CIN

CONNECTIONS

Summer 2018 Issue:

Beyond the Exam Room: Social Needs That Impact Health

CALIFORNIA IMPROVEMENT NETWORK:

BETTER IDEAS *for* CARE DELIVERY

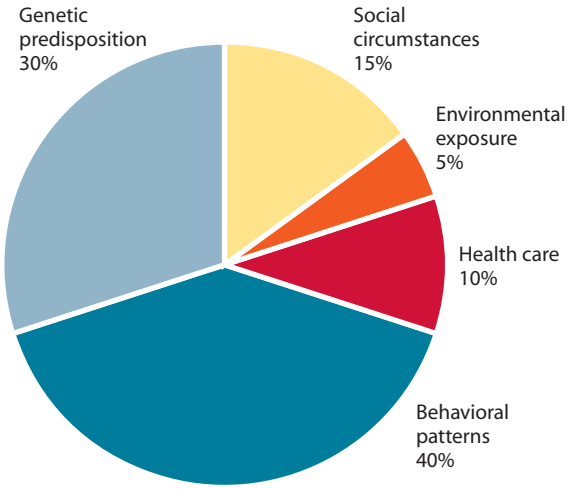
CONTENTS

Reflections from a Managing Partner

We've all seen the pie chart about factors contributing to a premature death: It's the one with the tiny slice for medical care; only 10% of premature deaths are related to the medical care we receive. The other 90% are determined by our behaviors, genetics, and the social and environmental influences in our lives. Not that we need pie charts to understand the obvious: Health truly begins at home, at school, and in our communities.

Anyone who has talked with me about social influences on health knows that I wrestle with the question of how much responsibility the health care system should take for solving problems that exist outside the doors of the exam room. Overcoming social obstacles to health can't rest only on the back of our country's health care system — Policy must be a key piece of the puzzle of addressing social needs. That said, I have come to believe that being patient-centered and taking care of the *whole* person (not just the body part affected by disease or injury) means venturing outside the exam room walls to know the social and environmental contexts of patients in their homes, schools, and communities that have such a deep impact on the care provided inside the exam room.

Proportional Contribution to Premature Death



J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman, "The Case for More Active Attention to Health Promotion," *Health Affairs* 21, no. 2 (March/April 2002): 78–93, doi:10.1377/hlthaff.21.2.78.

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Reflections from a Managing Partner

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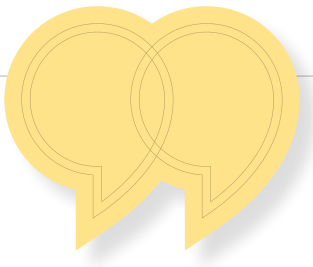


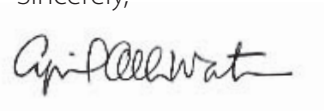
My own experience working with groups of independent practices and commercial delivery systems tells me that the importance of understanding social needs is agnostic to payer type and patient population. No matter who is paying the medical bills, social influences are key. Knowing about those influences is only the beginning, though, and actually supporting patients in overcoming social needs is the more important work we must attempt to do.

We are so fortunate to be part of the California Improvement Network (CIN) — a collaborative of organizations dedicated to improvement and sharing — so that we don't need to undertake this work alone. CIN's June partner-meeting yielded important learnings and resources to help all of us better support the social needs of our patients.

In this issue of *CIN Connections,* you'll learn about actionable information to address social needs. This includes six lessons from Kaiser Permanente; case studies from three leading organizations; and a resource page with tools, platforms and information to help leaders address social needs and implement cutting edge initiatives in your own organizations.

We hope these resources serve you well in your work to support patients where health truly happens.

