Panel II: Social Determinants of Health Assessment, Referral, Service Delivery and Programs, Reimbursement/Financing

2019 Bristol-Myers Squibb Foundation Grantee Summit

April 16th, 2019

Anthony Shih, MD, MPH

President, United Hospital Fund

United Hospital Fund

Defining the Social Determinants of Health (SDOH)

- "The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life." – World Health Organization
- "Good health begins in the places where we live, learn, work and play." – Robert Wood Johnson Foundation

Social Determinants of Health are the "conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." – Centers for Disease Control and Prevention, Healthy People 2020

Defining the Social Determinants of Health

Organizing framework for the social determinants of health developed by Healthy People 2020, Centers for Disease Control and Prevention

Economic Stability	Education	Social and Community Context	Health and Health Care	Neighborhood and Built Environment
• Employment • Food Insecurity • Housing Instability • Poverty	• Early Childhood Education and Development • Enrollment in Higher Education • High School Graduation • Language and Literacy	• Civic Participation • Discrimination • Incarceration • Social Cohesion	• Access to Health Care • Access to Primary Care • Health Literacy	• Access to Foods that Support Healthy Eating Patterns • Crime and Violence • Environmental Conditions • Quality of Housing

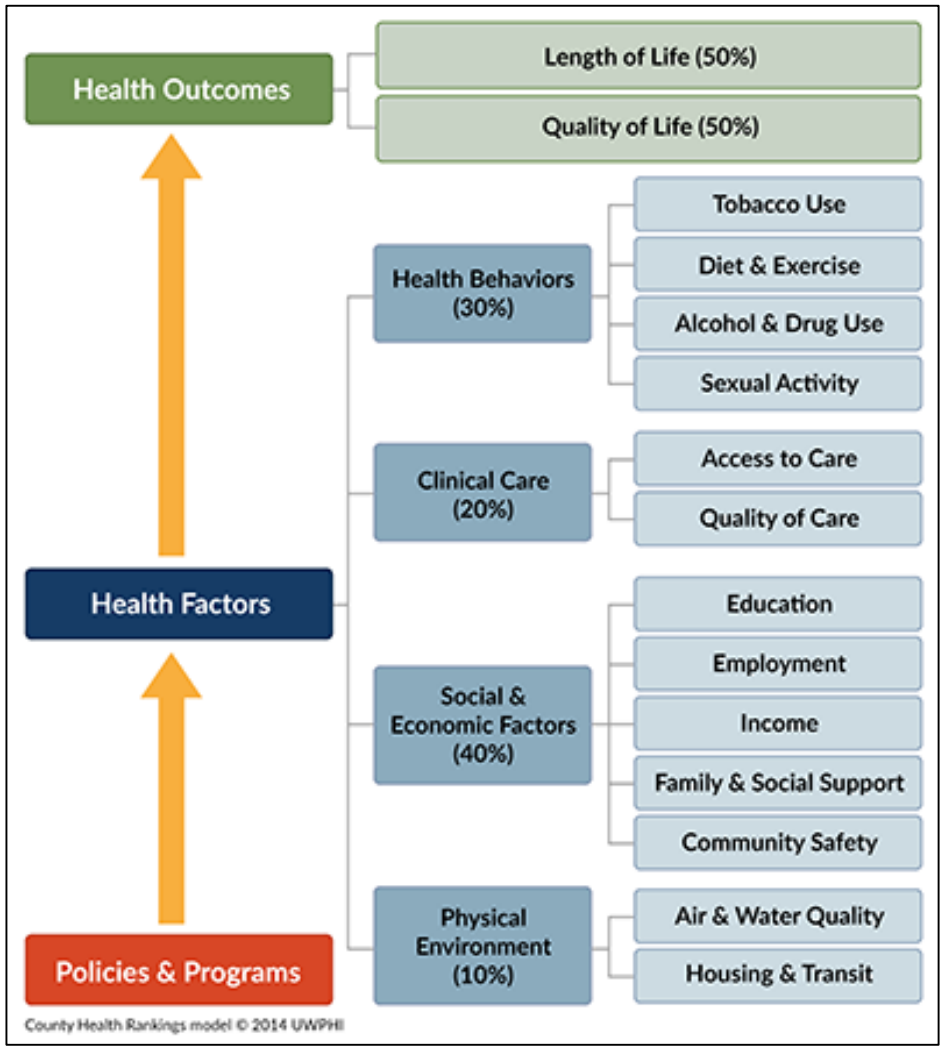
133K

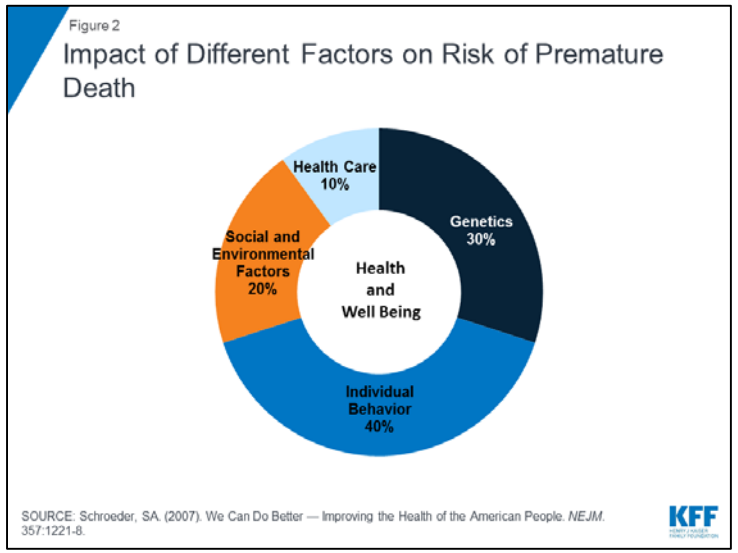
245K

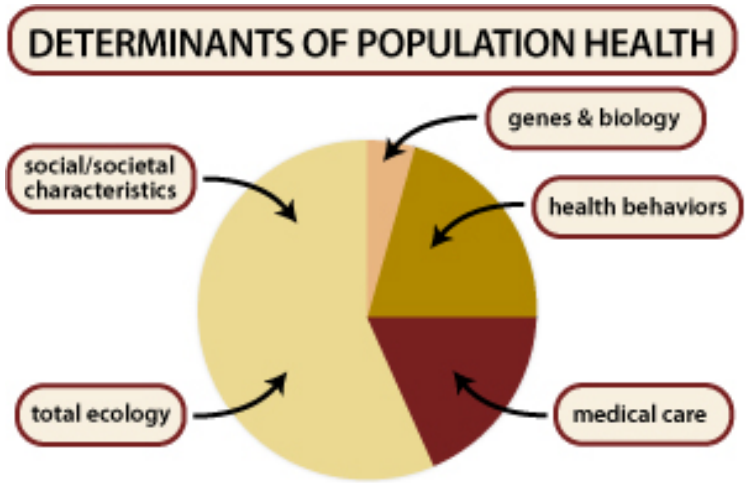
162K

Framework from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health. Estimated US Deaths in 2000 from: S Galea, M Tracy, K Hoggatt, et al., Estimated Deaths Attributable to Social Factors in the U.S., Am J Public Health. 2011 Aug; 101(8): 1456–1465.

Impact of SDOH on Health







Source: CDC, adopted from Tarlov in the Annals of the NAS, 1999.

