
2023 VIZIENT CONNECTIONS SUMMIT
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SEPT. 18–21, 2023
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Successful Systemwide Implementation of a Social Determinants of Health Program

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Taking What You Have to Produce What You Need: Hospitals and HBCUs

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AtlantiCare

Acute Care at Home: Can We Keep Up the Pace?

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Alissa Tran, PharmD, BCCCP, Director Acute Care at Home
Parkland Health, Dallas, Texas

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Learning Objectives

- Describe the importance of systemwide social determinants of health (SDoH) screening.
- Discuss successful strategies to diversify your workforce through community partnerships.
- Identify disparities in accessing acute care at home services between institutions with different payer mixes.

Successful Systemwide Implementation of a Social Determinants of Health Program

Teresa Pollack, MS, CPHQ, *Director, Quality Operations, Northwestern Medicine, Chicago, IL.*

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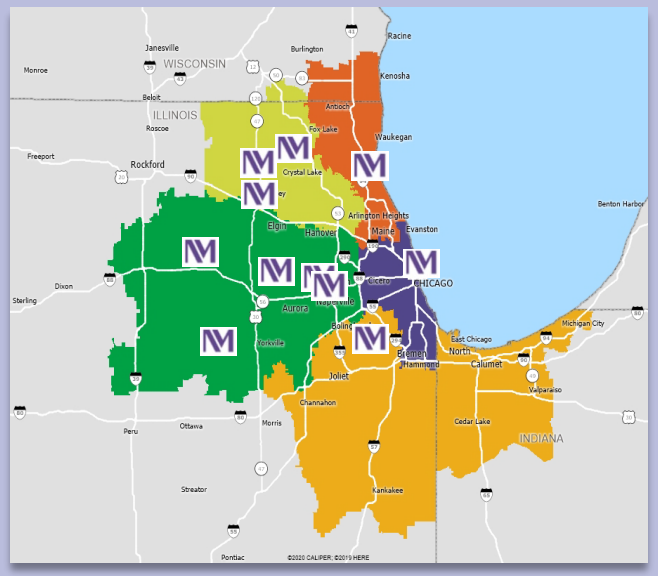
Northwestern Medicine Cares for a Diverse Patient Population

The Academic Health system spans the Chicago area in over 12 counties and 383 zip codes in small towns, suburban and urban communities.



Northwestern Memorial Hospital
US News Honor Roll Hospital

11 NM Hospitals

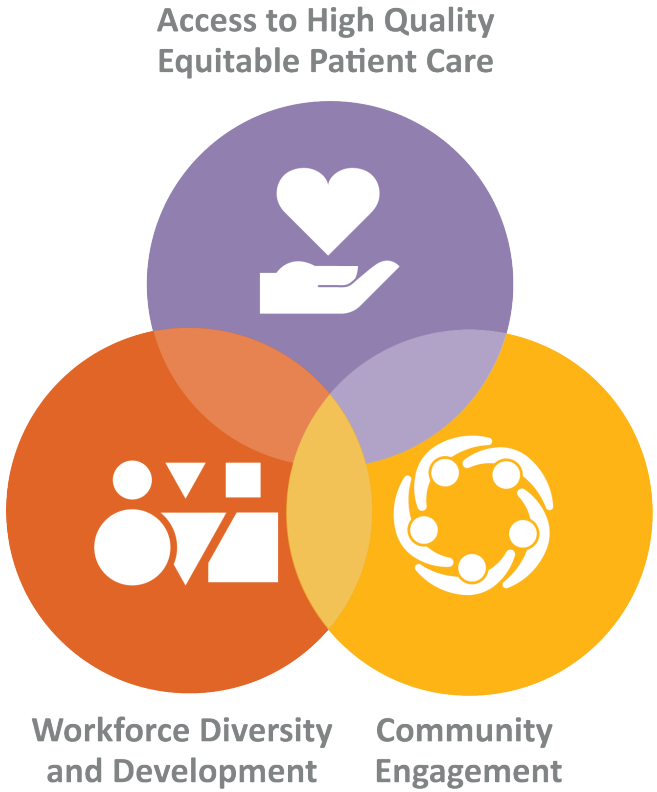
1 Comprehensive AMC
1 Large, Specialized Complex Care
4 Complex Care
3 Community
2 Inpatient Rehab

Outpatient Locations	More than 200
Physicians	5,500
Inpatient Admissions	104,000
Outpatient Registrations	2.2 million

Approach to Equity is Built on Fundamentals

Equity Aim:

Everyone has the opportunity to achieve their potential health and career advancement free of bias and racism, and regardless of the origination of their journey.

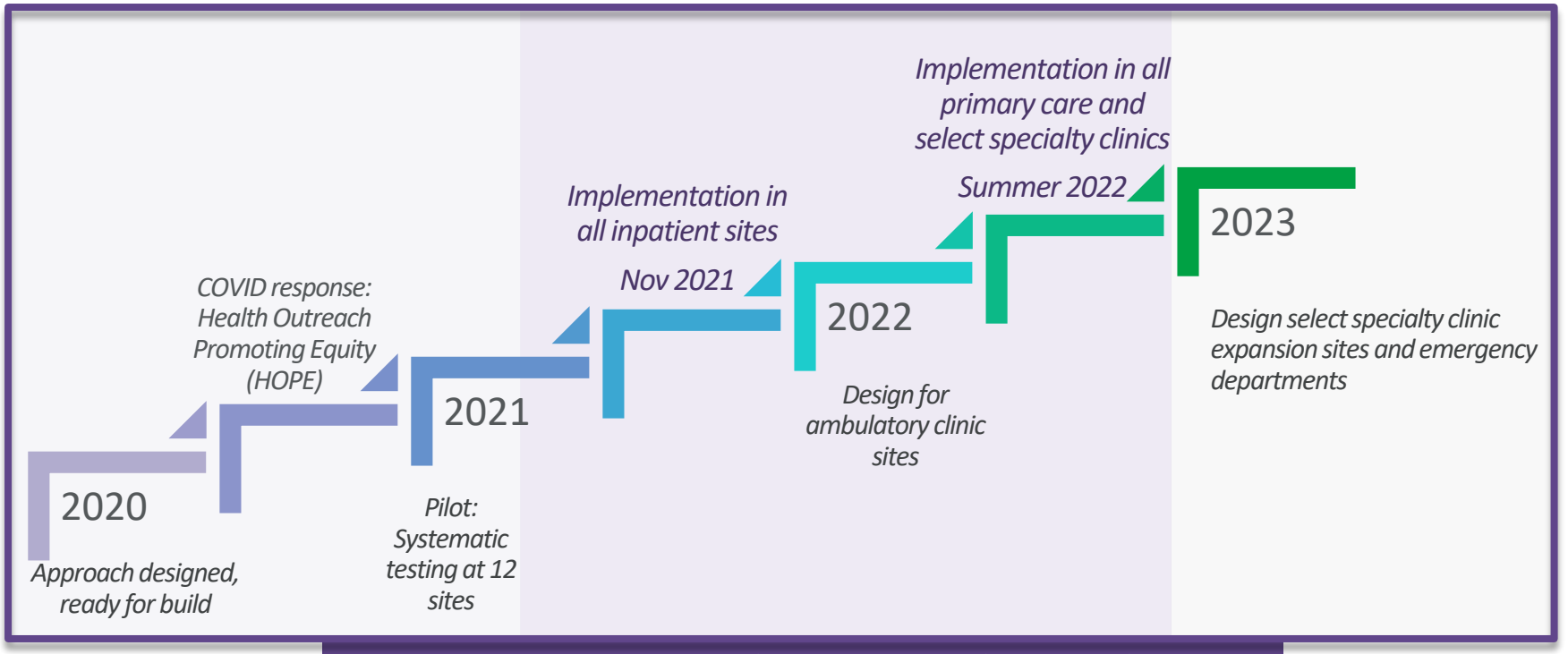


Quality Equity Goal:

*Optimize equitable care for patients**, measurably and sustainably reducing disparities** in structures, processes and outcomes of care, enabling us to advance our Patients First mission and deliver clinical excellence and safe care across the integrated, academic health system.*

Clinical Excellence: Development of the Social Determinants Program

5.6% of patients screened have a concern and request assistance



Patients Screened	Reported Concerns	Patients with Reported Concerns and Requesting Assistance
479,800	13.0%	43.3%

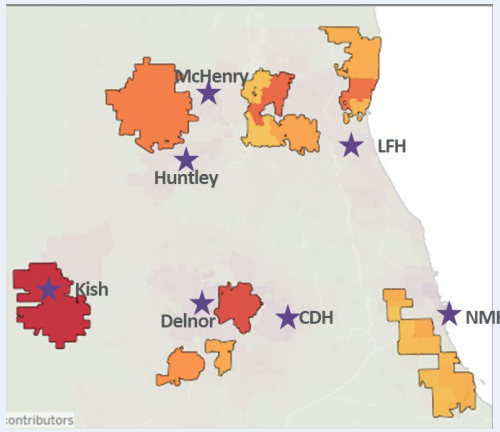
Source: Internal Northwestern Medicine data

Health Outreach Promoting Equity (HOPE): 2020

Proactive engagement with most vulnerable patients- Summer Pilot

Identified Patients for Outreach

High hardship, high COVID-19 communities



Analytics model to identify risk of each patient

Outreach to 18,000+ Patients

80+ interns, medical students, and staff made calls

Methods:

Phone Called **3,116 patients**

Text message to **15,435 patients**

Paper mail to **6,300 patients**

Connect Patients with Needed Resources

39% of patients identified at least 1 need during call

100+ referrals to social work:

- Transportation
- Social Isolation
- Help paying for medication
- Food insecurity
- Housing insecurity

150+ medication refills needed

200+ requests for PCP appointments

Social Determinants: Screening and Response

Program Vision

Overall aims:

- ✓**Screen all patients** for a concise set of Social Determinants which interfere with health and which we can help to mitigate
- ✓**Act on identified needs** through referrals and intervention

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- **Short Term** improve equity and outcomes by removing barriers
- **Medium Term** redesign care systems
- **Long Term** improve community health

Rigorous Testing Phase

- Comprehensive Pilot: 2021
  - 12 sites across health system
  - 16 weeks
  - 12,000 patients
- Workflow
  - ✓Methods
  - ✓People
  - ✓Assistance Provided
- ***Outcome*: Domains:**
  - **Medical Home**
  - **Medication Affordability**
  - **Transportation to medical appointments**
  - **Food Insecurity**
  - **Housing Instability**
  - **Mental Health**

Implementation Plan

- Universal System-wide Roll-Out
  - Inpatient Nov 2021
  - Primary care/OB spring/summer 2022
  - Specialty care pilot 2023
- First of its kind at this scale
- Revised domains/language
- Engaging operations, quality

- Measurement and Evaluation
  - Screening Process efficiency/ effectiveness
  - Patient and Staff Feedback
  - Resource referral process and efficacy
  - Patient Outcomes: Ongoing

Implementation Success, Methods and Tools

Creative Tools:

- ❑ User Design sessions with EHR developers
- ❑ Interactive workshops
- ❑ Modifying tip sheets for hospital or clinic huddles
- ❑ Integrated Learning Management System

Regional Implementation Teams:

Train the Trainer Model:

- ✓ Train clinical staff and operational leaders
- ✓ Use training materials and resource in intranet
- ✓ Lead discussions, make observations and escalate questions
- ✓ Observations of workflow
- ✓ Huddle with system leadership team

Project Oversight and Governance Structure

High-Level Universal SDOH Process Map

Inpatient

Collected by nurse during admission

Entered into nurse navigator flowsheet

Populated in graphic icons and visible to the care team

Does the patient have a need?
and
Does the patient request assistance?

