Leveraging Collaborations to Standardize SDoH Data Collection & Use

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Welcome & Introductions

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National Strategic Partnerships

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EL RIO HEALTH

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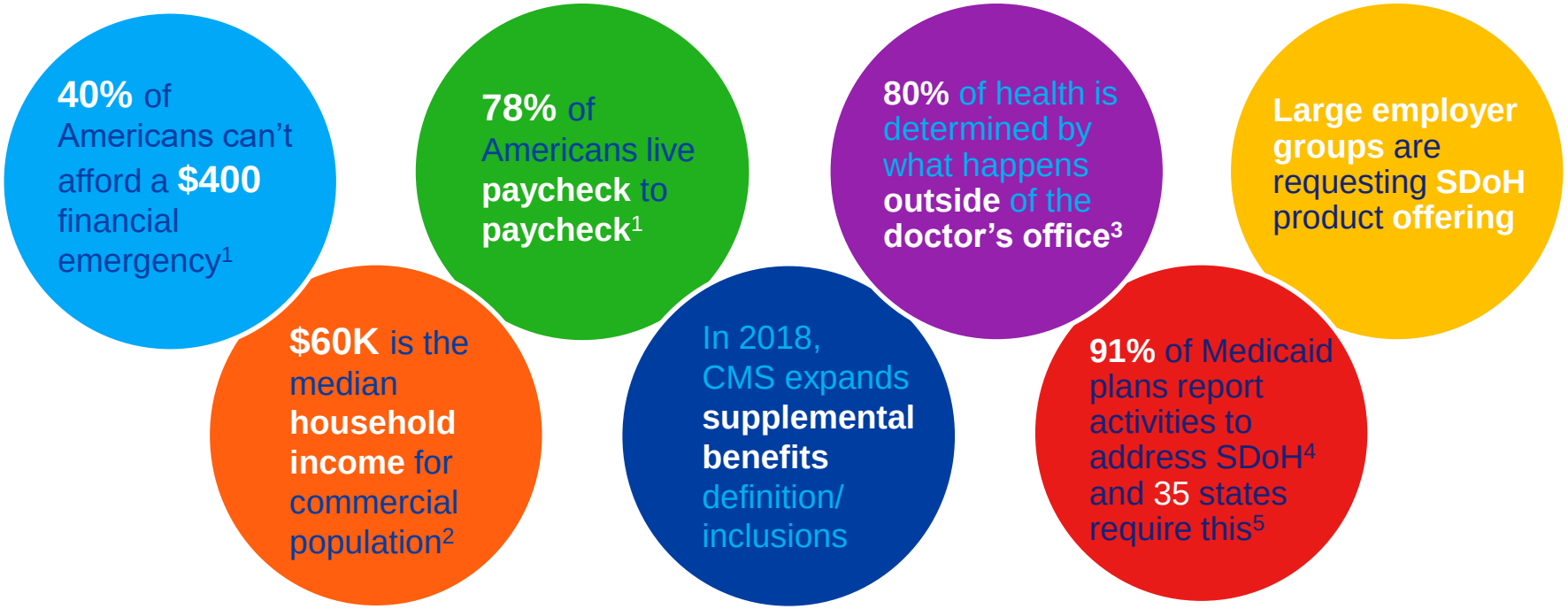
Concurrent Happenings: Socioeconomic and Health Care

As we pursued our SDoH work, related findings/changes validated the need for SDoH inclusion in health care.