Sincerely,



April Watson
CIN Managing Partner and Director,
Practice Transformation Initiative,
California Quality Collaborative

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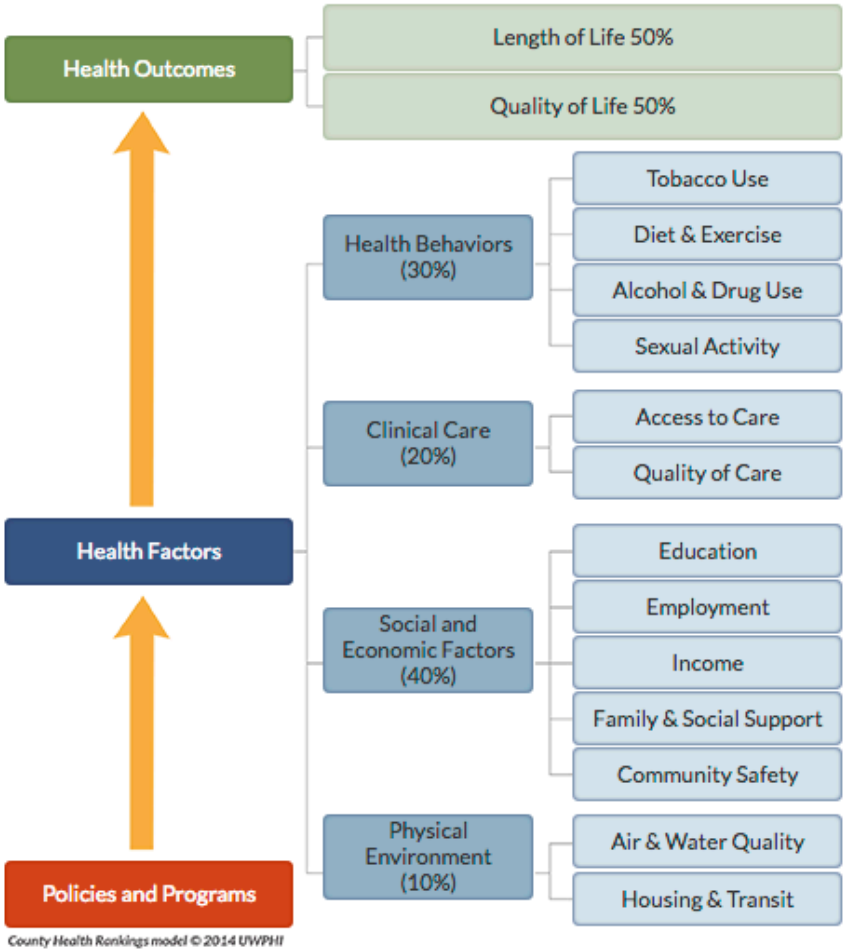
Three Leading Organizations Responding to Social Needs

Humboldt IPA Chief Operating Officer Rosemary Den Ouden, center, interacts with colleagues at CIN's first partner meeting in February.

Three health care organizations that are at the forefront of addressing social needs shared snapshots of their initiatives, advice for other health leaders, and next steps. Humboldt IPA described its leadership role in an Accountable Community for Health, Redwood Community Health Coalition offered advice on building partnerships, and the Center for Care Innovations provided an overview of its suite of social needs work.

County Health Rankings Model

The rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play.



County Health Rankings & Roadmaps
Source: Reprinted with permission from County Health Rankings & Roadmaps, http://www.countyhealthrankings.org/our-approach.

Three Leading Organizations Responding to Social Needs

Humboldt IPA: From Complex Care to Accountable Communities for Health

Featured speakers:

Rosemary Den Ouden
Chief Operating Officer

Jessica Osborne-Stafsnes
Grants and Program Development Manager

Humboldt IPA is a health care provider organization in rural Northern California that administers health plans and serves as the leading health care quality improvement organization for Humboldt County. The IPA has leveraged its experience in both population health management and complex care management to address social needs that impact health.

