North Carolina Population Health Collaborative
2017 NCMS M3 Conference

SOCIAL DETERMINANTS OF HEALTH

IMPLICATIONS IN THE REAL WORLD PRACTICE

THURSDAY SEPTEMBER 14, 2017

RALEIGH, NORTH CAROLINA

Learning Objectives

- Review Concept of Social Determinants of Health
- Impact of SoDH for Population Health Quality of Healthcare
- Impact of SoDH for Healthcare Payment Reform
- Practical Approach toward implementation of SoDH principles in Practice

Real Practice Scenario

The new office Population Health Administrator desired to implement strategy for improving patient lobby environment with addition of fruit flavored cold water to quench hot summer thirst and generous offering of free snacks.

The leadership desired to have the best selection of snacks which would not interfere with chronic diseases which were most prevalent in the patient population as well as set an example of "healthy snack selection."

The patient choices are as follow:

1. Salted Pretzels
2. Healthy choice pop corn
3. Fried Spicy Pork skins with John 3:16 scripture on each package
4. Dried Apple Slices

Please select the most popular snack preferred in Raeford, North Carolina

THE WINNER IS!

Social Determinants of Health

- Recognize shortfall of traditional healthcare especially for vulnerable populations
- Acknowledge social and economic needs in the healthcare setting
- Impact of SoDH factors on outcome of health and disease management

VULNERABLE POPULATIONS

- UNDER REPRESENTED MINORITY POPULATIONS
- SOCIOECONOMICALLY DISADVANTED GROUPS
- RURAL POPULATIONS
- DISABLED INDIVIDUALS
- IMMIGRANT POPULATIONS
- POPULATIONS AT RISK FOR SEXISM
- POPULATIONS AT RISK FOR RACISM
- POPULATIONS AT RISK FOR DISCRIMINATION

Examples of SoDH Factors in Practice

- Employment which provides health insurance, access to care when needed, enough income to cover out of pocket expense
- In community Physician/Provider access to care
- Education system with basic knowledge for health literacy
- Strategies promoting mental health well being
- Promotion of Healthy Family/Partner unit
- Racism
- Sexism
- Discrimination
- Role of Unconscious Bias in multifaceted encounters

Economic Impact for SoDH Population Health Reform

- Improved Patient Engagement leads to improved Quality not Quantity of care
- Improvement in HCAHPS
- Improved options for Risk Contract with Private sector
- Improved Efficiency and Cost of Care
- Improved Practice Financial Stability with consistent patient population

American Academy of Family Physicians

Health Equity

The American Academy of Family Physicians (AAFP) supports the attainment of the highest level of health for all people. Health includes the capacity to heal and to function within the context of the family, community, and environment. Numerous social, genetic, and environmental factors influence health to varying degrees. An individual's health is not measured simply by the absence of disease.

Family physicians promote health equity by considering the balance of social determinants that impact the health of an individual, family, community, population, and environment. Family physicians can mitigate health inequity by collaborating with government, business, and health and social service providers, to affect positive change for the populations they serve.

Definitions

Health equity: The AAFP adopts the Healthy People 2020 definition of health equity as, "The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

The WHO definition of health is modified by the AAFP to read as follows, "Health is a state of physical, mental, and social well-being and not merely the absence of disease or infirmity."

The WHO definition, although used internationally, has also been adapted to meet the needs of individual nations.

The AAFP is dedicated to improving the health of patients, families, and communities, and is a bold champion of health. As we call upon our organization's leaders, our members, patients, and society to promote individual and population health, we must question outdated thinking and redefine health for those individuals and populations. Health is complex, yet achievable and personal. Its definition should be adaptable and comprehensive.

