Welcome! The Program will begin at 8:00 a.m.

Social Determinants: At the Nexus of IPE and the Clinical Learning Environment
Nexus Summit 2019 Host

NATIONAL CENTER for INTERPROFESSIONAL PRACTICE and EDUCATION

Nexus Summit 2019 Co-Hosts

American Interprofessional Health Collaborative

NCICLE NATIONAL COLLABORATIVE FOR IMPROVING THE CLINICAL LEARNING ENVIRONMENT
Social Determinants:
At the Nexus of IPE and the Clinical Learning Environment

Sheila Shapiro  
Senior Vice President of National Strategic Partnerships  
UnitedHealthcare

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National Center for Complex Health and Social Needs

Maria Velasquez  
Senior Program Manager  
National Center for Complex Health and Social Needs

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Associate Professor of Health Systems and Community Based Care  
University of Utah
Strategic Community Partnerships

2019 Nexus Summit

Sheila Shapiro,
Senior Vice President
National Strategic Partnerships
Our commitment to Social Determinants Of Health
Our Hypothesis

By building an infrastructure around social determinants of health, we can...

- Redefine health to consider the whole person – not just medical care
- Remove barriers that limit access to care and address health disparities
- Improve overall health and well being of all vulnerable populations
80% of health and wellbeing is tied to social and economic factors, physical environment and health behaviors

20% of health outcomes can be directly attributed to clinical care

91% of Medicaid plans report activities to address social determinants of health

85% of physicians report that unmet social needs lead to poorer health outcomes

20% of physicians are confident in their ability to address unmet social needs

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1 Robert Wood Johnson Foundation, County Health Rankings, “Relationships between Determinant Factors and Health Outcomes”
2 Kaiser Family Foundation, “Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity”
Data, Technology + Relationships to address Social Determinants

2.5M
UnitedHealthcare beneficiaries self-identified at least one SDoH

758K+ referrals provided to over 600K individuals

$827M+
Imputed Market Price™ value provided to members

National Strategic Partnerships (NSP) July 2019. Proprietary and confidential. Not to be used without express consent from NSP.
Recognized for incorporating social determinants into clinician workflow to improve care management and enhance health
UnitedHealthcare’s SDoH Infrastructure: How it Works

Turning disparate data into actionable information to support our members’ social determinates of health.

**Various Data Sources**
- Clinical Systems
- House Calls
- HSA
- Claim Data
- Member Navigators
- Self-reported Data

**NEW! IDC-10 Diagnosis Code Set Categories**
- Counseling
- Economic Stability
- Education
- Employment
- Health/Health Care
- Personal Care
- Respite Care
- Social/Community

**Data Standardization**

**API**

**UHC Customer Advocates**
- MAR Advocate
- C&S Advocate

**Member**
- Network Provider Profile

**Clinician**
- Clinical Profile

**Transportation Vendors**

**Social Referral Sources**

**Network Provider Profile**

**Physician**

**New! Imputed Market Price (IMPTM)**

**Reporting, Analysis and Clinical Outcomes:**
- Identification data
- Referral data
- Fulfillment data

**Clinical Value to Member**

**Clinical Profile**

**Member**
- Advocate
- C&S Advocate

**Clinician**
- Advocate

**API**

**Physician**
ICD-10 Code Expansion to Address Social Determinants

Our proposal to add 23 new codes to the ICD-10-CM code set.

Strong Support from Industry Partners

ICD-10 Committee Timeline

April/May 2019: Two-month comment period
TBD 2019: Committee decision, next steps
April 2020: If approved, new codes available for adoption and use
What Clinicians Can Do

February 18, 2018

ICD-10-CM Cooperating Parties approved and the American Hospital Association (AHA) Coding Clinic published advice that allows the reporting of codes from categories Z55-Z65, based on information documented by all clinicians* involved in the care of the patient.

- Support the use of self-reported data. (AHA Coding Clinic will be recommending use to the ICD-10 Committee in August 2019)
- Document known social determinants of health (SDoH)
- Communicate this change to your organizations and billing staff

* Clinicians” has been loosely defined according to the AHA. 2018 American Hospital Association | April 2018 www.aha.org
National Strategic Partnerships (NSP) July 2019. Proprietary and confidential. Not to be used without express consent from NSP.
What We All Can Do – Together

Sheila Shapiro, SVP
National Strategic Partnerships
Sheila_Shapiro@uhc.com
Launched in 2016 by the Camden Coalition. Founding sponsors: RWJF, AARP, and Atlantic Philanthropies.