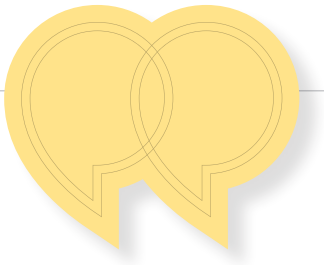
In 2010, Humboldt IPA implemented an intensive care coordination program led by registered nurses for patients with complex health care needs. Over the last eight years, they have noticed that many people among their commercially insured population of 18,000 patients faced the same challenges as the groups traditionally seen as vulnerable populations. "We learned we could no longer judge a book by its cover," said Chief Operating Officer Rosemary Den Ouden. "Food insecurity, transportation, housing, and financial issues were some of the biggest causes of the medical conditions we were seeing."

Since then, Humboldt IPA has emerged as a leader in the Humboldt Community Health Trust (HCHT), an Accountable Community for Health (ACH). HCHT was initiated in 2017 and uses the resources and partnership model of the California ACH Initiative (CACHI) to unite health care and a broad variety of community sectors to improve population health. The stakeholder partners in Humboldt County selected substance abuse as the first priority to focus their efforts, based on the overwhelming impact and loss of life caused by the opioid addiction epidemic and other substance use on the North Coast.

"There's not one of us that's untouched by substance abuse in Humboldt County," said Jessica Osborne-Stafsnes, grants and program development manager. "In our approach to solutions, we must balance priorities around treatment and prevention. While it is likely that we will start our work with a treatment strategy, due to perceived need in the community, we are striving towards a prevention focus over time." Osborne-Stafsnes reports that so far, there are about 50 individual leaders involved in HCHT, which is significant for a small area like Humboldt County.

The ACH model has allowed the community to organize and focus on specific measurable achievements. Humboldt IPA's sister organization, the North Coast Health Improvement and Information Network, the local health information exchange and health improvement organization, provides backbone-convening services and data support to HCHT.

Three Leading Organizations Responding to Social Needs



We learned we could no longer judge a book by its cover. Food insecurity, transportation, housing, and financial issues were some of the biggest causes of the medical conditions we were seeing."

Chief Operating Officer
Rosemary Den Ouden

The Wellness Fund, a vehicle for investing health care dollars in the community, is an innovative element of the ACH model. Two grants, including a small grant from CACHI, provide the resources to initiate ACH work and for seed funding for HCHT's community resource fund. A funding work group is exploring dedicated public sources of income, including cannabis excise tax funds.

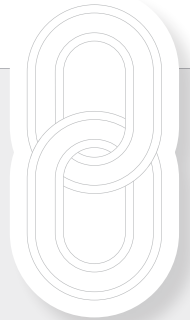
Advice for Other Health Leaders

"We recognize the power of partnership," said Den Ouden. "Relationships are key to success."

"Remember to start small," she said. "There is a natural tension between wanting to build and to do due diligence, between action and planning."

Next Steps

The organization is identifying opportunities within all sectors to find creative ways to deliver care for the whole person that extends to where people live, work, and play. Humboldt IPA is expanding services to a local elementary school and aiming for a launch date in fall 2018. This project will be focused on the physical health as well as social needs of students and their families. As they plan for launching this health center, they are working closely with community partners to leverage the resources already in place and identifying potential gaps that can be filled through the school-based health center.



Resource Page: Social Needs That Impact Health

To improve population health and manage the total cost of care, medical providers must support patients, families, and communities in addressing social needs that impact health. We've gathered a list of relevant and timely resources to help health care organizations in this complex endeavor, regardless of the organization's history of effort and investment.

Three Leading Organizations Responding to Social Needs

Redwood Community Health Coalition: A Shared Resources Approach

Featured speakers:

Claire Cain
Population Health Program Manager

Teresa Tillman
Chief Operating Officer

Redwood Community Health Coalition (RCHC) is a federated coalition of 18 health center organizations in four Northern California counties. Member health centers see over 200,000 patients annually in approximately one million visits. RCHC's focused efforts to understand and address the social needs of its members, patients, and communities began in December 2016 with the founding of a social determinants of health (SDOH) work group. This initiative builds on the eight years of experience by RCHC and its member clinics in assessing and addressing food insecurity through a close partnership with the CalFresh (SNAP) program.

