

Opportunities for Complex Care Programs to Address the Social Determinants of Health

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IN BRIEF

In recognition of the underlying social, economic, and environmental factors that contribute to poor health outcomes, many complex care programs are incorporating strategies to address the social determinants of health (SDOH). This brief explores opportunities to better meet patients' social needs, including: (1) identifying patients' non-medical needs; (2) employing non-traditional workers; (3) partnering with community-based organizations and social service agencies; (4) testing new uses for technology to help address social needs; and (5) identifying sustainable funding to support non-medical services. It features organizations that participated in *Transforming Complex Care*, a national initiative aimed at advancing innovations in complex care led by the Center for Health Care Strategies and supported by the Robert Wood Johnson Foundation.

Players, policymakers, and consumers have traditionally looked to the health care system to improve health outcomes. More recently, however, attention has shifted toward a broader approach that includes cross-sector collaboration to address the social, economic, and environmental factors impacting individual and population health, and providing opportunities to improve health equity. Commonly referred to as the social determinants of health (SDOH), these factors include, but are not limited to: transportation; employment; neighborhood safety; discrimination; and health care coverage.¹

With this understanding, providers are testing new approaches to address SDOH based on patients' needs and communities' capacity to support them. Individuals working in complex care are at the forefront of these efforts as the people they serve often have substantial health and social needs, requiring coordinated care efforts that span the medical, behavioral health, and social sectors. This brief draws from the experiences of six complex care providers that participated in *Transforming Complex Care* (TCC), a national multi-site demonstration led by the Center for Health Care Strategies and supported by the Robert Wood Johnson Foundation. It outlines key opportunities for complex care programs to address SDOH among their patient populations, including:

- Identifying the full range of patients' non-medical needs;
- Employing non-traditional workers to increase capacity to address social needs;
- Partnering with community-based organizations and social service agencies to provide non-health care services;
- Testing new technology to track social needs and interventions, and share information; and
- Identifying sustainable funding to support non-medical services.

Identify Patients' Non-Medical Needs

Complex care providers are exploring ways to identify the non-medical needs of their patient populations. This is most commonly done by screening patients for SDOH and, when possible, connecting them to community resources. A variety of assessment tools can be used or adapted by complex care providers and integrated into clinical workflows to screen for social, environmental, and economic factors impacting health. For example, Redwood Community Health Coalition (RCHC), a consortium of 17 health centers in Northern California, uses the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool at a subset of its health centers.² The Complex Care Clinic at Virginia Commonwealth University Health System (VCU Health) uses a selection of questions taken from Health Leads' Social Needs Screening Toolkit.³

To provide additional flexibility, other complex care providers participating in TCC have adapted existing tools, or created entirely new ones, to better align with their clinical practices and capacity to address patients' needs. OneCare Vermont, a statewide multi-payer accountable care organization (ACO), adapted the Arizona Self-Sufficiency Matrix to create its Vermont Self-Sufficiency Outcome Matrix.^{4,5} The tool is embedded into the ACO's care management platform, Care Navigator, and used by care teams across the state to assess for needs such as housing, employment, and income. Similarly, AccessHealth Spartanburg (AHS), a community-based organization that connects low-income, uninsured Spartanburg residents to health and social services, uses a homegrown 83-question assessment tool that asks clients for a wealth of information related to their medical, behavioral health, and social needs.⁶ The questionnaire is administered at enrollment and is used to generate a client's care plan and personal goals.

Complex care programs are also beginning to explore how to track patients' SDOH needs to assess the impact of their interventions. For example, VCU Health monitors patients' needs (e.g., food insecurity, utility needs, child care, health literacy, safety, etc.) over time. For patients working with outreach workers, needs are documented at enrollment, as well as periodically throughout the course of the intervention. This allows the outreach workers and the rest of the clinical care team to measure whether or not their interventions are benefiting patients, and tailor program activities accordingly.

SDOH Screening in Complex Populations: Implementation Considerations

There are a variety of questions that complex care providers should consider prior to screening for SDOH, including:

- What assessment tool should be adopted or adapted to collect SDOH information?
- How will the tool be administered, and by whom?
- How will the information collected inform clinical practice?
- How will patients with identified needs be referred to community resources?
- How will providers track whether patients' needs are addressed?

For more considerations on screening for SDOH in complex populations, see: *Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations*. Center for Health Care Strategies, October 2017. Available at: www.chcs.org/resource/screening-social-determinants-health-populations-complex-needs-implementation-considerations/.