Resources listed in EHR and care team can curate list further upon review

Inpatient Social Work or Case Manager consults patient and reviews resources before discharge

Automatically, no order needed

Patient answers questions → Integrated EHR Tools → Community Resource on discharge paperwork → Connects patient to NM personnel

Outpatient

Interviewed by staff

Paper/pen at check-in

Pre-visit Questionnaire

Included in flowsheet rows during rooming process

Notify clinician if need identified during visit

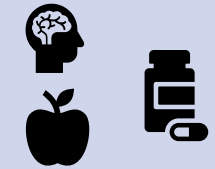
Clinic Staff: Informs patient referral on after visit summary

NM Outreach contacts patient via phone within 2-3 business days for direct follow-up

SDOH Screening and Follow-Up Results

Program launch through June 2023

	Hospitalized Patients Nov 2021	Clinic Patients June 2022
Volume of patients	67,063	440,681
Screened Rate	86.4%	57.0%
SDOH Need	14.6%	9.2%
and Requesting Assistance	42.9%	39.3%
Action Taken • Social Work • Community Resource • CHW Outreach (clinic)	88.9%	97.8%

	Hospitalized Patients	Clinic Patients
Highest Needs Identified		

NM Outreach Programs
Partnering with Community Affairs to disseminate **grocery store vouchers**
Referring to Ambulatory Pharmacy for **medication affordability and access counseling**

Source: Internal Northwestern Medicine data

The Outreach Team Equitably Addresses Short Term Clinical and Social Care

Address SDOH Needs ● Close Gaps In Care ● Impact Outcomes ● Reduce Administrative Burden

Community Health Workers

Social Work

RNs

How It Started

2020-2021
- COVID Emergency Response

2022
- Social Determinants of Health

How It's Going

2023
- Equity operations expansion

The Outreach Team

Role

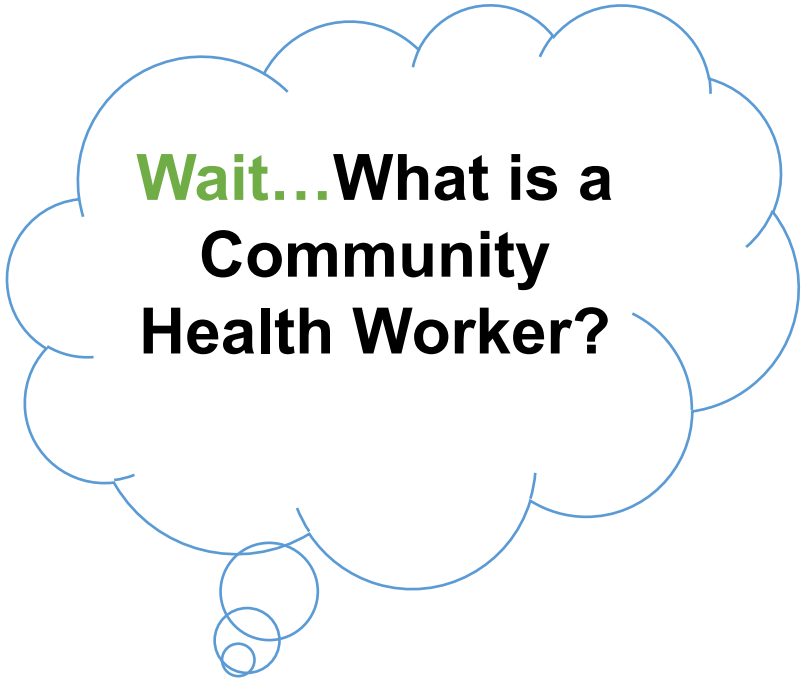
- **Frontline public health worker** who understands the community served

Patient Benefits

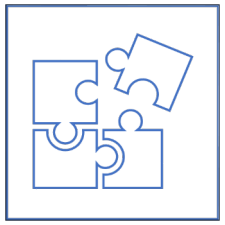
- **CHWs remove barriers to care** by serving as a liaison between health/social services and the community.

System Benefits

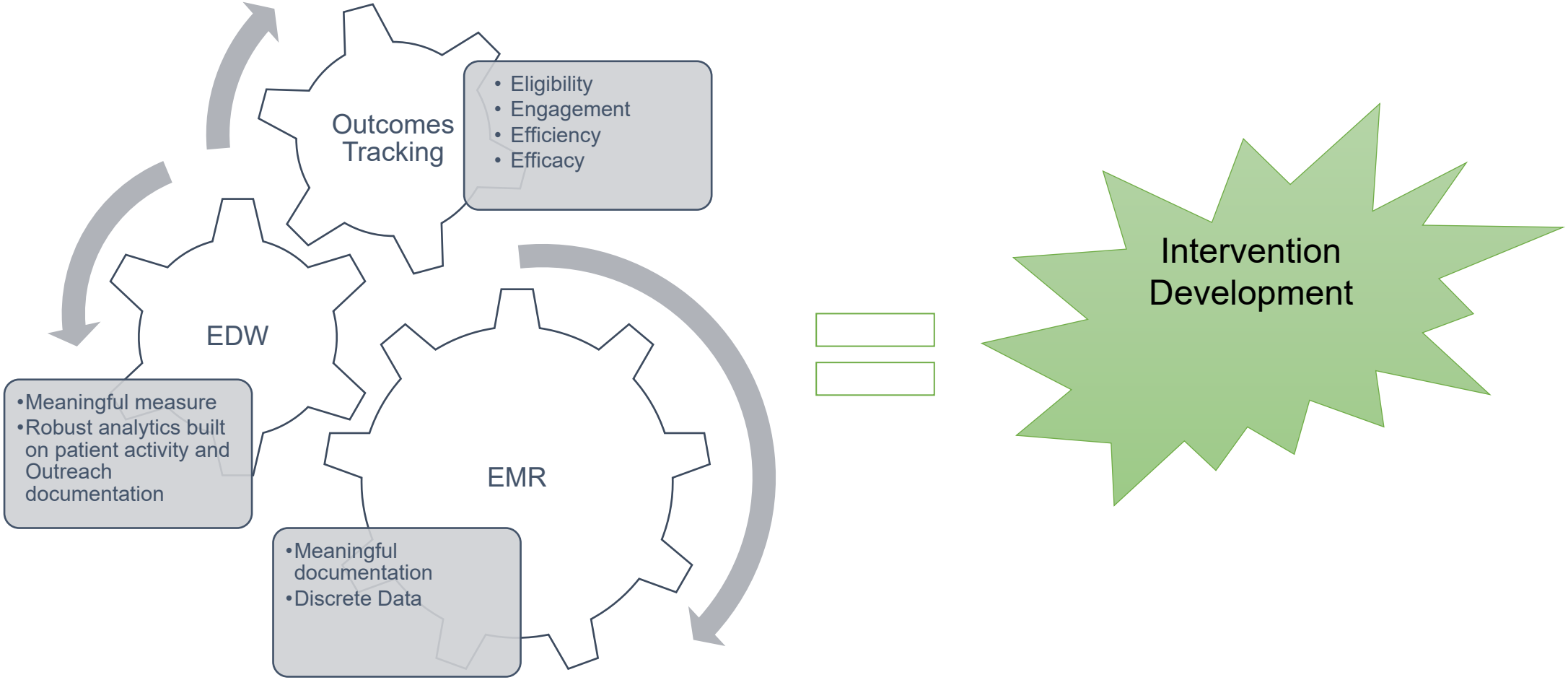
- Improve care quality and cultural competence
- Close gaps in care
- Decrease clinic burden
- Reduce cost of care



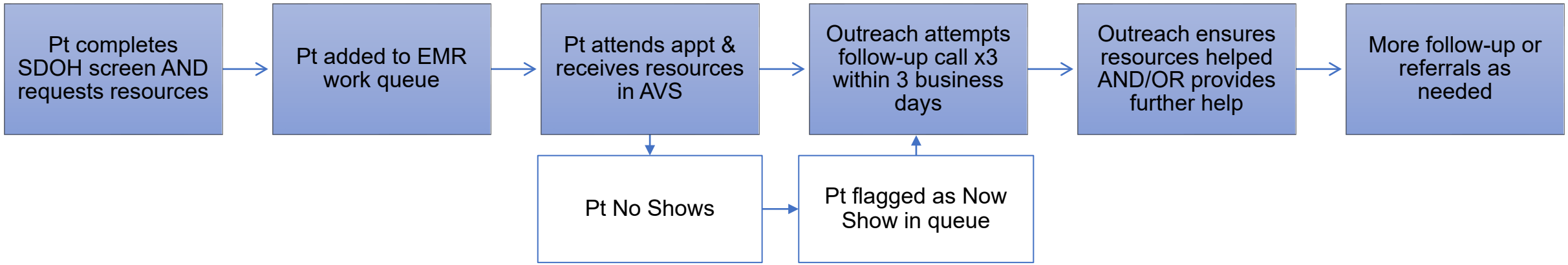
The Outreach Team: How We Support

 Automated Identification	Robust, automatic reporting **reduces need for referrals and increases ability to outreach**
Outreach 	Provide support that **promotes access** to services and **improves the quality** and **cultural competence** of service delivery
 Connection	Provide the **right resources at the right time** with respect, empathy and an understanding of the community served.
Follow-up 	Ensure the resources truly supported the need **and/or removed the barrier**

The Outreach Team: SDOH Follow-up Infrastructure and Improvement Cycle



The Outreach Team: SDOH Follow Up Operations



The Outreach Team: Outcomes

SDOH Follow Up Dec 2022-June 2023	**All Patients**	**Patients Living in Under-Resourced Communities**
Volume of patients	11,034	3,140
Outreach Rate	100%	100%
Engagement Rate	66.3%	67.3%
Intervention Rate	37.5%	42.2%
Escalation Rate	0.7%	0.9%