1 https://www.federalreserve.gov/publications/files/2017-report-economic-well-being-us-households-201805.pdf
2 Data USA; U.S. Census Bureau, 2017
3 Robert Wood Johnson Foundation, County Health Rankings, "Relationships between Determinant Factors and Health Outcomes"
4 Kaiser Family Foundation, "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity"
5 Source: "2019 Medicare Advantage Growth Outlook", Web Conference, Advisory Board, April 2019

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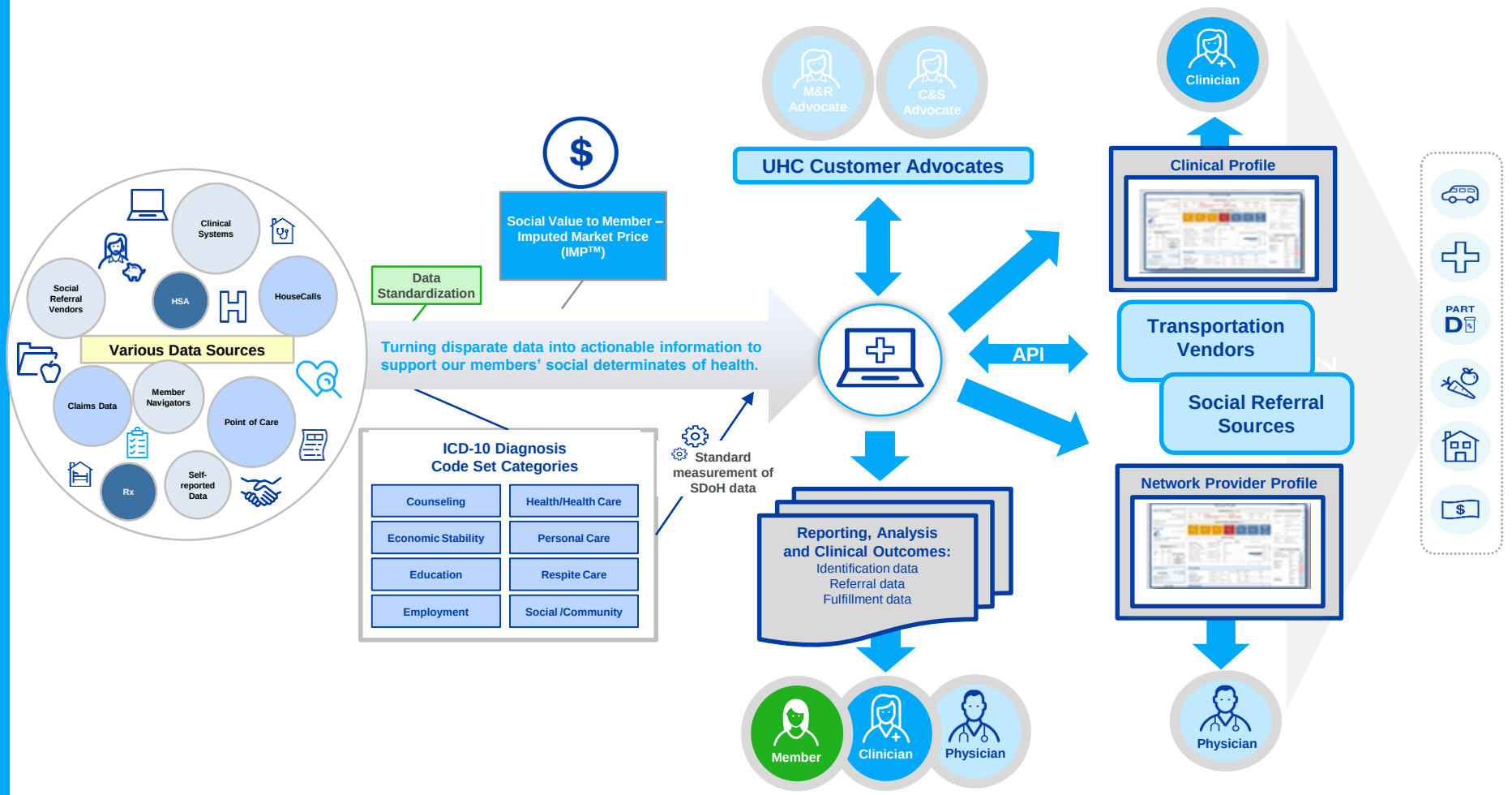
UnitedHealthcare's SDoH Infrastructure: How it Works