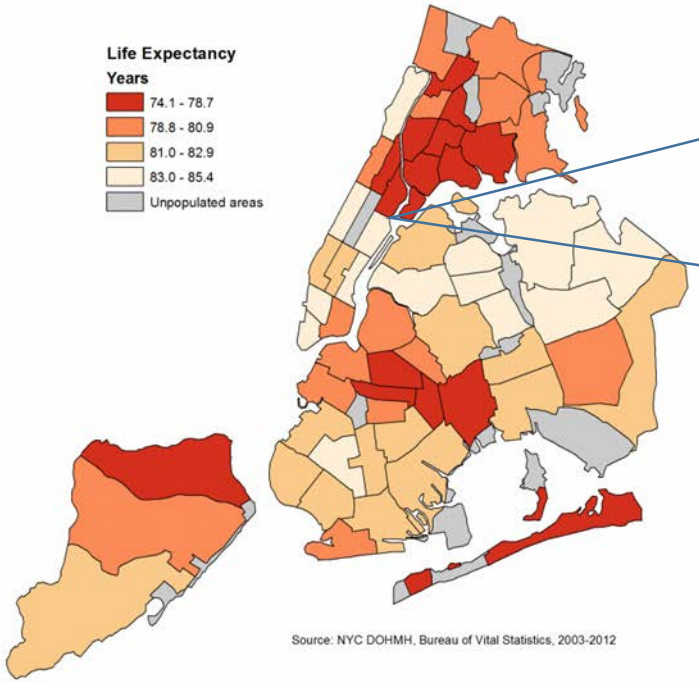
Impact of SDOH on Health

Life Expectancy

Life expectancy at birth

Highest		Years
1	Financial District	84.5
2	Stuyvesant Town and Turtle Bay	85.3
3	Upper East Side	85.0
4	Greenwich Village and Soho	84.3
5	Elmhurst and Corona	84.1

Lowest		Years
59	Brownsville	74.1
58	Bedford Stuyvesant	75.1
57	Central Harlem	75.1
56	Morrisania and Crotona	75.3
55	Rockaway and Broad Channel	75.9



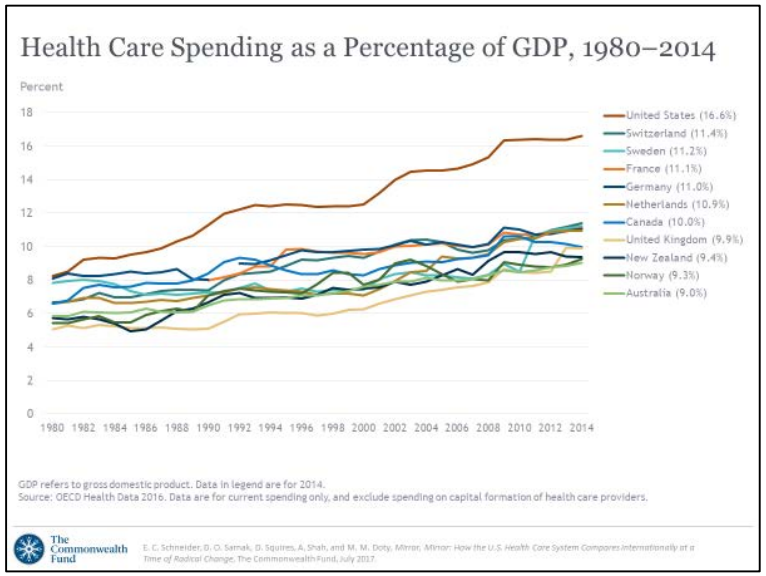
Community Health Profiles — 2015 Atlas 53

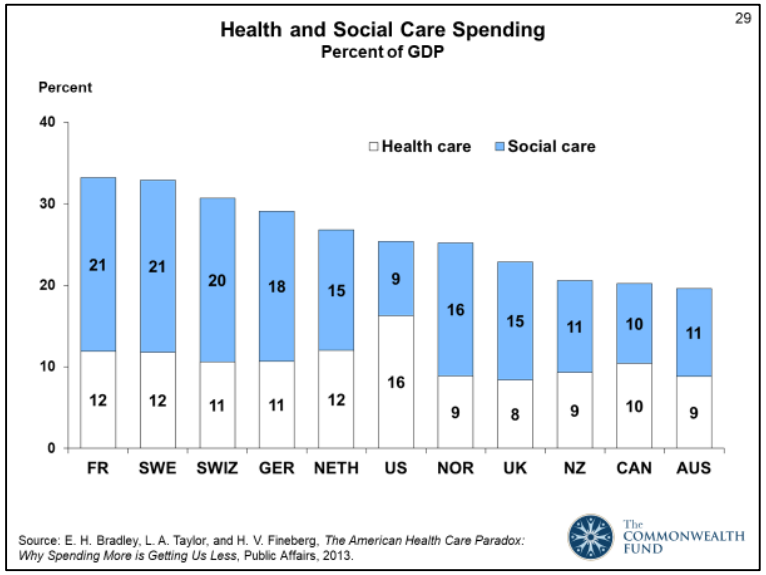
Life Expectancy:

- East Harlem: 76.0 Years
- Upper East Side: 85.0 Years

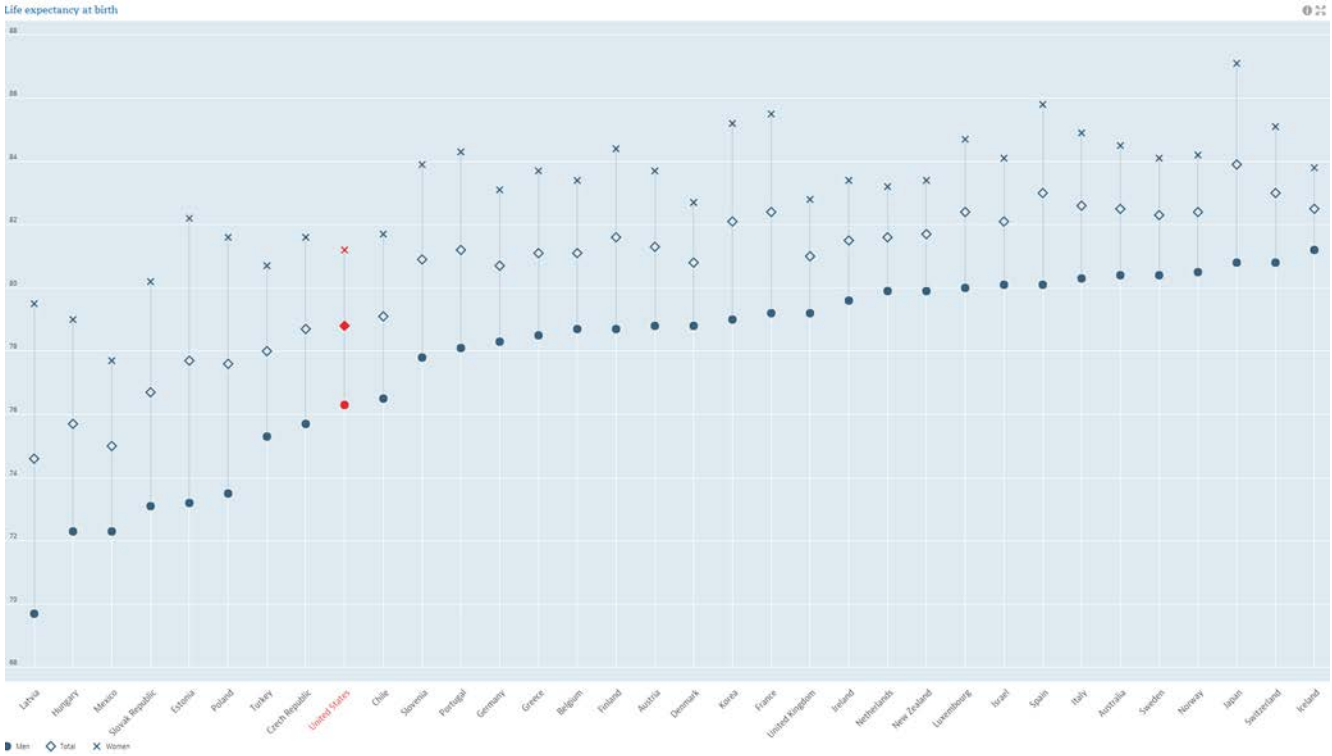
Source: Dragan KL, King L, Hinterland K, Gwynn RC. Community Health Profiles Atlas 2015; The New York City Department of Health and Mental Hygiene, 2015.