2,174 Additional Resources Provided

2 Food Emergency Programs Implemented

509 Zip Codes Served

Source: Internal Northwestern Medicine data

The Outreach Team: Intervention Development

Food Insecurity at NM
(based on SDOH screens completed for Primary Care visit Dec 2022-June 2023)

11% (1,942)	Patients identifying food needs
15% (293)	Of patients identifying food needs also report having a food emergency
30% (88)	Of patients identifying a food emergency ask for support

Source: Internal Northwestern Medicine data

Food Insecurity Support

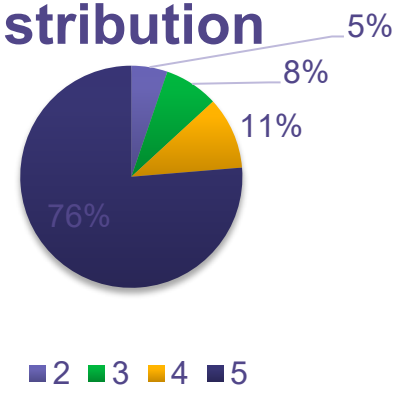
SDOH Completion & Request for Support → NM Outreach Follow Up & Assessment of Need & Family Size → Patient mailed food vouchers OR gift cards to grocery store in the community → NM Outreach follows up to ensure receipt & useability

Outcomes

3 months • 76 Patients • 186 Vouchers

77%	Patients received vouchers via mail with no issue
66%	Patients had no trouble accessing the store
Barriers to use: Transportation, Issue at Store, or Other	
10%	Patients who requested further assistance after receiving the vouchers
49%	Patients contacted for follow up and provided satisfaction rating

Star Rating Distribution



The Outreach Team: Patient Impact

Edwina Stennis-Dixon

Community Health Worker

Employee permission received to share photo and audio recording.

Lessons Learned

Leadership commitment is key with governance and accountability

Regional implementation teams delivered training with their local clinical teams and embedded in operations

Emerging quality pressure focused on equity, utilization and cost

Partner and collaborate with other leaders to streamline resources and clinical interventions

SDOH, Outreach and the Business of Healthcare

Recent extrinsic motivators like rankings, accreditation and regulatory requirements paired with internal organizational priorities of major projects, workforce development and community investment

Relationship Building

SDOH screening alone is not enough to support patient needs. Building trust with patients by following up on their needs is critical to impactful interventions and robust data which can lead to further investment.

Key Takeaways

Timing is everything

Implementation: Design sessions with multidisciplinary team members, socialization, engagement and implementation timeline

Sustainment: Value-Based Care by 2027, mandated risk for shared savings program leads us to an inflection point by 2030 where Medicare advantage surpasses fee for service

Measurement

- Implementation: Measures of success including fidelity of the tool and user feedback and patient engagement, outcome data as it becomes available

- Sustainment: SDOH data will be available for epidemiologic measurement, risk models, and we hope that stratification may eventually be used for benchmarking, particularly in the Vizient Clinical Data Base

Questions?

Northwestern Medicine®

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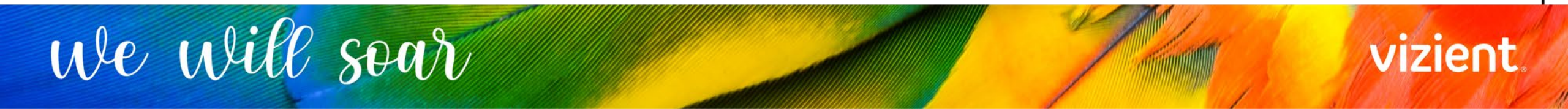

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Taking What You Have to Produce What You Need: Hospitals and HBCUs

Christian Ragland, MPA, *Assistant Vice President of Diversity, Equity & Inclusion*

Desiree May, MSN, RN-BC, *Clinical Director of Med-Surg*

AtlantiCare at a Glance

- Not-for-profit provider of health and wellness services
- Southeastern New Jersey's largest health system and largest non-casino employer
- Dedicated to improving the health of the community
- Over 5,000 team members in nearly 90 locations

AtlantiCare at a Glance

- 621 bed teaching hospital
- Campuses in Atlantic City (278 beds) and Pomona (345 beds)
- 5 time Magnet Designated
- Malcolm Baldrige National Quality Award Winner
- 11 Employee Resource Groups

Marketing Revealed Our Blind Spots

Marketing Revealed Our Blind Spots

Key Facts & Statistics Regarding Our Opportunity

While Black Americans represent 13% of the population, only 7.8% of nurses are Black, according to the Federal Health Resources and Services Administration. This gap is narrower than it used to be, but there continues to be a strong need for more Black nurses.

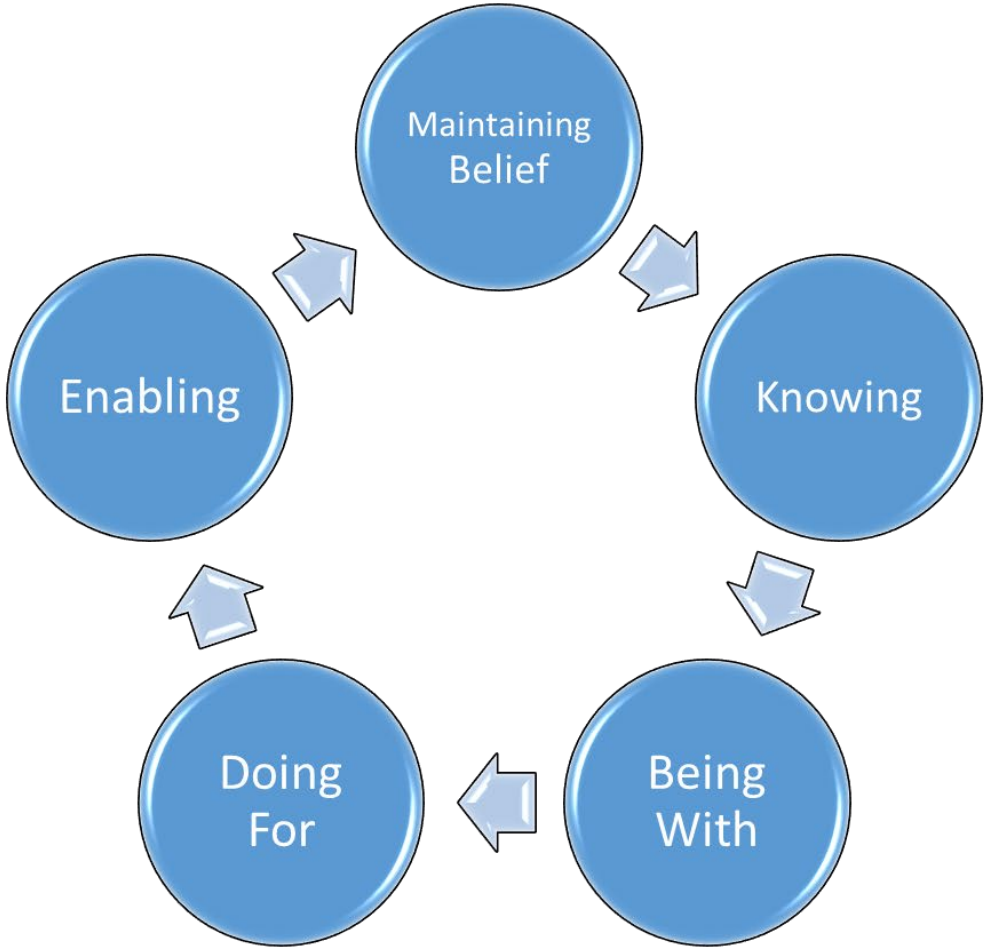
People who have healthcare professionals from the same racial or ethnic background are more likely to report care satisfaction, according to a study.

But there are challenges for Black people who want to become nurses. Factors like cultural alienation and discrimination can prevent Black students from graduating with college degrees.

African-Americans/Blacks are:

- 13 % of US population
- 11% of bachelor-level nursing students (American Association of Colleges of Nursing)
- 9% of academic nurse educators

Using Our Theorist- Swanson



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Cheyney University of Pennsylvania

AtlantiCare & Cheyney University Partnership

AtlantiCare and Cheyney University of Pennsylvania, the nation's first historically black college or university (HBCU), are enhancing their partnership aimed at expanding student learning and career opportunities. They also aim to create a more diversified workforce and to achieve greater health equity in communities across the region and healthcare in general.

- Representing AtlantiCare's first formal agreement with an HBCU, the partnership includes a series of opportunities AtlantiCare is hosting for Cheyney students through August 2023.
- The two organizations made the announcement during National Mentoring Month in a ceremony at AtlantiCare's Medical Arts Pavilion in Atlantic City January on 10.
- Closest HBCU to AtlantiCare
- Utilization of partnership to create pipelines and educational opportunities for our clinical provider shortages (Nursing, Respiratory, Laboratory, Social Worker, Internal Medicine)

Current Cheyney Graduates & Clinical Education Supported by AtlantiCare established in 2023

Nursing

- 4 Cheyney graduates enrolled into accelerated BSN program at another partner school, Stockton University, for Spring and Fall of 2023
- Provided full-tuition, scholarships, housing and entry-level job for all 4 students
- Provided mentorship for all students

Respiratory Therapy

- 3 Cheyney graduates enrolled in respiratory therapy school at Thomas Jefferson University for Fall 2023
- Provided full-tuition, scholarships and apprenticeships for all 3 students.
- Provided mentorship for students

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Lessons Learned & Key Takeaways

- Be creative and innovative to diversify all of your positions
- AtlantiCare addressed Cheyney University's academic and clinical needs via our other college partnerships (Stockton University & Jefferson University)
- The utilization of winter, spring and summer immersion programs in 2023 with Cheyney Health Science students
- Innovative usage of AtlantiCare's Education Investment Program & Scholarships
- Creative workforce opportunities for Cheyney University graduates (Patient Care roles)
- We connected our students to aligning community partners and stakeholders (Hispanic Associations, NAACP, Philippine Nurse Associations, etc.)
- AtlantiCare High School Hiring Blitz

AtlantiCare High School Hiring Blitz 2022 & 2023

Questions?

AtlantiCare

Contact:

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Acute Care at Home: Can We Keep Up the Pace?