With its member clinics, RCHC selected the National Association of Community Health Centers' Protocol for Responding to and Addressing Patient's Assets, Risks, and Experiences (PRAPARE) as its standard tool for SDOH screening. As a result of the pilots and efforts, more than 3,000 PRAPARE questionnaires have been completed, and nine health centers have implemented the recommended core domains of the PRAPARE tool in their patient screenings.

Now RCHC and its clinics are acting on the information shared by patients about their needs by providing referrals to partner organizations. They plan to begin tracking progress in improving both the clinical and social outcomes of individuals and patient populations."

As Claire Cain, RCHC's population health program manager, said, "It's important to health center staff that they're able to do something when a need emerges in a screening interview." Community partners stress the importance of being able to offer relevant resources when assessing patients for social needs.

Advice for Health Leaders

Clinics have had to navigate a changing policy environment, which prepared RCHC for this new change process, said Chief Operating Officer Teresa Tillman. "Start with small pilots to test workflows and resolve any issues before spreading to the broader population. This provides an opportunity to show the value of doing this work and allows you to secure buy-in across the organization."

Health leaders should also mine and leverage data to build partnerships and secure funding. Social needs data collected by health centers can be used to inform social service providers'

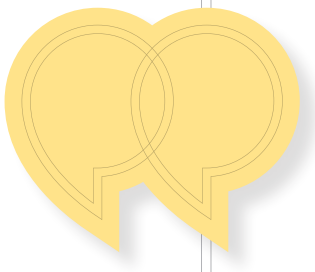
Three Leading Organizations Responding to Social Needs

work. "If we discover that most of our patients live in a food desert and don't have access to healthy foods, we can leverage this data to secure funds to support farmers markets and other healthy food options," Cain said.

Next Steps

The RCHC work group's focus is to standardize and spread tools and protocols for their clinics and to further develop effective community partnerships to achieve measureable impact. Their next steps include the following goals and activities:

- Selecting a common resource and referral platform for all member health centers for use in closed-loop referral relationships and data tracking. From six options, the work group will choose one finalist by the end of June and establish a shared-services contract with the chosen vendor.
- Developing an action-oriented approach to the growing amount of available data on social needs. For example, RCHC would like to add social needs data to clinics' patient risk stratification models, use GIS mapping to identify clusters of specific needs, and combine social needs data with clinical and claims data to identify opportunities for interventions targeting medically and socially complex patients.



> If we discover that most of our patients live in a food desert and don't have access to healthy foods, we can leverage this data to secure funds to support farmers markets and other healthy food options." Claire Cain, Population Health Program Manager

Three Leading Organizations Responding to Social Needs

Center for Care Innovations: Establishing the Value Proposition for Safety-Net Providers

Featured speaker:

Megan O'Brien
Program Manager, Value-Based Care

The Center for Care Innovations (CCI) is addressing social needs in four of its current improvement and innovations programs, and through this work is seeking to answer the question: What is the role of safety-net clinics in addressing social needs?

CCI emphasizes action, with a focus on the use of data and on developing effective community-based partnerships.

- The ROOTS program: A yearlong learning and innovative collaborative that involves seven organizations addressing food insecurity, job insecurity, school absenteeism, and reentry from incarceration.
- Innovation Lab (iLab): A program that provides grants and technical assistance to support bold ideas with the potential to address upstream barriers to health. Five organizations in the program are working on the following efforts in partnerships between health clinics and community-based organizations:
  - ☐ Leveling the rental market to increase affordable housing
  - ☐ Addressing safety and security for immigrant populations
  - ☐ Piloting a Wellness High School for students struggling in the current education system
  - ☐ Collaborating with schools to manage kids with challenging social and emotional needs
  - ☐ Partnering with a technology transportation startup to increase access to care at the clinic
- Population Health Learning Network: A two-year network of 25 organizations focused on learning, sharing best practices, and taking action to advance population health overall, including addressing social needs.