- **INSPIRE** people to join the complex care community
- **CONNECT** complex care community with each other
- **SUPPORT** the field with tools and resources

Maria Velasquez: maria.velasquez@camdenhealth.org

Lauran Hardin: lhardin@camdenhealth.org
Camden Coalition’s National Center partners with dozens of institutions across the country, co-creating interventions addressing SDOH tailored to unique population and institutional context.

**Types of Projects:**
- Model Co-Design
- COACH model implementation
- Care Coordination re-design and training
- Community Collaboratives
- Addiction Treatment and Behavioral Health

**Types of Partners:**
- Health Systems
- FQHCs & CMH
- Communities
- Payers
- Government
- National Associations
One example of an Interprofessional Team caring for multi-system high utilizing community members.

**Adventist Health**
- Based in Lake County, CA
- County has the poorest health outcomes in CA – addiction, fires, access issues

**Project Restoration**
- County-wide cross-sector collaborative (Police, Fire, EMS, Criminal Justice, Mayor, Health, Social Services, Education)
- Shared data
- Process improvements to change root cause
A continuum of interprofessional care to address complexity.

### CONTINUUM OF SERVICES

**Live Well**
- A multidisciplinary, holistic clinic approach to serve at-risk patients with increasing complexity.

**Live Well Intensive**
- Intensive Out Patient Case Management
- Top 5% capitated utilizers

**Project Restoration**
- Cross Continuum approach to community-wide high utilizers of multiple agencies and services.

**Restoration House**
- Medical respite focused on four primary goals: reducing inpatient length of stay, preventing readmission, preventing ED utilization, and enrollment into Project Restoration.
The team worked with **28** patients over the first **12** months and saw reduced utilization and strengthened community partnerships.

<table>
<thead>
<tr>
<th>Utilization</th>
<th>Cost Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Reduction (ED &amp; IP)</td>
<td>44%</td>
</tr>
<tr>
<td>Community Services (Police, EMS, Jail)</td>
<td>83%</td>
</tr>
</tbody>
</table>

**Patient Experience**

- Access To Care and Safety
- Primary Care Visits 133%
- Housing 93%
Given its success, Adventist Health is in the process of scaling Project Restoration nationally.

- Community Integration Institute
- 80 Communities across California, Oregon, Washington and Hawaii
- Plan scale to all markets for the next 4 years
- Funded by a percentage of Community Benefit
- Plan for Learning and Training center for communities outside of Adventist
Three Principles of Student Hotspotting:

1. Students will learn by doing
2. Patients experiencing high utilization are our greatest teachers
3. Deep medical expertise exists within health systems and is not our program focus
Student Hotspotting Intervention

- Identify patients
- Establish relationships
- Create care plan
- Support and navigate care plan
- Present patient story

Student Hotspotting Hubs

- SMU
  Oakland, CA
- UofU
  Salt Lake City, UT
- SIU
  Springfield, IL
- TJU
  Philadelphia, PA
Save the Date: *Putting Care at the Center 2019*

November 13 – 15, 2019 | Memphis, Tennessee

www.centering.care

This year’s conference will be co-hosted with Regional One Health
Addressing Social Determinants of Health through Community-based Interprofessional Education

Sara Hart, PhD, RN
A Compelling Vision is Critical.**

1. Build relationships between interprofessional education and community practice, including non-health sectors

2. Address social determinants of health and advance health equity

3. Develop students’ IPEC core competencies with an orientation to community and population health

Care Redesign Requires Culture Change.**

Shift in Health Care → VALUE

↑ SDOH Curricular Emphasis

Community-based IPE

Non-Health Sectors

IPEC Competencies for Systems-based Practice

Student Value-Added

IPE Resourcing is Key.**

**Community Partnerships**
- YR1. Local Housing Authority
- YR2. Community Clinics
- YR2. Outpatient Care Management
- YR3. Health Plans
- YR3. Intensive Outpatient Clinic

**Academic Programs**
- Dentistry
- Medicine*
- Nursing (BSN & DNP)*
- Nutrition
- Occupational Therapy*
- Pharmacy*
- Physical Therapy
- Physician Assistant
- Public Health
- Social Work*
- Geography
- Health Society and Policy
- Kinesiology
- Marketing
- Business

*curricular integration

Senior **Leadership** is Essential.**

**Learning Outcomes**
- INTERPROFESSIONAL ATTITUDES SURVEY
- HOTSPOTTING KSAs
- LOGBOOK ANALYSIS

**Health Outcomes**
- RAND SF-36
- HEALTH CARE NAVIGATION
- GUIDED INTERVIEWS

**Systems Outcomes**
- HEALTHCARE UTILIZATION
- HEALTHCARE COSTS

**Senior Leadership is Essential.**

**IPE Program Director Champion**

**Administrative Resources**

**National Funding/National Recognition**

**Build Buy-in Across Academic and Health Systems**

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