Integrating Social Determinants of Health into Risk Bearing Models

June 2019

SJH Stats: (FY 2017)

- 451 Beds in Syracuse, NY
- 9,000 inpatient surgeries
- 5,000 outpatient surgeries
- 66,000 emergency room visits
- 26,000 inpatient visits.
- 400,000 primary care visits
- 83,000 outpatient psych visits
- 121,000 visits through St. Joseph's Certified Home Health Care Program

Medicaid Health Homes

St. Joseph's Care Coordination Network

- Program launched in 2014 (0 patients) – has grown to over 4,000 patients in 6 NYS counties
- Patient success stories are profound – touching families, enabling recovery and improving health
- Community Based Organizations participate in the healthcare system

Affordable Care Act of 2010, Section 2703 created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. As of January 2019, 22 states have health homes = 37 unique models.

WHY IT WORKS–THE MODEL:

PROGRAM IS COMMUNITY BASED

Care Managers meet the patient where they are or where they need them to be – community, home, shelter, clinics, social services – face to face engagement by staff with the client is required as much as possible.

COMPREHENSIVE ASSESSMENT

That extensively explores clinical history inclusive of mental health and social determinants of health. Buildout of this assessment in EPIC (took time but worth it and necessary!)

PATIENT CENTERED CARE PLAN

Patient Centered Care Plan is created from the comprehensive assessment and mandated to be updated annually. Goals, timelines are self identified by the patient and progress against the care plan is monitored/audited

PROGRAM IS VOLUNTARY

Patient is participative because they want to be, or see a benefit. This drives engagement and productivity

DOCUMENTATION DIRECTLY IN THE EHR (EPIC)

By care managers AND subcontracted care management partners

CBOS ARE PART OF THE TEAM

Program subcontracts with community based organizations (CBOs) to care manage specific populations or needs. Medicaid billing is conducted and submitted on their behalf.

OPPORTUNITY FOR CLIENT/PATIENT SUPPORT IS EXTREMELY BROAD

Includes opportunities to support in almost all needs related to social determinants (employment, transportation, housing, access to food, etc).

EMBEDDED IN A HOSPITAL HEALTH SYSTEM

A community based program embedded in a health system allows for greater fluidity of team across care settings and care transitions.

Medicaid Health Homes

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CLINICAL IMPACTS:

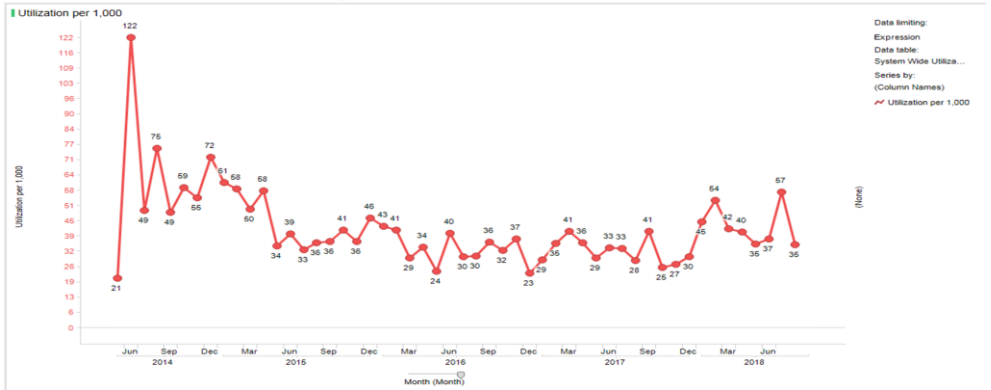
Some stats on enrolled population (per 1000 per member per month):

- 58% reduction in inpatient utilization
- 53% reduction in emergency department utilization
- 80% reduction in psychiatric emergency visits

