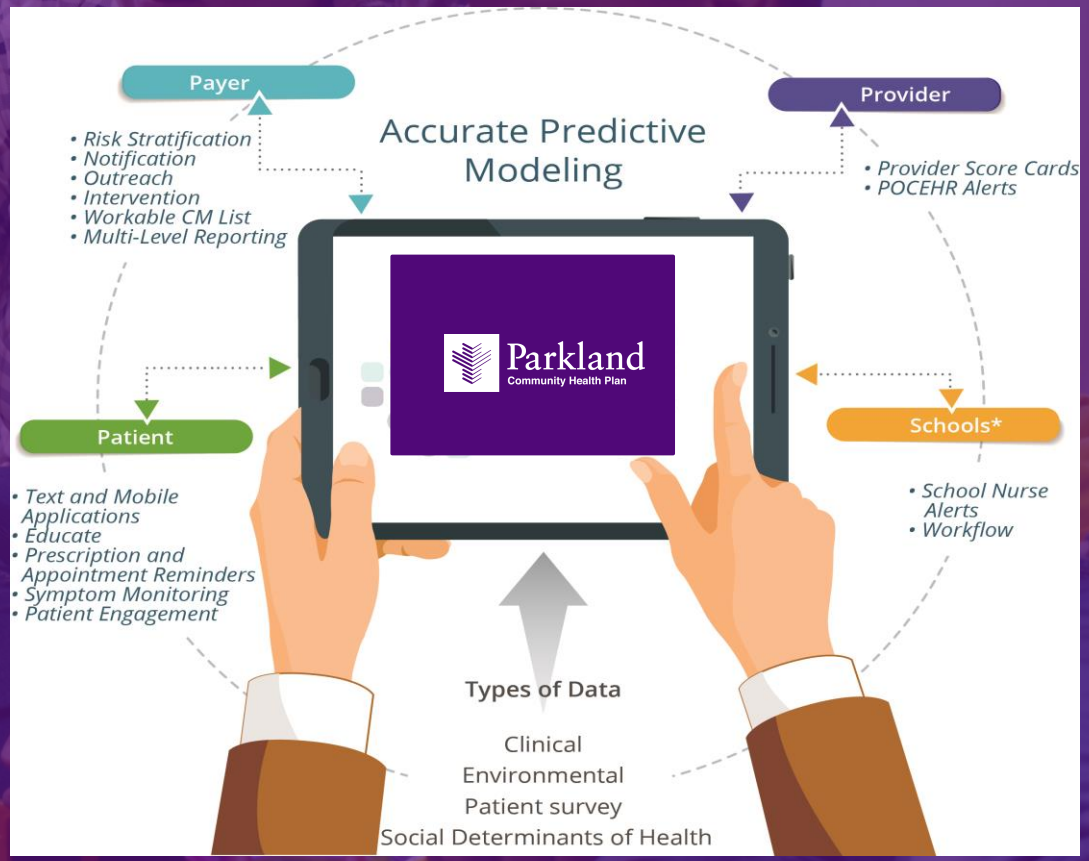
The Plan of Choice

Parkland
Community Health Plan

FOUNDATION

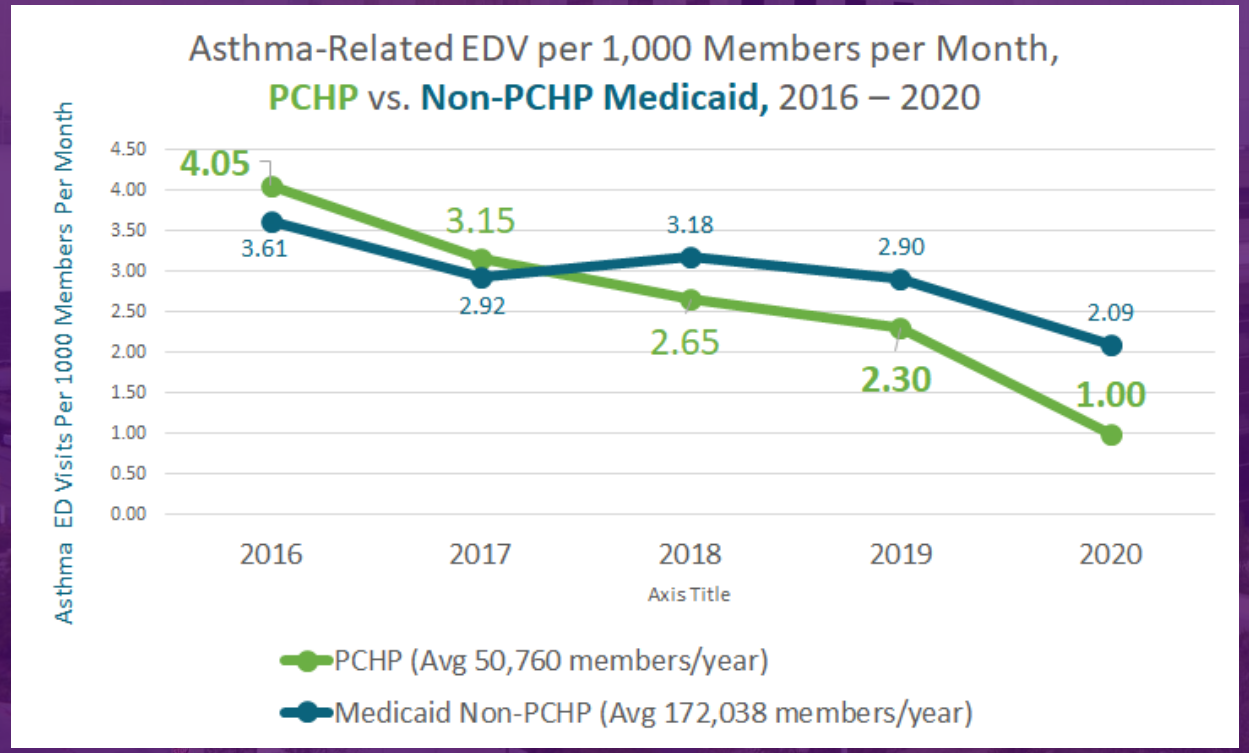
Risk-Driven Multi-Stakeholder Approach to Population Health

