Caring for Individual Patients – Addressing Social Determinants of Health through an Accountable Health Community Model

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Agenda

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• Social Determinants of Health (SDOH)
• 2MATCH Project
  - Purpose
  - Goals
  - Model
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Introduction

Social Determinants of Health

- Definition
- Importance
  - Largest drivers of health care costs fall outside clinical
- CMS Interest
  - Better Care, Smarter Spending, Healthier People
  - Accountable Health Communities Grant
  - The AHC model leverages opportunities created by existing programs & benefit from mutually strengthened service delivery resulting in greater impact, while not duplicating existing federal spending on similar services.
Social Determinants of Health

<table>
<thead>
<tr>
<th>Social Needs Domains</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Insecurity</td>
<td>Limited or uncertain access to adequate &amp; nutritious food</td>
</tr>
<tr>
<td>Housing Instability</td>
<td>Homelessness, unsafe housing quality, inability to pay mortgage/rent, frequent housing disruptions, eviction</td>
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<tr>
<td>Utility Needs</td>
<td>Difficulty paying utility bills, shut off notices, disconnected phone</td>
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<tr>
<td>Transportation</td>
<td>Difficulty accessing/affording transportation (medical or public)</td>
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<tr>
<td>Exposure to Violence</td>
<td>Intimate partner violence, elder abuse, community violence</td>
</tr>
</tbody>
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2MATCH Project: Overview

To MATCH, Align, Through Community Hubs (2MATCH)
2MATCH Project: Purpose

- Build upon the Arizona Community of Care Network and ACTIVATE
- Further identify SDOH, facilitate links to community services, address gaps between health care delivery and community services and
- Align these efforts to improve health outcomes and decrease health care costs.

Hypothesis

*If SDOH are addressed, health issues will be as well.*

Project Flow
### Low Risk Population

- **Survey tool**
- **High Risk**
  - Connects to patient to Community Resources
  - Health/Community Navigator
- **Low Risk**
  - Resources will be given to Patient

### High Risk Population

- **High Risk**
  - Referred to Health/Community Worker to refer to community resource
  - Health/Community Worker connects with Patient
  - Community Partners report back to Health/Community Worker on outcome
  - Community partners connect with patient and/or Health/Community worker on status
- **Health/Community Navigator connects with patient to close referral**
- **Information placed in system to close the referral**
2MATCH Project: Goal

- Goal: Improve Health Outcomes & Decrease Healthcare Costs
  - Systematic screening to identify unmet health related social needs
  - Referrals to community services to increase awareness and use of these services
  - Test effectiveness of community services navigation
  - Partner alignment at community level & implementation of QI approach to address beneficiary needs

2MATCH Project: Model

- As the Bridge Organization, Dignity SJHMC will serve as the ‘hub’.
  - Coordinate screening & referrals
  - Identify partners
  - Align partners to optimize community capacity to address social needs
2MATCH Project: Partners

- AHCCCS
- Clinical Delivery Sites
  - Hospital, primary care, behavioral health services
- Community Service Providers
  - Food, Housing, Transportation, Utility Services, Safety & DV Services
- HIE: Arizona Health e-Connections
  - Cloud-based IT Solutions Program
- Evaluation & Quality Improvement Contractor
- Consortium & Advisory Board

2MATCH Project: Clinical Delivery Sites

- Dignity Health SJHMC
  - Inpatient
  - Emergency Department
  - Family Medicine Clinic
- Valle del Sole, Inc.-1 location
- Bayless Healthcare Group
- Parsons Family Health Center at Circle the City
- MIHS-2 locations
- Native American Connections
2MATCH Project: Outcomes

- Will a combination of **community service navigation** (at beneficiary level) & **partner alignment** impact total health care costs and inpatient and outpatient health care utilization?
  - Track our ability to:
    - Increase beneficiary awareness and use of community resources
    - Increase connections of high-risk beneficiaries with unmet SDOH community resources using navigation services
    - Optimize capacity to address SDOH
    - Reduce inpatient and ED use and cost

2MATCH Project: Summary

- **What**: Five year CMS Grant
  - Dignity Health SJHMC serves as Bridge Organization
- **Activity**: Screen, Refer, Navigate and Track ≥ 75,000/year Medicare & Medicaid beneficiaries for SDOH
- **How**: Community Partners, IT Solutions Program, Evaluation/QI, Community Consortium and Advisory Board
- **Goal**: Improve Health Outcomes & Decrease Healthcare Costs

  **Funded**: April 2017
  **Began**: May 1, 2017
Thank You

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