Three Leading Organizations Responding to Social Needs

Advice for Health Leaders

CCI Value-Based Care Program Manager Megan O'Brien shared some of the early lessons and tips from their social needs work so far:

- Working on social needs is overwhelming at first. Building capacity is a heavy lift, with many outstanding questions and technical assistance needs.
- The expertise required to guide organizations in addressing social needs in effective partnerships is diffuse. There is no one person or organization that can answer all the questions.
- Partnerships are challenging. Most clinics have existing relationships with community partners like social service providers. Working together in a new way, including with data front and center to guide the effort, is a struggle.
- The verdict is still out on the best role of the clinic. There are differences in philosophy and approach among the clinics that determine how they see their responsibilities and the roles they want to play.

Next Steps

Stay up to date on grants and other opportunities offered through CCI at www.careinnovations.org.

Sign up here.

Join CIN

Learn more and stay apprised of quality improvement resources, events, and opportunities for engagement offered through CIN.

Six Lessons from Kaiser Permanente on Addressing Social Needs

June partner meeting speakers from Kaiser Permanente:

Winston F. Wong
Medical Director, Community Benefit and Director, Disparities Improvement and Quality Initiatives

Sarita A. Mohanty
Vice President, Care Coordination, Medicaid and Vulnerable Populations, National Medicaid

Irene Alvarez-Zamzow
Manager, Geographic Managed Care, Sacramento Valley

Kaiser Permanente (KP) has historically emphasized prevention and wellness and has invested time and resources to tackle issues ranging from childhood obesity to food insecurity. Yet KP does not have a standard, enterprise-wide approach to address the social needs of its 12.2 million members. That could change soon with new initiatives that aim to connect members to community resources and track outcomes.

This year, KP will be launching the first phase of a tool that connects KP staff, clinicians, and members to community resources called the social services resource locator (SSRL). In addition, KP has implemented a social needs questionnaire for Medi-Cal members in Sacramento. Although KP is in the early stages of both initiatives, these projects offer lessons for other health care leaders.

Below are six lessons KP has learned from this work so far:

1 **Storytelling can help achieve buy-in.** To achieve buy-in from stakeholders — including leadership, staff, and physicians — for the concept of an enterprise-wide social services navigator (the SSRL), Sarita Mohanty, KP's vice president of Care Coordination, Medicaid, and Vulnerable Populations, leveraged real stories to demonstrate the need for a SSRL.

One such story featured Jaime, a patient navigator who worked with a woman who had severe back pain because of an accident that caused her to miss work and enter a dire financial situation. A home stabilization program that Jaime discovered enabled this woman to financially recover and made a huge impact on her life.

After discovering the home stabilization program, Jaime wanted to share the resource with his peers, but KP had no systematic way of connecting members to community resources and closing the loop on whether social needs get resolved. As a result, other patients missed out on this resource, and

> "I think the unchartered territory is looking at: How does the delivery system take some accountability for very upstream issues such as power dynamics, the disproportionate burden on communities, and resource allocation?
>
> Winston F. Wong, Medical Director, Community Benefit and Director, Disparities Improvement and Quality Initiatives

other navigators wasted precious time searching for something that had already been found. Storytelling helped Mohanty advance the SSRL to the next level.

2 **Demonstrating return on investment is difficult, but necessary.** Defining and measuring the ROI for social needs is challenging work that is critical to the ongoing time, resources, and energy spent on these efforts. KP offered insights into two approaches they are taking: (1) Look outside the US for methods, and (2) invest in evaluation.

In thinking about ROI, KP has been learning from the United Kingdom. The National Health Service uses a formula known as the incremental cost-effectiveness ratio (ICER). In order to assess the cost effectiveness of an intervention, they subtract the cost of the intervention (C1) from the cost of not doing the intervention (C0). They then divide that by the effect of the intervention (E1) minus the effect of not doing the intervention (E0).