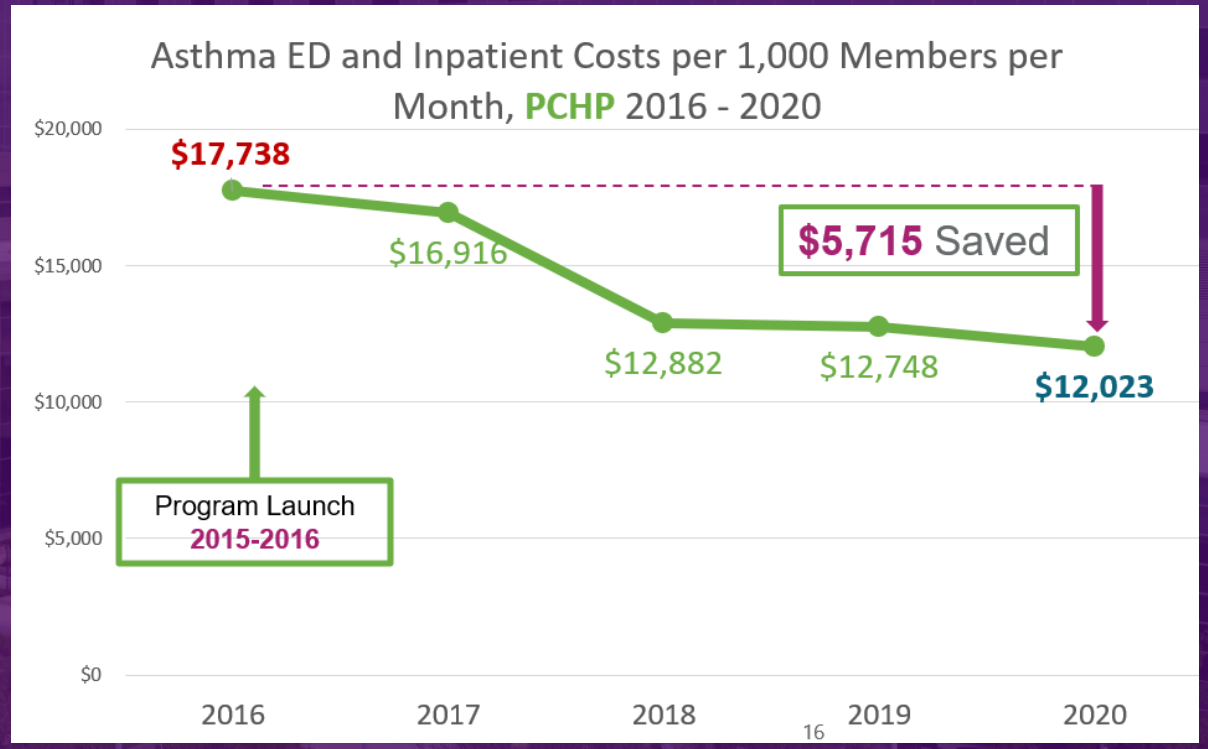
- Pediatric Asthma Program
  - Risk-Driven Campaign Outreach
  - 3-5 educational messages a week (2 asthma/ 3 resource based)