The SDOH and the Broad Value-Equation



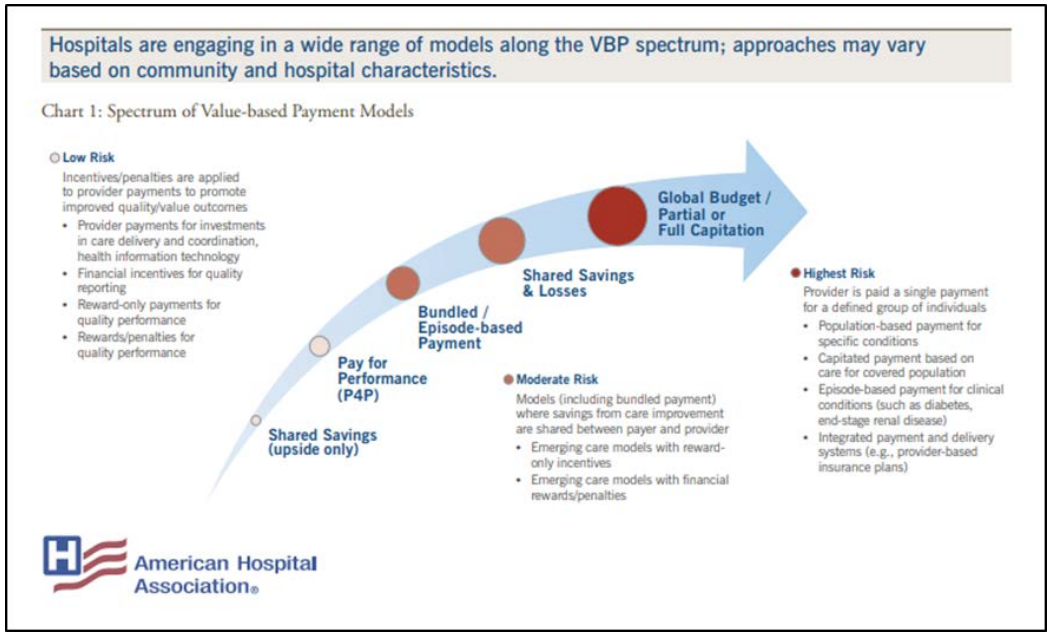


Life expectancy at birth by OECD countries



OECD (2018), Life expectancy at birth (indicator). doi: 10.1787/27e0fc9d-en (Accessed on 25 May 2018)

Drivers and Challenges of Health Care and SDOH



Source: American Hospital Association. Trendwatch: Hospitals and Health Systems Prepare for Value-Driven Future, December 2017

- Value-based payment driving health systems interest in SDOH
- Partnerships between the health care sector and human services critical, but multiple barriers exist:
  - Culture and language
  - Technology and infrastructure
  - Capacity and financing
  - Trust

Addressing the SDOH in Health Care

- **Erin Bradshaw**, Chief of Mission Delivery, Patient Advocate Foundation
- **Rebecca Young**, Senior Project Director – Community Engagement, Farmworker Justice & **Emma Torres**, Campesinos Sin Fronteras
- **Henri Levy**, Cancer Program Development Specialist, Levine Cancer Institute
- **Jennifer Abraczinskas**, Physician, Cooper University's Urban Health Institute
- **Amanda Kramar**, Chief Learning Officer, Association of Community Cancer Centers

West Virginia Lung Cancer Project
Linking Patients to Case Management Support

Patient Advocate Foundation
Erin Bradshaw, Chief of Mission Delivery

Bristol-Myers Squibb Foundation
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Care Collaborations & Patient Support

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Community Awareness, Prevention and Care

Project Goals, Objectives and Activities

WV LUNG CANCER CareLine

Goals:

- Increase lung cancer screening among eligible Medicaid Managed Care beneficiaries
- Improve early diagnosis of lung cancer among low-income and limited resources individuals
- Increase access and adherence to lung cancer treatment
- Decrease lung cancer mortality

Objectives:

- To establish a case management program designed to support providers and patients by linking to solutions intended to address a myriad of barriers hindering adherence to early detection and access to care
- To eliminate ancillary barriers prohibiting individuals to screening for lung cancer
- To address challenges preventing lung cancer patients from seeking timely treatment due to logistical and financial barriers

Activities:

- The WV Lung Cancer CareLine is operated by Patient Advocate Foundation. This a free support hotline designed to provide assistance to patients, caregivers and professionals for patients diagnosed or screening for lung cancer when barriers prevent them for accessing prescribed and recommended treatment and testing.

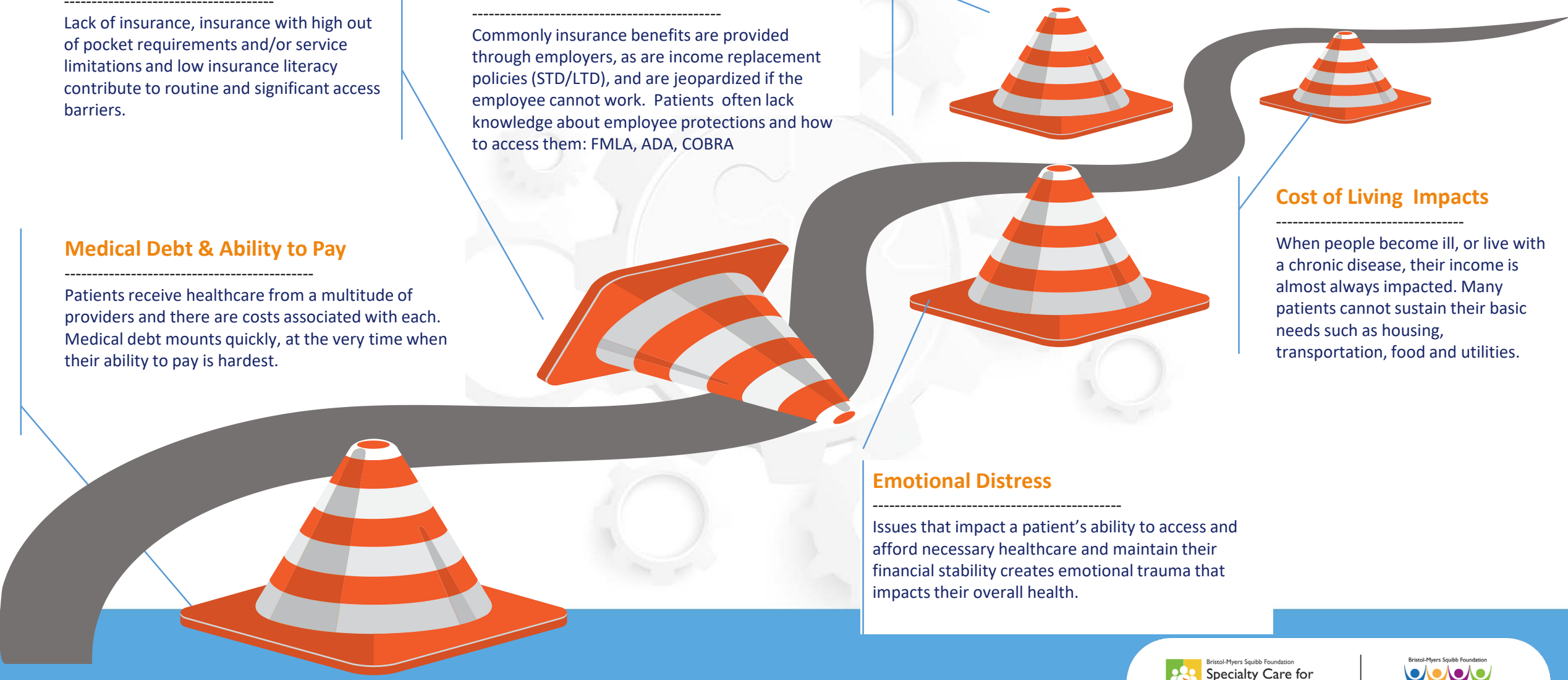
Road Map to Patient Support

Insurance Access

Lack of insurance, insurance with high out of pocket requirements and/or service limitations and low insurance literacy contribute to routine and significant access barriers.

Employment Protections & Workplace Entitlements

Commonly insurance benefits are provided through employers, as are income replacement policies (STD/LTD), and are jeopardized if the employee cannot work. Patients often lack knowledge about employee protections and how to access them: FMLA, ADA, COBRA



Medical Debt & Ability to Pay

Patients receive healthcare from a multitude of providers and there are costs associated with each. Medical debt mounts quickly, at the very time when their ability to pay is hardest.

Cost of Living Impacts

When people become ill, or live with a chronic disease, their income is almost always impacted. Many patients cannot sustain their basic needs such as housing, transportation, food and utilities.

Emotional Distress

Issues that impact a patient's ability to access and afford necessary healthcare and maintain their financial stability creates emotional trauma that impacts their overall health.

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Key Challenges to Date

- WV ranks among the top states in public risk factors for tobacco use[1] and among the bottom in American's Health ranking.

- Age-adjusted WV lung cancer rates for men and women are statistically significantly greater than the corresponding US rates; approximately one-fifth of lung cancers are diagnosed at an early stage, and close to half of lung cancers are diagnosed at a distant stage.
- Barriers to health care include lack of insurance, access to care, availability of specialists, transportation, and a lack of follow-up for health care services and case management.