Monal Shah, MD, ACMO, *Clinical Strategy & Value*

Alissa Tran, PharmD, BCCCP, *Director Acute Care at Home*

Parkland Health, Dallas, Texas

Acute Care at Home

- Acute, hospital-level care provided in patient homes
- Alternative that recognizes the traditional hospital setting may not be the right environment for many patients
- Patients directly admitted from the ED or as a transition from the traditional inpatient setting for ongoing acute care

INCEPTION

- Johns Hopkins and John A Hartford Foundation
- Geriatric study team conducting a pilot trial
- Goals – decrease cost and improve outcomes/satisfaction

EXPANSION

- 65+ age group
- 3 Medicare-managed care health systems + 1 Veterans Administration hospital
- Diagnoses limited to CAP, CHF, COPD, or cellulitis

EVOLUTION

- 2-way, real-time, tele-video capabilities
- In-home evaluation via a virtual physician

COVID

- CMS announces *Hospitals Without Walls* program
- Waiver: 24/7 on-site nursing
- Allows Medicare FFS reimbursement
- Passage of Omnibus Spending Bill extends HaH program through December 2024

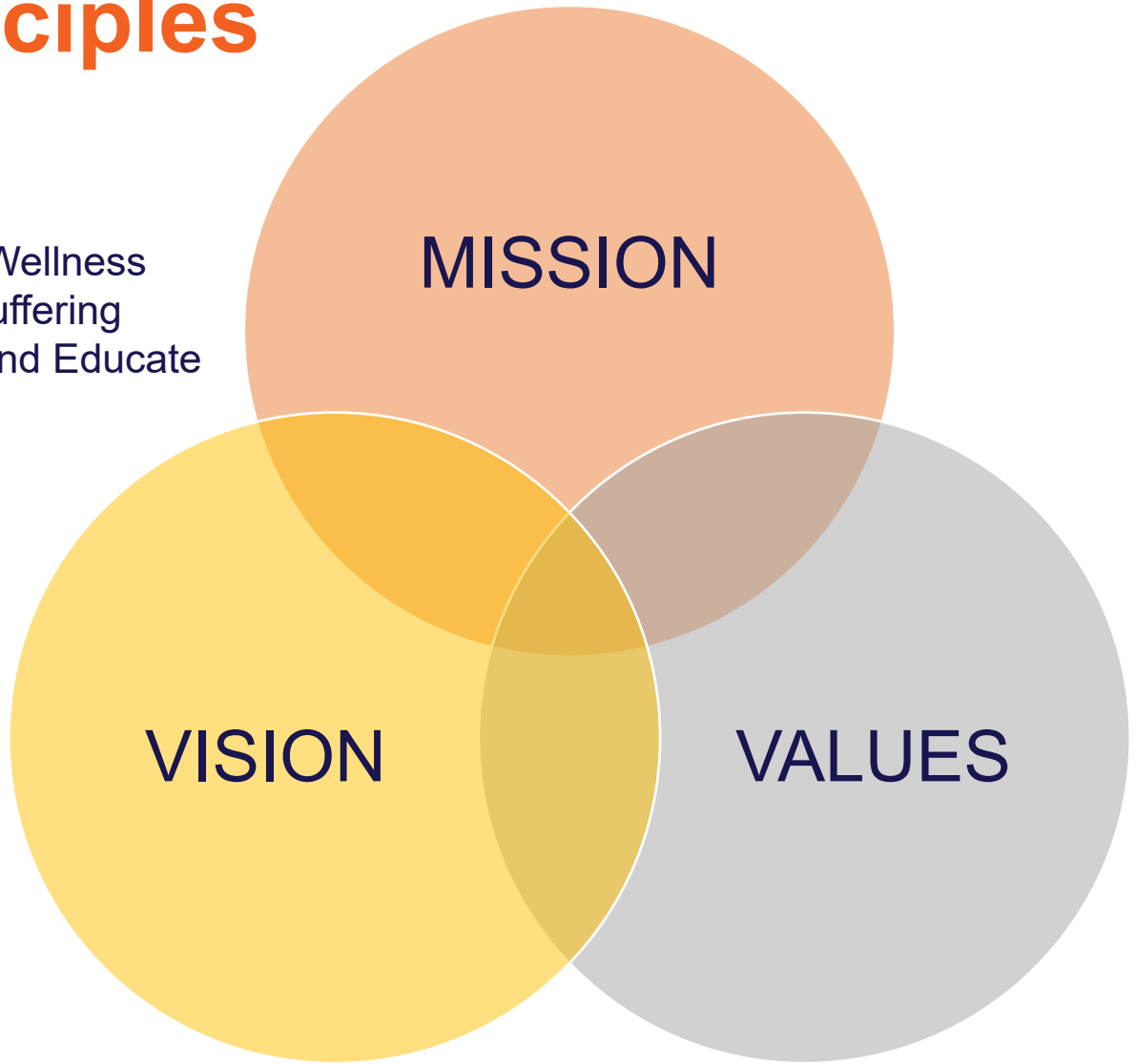
AKA: Hospital at Home, Home-Based Care, Home Hospital Care

Parkland Health

- **882** licensed beds
- **12** Primary Care Health Centers
- **30** Specialty clinics
- Serves Dallas County's homeless population and correctional health
- **70%** of patients are either uninsured, self-pay, charity or Medicaid
- **$1.4 billion** in uncompensated care
- **2 million** interpretations in 240+ languages

Guiding Principles

Advance Wellness
Relieve Suffering
Develop and Educate

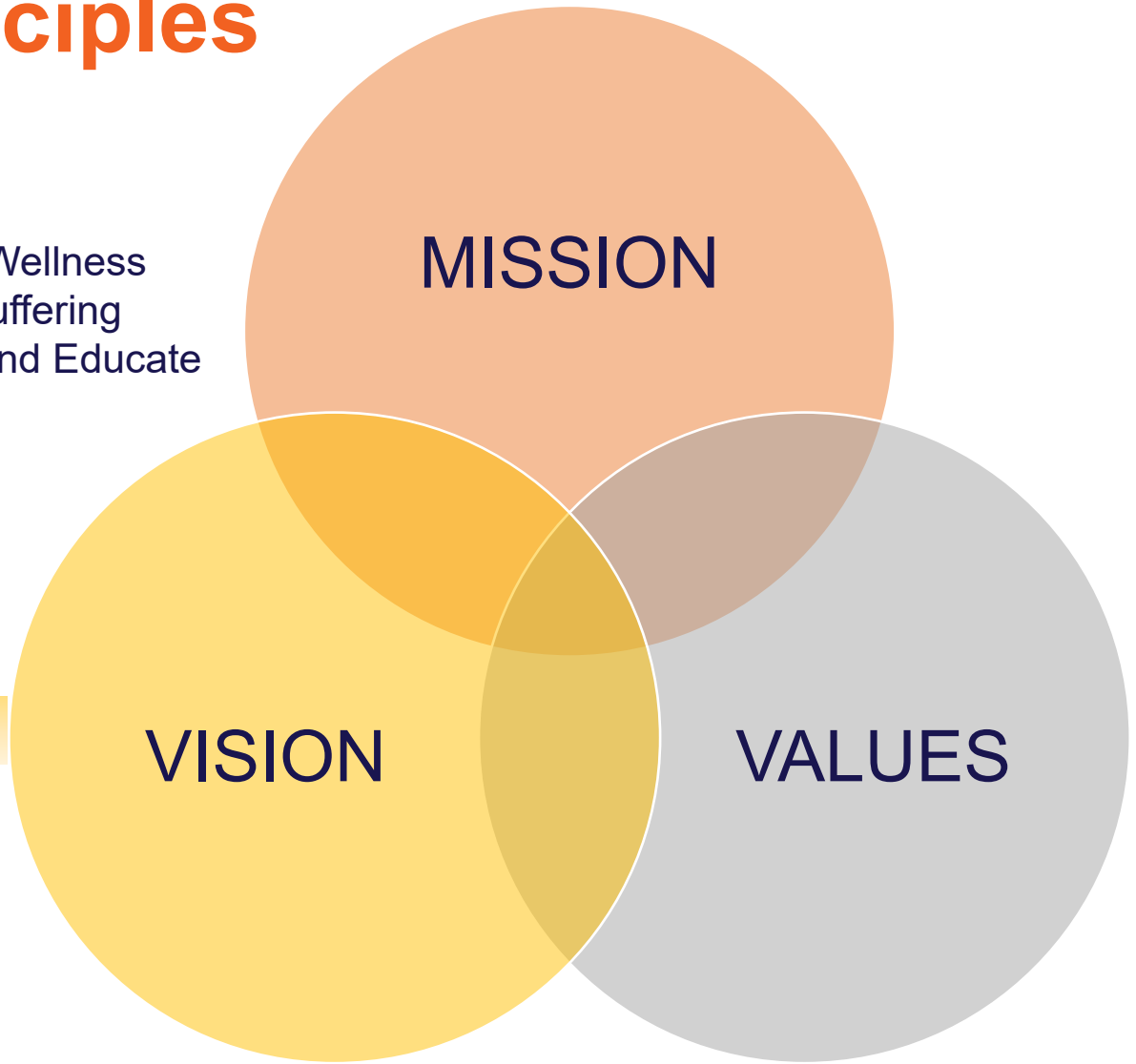


Advance health equity through excellence as a public institution

I CARE
Integrity
Compassion/**C**ollaboration
Accountability
Respect
Equity

Guiding Principles

Advance Wellness
Relieve Suffering
Develop and Educate



Advance **health equity** through excellence as a public institution

I CARE
Integrity
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Equity

Health Equity

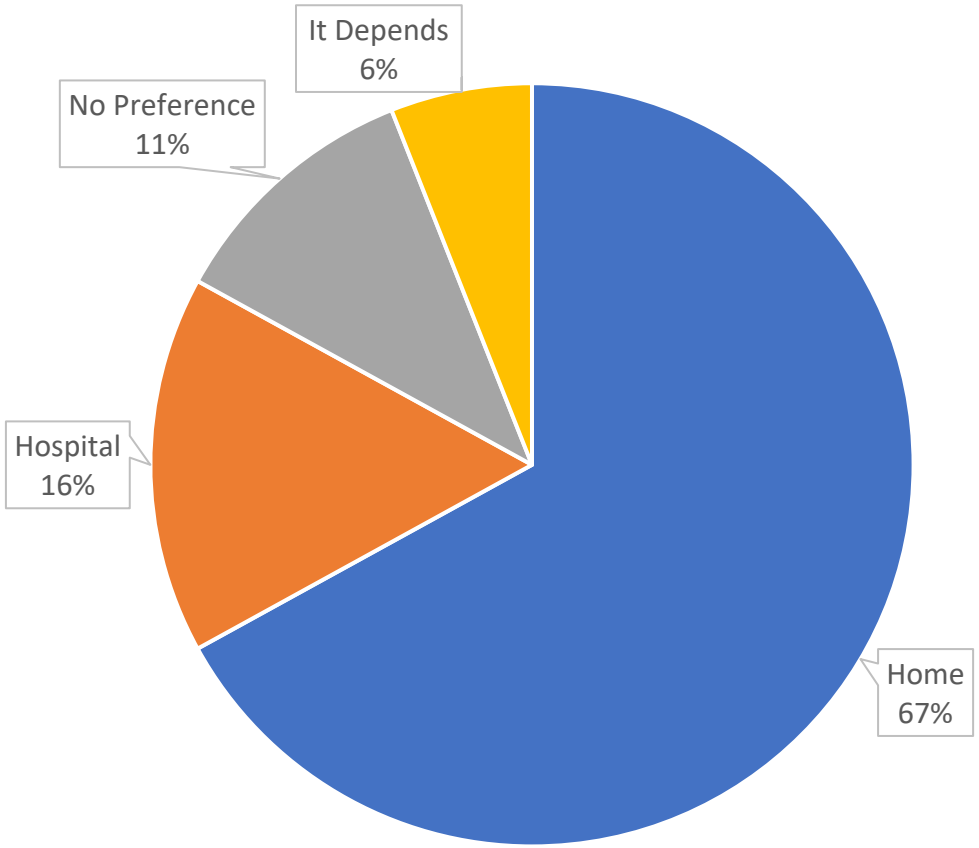
https://www.cdc.gov/publichealthgateway/sdoh/index.html#:~:text=Social%20determinants%20of%20health%20(SDOH,the%20conditions%20of%20daily%20life.