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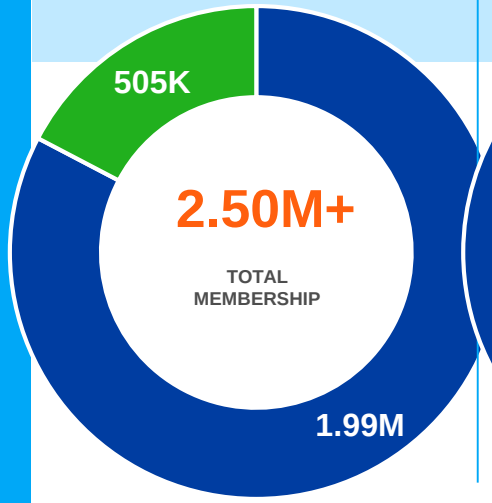
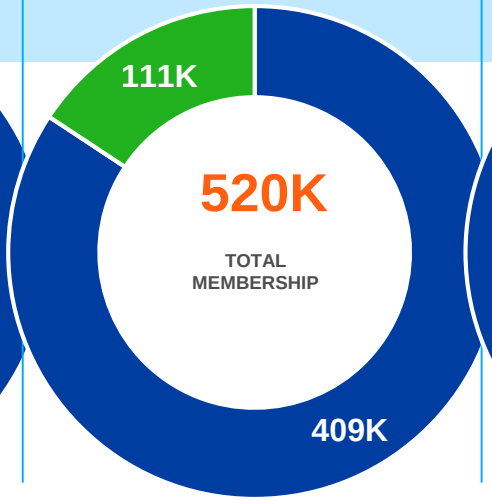
What We've Accomplished to Date

Data from 1/1/2017 (inception) – 12/31/2019

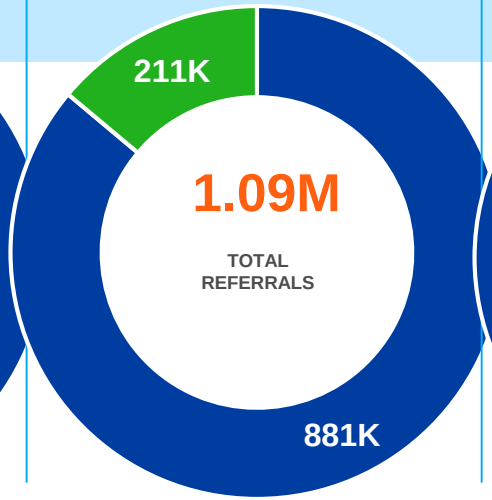
of members who identified at least 1 SDoH



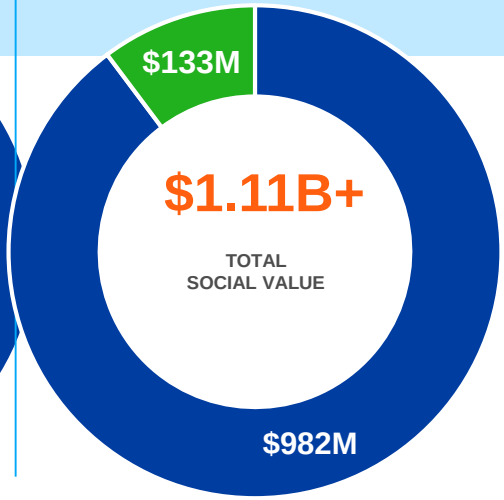
of members referred



of referrals provided



Imputed Market Price™ valuation (to members)



Medicare & Retirement (Medicare Advantage (MA) and Dual Special Needs (DSNP) members)

Community & State Dual Special Needs (DSNP) Membership

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Data source: National Strategic Partnerships (NSP), December 2019.