    - Complexity of issues: The average contacts per case equate to 21%, compared to PAF's overall average of 19 per case
    - Late stage of Lung Cancer at initial diagnosis: Of those reaching the CareLine, over 26% were diagnosed Stage III, and over 42% were diagnosed as Stage IV
    - Practical Support Needs: Transportation, the inability to afford care and disability were the top 3 reported issues representing nearly 42% of all issues reported. On average patients have two issues
    - Comorbidities: 25% of patients served reported a secondary diagnosis to lung cancer

Key Findings and Sustainability Planning

Results

- The WV Lung Cancer CareLine is an effective intervention with non-clinical barriers to care
- Proactively assess and determine other potential pitfalls when addressing the patients reactive need to minimizes barriers to treatment adherence and access to screening
- Empowerment through demonstrating problem solving through conference calling
- Persons with lung cancer and dealing with complex administrative and financial barriers that are amplified with late stage diagnosis

Sustainability

- Case studies to support marketing efforts with WVU Cancer Institute. Showing real examples to build awareness and trust from patients.
- Establish mobile screening program to get those who meet the screening guidelines screened and connected to care sooner.
- Partnerships with key groups to navigate at risk patients to screening sooner with a resource of the CareLine if there is an identified barrier
- Increase awareness of providers about Careline resources for those who may be apprehensive to recommend screening due to barriers expressed by patients

In the words of a patient, “{My case manager was} very courteous and prompt! The lady who picked me up was super nice and friendly, very sweet lady. I felt very comfortable.”

New Outreach Rack Card

WV | Lung Cancer Project

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A Case Study

ISSUE:

- Caucasian male in his 60's
- Insured
- Diagnosed with stage IV lung cancer
- Needs urgent assistance with medical co-payments
- Missed appointments with his specialist due to an inability to afford required per visit co-payment

PAF STEPS TO RESOLUTION:

- Researched possible co-pay assistance resources- none were available
- Researched his DHHS correspondence – learned that that patient had a 6 month SSI approval in place while Social Security Administration completed his presumptive SSDI benefit review
- His SSI approval under presumptive disability automatically made him eligible for Medicaid. The case manager organized a series of conference calls which resulted in coverage for the patient and timely access to the necessary healthcare providers.
- A co-payments and out of pocket medical cost not covered by his primary insurance were now covered by Medicaid and no longer a barrier for the patient
- Once he was eligible for his SSDI payment confirmation was made that he would continue with Medicaid Spend-Down.

PAF Patient Advocate Foundation
Solving Insurance and Healthcare Access Issues | since 1996

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A Case Study

ISSUE:

- Caucasian male in his 30's
- Insured
- Diagnosed with stage IV lung cancer
- Seeking assistance with affording food, rent and utilities. He was in arrears on his electricity bill and had a shut of notice the day of the call

PAF STEPS TO RESOLUTION:

- Case manager confirmed that the patient had been awarded Social Security Disability and now had a source of income
- A conference call was made to the utility company where the case manager explained the situation. The patient was granted an exception and the electricity was kept on. A reasonable payment arrangement was agreed upon on the overdue amount.
- A conference call was made to the local DHHS where an application for SNAP. An appointment was arranged to apply in person to provide a monthly food allowance
- 4 national programs were identified to support with basic living necessities, to include transportation and food.

PAF Patient Advocate Foundation
Solving Insurance and Healthcare Access Issues | since 1996

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WV LUNG CANCER CareLine

WV | Lung Cancer Project

Toll-Free Telephone **(866) 684-2479**

Live Call Hours:

Monday – Thursday, 8:30 AM to 5:00 PM Eastern Time
Friday, 8:30 AM to 4:00 PM Eastern Time

Secure online intake form accessible 24/7: http://tinyurl.com/wvlccl-intake

Learn more about the program at: https://wvlungcancer.pafcareline.org

WV LUNG CANCER CareLine

WV | Lung Cancer Project

Thank you

Bristol-Myers Squibb Foundation

West Virginia Lung Cancer Project Team	
Shonta Chambers, PI	Patient Advocate Foundation
Stephenie Kennedy –Rea	WVU Cancer Institute
Jenny Ostein	WVU Cancer Institute (Mobile Screening)
Lauren McCauley-Hixenbaugh	Mountains of Hope Cancer Coalition
Amy Allen	WVU-Cancer Prevention and Control
Shauna Shafer	American Cancer Society
Michelle Chappell	American Cancer Society
Johna Easter	Aetna Better Health

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WV LUNG CANCER CareLine

WV | Lung Cancer Project

Thank you

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The Unidos Initiative

Rebecca Young, Farmworker Justice
Emma Torres, Campesinos Sin Fronteras

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THE UNIDOS INITIATIVE

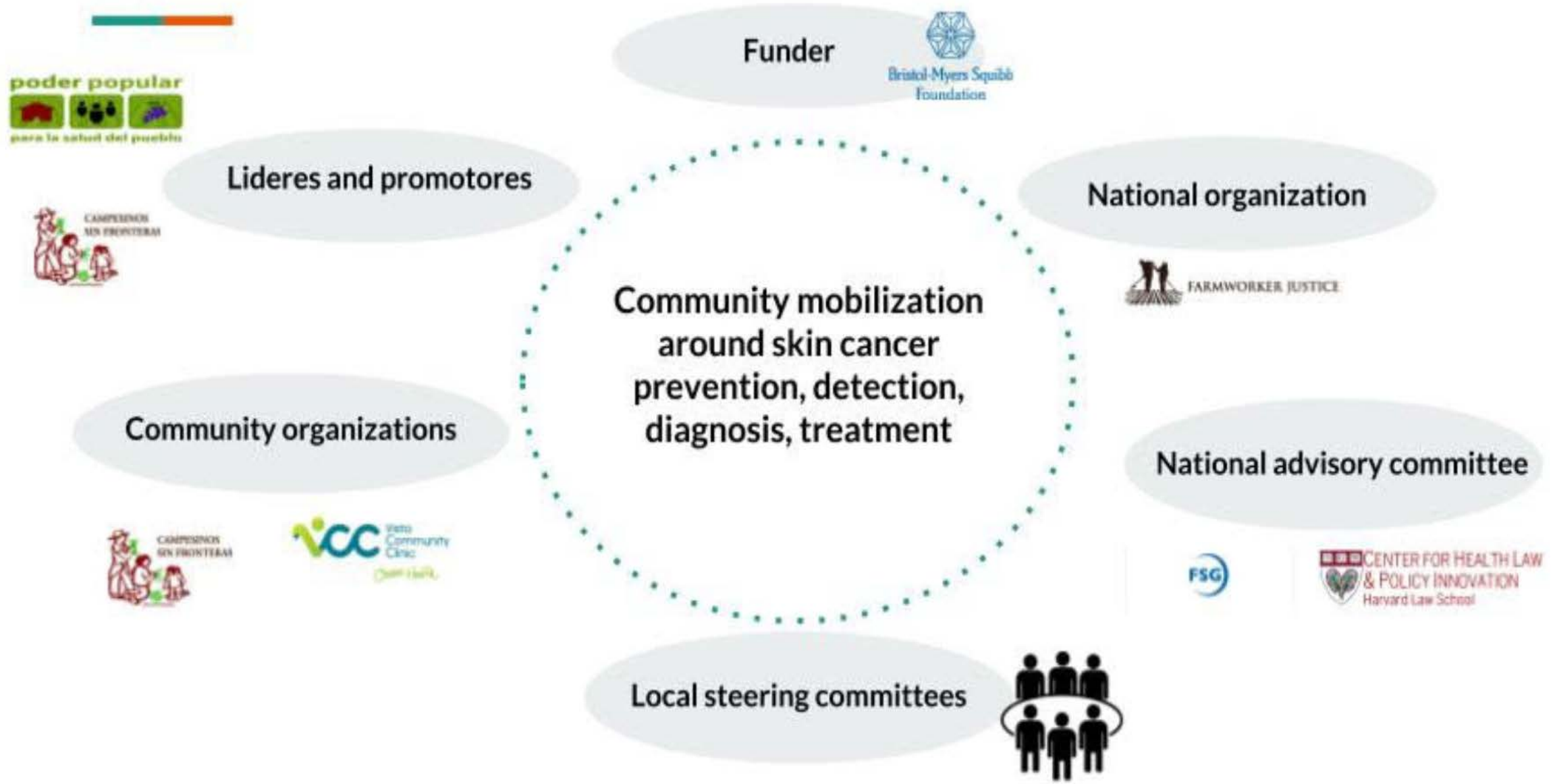
Mobilizing to Eliminate Barriers to Health and Healthcare in Farmworker Communities