(2015 December BOD) (2016 COD)

DIRECTIONS FOR SoDH REFORM IN THE PRACTICE SETTING

- Healthcare provider Awareness of key concept encompassing SoDH
- Self Awareness of Unconscious Bias
- Office Environment, internal policies and procedures, Staff engagement
- Community Engagement as multifaceted approach
- Advocacy for county, state, federal legislation which impact SoDH factors via "Speak Out" tools
- Recognize and Refrain from the "Blame Game"

INSTITUTE OF MEDICINE UNEQUAL CARE

2003 REPORT "UNEQUAL TREATMENT:CONFRONTING RACIAL AND ETHNIC DISPARITIES" (Smeldy, Stith, & Nelson, 2003).

Institute of Medicine Strategy for Addressing Health Disparities

- IOM FINDINGS

Finding 1-1: Racial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable.

Finding 2-1: Racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life.

Finding 3-1: Many sources -- including health systems, healthcare providers, patients, and utilization managers - may contribute to racial and ethnic disparities in healthcare

Finding 4-1: Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare. While indirect evidence from several lines of research supports this statement, a greater understanding of the prevalence and influence of these processes is needed and should be sought through research.

Finding 4-2: A small number of studies suggest that racial and ethnic minority patients are more likely than white patients to refuse treatment. These studies find that differences in refusal rates are generally small and that minority patient refusal does not fully explain healthcare disparities.

Institute of Medicine Findings and Recommendations on Health Disparities

IOM RECOMMENDATIONS

- General Recommendations

Recommendation 2-1: Increase awareness of racial and ethnic disparities in healthcare among the general public and key stakeholders.

Recommendation 2-2: Increase healthcare providers' awareness of disparities.

- Legal, Regulatory, and Policy Interventions

Recommendation 5-1: Avoid fragmentation of health plans along socio-economic lines.

Recommendation 5-2: Strengthen the stability of patient-provider relationships in publicly funded health plans.

Recommendation 5-3: Increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals.

Recommendation 5-4: Apply the same managed care protections to publicly funded HMO enrollees that apply to private HMO enrollees.

Recommendation 5-5: Provide greater resources to the U.S. DHHS Office for Civil Rights to enforce civil rights laws

Institute of Medicine Findings and Recommendations on Health Disparities

- Health Systems Interventions

Recommendation 5-6: Promote the consistency and equity of care through the use of evidence-based guidelines.

Recommendation 5-7: Structure payment systems to ensure an adequate supply of services to minority patients, and limit provider incentives that may promote disparities.

Recommendation 5-8: Enhance patient-provided communication and trust by providing financial incentives for practices that reduce barriers and encourage evidence-based practice.

Recommendation 5-9: Support the use of interpretation services where community need exists.

Recommendation 5-10: Support the use of community health workers.

Recommendation 5-11: Implement multidisciplinary treatment and preventive care teams.

Institute of Medicine Findings and Recommendations on Health Disparities

- Patient Education and Empowerment

Recommendation 5-12: Implement patient education programs to increase patients' knowledge of how to best access care and participate in treatment decisions.

Cross-Cultural Education in the Health Professions

Recommendation 6-1: Integrate cross-cultural education into the training of all current and future health professionals.

Institute of Medicine Findings and Recommendations on Health Disparities

- Data Collection and Monitoring

Recommendation 7-1: Collect and report data on health care access and utilization by patients' race, ethnicity, socioeconomic status, and where possible, primary language.

Recommendation 7-2: Include measures of racial and ethnic disparities in performance measurement.

Recommendation 7-3: Monitor progress toward the elimination of healthcare disparities.

Recommendation 7-4: Report racial and ethnic data by OMB categories, but use subpopulation groups where possible.

- Research Needs

Recommendation 8-1: Conduct further research to identify sources of racial and ethnic disparities and assess promising intervention strategies.

Recommendation 8-2: Conduct research on ethical issues an other barriers to eliminating disparities.