Overall Program Impact - Annual Trends in Asthma Total, IP, ED & Meds Costs

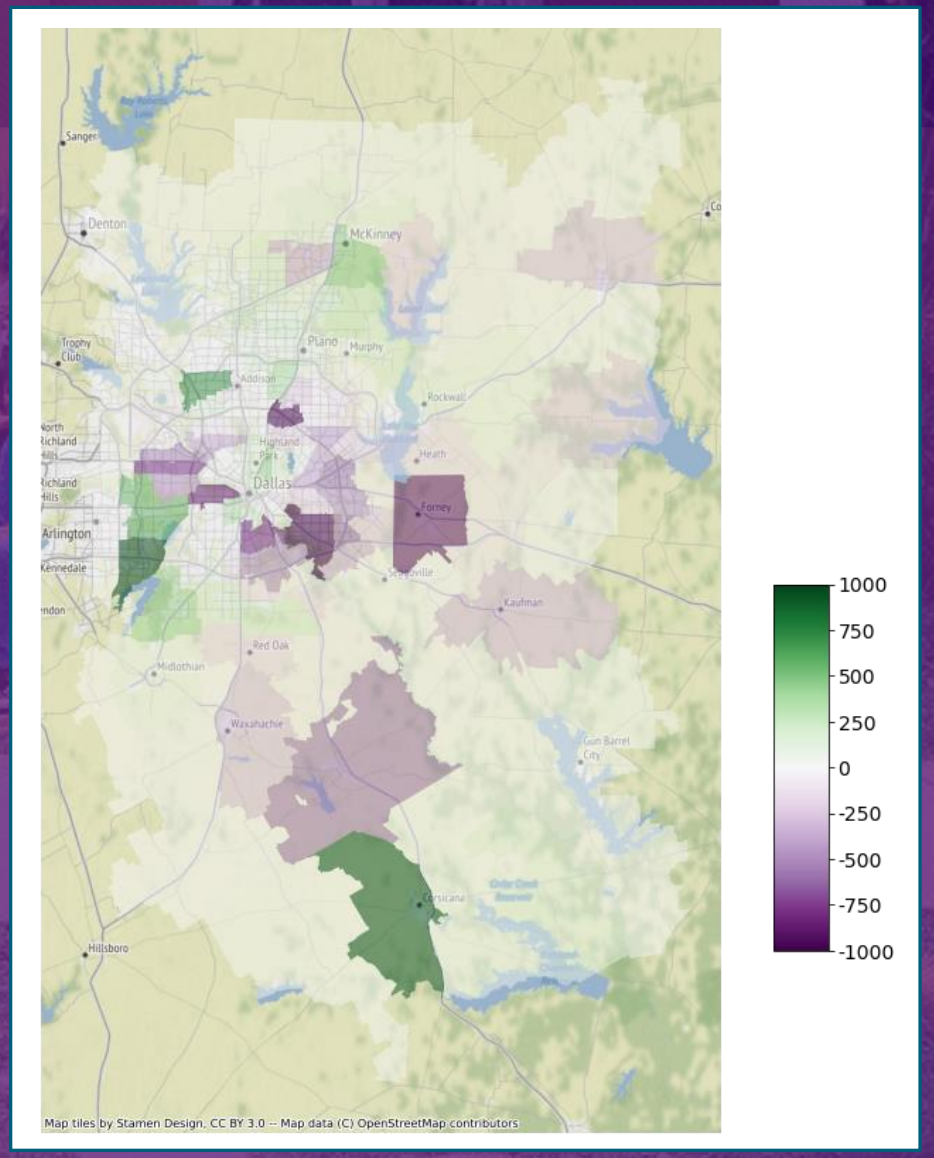
- 42% drop in asthma EDV
- 32% drop in asthma ED and IP Costs





Looking Ahead

- Leverage the population data to identify common threads around SDOH:
  - Pre-term birth
  - Food and digital deserts
  - Social isolation
- Activating on the insights:
  - Developing programs to manage conditions
  - Leveraging behavioral profiles to customize communication
  - Monitor and optimize performance



Group Discussion

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THANK YOU!