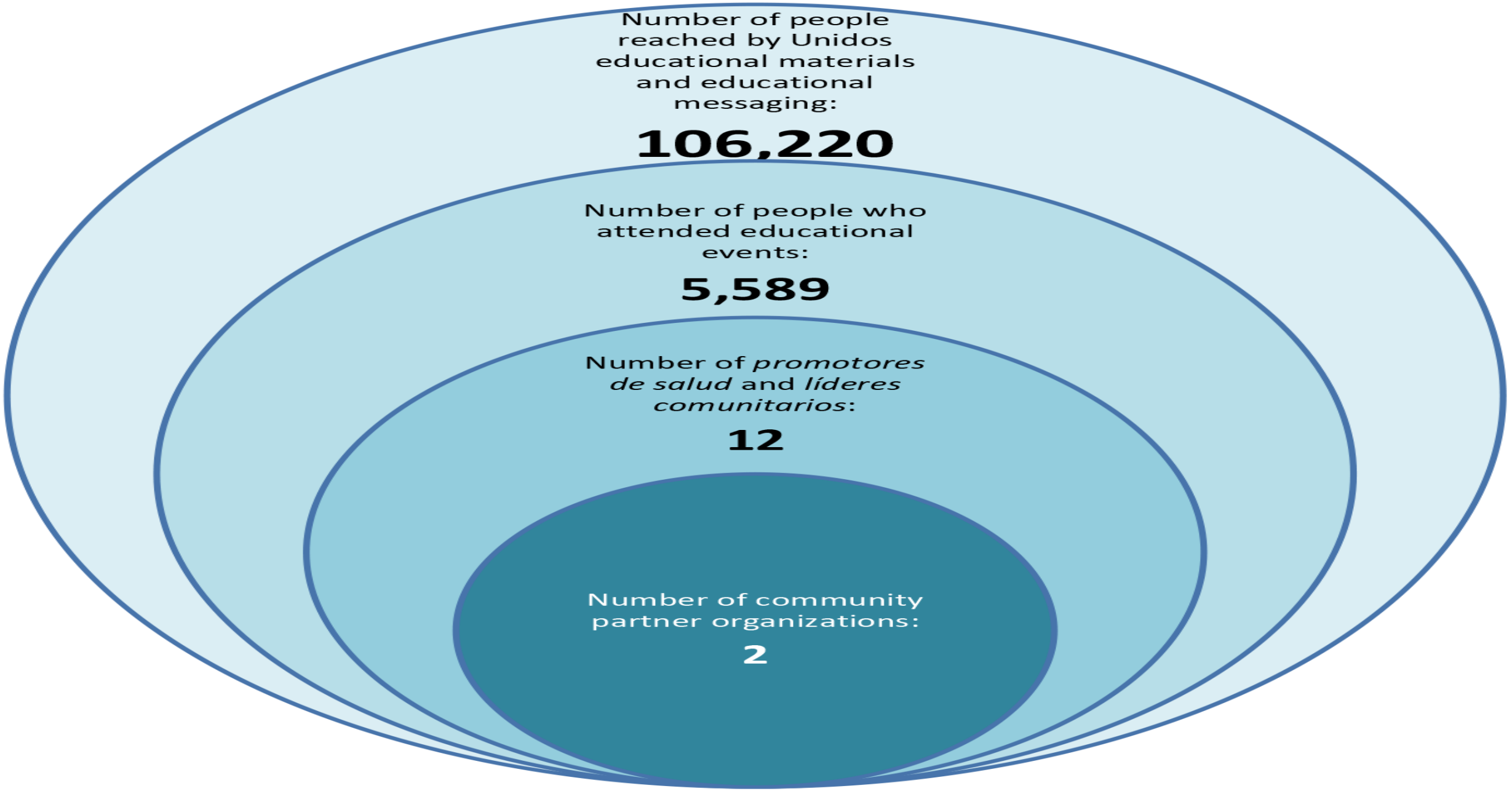
FARMWORKER JUSTICE

Specialty Care for Vulnerable Populations

VCC Vista Community Clinic

CAMPESINOS SIN FRONTERAS


poder popular
para la salud del pueblo
Funder
Bristol-Myers Squibb Foundation
Lideres and promotores
National organization
FARMWORKER JUSTICE
Community mobilization around skin cancer prevention, detection, diagnosis, treatment
Community organizations
National advisory committee
FSG
CENTER FOR HEALTH LAW & POLICY INNOVATION
Harvard Law School
Local steering committees

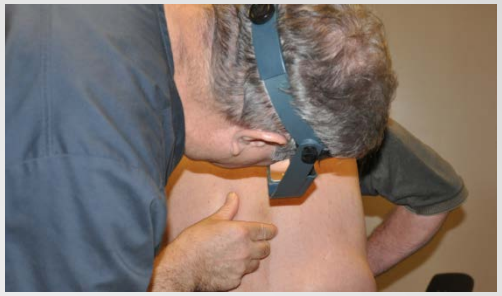

Number of people reached by Unidos educational materials and educational messaging:
106,220
Number of people who attended educational events:
5,589
Number of *promotores de salud* and *líderes comunitarios*:
12
Number of community partner organizations:
2

Elements of *Unidos*

Community Analysis

Steering Committees

Outreach



Screening , Detection, Care

Unidos Outcomes

- **201** Community Members Screened
- **46** Referred for Biopsies and/or Treatment.
- **3** Skin CA Cases Diagnosed
- Outreach and Mobilization Continues…

Yuma County, AZ

Health risks and challenges lead to health disparities

- Hazardous work environment
- Poverty status
- Inadequate housing
- Limited availability of clean water and septic systems
- Inadequate healthcare access
- Continuity of care issues
- Lack of insurance
- Cultural and language barriers

- **Urinary tract infections and other infections** can occur from the lack of toilet facilities available while on the job (specially for women)

Farmworker's Health

- Ergonomic and other physical challenges
- Higher susceptibility to infectious disease,

Occupational Hazards

- Heat-related illnesses
- Exposure to a variety of pesticides and toxic chemicals
- Dangerous tools

Barriers to Health Care

- Prohibitive costs of healthcare
- Shortage of healthcare services
- Lack of culturally or linguistically appropriate services
- Lack of information about healthcare coverage
- Inability to get sick leave
- Concern of losing paid work

Poverty and stress lead to mental health issues.

Unidos outreach events help to address the challenges

Farmworkers face challenges to continuity of care

CHW's Bridge the Cultural Gap and Lack of Access to Care for Farmworker and Latino Families

1) Provide effective, equitable diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Culturally sensitive outreach strategies to meet them”meet them where they are.”

Mobilize Community to Put Farmworkers' Health on the Health Care Agenda (Unidos)

Farmworker Families Feed our Nation

Atrium Health

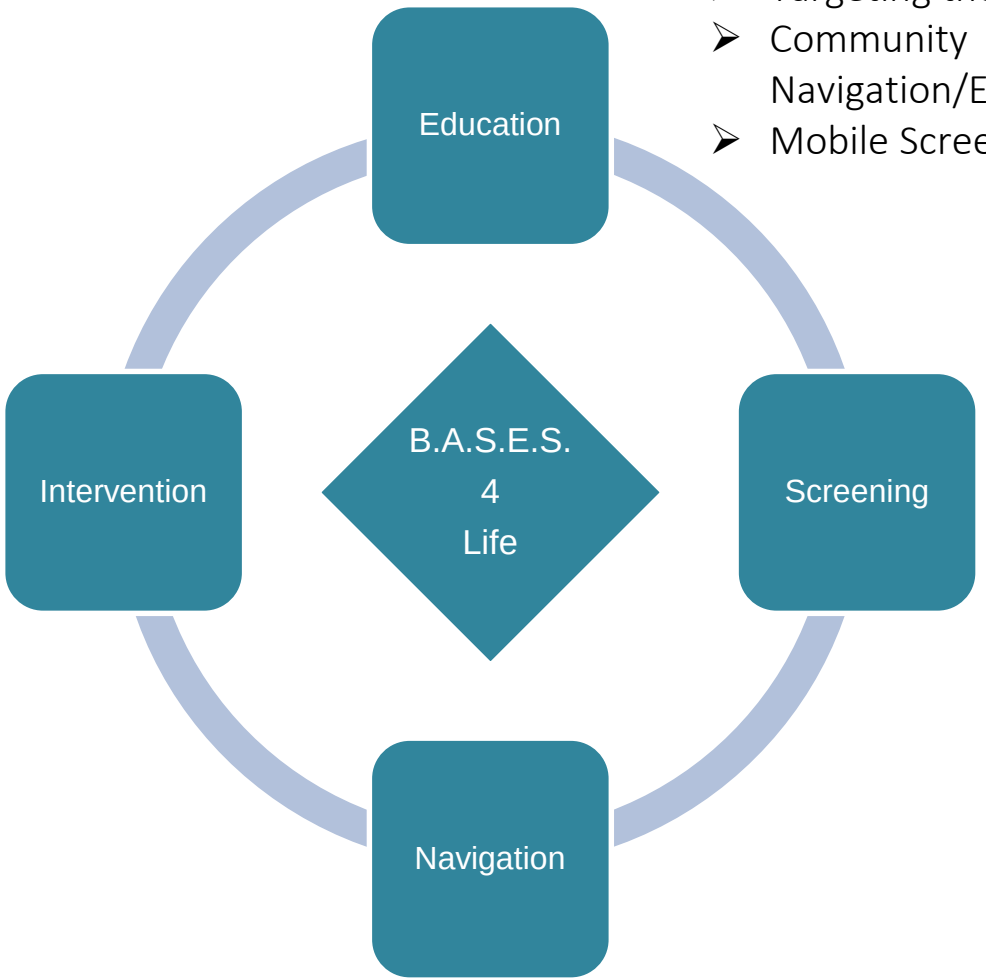
A Pack A Day Sends The Lung Bus Your Way