Practical Impact of SoDH Efforts in Rural Setting

- As part of ACO practice initiated challenge of Chronic Care Management, Transitional Care Management, and AWV completion with benchmarks established based on total population
- Identification of Medicare Subpopulation who qualified for the service
- Provider and staff education via evidence based opportunities with live and webinar tools
- Established practice policy and procedures for CCM, TCM, AWV
- Engaged technology vendors including web designer for patient portal access
- Implemented PDSA and then Small step of change for test

TRANSITIONAL CARE MANAGEMENT POLICY PURPOSE

To assist patients with transitions between levels of care and reduce hospital readmissions. These services are furnished under supervision of the provider and are subject to the scope of the practice rules and regulations. The office team must contact and notate this contact with the discharging party within 2 business days via the discharge summary or contact by the discharge planning staff, to schedule the patient to be evaluated by the provider. With the assistance of the Health Information Exchange Authority the practice is able to evaluate patients and review discharge instructions within 2-14 days of discharge for initiation of a medical treatment plan. The practice coordinates and communicates with multiple external entities including but not limited to area skilled nursing facilities and hospitals. Transitional care appointments consist of direct face-to face contact with a provider within the designated 7-14 days.

TRANSITIONAL CARE MANAGEMENT POLICY

- Access Initiation:
- The provider receives notice of admission via the hospital or nursing homes admission process. Once the patient is ready for discharge the discharge planner or hall secretary contacts the office for required appointment date and time; normally within 7-14 days or as per the office protocol within 3-5 days of discharge.
- The Patient Service Representative completes initial evaluation while scheduling appointment.
- Once the patient enters the office, the PSR updates preferred communication as per the Access Policy prior to check-in. IMH information is imported in the record via reconciliation process through Athena Health EMR.
- The PSR offers online access via the website at www.karensmithmd.com for symptom assessment completion

TRANSITIONAL CARE MANAGEMENT POLICY

- Personal Medical History:
- The clinical team continues the five-stage workflow process allowing for documentation of new, modified and updated information to previously established data.
- Information is then highlighted for review by the clinical team.
- The clinical team incorporates preventive health needs via quality measure reminder sets.
- New and established patients are encouraged to provide information regarding their hospital or home health admission and discharge instructions. Documents are scanned into the EHR. Their past medical history, psychosocial needs, preferred communication, literacy skills, computer access availability, and transportation, are updated. A thorough care team update and medication reconciliation are completed and notated.
- The patient is encouraged to bring their Advanced Directive and/or Living Will for inclusion in their EHR. A copy of an electronic version can be accessed via the website provided by Total Legal. Opportunity to document the Medical Orders for Scope of Treatment (MOST) is offered.
- Mental health and substance abuse screenings are completed and reviewed by the clinical staff with the patient.

TRANSITIONAL CARE MANAGEMENT POLICY

- **Physician Review of hospital or nursing home discharge instructions and office clinical intake:**
- The physician reviews entered information and establishes a management plan for short and long term goals.
- Educational Resources are provided via paper form and the website is also mentioned at this point for reference
- Preventative health goals and strategies for Healthy Living are addressed.
- Invitations to the Group Medical Visits and Sessions are expressed.
- Identification for SBIRT (Screening Brief Intervention Referral and Treatment Tool) evaluation/intervention is noted.
- The provider reviews and compiles hospital or nursing home discharge documents for medical treatment plan discussion and implementation by the patient/caregiver and/or family.
- Upon discharge the PSR is given notice of discharge date for completion of billing after the 30-day release.

TRANSITIONAL CARE MANAGEMENT POLICY

Quality Measures

- The practice currently incorporates SBIRT within the workflow to ensure patient stability during transitions of care when receiving medications and treatments aimed at relieving pain, psychosocial illnesses, and/or substance abuse treatment (SBIRT defined above).
- Hospital provided reports are evaluated for readmission rates within 30 days, to determine effectiveness of transitional care policy measures. (COPY OF ADMISSION REPORT ATTACHED)
- The Practice Administrator reviews the hospital provided admission reports and compares these with the practice transitional care billing to determine percentage of patients seen within the 7-14 days post discharge.