"ICER is basically a medically cost-effective paradigm, but we're trying to apply this to a nonmedical situation," said Winston F. Wong, medical director, Community Benefit and director of Disparities Improvement and Quality Initiatives.

$$ICER = \frac{(C_1 - C_0)}{(E_1 - E_0)}$$

Incremental Cost-Effectiveness Ratio. Retrieved from http://www.gabionline.net/Generics/General/What-is-the-incremental-cost-effectiveness-ratio-ICER

The other approach KP is taking is much closer to home: their SSRL. In addition to storytelling, a key component of securing buy-in from KP leadership was a commitment to a rigorous evaluation to explore this question of ROI. KP will track and assess a range of metrics for their evaluation, including the tool's impact on quality, provider, and member satisfaction; utilization (e.g., length of hospital stay and emergency department utilization); and cost.

"I think the unchartered territory is looking at: How does the delivery system take some accountability for very upstream issues such as power dynamics, the disproportionate burden on communities, and resource allocation?" Wong said.

Six Lessons from Kaiser Permanente on Addressing Social Needs

Leaders from Kaiser Permante discuss their organization's initiatives to address social needs.

3 Addressing social needs may require reorganizing teams. To implement a new social needs questionnaire for Medi-Cal members in California, KP restructured its department in Sacramento. They hired health care coordinators who triage patient medical and social needs and collaborate with clinicians to coordinate care for patients and family members. KP also reclassified and trained their member outreach specialists — nonclinical, nonlicensed staff — to become member engagement specialists (MESs) who would administer the social needs questionnaire by phone.

Irene Alvarez-Zamzow manages the Sacramento Medi-Cal MES team that was restructured under this initiative. When she originally hired member outreach specialists, she sought people with customer service backgrounds, but as the role expanded, she started to look for people with health education or social services backgrounds.

"Every member we touch gets connected to a primary care physician [PCP], but the PCP doesn't have to take on the conversation about housing needs or other social needs because the health care coordinator has already had that conversation," said Alvarez-Zamzow. "The PCP is kept in the loop and they are working with the social worker, registered nurse, and specialist, but they don't have to have all the answers."

With approval from the state, KP partnered with physicians and merged their social needs questionnaire with the state's required Staying Healthy Assessment, launching the new survey in April 2018. Because they administered the surveys by telephone, they expanded their hours so they would be more likely to reach members at home in the evenings. The calls started to run long at about 40 minutes, so they looked for ways to find that sweet spot where they could establish rapport and get enough information but not take up too much of people's time. That sweet spot turned out to be about 20 minutes.

They also had to restructure their scripting for these calls to encourage members to open up. "We explained to members that we're calling on behalf of your primary care physician and your care team," Alvarez-Zamzow said. "It's about letting members know 'We can help you and we can help connect you to the right resources.'"

Six Lessons from Kaiser Permanente on Addressing Social Needs

> "We're evolving into this space as new territory. This is a whole new frontier that I'm extremely excited about.
>
> Sarita A. Mohanty, Vice President, Care Coordination, Medicaid and Vulnerable Populations, National Medicaid

4 **Building sustainable community networks will be integral to the SSRL's success.** Using the SSRL, KP is working to deepen their learning about the needs of members and patients and the communities in which KP resides. KP's tool will have community resource data that can be updated. It will include search and filtering capability and referral and tracking information to help KP close the loop and inform their understanding of the connections being made between patients and community resources.

"The need to build community networks and partnerships was a real 'aha' for us," Mohanty said. "We thought we needed a tool to solve this problem, but when we started to really embark on this journey, we also discovered the need to establish stronger community networks."

KP's relationships with community organizations vary across service areas and regions, and this work has required them to think critically about the best ways to forge those connections. To avoid overburdening community organizations with an influx of patients, KP aims to form partnerships that are part of a team-based, interdisciplinary model.