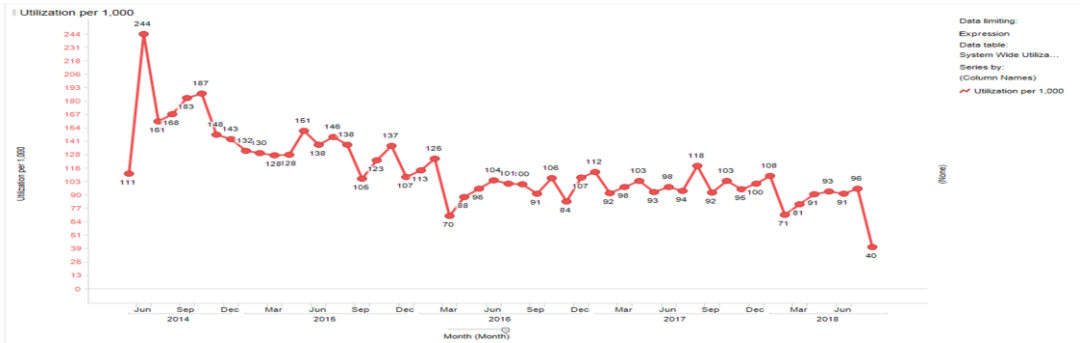
VBP IMPACTS/HEALTH SYSTEM OPERATIONS:

- Significant decrease in total healthcare charges
- Significant reductions in readmissions
- Length of Stay Reduction
- Supports Medicaid VBP Performance (gap closure, measure performance)
- Supports our Track 3 ACO performance (dual eligible)

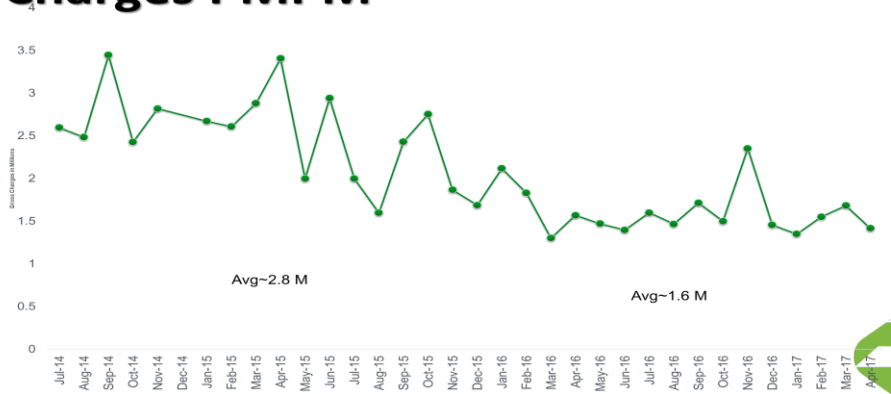
Health Home Inpatient Admissions PMPM



Health Home ED Visits PMPM



Charges PMPM



MORE EXCITING WORK:
Transformational System Design and Support

CMMI: Accountable Health Communities

- 5 year cooperative agreement.
- Study to test the effectiveness of screening all patients for the social determinants of health across clinical care sites, connecting them to community resources and supporting them in the community through care management,
- SJH AHC: An expansion of the St. Joseph's Medicaid Health Home (SJCCN) - provides care management to address the social determinants of health for **Medicare** beneficiaries with chronic conditions.

Non traditional care teams integrating Health Home and SIOH into team/care plan:

- **Transition Nurse and Physical Therapist Team (TNT Team):** Team assesses patient while "in house"/on inpatient unit to define optimal discharge plan/"next level of care".
- **Mobile Integrated Service Team (MIST):** Mobile "health home" team utilizing a combination of resources (telemonitoring and NP home visits) to connect dual-eligible beneficiaries to reduce unnecessary/avoidable utilization.
- **Network Care Coordination Team (NCCT):** multi-disciplinary care team focusing on "super-utilizers" to address the medical, social and psychological drivers of utilization including social determinants of health

JVION:

- AI Software utilized by various care teams integrating thousands of publically available data points including zip code, social indicators, MERGED with clinical data and claims (through VBP) etc to risk stratify patients and prescribe interventions to reduce preventable admissions and reduce readmissions