Henri Levy, MHA
Cancer Program Development Specialist
Levine Cancer Institute

Lung B.A.S.E.S. 4 Life Program

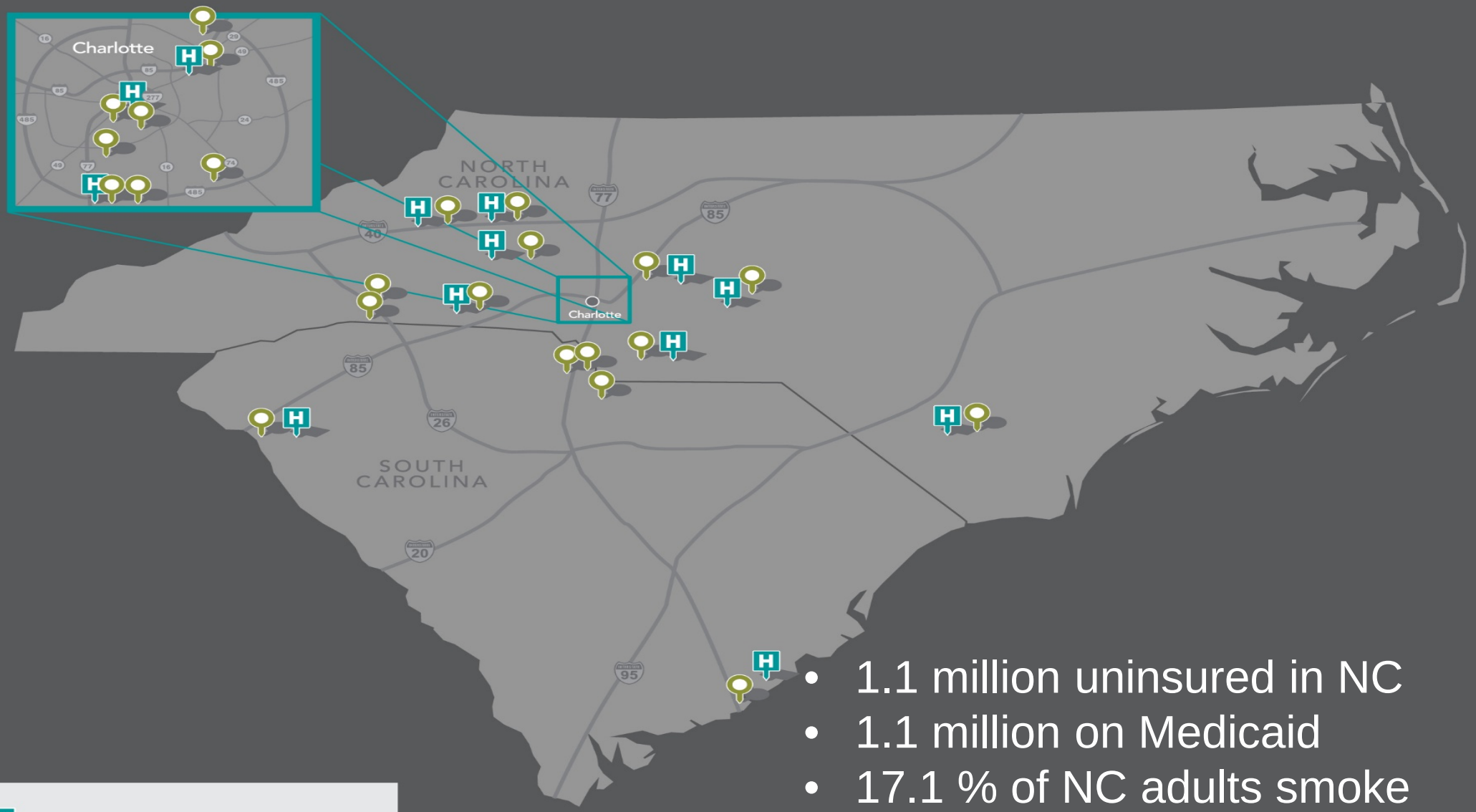
B- Bringing
A- Awareness
S-Screening
and
E-Education
to improve
S-Survival

- Targeting the Underserved
- Community Navigation/Education
- Mobile Screening Component



The number 4 represents our 4 key strategies:

- Community-based education
- Mobile/Regional screening 25 sites
- Community Navigator for education/care coordination
- Navigator to transition positive screens into the System for care and clinical intervention



- 1.1 million uninsured in NC
- 1.1 million on Medicaid
- 17.1 % of NC adults smoke
- 18.8 % of SC adults smoke

MAP KEY

HOSPITAL LOCATIONS

PRACTICE LOCATIONS

LOCATIONS

The Lung Bus and SDHs

- Transportation
- Stigma of screening
- Culture of smoking
- Financial hurdles
- Resource availability
- Relationship building

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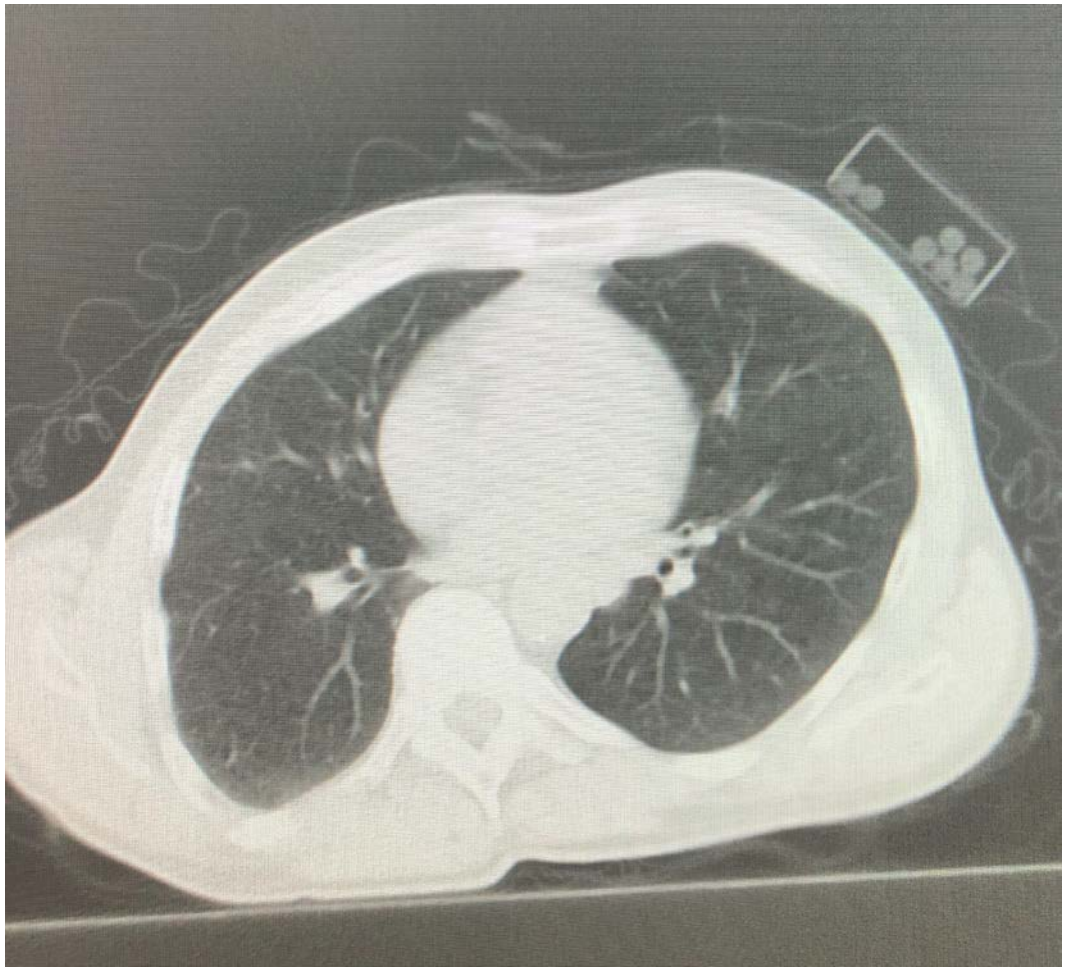
Levine Cancer Institute