Health Equity

- s-OPAT
  - Self-administration of IV antibiotics at home via gravity
- Home Inotrope
  - Patient-managed pumps
  - Intensive provider monitoring in clinic setting
- Peritoneal Dialysis

https://www.cdc.gov/publichealthgateway/sdoh/index.html#:~:text=Social%20determinants%20of%20health%20(SDOH,the%20conditions%20of%20daily%20life.

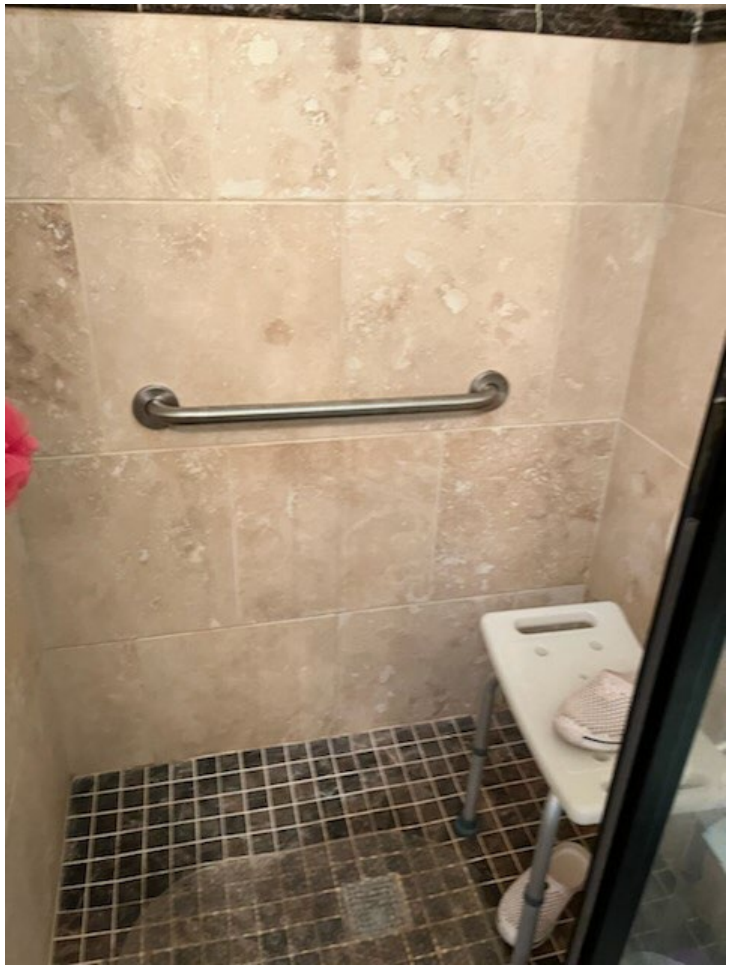
Pre-Implementation Evaluation



- 85% “Comfortable” or “Very Comfortable” with cell phone
- 70% “Comfortable”, “Very Comfortable” or “Somewhat Comfortable” with tablet
- Willing to learn if taught and provided with a device

Source: Internal Parkland Health data

Community Partnership

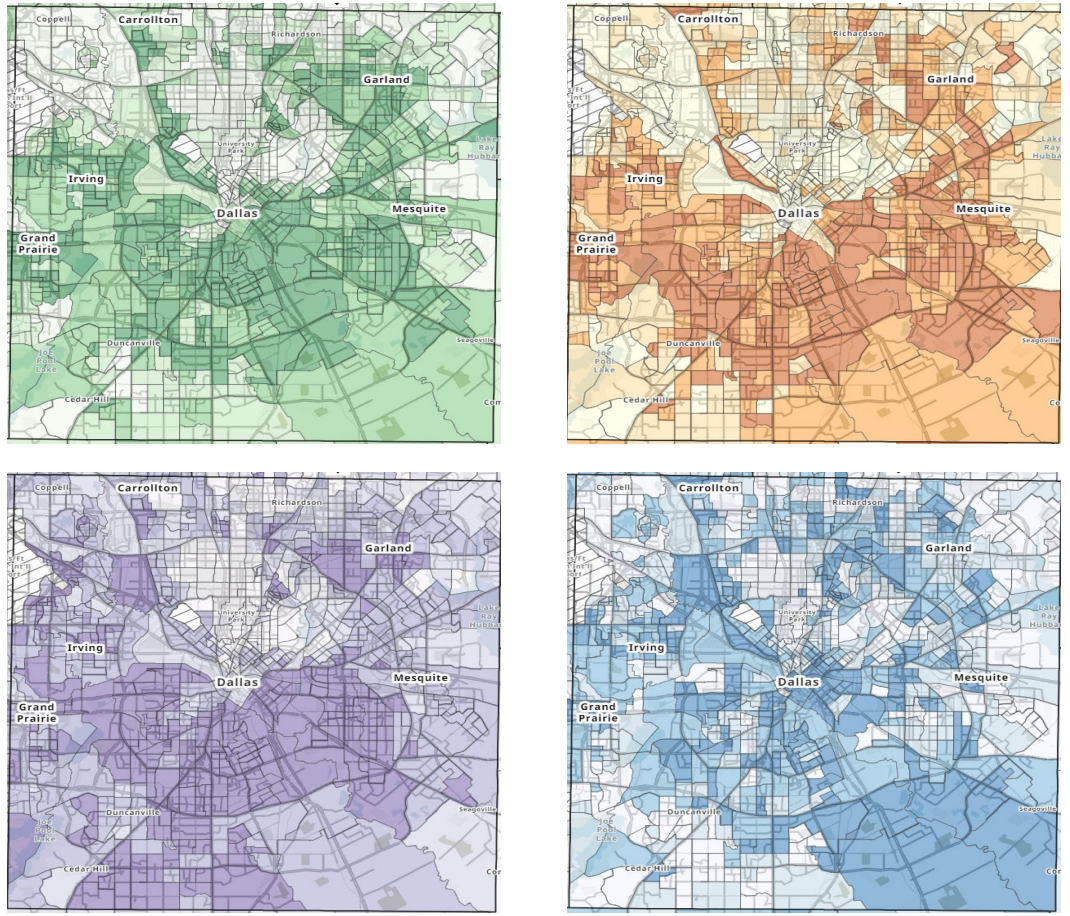


Employment

CDC Social Vulnerability Index (SVI)

Overall Vulnerability

Socioeconomic Status	Below 150% Poverty Unemployed Housing Cost Burden No High School Diploma No Health Insurance
Household Characteristics	Aged 65 & Older Aged 17 & Younger Civilian with a Disability Single-Parent Households English Language Proficiency
Racial & Ethnic Minority Status	Hispanic or Latino (of any race) Black or African American, Not Hispanic or Latino Asian, Not Hispanic or Latino American Indian or Alaska Native, Not Hispanic or Latino Native Hawaiian or Pacific Islander, Not Hispanic or Latino Two or More Races, Not Hispanic or Latino Other Races, Not Hispanic or Latino
Housing Type & Transportation	Multi-Unit Structures Mobile Homes Crowding No Vehicle Group Quarters