UHC, AZ AHCCCS Medicaid Proof of Concept Collaboration with El Rio Health and Equality Health

Proof of Concept (POC) Goal:

- UHC is collaborating on a proof of concept study with the Arizona State Medicaid Agency, known as AHCCCS, El Rio Health, a Federally Qualified Health Center (FQHC) and Equality Health an Accountable Care Organization (ACO).
- Utilize UHCs SDoH model which leverages ICD-10 coding and it's patent pending Imputed Market Price (IMP™) application allowing for aggregation, valuation and analysis of total care while leveraging the providers existing workflows and referral tools.
- Interventions and the potential impact of the social referrals and clinical outcomes will be measured, analyzed and reported by UHC's Health Care Economics (HCE) data analytics team.
- Project began on 07/01/19 and will run through 05/31/20 with results being delivered to all parties in July of 2020.

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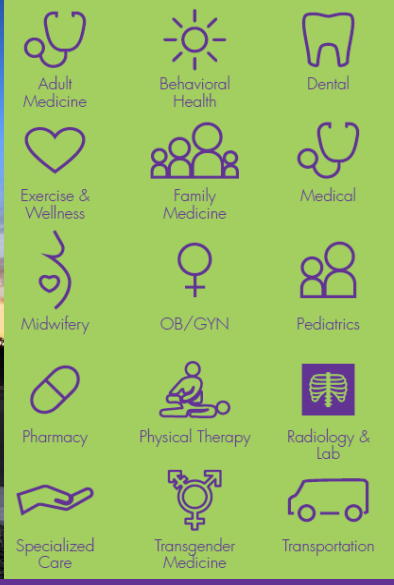
EL RIO Health



- Established 1970
- FQHC – 24th largest in the nation
- Approximately 1,400 employees
- Over 107,000 patients (approximately 38,600 children, 2,000 babies born annually and 63,000 adults)
- 51% patients on AHCCCS
- 15% remain uninsured
- 34% Private insurance/Medicare
- Centralized Call Center – 70,000 calls per month

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Electronic Health Record Workflow

1.

Patient completes the PRAPARE survey on tablet at appointment check-in

2.

An alert is generated on patient's EHR based on survey response, provider sends a referral to the appropriate staff

3.

EL Rio staff (i.e. Behavioral Health or Community Health Advisor) meets with patient and connects them to a community partner or resource via EHR referral or warm handoff

4.

Community partner assists patient to help them meet their needs

5.

El Rio and community partners communicate and coordinate to document outcomes through EHR

6.

Outcome: Improved Patient Health and Well-Being

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PRAPARE Template Workflow Improvements

- Push ICD codes to today's assessment
- Ability to set patient age, parameters for query, etc.
- Able to see and use the historical data

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Community Partnerships

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Community Partners

- Community Food Bank
- Southern Arizona Legal Aid
- Interfaith Community Services
- Southwest Medical Aid
- DKA Advocates
- Arizona Youth Partnership
- Old Pueblo Community Services
- Child Development Specialists
- Community Health Workers
- Health Builders Team
- Behavioral Health Consultants

Partner Indicators

- Responses to Referrals
- Documentation of Referral Completion/Close the Loop
- Upload documentation, screening tools, etc.

Goals Going Forward

- Increase efficiency of the needed care and resources as bench strength of community partners realized
- Activity based cost accounting at El Rio around the process
- Prepare for additional opportunities through value-based contracting

What have we learned?

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Electronic data collection from our patients more complete

Health Home model supports our work

Community partners are many—but with high demand and limited funding, they need to be integrated in the care model
(co-located, sharing in value-based contracts, etc.)

Health Department needed for long-term planning and success

Why Partner with Payers?

- Ability to fully utilize all data within El Rio system as well as that of the payer
- Opportunity to improve the care for our most vulnerable while increasing efficiency and decreasing total cost of care across all populations
- Ability to see the price on the SDOH referral data as well as continue to optimally manage our population's tertiary care utilization
- Challenge to build more effective community-based systems in concert with providers, government, and payers

What We All Can Do – Together

Thank you!

If you have questions, please reach out to:

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