Free Tobacco Cessation

- Familiar faces
- Customized plan
- Doorstep NRT
- 1-on-1 counseling
- Lung Bus Community



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Challenges

- Elements
- Connectivity
- Mobile Medicine
- Secure spaces
- Patient tracking

Impact

- Number screened
- Whole patient approach
- Head and neck screenings
- Intense navigation
- Close follow up
- Referral to other screenings

Action Shots

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Levine Cancer Institute

Sources

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THANK YOU

Atrium Health
Levine Cancer Institute

Reducing Disparities in Cardiovascular Disease (CVD) Care in an Underserved Population

Cooper University Hospital, Camden, New Jersey

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John McClay, BA HES (Program Assistant)
Steven Kaufman, MD (Medical Director)

Project Goals, Objectives and Activities

VISION: All underserved Camden residents with CVD will have outcomes equal to or better than patients receiving specialty care in surrounding areas

Goals

1. Address unmet social determinants of health (SDOH)
2. Stabilize high-needs/high-cost patients
3. Increase access to specialty care
4. Improve self-management for CVD-related risk factors

Activities

1. Health coach-led SDOH assessments
2. Complex care & ambulatory ICU programs
3. Nurse-led protocols, transportation to office visits
4. Shared medical appointments

Cooper University Health Care

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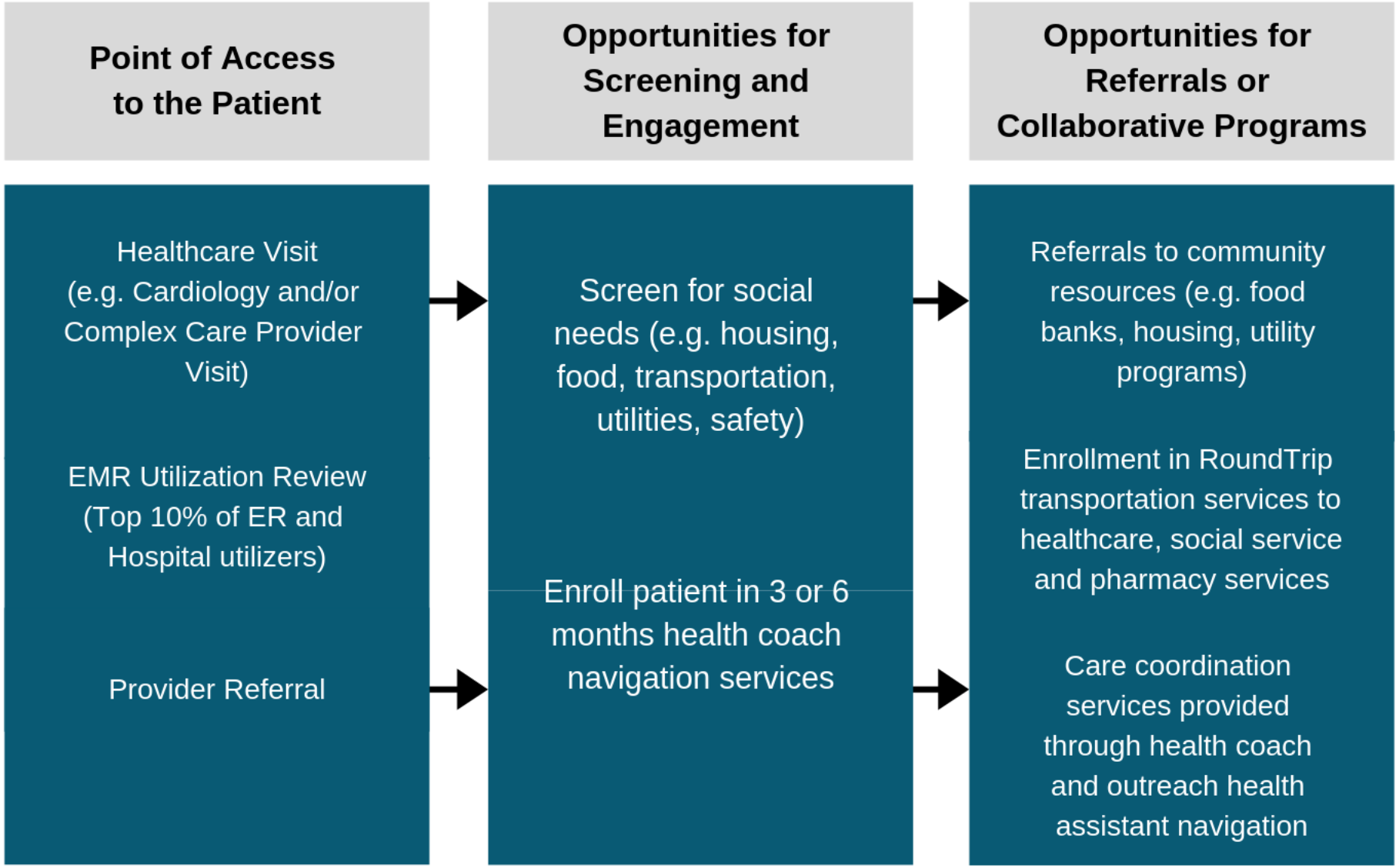
Bristol-Myers Squibb Foundation Bridging Cancer Care Community Awareness, Prevention and Care

Service Flow Map



How do we screen for SDOH?

<u>15 Question Survey</u>

<u>5 Domains Addressed</u>

Housing instability

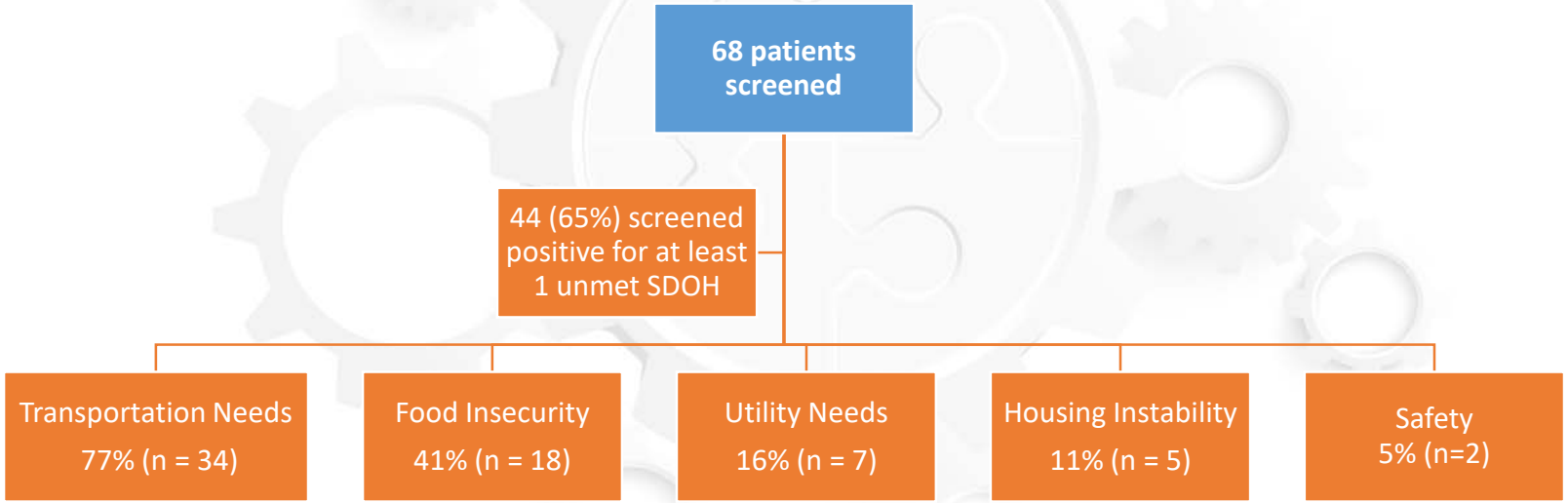
Food insecurity

Transportation problems

Utility help needs

Interpersonal safety

Project Results to Date: SDOH Screening



Project Results to Date: SDOH-Related Services Provided

Transportation

- Set up non-emergency transportation through RoundTrip platform (Lyft rides)-medical and Social Services
- Parking vouchers -