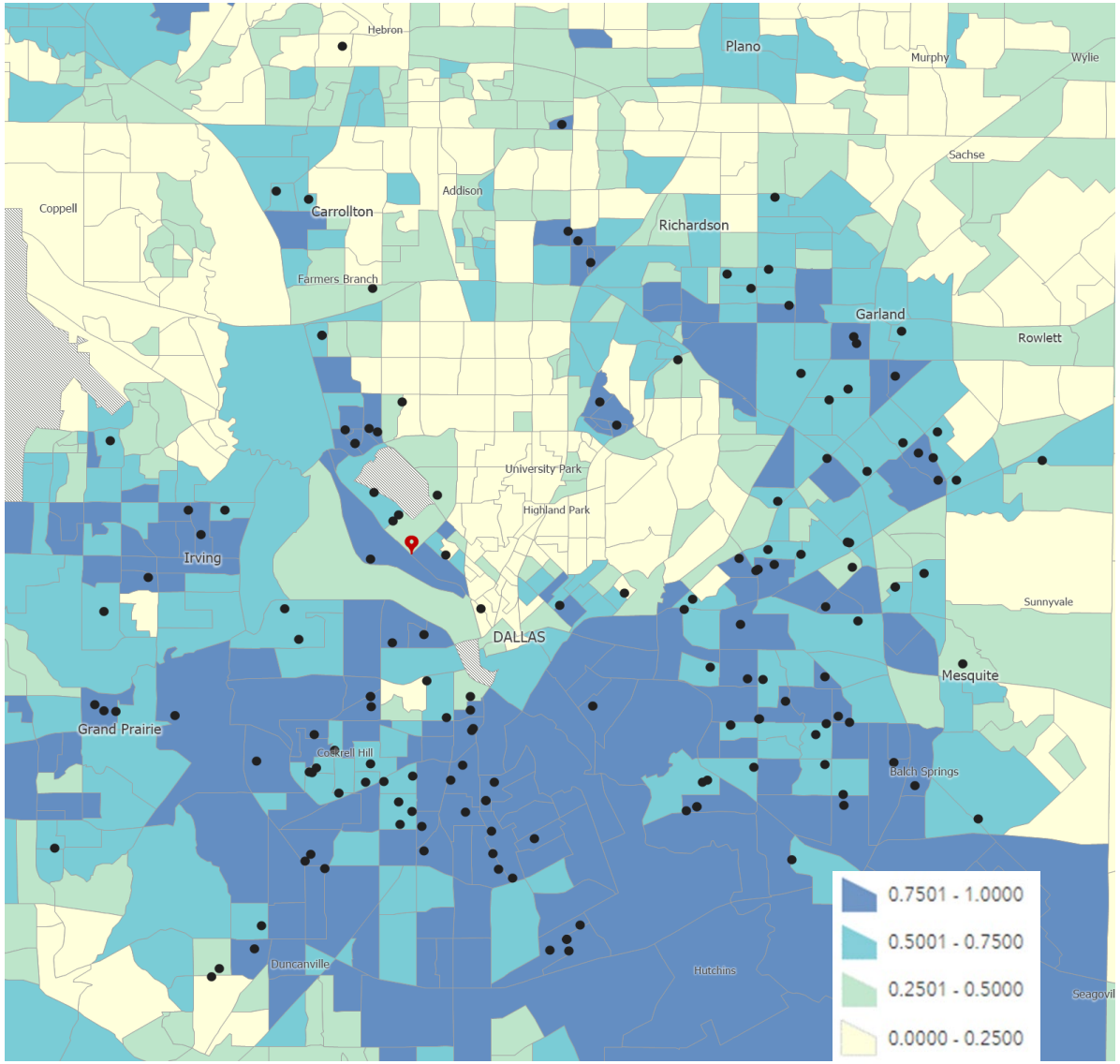


https://www.atsdr.cdc.gov/placeandhealth/svi/documentation/SVI_documentation_2020.html

Dallas, Texas: SVI Themes

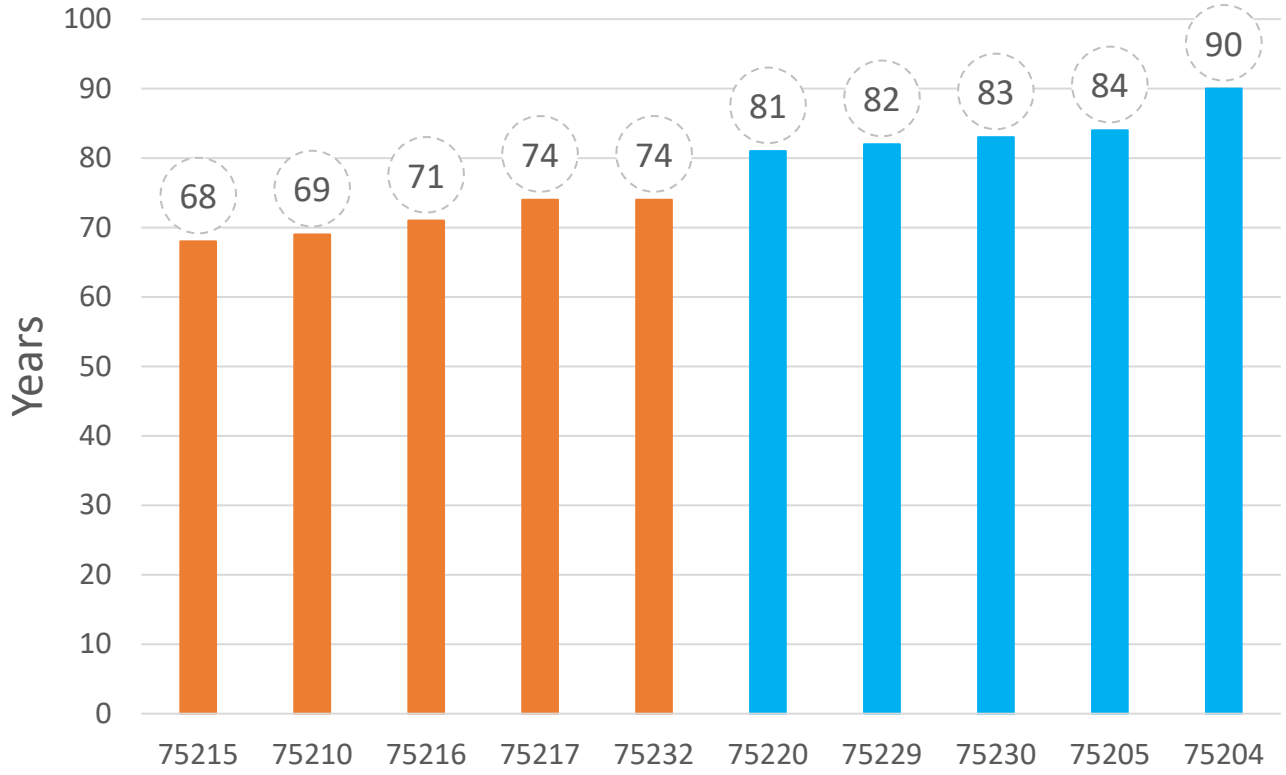
Enrollment by 2020 CDC Social Vulnerability Index (SVI)

Overall SVI	HaH Hospitalizations
High	80
Medium-High	66
Low-Medium	8
Low	5



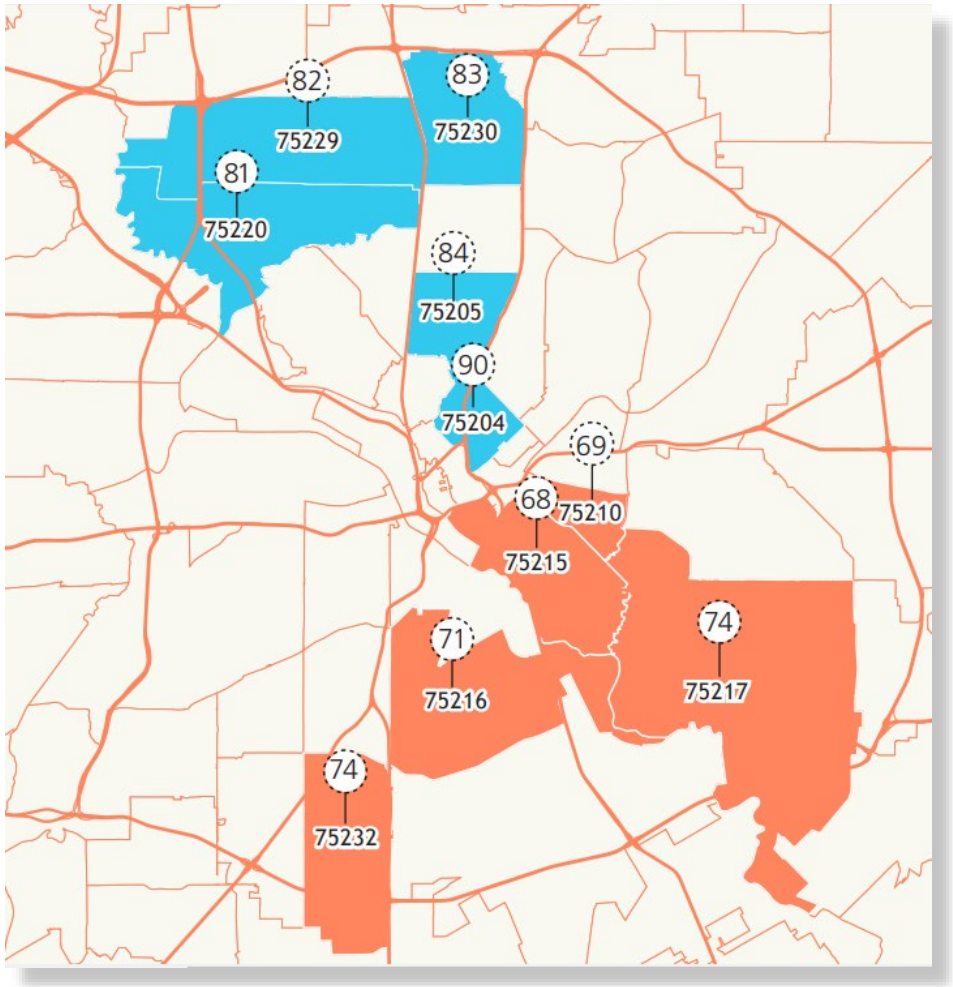
https://www.atsdr.cdc.gov/placeandhealth/svi/interactive_map.html

2022 Community Health Needs Assessment, Dallas County



Life Expectancy Variances Between Zip Codes, Dallas County 2019

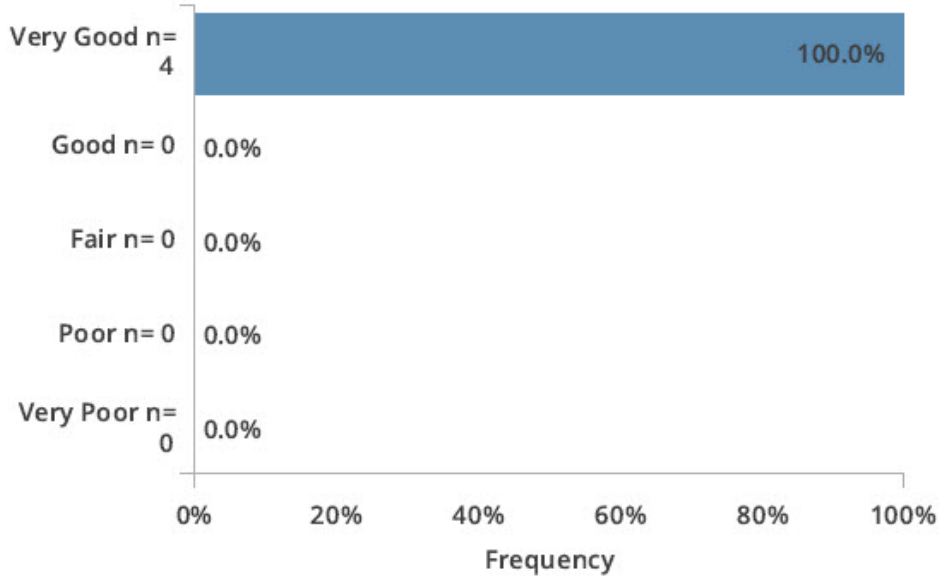
Data Source: University of Texas Southwestern Medical Center, UT Health



Patient Satisfaction

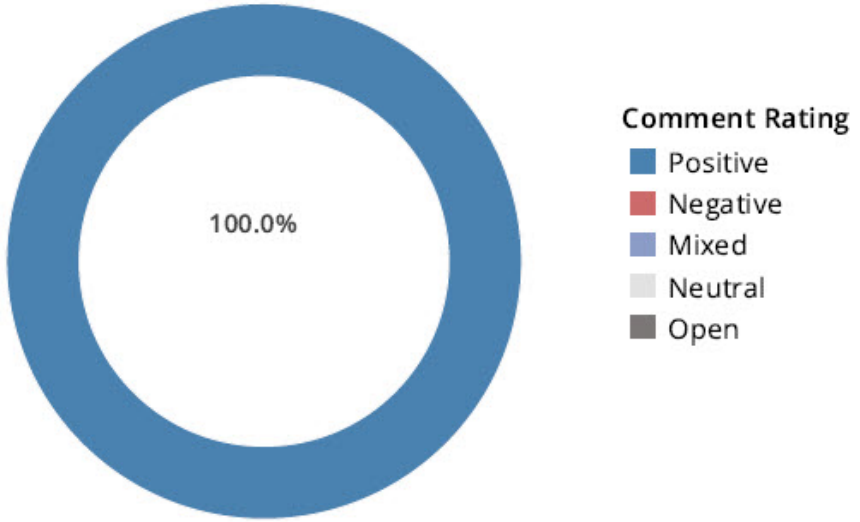
Distribution of Responses

PG Likelihood to Recommend



Comment Distribution

Data from Press Ganey surveys. CAHPS surveys do not collect comments.