5 **Codesign is essential.** The SSRL's first codesign session sought to answer the question: What do we want from the SSRL and where do we want it to go? The two-day session included more than 50 people from across the organization and encouraged staff and clinicians to step into the worlds of their members, caregivers, and the workforce. "It gave people the realization that the organization is committed to this work," Mohanty said.

6 **Transformation can be incremental.** Although it's important to work quickly and effectively, change can be incremental or require a "squeaky wheel" approach. The SSRL, for example, started with Mohanty explaining to her leaders that KP was performing inefficiently in the way it connected members to community resources. Sometimes starting small is all a health organization can do. "We're evolving into this space as new territory," Mohanty said. "This is a whole new frontier that I'm extremely excited about."

To access additional tools and resources that KP and other health care organizations are using to address social needs, please see the CIN Resource Page.

Why I Value CIN

CIN is valuable as a place for resources, learning, reflection, and connection, according to CIN partners. At the June meeting, partners were asked what they value most about CIN. Hit the play button to watch a short video of their responses and preview some highlights here.

It's great to get out of the operational space and have an opportunity to dialogue with these amazing, smart people from these great organizations that are moving in the same direction."

Michelle Wong
Kaiser Permanente

"We all know our environmental and social outcomes are important in our health outcomes. But sometimes it's difficult to find the action you can actually take on. As a physician, I obviously focus on what I've been trained to do, which is medical management and pharmaceutical management. This was really inspiring today." Albert Chan, Sutter Health

"In Humboldt County, we're often remote and removed from a lot of what's going on across California, so this gives us an opportunity to network with our peers and find out what's going on across California in this space." Rosemary Den Ouden, Humboldt IPA

"Coming to a meeting like this really allows us to not only get a full spectrum of references outside of things that we would have access to but also that discussion with other folks who are working in the area in the same way or different ways, so you can either get support to know that you're going in the right direction or you can get different ideas as to what different directions you could go in."

Katrina Miller
L.A. Care Health Plan

"What I value about CIN is the ability to take time away from work and give time to deep thought, reflection, planning, and pure learning." Giovanna Giuliani, California Health Care Safety Net Institute

About CIN

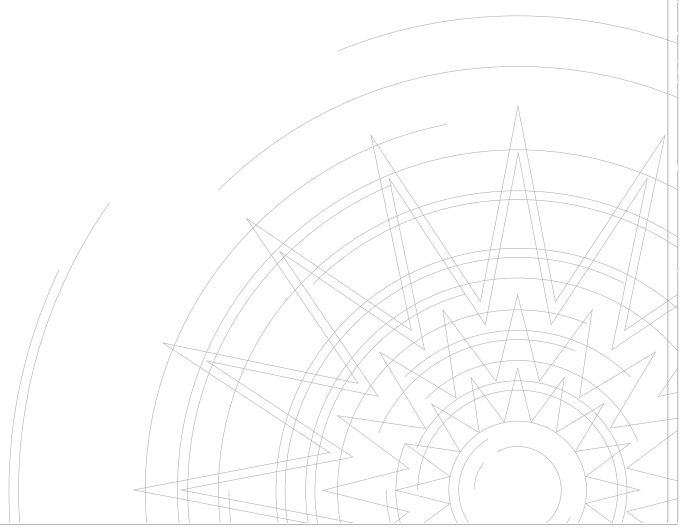
Established in 2005, CIN is a community of health professionals committed to identifying and spreading better ideas for care delivery to improve patient and provider experience and the health of populations while lowering the cost of care. CIN seeks to strengthen relationships across the commercial and safety-net provider and health plan communities in California.

CIN accelerates the spread of quality improvement innovation through:

Connection ■ Learning ■ Action

To achieve its goals, CIN will focus on five critical topic areas in 2018 and 2019:

- Making improvements in behavioral health care, with an emphasis on cost management
- Addressing social needs that affect health, with an emphasis on cost management
- Understanding the fundamentals of managing financial risk and the cost of care
- Preventing burnout and promoting provider and staff resilience
- Leading change



Top Challenges and Opportunities for Addressing Social Needs

After a day of learning and sharing initiatives and projects focused on social needs that impact health, partners engaged in an action planning session to narrow the topic to specific areas where CIN could provide programming or resources to help advance the work. Three clear areas for continued focus emerged.