Food Insecurity

- Referrals to SNAP or home meal delivery programs (e.g., Meals on Wheels, MANNA)

Utilities

- Set up patients with programs that help pay utility bills

Other Services

- Care coordination (e.g., re-establish primary care)
- Set up home delivery/blister packaging of medications
- Accompany patients to Board of Social Services

Key Challenges to Date

Domain	Challenges
Interventions	• Patient recruitment and retention • SDOH screening tool initially too expansive • 3-month follow-up screenings: patients not connecting with social services from printed resources
Provider engagement	• Previous experience with health coaches • Concerns for visit efficiency
External policy issues	• Lack of consistent terminology around SDOH, complex care, ambulatory ICU • Silos between health and social service industries • Lack of framework for assessing outcomes of social needs interventions

Sustainability Planning

Influence institutional policies

- Institute routine SDOH screening across primary and specialty care
- Uniform understanding of complex care/ambulatory ICU patient criteria, referral strategies, & interventions

Build community partnerships

- Build SDOH referral network in local community
- Improve sharing of information between providers and social service agencies

Conduct research to move the field forward

- What is the return on investment for SDOH and complex care interventions?
- Provide evidence of how addressing SDOH in specialty care affects clinical outcomes

Highlighting Patient Success Stories

- *“Patient is recently homeless, and was referred to me by one of the cardiology MAs. She suffers from a history of trauma, mental health issues, and heart failure. I gave her homeless shelter resources and directed her to the Board of Social Services to meet with the housing department (and provided transportation). I helped her obtain all of the documents she needed to provide the Board with in order to get help with housing. She is currently on the waiting list for several apartments/rooming houses. I assisted in applying for Section 8 housing for her.”*
- *“Patient is part of complex panel. Uncontrolled HTN and A1C. Fell out of contact with PCP office when miscarriage of child and lost to follow up with bariatric center. Once re-established with PCP, was able to start PT 3x per week thanks to LYFT, is able to get all of her medications, sees Behavioral Medicine regularly as part of Complex Care, and starts Bariatric Prep again. She could not do this without our close follow up and mentorship of our Health Coach and relationship with her PCP team.”*

Creating an Optimal Care Coordination Model for Lung Cancer Patients on Medicaid

Association of Community Cancer Centers (ACCC)

Amanda Kramar, Chief Learning Officer

Co-PIs: Dr. Christopher Lathan & Dr. Randall Oyer

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Project Goals, Objectives and Activities

- **Goal**
  - Create an Optimal Care Coordination Model (OCCM) that reduces disparities related to access to care for lung cancer patients on Medicaid
- **Objectives**
  - Provide practical guidance to cancer programs to achieve patient-centered, multidisciplinary, coordinated care for lung cancer patients on Medicaid
  - Designed to be used by any cancer center, regardless of program size, location, and resource level
- **Activities**
  - Development of beta OCCM (2016-2017)
  - Selection of OCCM Testing Sites (2017)
  - Testing Sites implement QI projects (2017-2018)
  - Advisory Committee and TEP finalize OCCM (2018-2019)
  - Dissemination of final OCCM and supporting resources (2019)

Key Challenges to Date

- Hundreds of hours spent with Testing Sites developing QI projects, data collection plans, and providing direction on adaptations needed throughout
- Staff turnover – ACCC and Testing Sites
- Untested assessment areas

Project Results to Date and Sustainability Planning

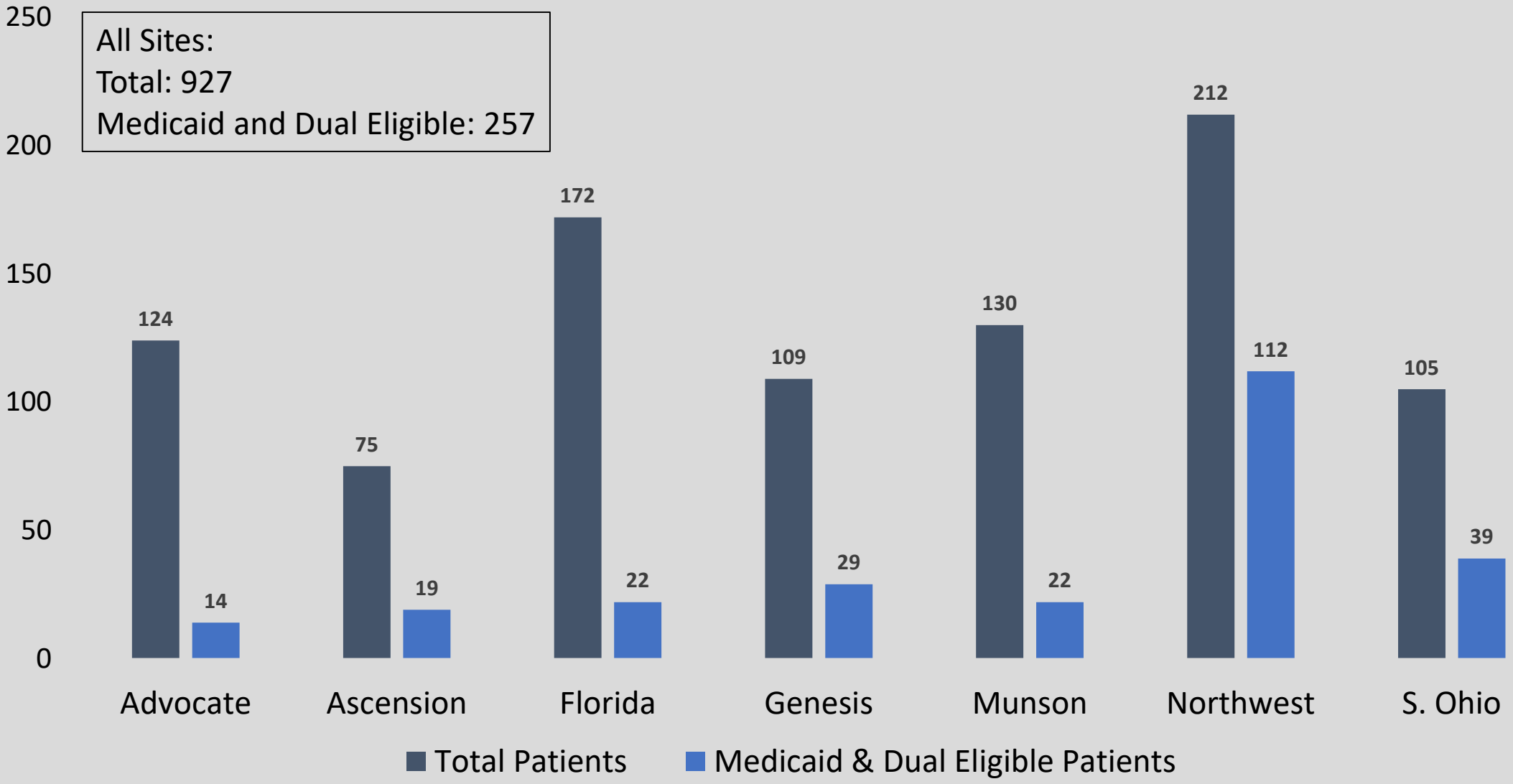
Recent Accomplishments

- Presentations made at 2018 IASCL and 2018 ASCO Quality
- All 7 Testing Sites completed QI projects and presented November 2018
- TEP finalized OCCM (March 2019), sent to Advisory Committee for final review (April 2019)

Sustainability Strategies

- Manuscript in development for submission to JOP
- OCCM launch on ACCC website, journal, national/regional meetings
- Additional testing, QI implementation support
- Numerous abstract submissions

Number of Patients



OCCM Model Summary- Initial Self Assessment to Achieved Target Goal

	Advocate	Ascension	Florida	Genesis	Munson	Northwest	Southern Ohio
Patient Access to Care		1 → 4					2 → 4
Prospective Multidisciplinary Case Planning		1 → 3	2 → 4	3.5 → 4			
Financial, Transportation, Housing- (Transportation supportive role to main project)					Limited Scope	Assessed at 2	
Care Coordination						2.5 → 4	
Electronic Health Records	2 → 4						
Survivorship Care			3 → 4				
Supportive Care						3.5 → 4	
Tobacco Cessation				3.5 → 5	3 → 5		
Clinical Trials	2 → 3.5						

*Table Courtesy of Christine Amorosi, Health Quality Solutions