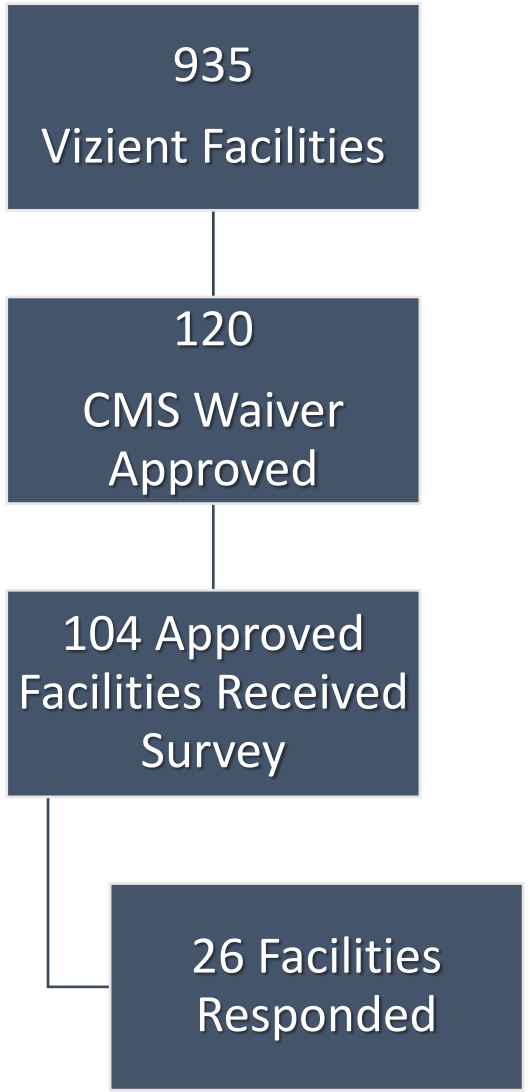
Vizient Data

- Compare Parkland's experience with the experience of Vizient members
- Utilize available Vizient data to identify if disparities exist related to acute care at home service offerings amongst facilities
- Understand the accuracy of data through member surveys
- Identify barriers and challenges to program implementation

Methodology

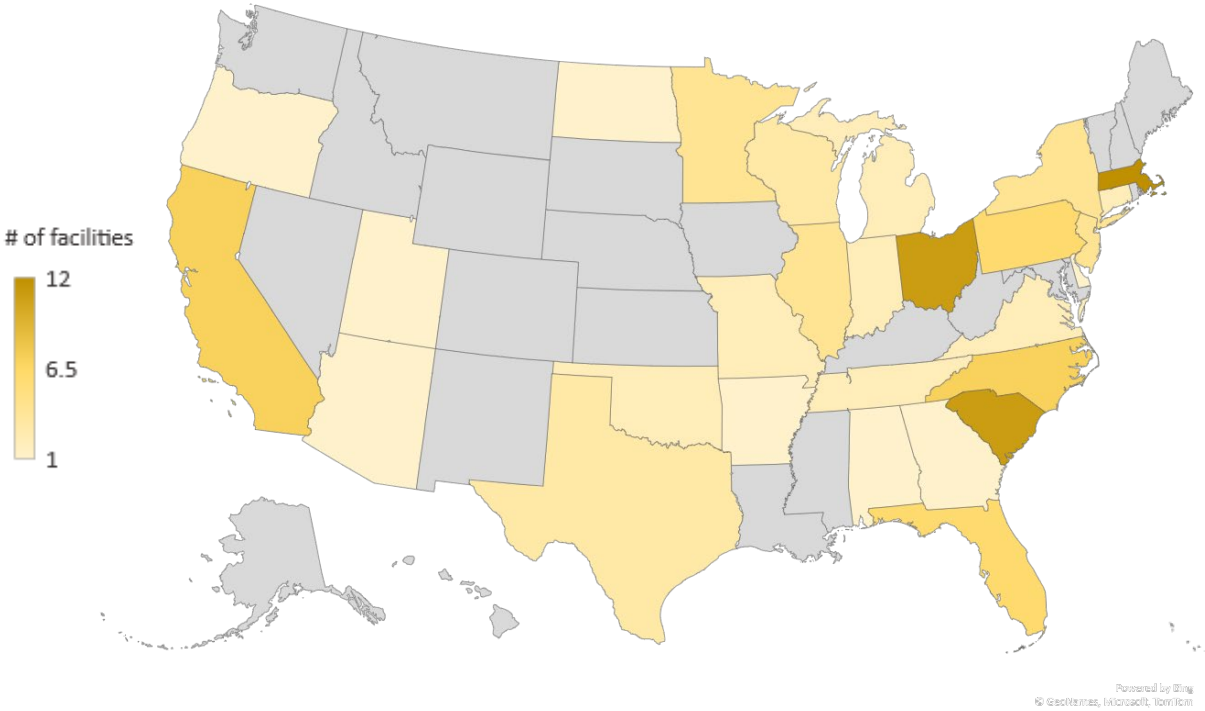
- Facilities were categorized into quartiles based on the proportion of patients with government funding* or no funding

- Outcomes by Payor Mix:
  - Acute Care at Home Waiver-Approved Programs
  - Active Acute Care at Home Programs based on Rev Code 0161 and surveys
  - Time from approval of program to 1st discharge
  - Volume of discharged patients per 10,000 discharges

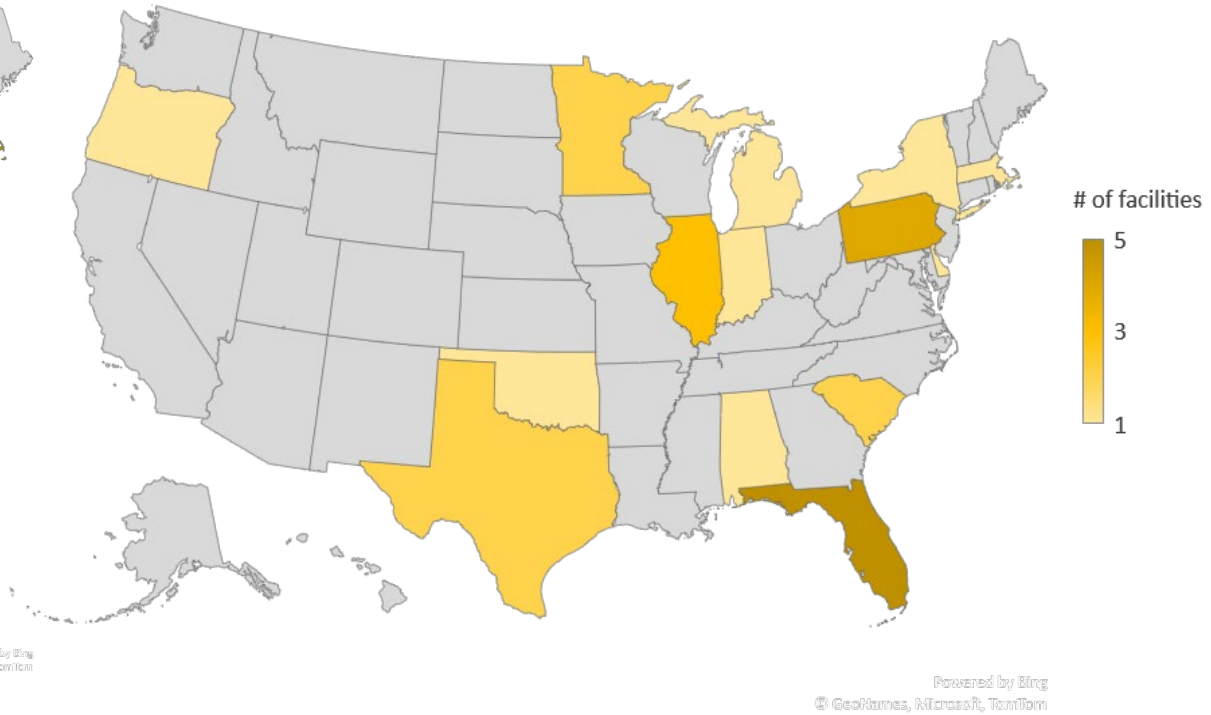


*Government funding includes Federal, state, and local funding

Survey Results



104 surveys were sent to 28 states



26 survey responses were received from 14 states

Survey Results

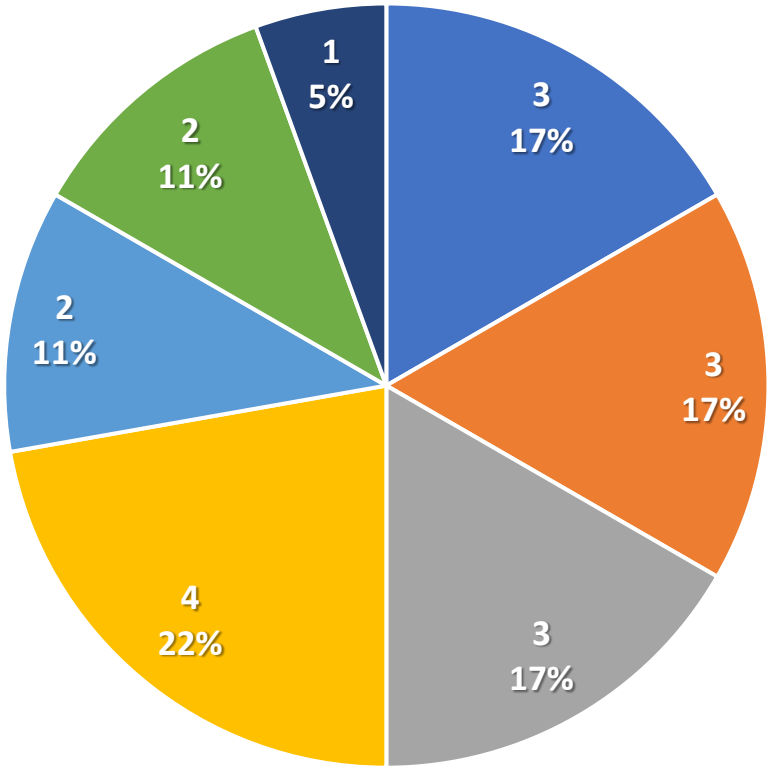
	Top Quartile 75-100%	Middle Quartile 25-75%	Bottom Quartile 0-25%	P-value
Total Facilities	229	477	299	---
Approved Facilities (Vizient – 02/2023)	25/229 (10.9%)	61/477 (12.8%)	18/229 (7.9%)	---
Approved Facilities (Post-survey – 07/2023)	26/229 (11.4%)	69/477 (14.5%)	25/229 (10.9%)	---
Active Programs*	10/26 (38%)	21/69 (30%)	6/25 (24%)	NS
Approval to Discharge Time (months)	11	10	14	NS
Discharge Volume (per 10,000)	1.4	4.5	6.5	< 0.001