1. Analyze return on investment (ROI) to address social needs that impact health.

To improve population health and manage total cost of care, health care organizations must also address social needs. Doing this work effectively, at scale, requires considerable resources. Progress in this area requires the ability to analyze the financial costs relative to the impact and outcomes. CIN partners want to learn from those who have assessed returns from investments and explore how ROI variables may differ for different organizations and populations.

2. Share leading practices and workflows for screening and referrals.

CIN partners want to share and spread best practices rather than re-create the wheel. This means not redoing the work of reviewing options and ideas for infrastructure and processes such as screening surveys, referral management platforms, and staffing models. They are interested in consolidating what has already been learned by the field, capturing best practices, and better understanding the experiences that people are having with different surveys and platforms currently available.

3. Identify and promote proven steps to create effective partnerships to improve health.

CIN partners recognize the need for meaningful and effective partnerships with other community-based organizations to meet community needs. To do this, they must ask and answer such complex questions as: What is the best way to create cross-organization collaborations that generate results for patients, families, and communities? What is the role of health care organizations in addressing social needs? How can we more effectively share data? How do we secure and align payment for services? How do we address the capacity constraints of community-based organizations? How do we bridge "territory" concerns?

Stay tuned for future programming and resources from CIN in these topic areas.

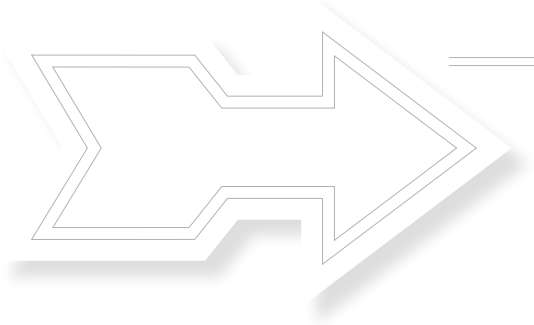
Resource Page:
Social Needs That Impact Health

Partner Efforts to Address Provider Well-Being

Since CIN's February 2018 meeting on provider well-being, several partners have made significant strides in their work to help providers and staff thrive.

Some highlights shared at the June 2018 meeting include:

- **Increasing awareness** — The majority of CIN partners reported that they utilized or distributed the resources on burnout and staff/provider experience that were released following up to the last meeting. One group, for example, discussed and distributed the provider burnout articles from CIN's resource kit at a peer group of health center chief medical officers.
- **Assessing burnout** — Several organizations noted that they are making efforts to assess the level of burnout at their organization using tools like the Mayo Clinic's assessment of physician supervisor leadership qualities on page 13 of the last CIN report, or through wellness surveys.
- **Launching new initiatives** — Some organizations have even launched new initiatives since the last meeting. For example, one prominent organization has implemented a campaign to increase emotional wellness within its staff. Another group is looking into incorporating a provider/staff experience workshop at an upcoming regional quality-improvement summit.
- **Finding a solution that fits an organization's unique needs** — Organizations are at different stages of creating programs and structures to support provider well-being. One organization noted that they are still in the exploratory phase but have attended conferences and events to find the best wellness or resilience program for their organization.



If you haven't already, check out the *CIN Connections, Spring 2018 Issue: Healing the Healers* and the associated resource page on improving provider well-being.

California Improvement Network Better Ideas for Care Delivery

CHCF

Healthforce Center at UCSF

CIN is a project of the California Health Care Foundation and is managed by Healthforce Center at UCSF.

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Learn more and stay apprised of quality improvement resources, events, and opportunities for engagement offered through CIN.

Have you tested out any of the quality improvement recommendations or tools included in this issue? Tell us how it went. We are here to answer your questions or connect you to additional resources. Email us at **CIN@ucsf.edu**.

Contact Us

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