How social determinants can help manage costs and improve patient outcomes

The Dbriefs Health Science series

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Agenda

• Setting the stage: Policy and market triggers
• Trends: Integration of community care
• Moving forward: Challenges and opportunities
Setting the stage: Policy and market triggers
Social determinants of health (SDoH)

Social determinants of health are the economic and social conditions that impact health.¹ They include the environment in which people are born, grow, live, work and age, and are shaped by wealth distribution, power and resources at global, national and local levels.² They generally refer to health determinants outside of health care and an individual’s control.³,⁴

This means addressing:

- Housing instability/Homelessness
- Food insecurity (Hunger and nutrition)
- Transportation
- Education
- Utility needs
-Interpersonal violence
- Family and social supports
- Employment and Income

Environmental and social factors greatly impact patient health. But they are often not addressed or prioritized by the health care system.

20 percent of health outcomes are determined by clinical care, yet this accounts for 88 percent of health care investment. 80 percent of health outcomes are determined by environmental and social factors, yet few players understand these factors or are able to integrate relevant services into their treatment protocols.

Sources: Health Aff (Millwood). 2010 Sep

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The US population is relatively unhealthy

Obesity rates among US adults have increased from 30.9 percent in 2000 to reach 35.3 percent in 2012. This is the highest rate among OECD countries.

Complex patients with two or more chronic illnesses are primary drivers of health care costs. According to estimates, the top five percent of patients in complexity account for over 50 percent of costs.

$245 billion
29.1 million US residents have diabetes and comprise $245 billion in direct and indirect costs.

About 610,000
Americans die from heart disease every year. It is the leading cause of death for most racial/ethnic groups in the United States.

About 595,690
Americans are expected to die of cancer in 2016.

Health system targets the treatment of problems, not the people. Funding structures and processes may contribute to a divide between the different sectors that affect health.

- The “Wrong Pocket” problem may discourage cross-sector collaboration.
- Integrated, multi-sector approaches to health can be impacted by a trust deficit and different interests.
- Operational challenges, including siloed funding, data sharing, and project management, may inhibit an integrated, person-centric approach to health.
- There is no sustainable integrated funding infrastructure.
- Institutional responses to these challenges are emerging in communities around the United States.
- Fostering a new model for integrated funding can benefit community health.

Source: Deloitte research on local health improvement funding institutions

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Polling question #1

In your opinion, who should play a primary role in addressing social needs (defined as nonmedical needs that could affect health, but may not be routinely addressed as part of clinical care, such as an individual’s housing stability, access to nutritious foods, access to transportation to get to medical appointments, etc.)?

- Health care providers
- Health plan
- Federal government
- State government / local government
- Community organizations
- Other / no opinion
Regulations are shifting the way providers are reimbursed
Providers are increasingly interested in managing costs and improving health outcomes; MACRA furthers these goals

80 percent of revenue still comes from FFS
75 percent of providers participate in one or more value-based payment models
CMS to tie 90 percent of FFS payments to quality or value by the end of 2018

Fee-for-service still the majority of revenue
Value-based care is growing
Government is pushing toward value

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Trends:
Integration of community care
Accountable Health Communities Model
First-ever CMS innovation model to focus on the social determinants of health

**Accountable Health Communities Model.** Funded by the Centers for Medicare and Medicaid Services (CMS) this five-year program will plans to look at the health-related social needs of and Medicaid beneficiaries. CMS is providing funding to help align between clinical and community-based services at the local level. The goal is to increase Medicaid and Medicare beneficiaries' awareness of community-based services, making it more likely they will access community services to receive assistance in times of need or crisis.¹

**California Accountable Communities for Health Initiative:** In 2016, California launched a series of pilots called Accountable Communities for Health. In California, they have a multi-payer, multi-sector alliance between health care systems, providers, and health plans, and public health, key community and social service organizations, schools, and other partners. ACHs are working to improve health of an entire community.²

Bridge organizations can develop and maintain relationships Particularly with state Medicaid agencies, clinical delivery sites, community service providers and other community partners

Funding of bridge organizations supports the screening of beneficiaries for unmet health-related social needs and the provision of referral information to beneficiaries if needs are identified

<table>
<thead>
<tr>
<th>Track 1</th>
<th><strong>Awareness</strong></th>
<th>Increase beneficiary awareness of available community services through information dissemination and referral</th>
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<tbody>
<tr>
<td>Track 2</td>
<td><strong>Assistance</strong></td>
<td>Provide community service navigation services to assist high-risk beneficiaries with accessing services</td>
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<tr>
<td>Track 3</td>
<td><strong>Alignment</strong></td>
<td>Encourage partner alignment to ensure that community services are available and responsive to the needs of beneficiaries</td>
</tr>
</tbody>
</table>
Polling question #2

To what degree are your organization’s mission, vision, and values aligned with addressing the social needs of the population it serves?