CHRONIC CARE MANAGEMENT POLICY PURPOSE

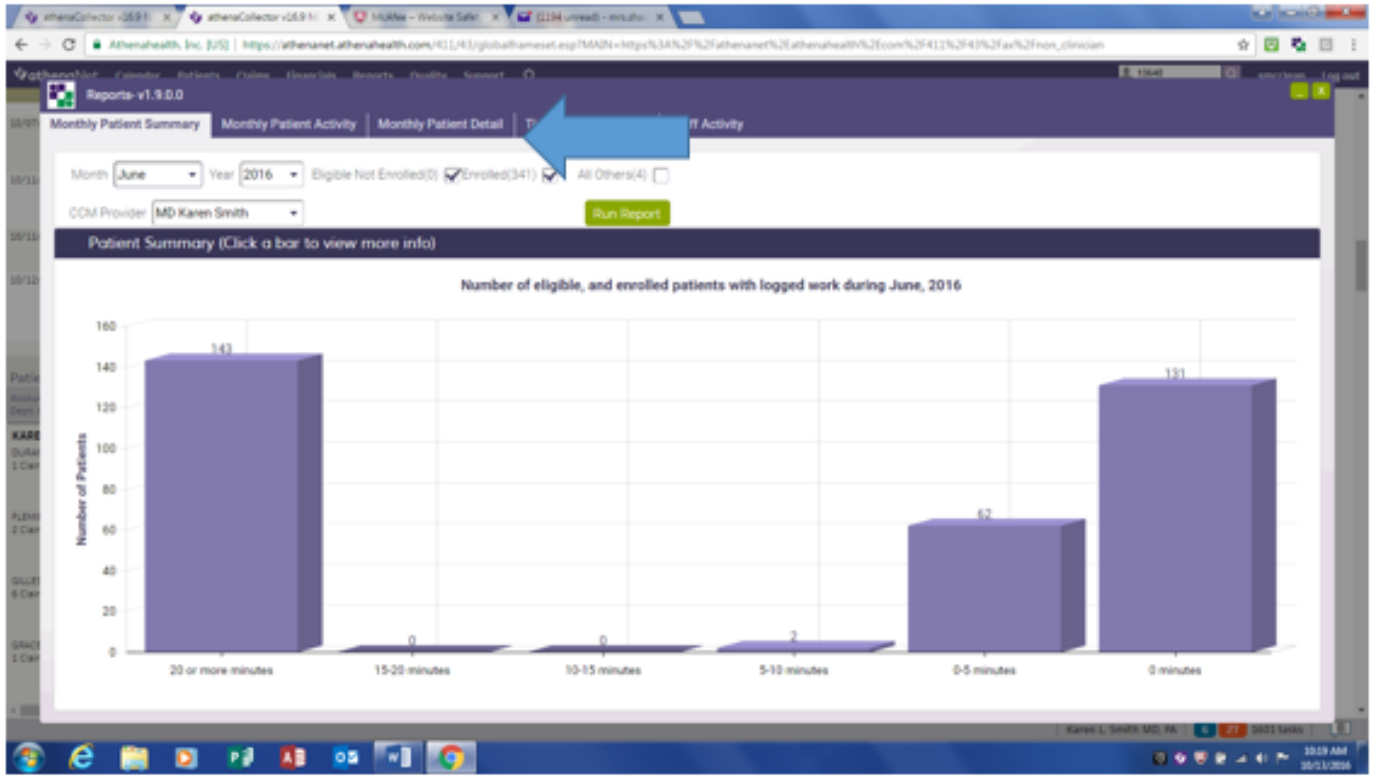
The purpose of this policy is to assist the practices Medicare eligible patients who have two or more chronic conditions in preventing hospital readmissions, repeat urgent care visits and unnecessary emergency room visits. This is provided by non-face-to-face monitoring of the patient's chronic conditions and goals to promote the patients and/or families understanding of their medications, chronic diseases, management of those diseases and use of durable medical equipment. This policy and procedure utilizes the current workflow to communicate with the patient in developing the plan of care allowing for optimal desired outcomes for identified disorders, tracking and providing preventive care services and to provide cost effective healthcare services with maximal utilization of outpatient resources.