Employ Non-Traditional Workers to Increase Capacity to Address Social Needs

Complex care programs often employ “non-traditional” workers,⁷ such as community health workers (CHWs) and community paramedics, to bridge the gap between the medical system and the community served. These individuals are experts in navigating local neighborhoods, as well as the resources available to patients. At AHS, care navigators connect clients to social services in the county and, when needed, accompany clients to appointments to support them and ensure they receive the care they need.

Non-traditional workers also help mitigate the barriers to health care services that patients with complex health and social needs often encounter. For example, at VCU Health, the care team realized that many patients had difficulty attending medical appointments due to a lack of affordable transportation. To solve this problem, the clinic equips its outreach workers with pre-paid debit cards that can be used to solve “low-cost” problems, such as purchasing bus fare to an appointment. Furthermore, the outreach workers at VCU Health often act as an interpreter between their patients and the health care system. When needed, they provide health education and work with patients to review all clinical instructions and care plans.

Many of the TCC sites have used non-traditional workers to augment their care teams and extend services into patients’ homes and communities. For example, ThedaCare Health System’s community paramedicine program sends trained community paramedics into patients’ homes to provide enhanced primary care services. During visits, the community paramedic screens patients for SDOH and surveys the environment, noting any environmental hazards (e.g., loose wires, uncontrolled room temperature) that may impact the patient’s health or put him/her at risk for injury. This information is then reported back to the patient’s care team through ThedaCare’s electronic health record, to which community paramedics have access. In this way, providers have a wealth of additional information that they would likely never uncover during a visit in a typical office setting.

Partner with Community-Based Organizations and Social Service Agencies to Provide Non-Health Care Services

Complex care programs often create partnerships with community-based organizations and social service providers to address patients’ non-medical needs. The provider organizations participating in TCC did so through both formal and informal partnerships. For example, AHS uses a network of volunteer primary and specialty care providers. They also have relationships with a variety of community-based and social service providers to whom they can refer clients. This includes partnerships with local farmers markets, ministries, libraries, medical equipment lenders, and many others. AHS’ leadership encourages employees to become

Bridging the Gap Between Clinical Care and the Community: Accountable Health Communities

Efforts are underway at the federal level to more effectively connect Medicaid and Medicare beneficiaries to community resources. Through the Center for Medicare and Medicaid Innovation’s Accountable Health Communities (AHC) Model, 31 organizations are testing local strategies to bridge the gap between clinical care and the community resources needed to address peoples’ health-related social needs.⁸ The AHC Model is fostering the use of standardized tools to identify social needs and technologies to track the availability of social services and referrals to community providers.

involved in local community efforts by joining governing boards and participating in volunteer events with the goal of identifying future resources that could benefit AHS' team and clients. Likewise, VCU Health created formal relationships with a number of community partners to support patients' social and behavioral health needs, and to offer clinic outreach workers a neutral space when meeting with patients. The YMCA of Greater Richmond offers pre-diabetes and diabetes self-management education classes to VCU Health patients, and the Peter Paul Development Center provides space to the clinic for individual and group meetings. In addition, a long-standing partnership with the Richmond Behavioral Health Authority offers support to clinic patients in need of mental health, intellectual and developmental disabilities, and substance use disorder services.

Test New Uses for Technology

Complex care providers are employing technology to improve access to care, address transportation issues, and overcome additional logistical barriers. In Montana and other rural areas where providing high-touch care coordination and management is resource intensive, complex care providers are leveraging tablet technology to virtually connect providers to patients in their homes. Mountain-Pacific Quality Health's ReSource team in Kalispell uses video and cellular-enabled iPads to connect patients to a care team nurse (as well as pharmacists, nutritionists, and primary care providers) to address a variety of topics including diabetes management, complex medication regimens, and recent hospitalizations. In this way, technology enables the care team to maximize clinical and operational efficiency by reducing travel time and increasing time spent with patients.

Providers are also piloting electronic platforms to inventory community resources and manage patient referrals. AHS, for example, uses Healthify,⁹ a community referral and SDOH management platform. Through the software, care navigators can quickly search for available resources to help meet patients' needs, make referrals, and track whether those referrals are completed.