*Includes Rev Code 0161 + survey

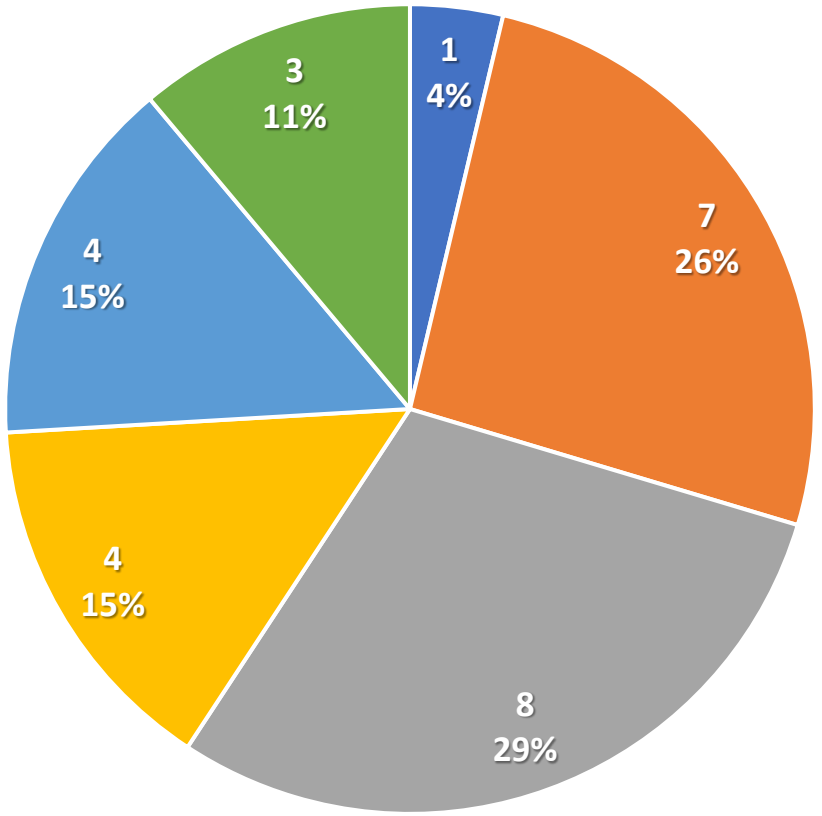
Source: Vizient, Inc. databases

Barriers/Challenges Identified

Approved, No Discharges (12 Facilities)



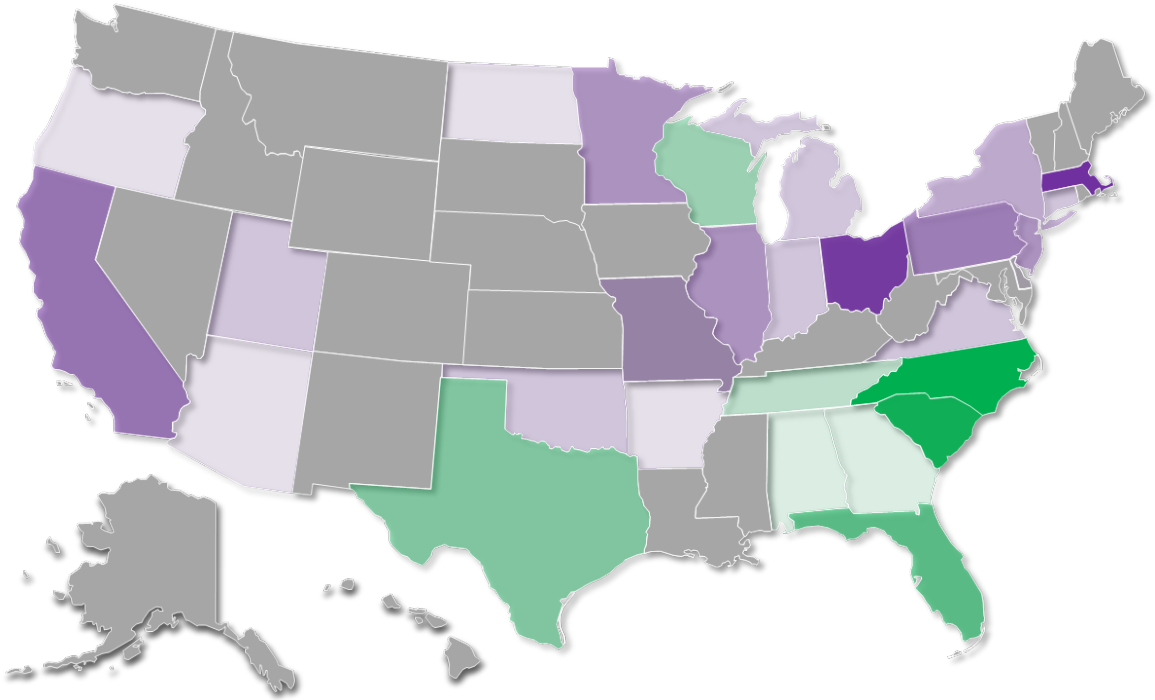
Approved, With Discharges (10* Facilities)



Source: Vizient, Inc. databases

*4 facilities did not answer question

Approved Facilities by Medicaid Expansion State Status



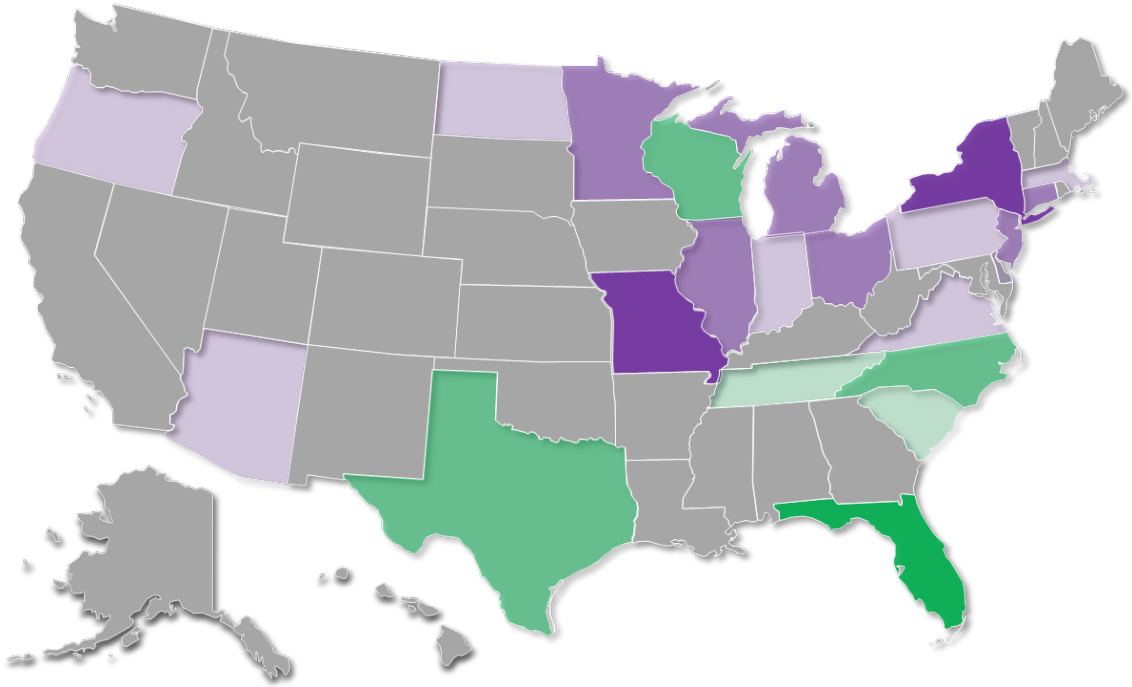
120 CMS Approved Vizient Facilities

# of Facilities by Expansion States

13 6.5 1

# of Facilities by Non-Expansion States

15 7.5 1



37 Approved Vizient Facilities with Discharges

# of Facilities by Expansion States

3 2 1

# of Facilities by Non-Expansion States

3 2 1

Source: Vizient, Inc. and public databases

Health Equity and Acute Care at Home

- Limited data
- Lack of high-levels of social support had little effect on positive outcomes of HaH care
- Racial/Ethnic minority groups in the home-based hospital had similar odds of care escalation as non-Hispanic Whites
- Economically disadvantaged patients may have a greater benefit from HaH

Lessons Learned

- Public-serving institutions can successfully provide in-home acute level care
- Community partnerships are integral to address vulnerable population needs
- Challenges
  - Payer reimbursement
  - Technology
  - Staffing resources
  - Operations

Key Takeaways

- Low number of facilities approved for CMS waiver (~1 in 8)
- No difference in approval amongst quartiles, but significantly lower discharge volumes for facilities with the highest proportion of government and unfunded patients
- Mixed methods are required to provide complete picture
- Challenges/Barriers
  - State law
  - Payer reimbursement
  - Technology
- Provides a platform to collaborate

Thank you!

- Kristin Alvarez, PharmD
- Cristiano Fitzgerald
- Stephen Harder, MD
- Kassidy James, PA-C
- Jillian Smartt, RN
- Monica Vaz, RN
- Acute Care at Home Nursing & Medical Staff
- Natalie Provenzale, RN
- Survey Responders

Questions?

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