CHRONIC CARE MANAGEMENT POLICY PROCEDURE

- The Patient Service Representative (PSR) determines patient eligibility then provides and explains Chronic Care Agreement.
- The system has pre-determined structure and a required data field on the initial registration page for Medicare eligible patients to note whether a patient is enrolled, not enrolled or enrolled elsewhere for the chronic "Elite" care management.
- The PSR provides the chronic care agreement for signature and a care plan to engage the patient in their care by asking them to notate two to three chronic conditions they wish to monitor or improve for the year and the remainder of their life.
- During the intake process the clinical team completes and reviews the chronic care plan with the patient.
- The provider then reviews the care plan assisting the patient with goals to be monitored by the clinical team. Patient-centered brainstorming occurs with the provider to incorporate healthy living practices in the patient's daily routine.
- Patients are highly encouraged to create a Personal Health Record profile. An email address is requested which will allow for transmission of lab data, office visit summaries, medication refill requests, billing inquires and non-urgent messages to the provider. Accessing the secure patient ports also provides a method for the elderly to engage their families in their care goals. In addition, the office is prepared for Health Information Exchange access from all participating health care entities.
- Each time the patients chart is accessed, outside of a regular face to face visit, the Electronic Health recorded chronic care timer is initiated for calculating the time spent managing the patients chronic care. This includes reviewing with the patient via telephone or other any referrals, medication concerns or questions, and/or support and consultation of their condition. If the required 20 minutes of chronic care management time is met within a month, then the service is billed.