Similarly, RCHC health centers located in Sonoma County have started using Aunt Bertha,¹⁰ a web-based platform that enables providers to access comprehensive local listings of available social services in patients' zip codes. Previously, one clinic, Petaluma Health Center, developed and distributed a physical resource binder, akin to Yellow Pages, that inventoried available community resources. The binder was difficult to use, often included outdated information, and lacked the ability to track referrals. With the adoption of Aunt Bertha, providers at Petaluma Health Center and other RCHC health centers can more efficiently manage referrals to available resources, as well as monitor patient outcome measures.

Identify Sustainable Funding to Support Non-Medical Services

Complex care providers increasingly recognize the benefit of addressing patients' social needs; however, they often struggle to identify sustainable funding to support these efforts. At the state level, innovative approaches are beginning to emerge that support reimbursement of social services, including via ACOs, managed care contracting,¹¹ and other models. Through its all-payer waiver, OneCare Vermont is seeking to increase the number of patients cared for under risk-based contracts and better coordinate care for people with complex health and social needs.¹² Building on its long-standing statewide care coordination initiative, the Vermont Blueprint for Health, OneCare Vermont is using its existing community-based care teams to coordinate and manage high-risk patient care while aligning the physical health, behavioral health, and social service sectors these patients often encounter.¹³ Under the waiver, primary care providers can receive an increased per member per month (PMPM) payment for high-risk patients. In addition, mental health providers, home health agencies, and Area Agencies on Aging receive a \$15 PMPM for high-risk patients based on the share of those engaged in care coordination activities.¹⁴ Although these providers are not at risk under the ACO contract, the additional payments provide enhanced support when compared to what was previously received under the Blueprint for Health initiative. In turn, additional revenue generated through this arrangement enables providers to enhance their practices by hiring care coordinators or investing in health information technology — all of which improves the way care is provided to people with complex needs.

At the provider level, Mountain-Pacific Quality Health's ReSource team in Billings integrated a robust SDOH screening process in combination with individual care planning by creating a cross-walk based on the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) Z codes.¹⁵ These widely used provider codes were expanded to reflect patients' social characteristics, including problems related to housing, economic circumstances, education, literacy, and others.¹⁶ The Billings ReSource team's cross-walk is used to: (1) identify specific unmet social needs; (2) capture referrals to available resources; (3) assign team members to the intervention; (4) track follow-up and progress; and (5) establish a specific target date for goal completion (see Exhibit 1). The team selected these codes because they are standardized, generate actionable data, and could potentially be used in the future for reimbursement in combination with a primary diagnosis.

This year, Montana Medicaid is piloting an SDOH program whereby federally qualified health center and Targeted Case Management providers who bill Medicaid for services can use Z codes as a primary diagnosis to identify potential health hazards posed by social, economic, or psychological concerns typically not included in clinical diagnoses.¹⁷ The opportunity to link reimbursement for the delivery of targeted case management services will offer insights for others in the field as they advance sustainable reimbursement for the integration of social services and medical care.

Exhibit 1: Example of Mountain-Pacific Quality Health Cross-Walking ICD-10 Z Codes with Care Plan Goals¹⁸

Identified Needs/ ICD-10 Codes	Interventions (e.g., referrals)	Care Team Member Responsible for Intervention	Follow-up and Progress	Target Date and Goal Completion	Outcome
Food Acquisition <ul style="list-style-type: none"> Z56.0: Unemployment, unspecified Z59.7: Insufficient social insurance and welfare support 	<ul style="list-style-type: none"> Pantry PALS SNAP 	CHW	<ul style="list-style-type: none"> Pantry PAL approved and in place. SNAP application completed. Client needs to complete the phone interview process when the letter for approval is received. 	7/13/17	Open
Medication Management and Affordability <ul style="list-style-type: none"> Z55.9: Problems related to education and literacy, unspecified Z59.6: Low income Z59.7: Insufficient social insurance and welfare support 	<ul style="list-style-type: none"> Walgreens Veterans Affairs Medicare Part D 	RN/CHW	<ul style="list-style-type: none"> Walgreens has no additional options for decreased co-pays. Veterans Affairs (VA) benefits have been approved. Options for decreased co-pays and medication mailing. Client needs to decide whether to use VA or not. Medicare Part D is now in place. 	7/13/17	Ongoing

Looking Ahead

The experiences of the TCC pilot sites offer early lessons for the many complex care programs across the U.S. that are exploring new approaches to address the social, economic, and environmental factors impacting patient health and well-being. Although specific strategies vary broadly, they typically fall under the same framework of: (1) identifying social needs; (2) employing non-traditional workers; (3) partnering with community-based and social service organizations; (4) piloting technology to support care team efforts to address SDOH; and (5) thinking strategically about ways to sustain SDOH-related activities. Continued efforts by innovative providers and delivery systems will be critical to better understand how best to bridge the gap between the health and social service sectors and support people with complex health and social needs.