• Completely aligned
• Somewhat aligned
• Not aligned
• Other / no opinion
Many states and communities are also trying new delivery models. States are using waivers and joint community efforts to integrate physical, behavioral, and social welfare programs.

Opportunities for savings
Pilot projects and community efforts demonstrate potential for savings by targeting the social determinants of health

1. **Federally Qualified Health Center in Denver increased primary and specialty care**
   Researchers found that community health worker (CHW) outreach increased primary and specialty care visits, urgent care, inpatient, and outpatient behavioral health care utilization decreased, resulting in a return on investment of $2.28 per every $1.00 spent.

2. **CHW asthma management with Medicaid covered children in Chicago**
   Researchers found that three to four CHW home visits over 6 months with a liaison or case could improve asthma control among disadvantaged children. Specifically, reducing symptoms lead to an ROI of $5.58 per every $1.00 spent.

3. **Housing and health**
   Relocating residents from traditional public housing to more health-promoting designs has reduced fear and anxiety. Children in relocated families had fewer reported behavior problems.

4. **Duals/those on long-term care services & supports (LTSS) have many social needs**
   LTSS are the fastest growing piece of Medicaid Budget and a national effort to better integrate care is occurring – 26 states have implemented or are negotiating with CMS to implement managed long-term care programs.

5. **Tackling social determinants can reduce readmissions and improve outcomes**
   In Pennsylvania, the Lehigh Valley Network has social workers in the ER to identify people who come at least five times in four months. The social workers help them develop a plan for medical appointments – from transportation to childcare. In the first four months, visits by some dropped by 68 percent, and costs to care for them fell from $1.5 million to $440,000.

Peer-based coaching: Reaching the hard to reach
A study found the greatest improvements for those with low initial medication adherence

Clinical Setting: Six safety-net primary care clinics serving patients covered by Medicare/MediCal or San Francisco’s coverage for uninsured residents

Majority of patients were non-white, ethnically and culturally diversity

Contact: Avg. of 7.02 interactions with coach, including 5.37 telephone calls

Found greater benefits of peer support among individuals characterized by disadvantage, such as low health literacy

Changes in Hemoglobin A1c at 6 Months (p=0.01)

Moving forward:
Challenges and opportunities
Polling question #3

In your opinion, what is the biggest challenge of addressing social determinants of health?

• Limited funding or financial incentives
• Disjointed health and social service agencies
• Lack of understanding and data on what communities and people need
• Other / no opinion
How might you optimize investment on social determinants? Challenges to measure and invest in the social determinants of health

Lack of evaluation – programs chosen based on anecdotal evidence or unproven ideas

Skewed priorities – focus on volume of outputs and compliance rather than outcomes

Limited capital – government budgets are tight with a short timeframe

How might you tie payments to measurable outcomes, Given the constraints in public spending?
How could pay for success financing help direct spending and improve health outcomes?

Pay for Success (PFS) financing models are cross-sector partnerships in which private investors pay upfront for a social service and then government, private health care, or other payers repay the investment if and only if agreed-upon outcomes are met.
Polling question #4

Which of the following factors do you think would encourage health care organizations to initiate or increase their investments in social needs?

• Information on the business case (e.g. return on investment) of social needs related activities
• Support (monetary or staff) from community partners
• Support (monetary or staff) from private or government sources
• Value-based models or initiatives (such bundled payments, pay for performance etc.)
• Other / no opinion
But questions remain

Forthcoming Deloitte Center for Health Solutions research on social determinants of health

**Some of the biggest challenges**

- Sustainable funding to address social determinants
- Showing the ROI: identifying meaningful measures and having patience across the organization for long term results
- Identifying data sources: finding ways to use nontraditional data (outside of EHRs, claims, etc.) and segmenting populations in different ways

**Some lessons to consider**

- Focus less on supply side solutions: learning to listen to communities and patients that you are trying to impact
- Find trusted people in the community: forming advisory committees with multiple stakeholders, broadening reach through relationships with beauty salons and barbers, churches, homeless shelters

**Looking ahead...with optimism**

- For many health systems, addressing SDoH is “right thing to do”
- Pilot data is impressive on a wide variety of programs
- SDoH alignment with value-based care will likely continue to spur partnerships and innovative solutions
Considerations moving forward

Life sciences

Government

Health plans

Consumers

Health care providers

Technology companies
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