Chronic Care Management Tool

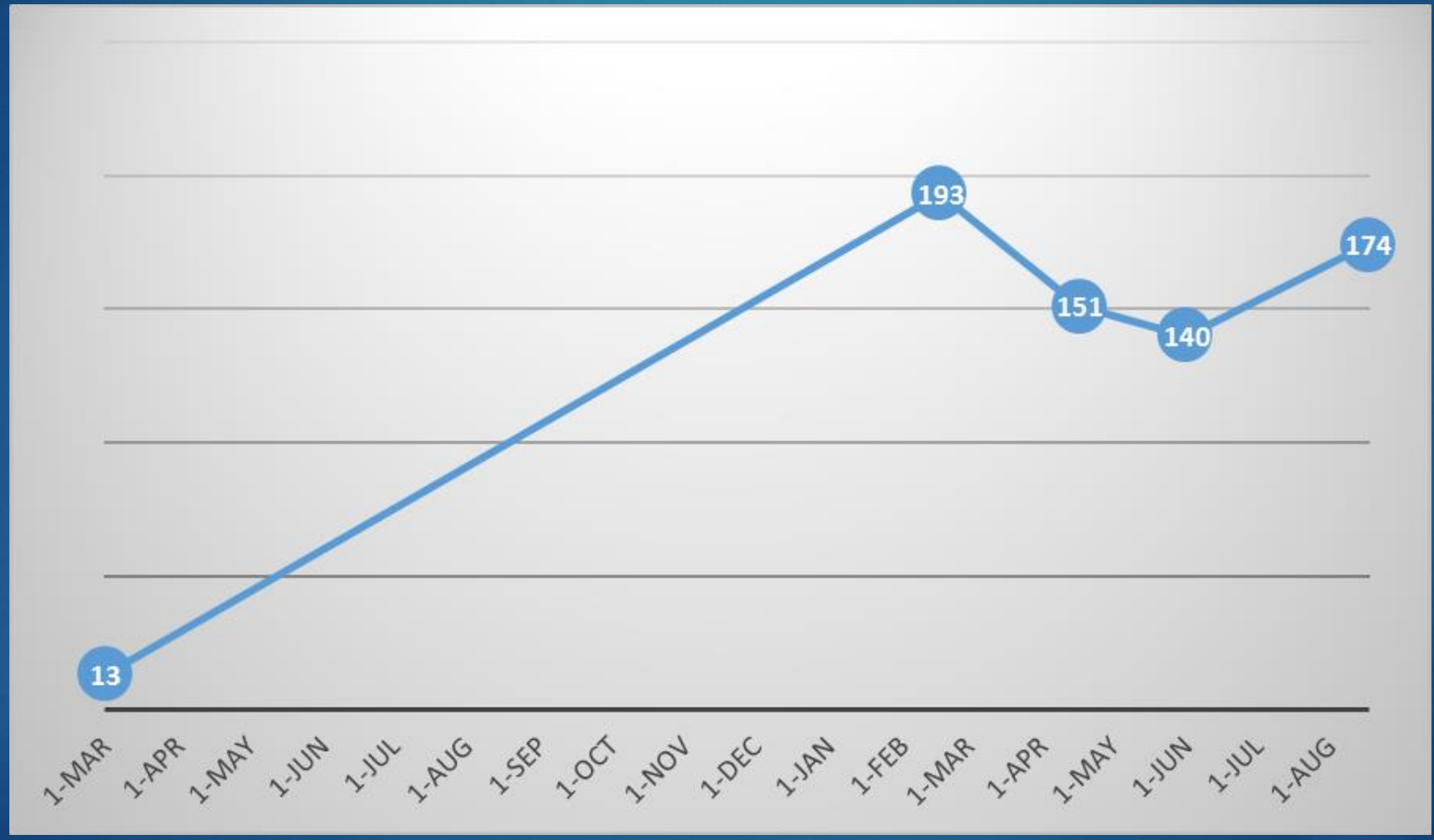
JUNE 2016



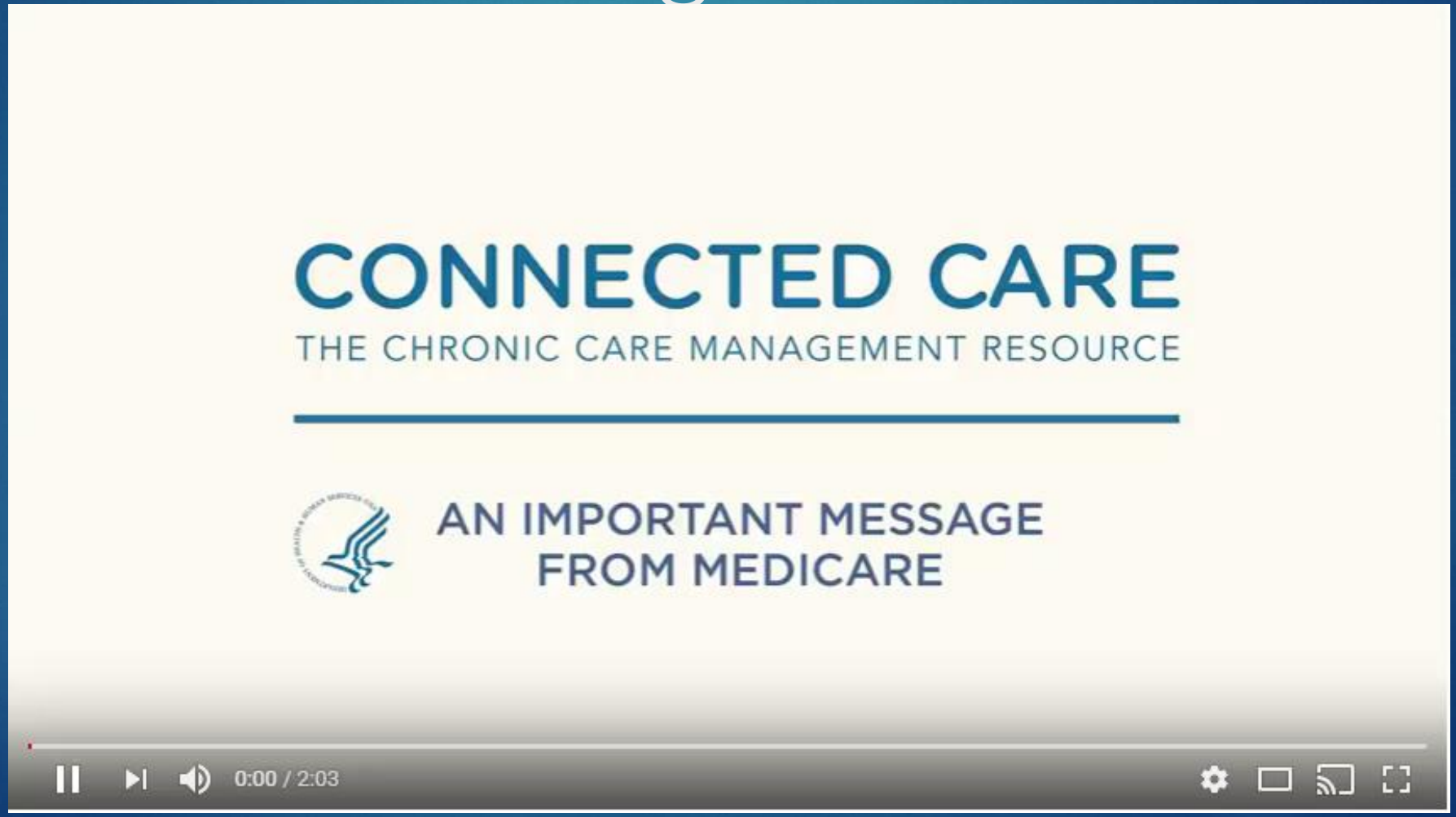
CHRONIC CARE MANAGEMENT POLICY QUALITY MEASURES

- The Elite Care Coordinator performs monthly assessments to ensure patients goals are on track for the month.
- The practice manager performs quarterly assessments to ensure the office standard for this task is 80% performance proficiency. Opportunity for modification is reviewed in accordance to the PDSA model with management and the full staff at appropriate meetings and also upon clinical intake with the patient at each encounter.

Results of Performance



Connected Care: Physician Testimonial about Chronic Care Management



CCM Recognized Barriers and Challenges Addressed

- Documentation Requirements and Time monitoring for each incident of care
- Patient consent for services performed and ABN
- Completion of Care plans with HCC for each patient
- Co-payment requirement and denial of service under Medicaid
- Medical Necessity requirement for private insurance
- Monthly tracking and outreach phone calls to qualified patients
- Patient acceptance of phone call and sharing information via phone

Ongoing Initiatives

- Expanded additional Quality measures into workflow such as Audit and PHQ-9 screening
- Initiated Physician and Clinician Analytical Education and Skills via activities such as Performance Navigator
- Improved Staff Education and Clinical Skills knowledge
- Collaboration with Academic departments for Primary Care Research initiatives
- Collaboration with CMS QIO for continuous quality improvement opportunities

Future Modifications from Lessons Learned

- Establish framework to modify MIPS performance
- Technological efficiencies anticipated
- Advocate for alternative payment model for optimal patient participation
- Address all People/patient care SoDH factors
- Repeat Workflow Modifications and Small steps of Change
- Leadership Change Management

Unexpected Outcome

- Exceeded ACO Benchmark Performance
- Peer to Peer Review with Sharing of Best Practice
- Recognized need for Population Health Administrator
- Improved Patient Engagement with patient acceptance of “High Touch” initiative
- Improved Website and patient portal activities

Thank You !

ANY QUESTIONS?

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"THE POWER OF TOUCH"

"PHYSICAL, EMOTIONAL, SPIRITUAL"

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References

Smeldy, B. D., Stith, A. Y., & Nelson, A. R. (2003). Institute of Medicine (US) Committee on understanding and eliminating racial and ethnic disparities in health Care. *National Academies Press*.