ENDNOTES

- ¹ S. Artiga and E. Hinton. “Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity.” Kaiser Family Foundation, May 2018. Available at: <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>.
- ² For more information on the PRAPARE tool, see: National Association of Community Health Centers. Available at: <http://www.nachc.org/research-and-data/prapare/>.
- ³ For more information on Health Leads’ Screening Toolkit, see: Health Leads. Available at: <https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/>.
- ⁴ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. “Exhibit 1. Self-Sufficiency Matrix.” Available at: <https://aspe.hhs.gov/report/toward-understanding-homelessness-2007-national-symposium-homelessness-research-accountability-cost-effectiveness-and-program-performance-progress-1998/case-study-arizona-evaluation-project>.
- ⁵ For more information on the OneCare Vermont’s Self-Sufficiency Outcome Matrix, see: TBD. (Note: OneCare Vermont’s Community Care Coordination Core Team workgroup is in the process of revising the Vermont Self-Sufficiency Outcome Matrix).
- ⁶ For more information on AccessHealth Spartanburg’s screening tool, see: Addressing Social Determinants of Health: Connecting People with Complex Needs to Community Resources. Available at: <https://www.chcs.org/resource/addressing-social-determinants-of-health-connecting-people-with-complex-needs-to-community-resources/>.
- ⁷ For more information on non-traditional workers, see: New Faces of the Complex Care Workforce: Reflecting and Connecting with Patients. Available at: <https://www.chcs.org/resource/new-faces-of-the-complex-care-workforce-reflecting-and-connecting-with-patients/>.
- ⁸ For more information on the Accountable Health Communities Model, see: the Centers for Medicare and Medicaid Services. Available at: <https://innovation.cms.gov/initiatives/ahcm/>.
- ⁹ For more information on Healthify’s social determinants of health care management platform, see: Healthify. Available at: <https://www.healthify.us/>.
- ¹⁰ For more information on Aunt Bertha’s closed loop referral network for social services, see: Aunt Bertha. Available at: <https://company.auntbertha.com/>.
- ¹¹ Center for Health Care Strategies. “Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations.” December 2018. Available at: <https://www.chcs.org/resource/addressing-social-determinants-of-health-via-medicaid-managed-care-contracts-and-section-1115-demonstrations/>.
- ¹² For more information on Vermont’s all-payer waiver, see: Vermont’s Bold Experiment in Community-Driven Health Care Reform. Available at: <https://www.commonwealthfund.org/publications/case-study/2018/may/vermonts-bold-experiment-community-driven-health-care-reform>.
- ¹³ For more information on the Vermont Blueprint for Health initiative, see: State of Vermont Blueprint for Health. Available at: <https://blueprintforhealth.vermont.gov/>.
- ¹⁴ “2018 Budget Presentation to the Green Mountain Care Board.” OneCare Vermont presentation, July 13, 2017. Available at: <https://legislature.vermont.gov/assets/Documents/2018/WorkGroups/House%20Appropriations/Other%20Presentations/W~OneCare~OneCare%202018%20Budget%20Presentation%20to%20GMCB%20-%20July%2013,%202017~7-10-2017.pdf>.
- ¹⁵ For more information on the International Classification of Diseases, Tenth Revision, see: the Centers for Disease Control and Prevention. Available at: <https://www.cdc.gov/nchs/icd/icd10cm.htm>.
- ¹⁶ L. Gottlieb, R. Tobey, J. Cantor, D. Hessler, and N.E. Adler. “Integrating Social and Medical Data to Improve Population Health: Opportunities and Barriers” *Health Affairs*, 35, no. 11 (2016): 2116-2123.
- ¹⁷ TCM Social Determinant Diagnosis Code Update, Montana Healthcare Programs Notice: Targeted Case Management and FQHC Update, Montana Department of Public Health and Human Services, February 2018. Available at: <https://medicaidprovider.mt.gov/Portals/68/docs/providernotices/2018/provnoticetcmdeterminantdiagnosiscodeupdate02212018.pdf>.
- ¹⁸ J. Hough. “Z-Codes and the Billings Care Transition Team.” Presentation to the Center for Health Care Strategies at the Mountain-Pacific Quality Health Annual Site Visit, September 2017.