Addressing Social Determinants of Health

UNC Health Alliance Storyboard

December 2021

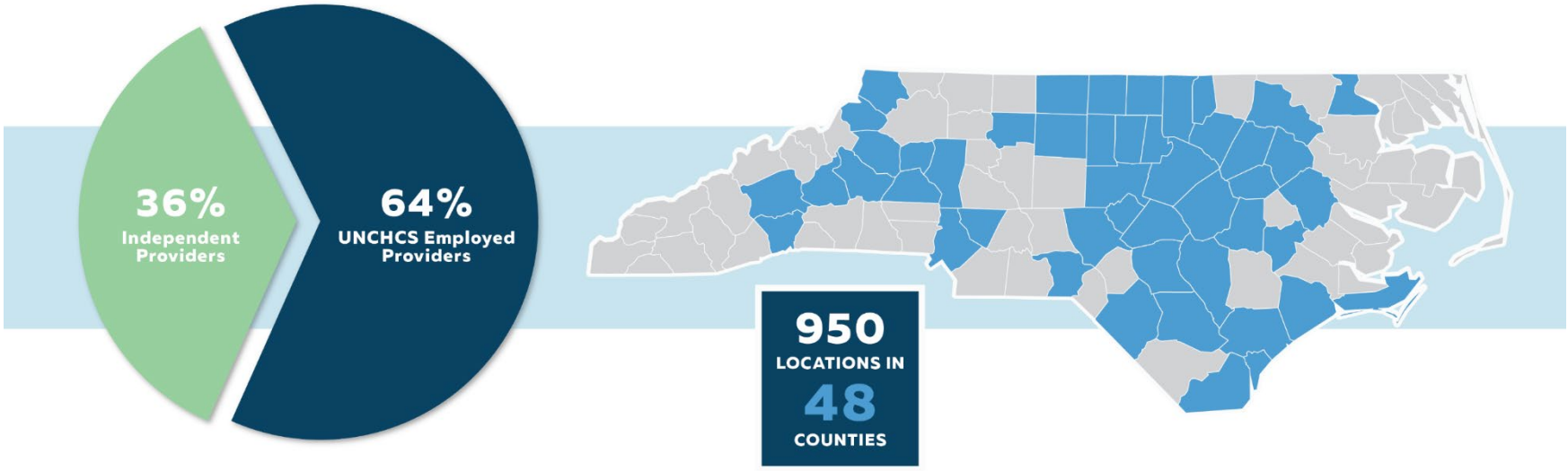
NAACOS
National Association of ACOs

IAC
Institute for Accountable Care

UNC Health Alliance Overview

UNC Health's Clinically Integrated Network (CIN), Accountable Care Organization (ACO), and Population Health Services Organization (PHSO)

- **7,200** providers with more than 2,600 from independent practices
- **1,500** primary care physicians and advanced practice providers
- **5,100** specialty providers, covering 170 specialties & subspecialties
- **11** UNC Health hospitals and counting …
- **30** SNFs and home health agencies in a preferred network and community-based palliative care
- **~325,000** covered lives across contracts



One Great Team: Addressing SDOH Across UNCHA

In our practices:

- Embedded care managers (nurses & social workers) screen for SDOH during Medicare Annual Wellness Visits, behavioral health counseling
- Registered dietitians assess food insecurity
- Hospital-based care managers assess for food, transportation, housing, financial needs pre-discharge

Via PHSO:

- Centralized nurse case mgmt. teams provide phone support to high-risk patients, patients transitioning from hospital
- PharmDs and pharm techs help with medication assistance
- Community health workers (CHWs) provide 2nd-level resource coordination as needed

In the community:

- CHWs conduct home visits to provide in-person support with things like Medicaid applications
- Community partners use secure online platform (NCCARE360) to accept referral requests

Across care settings: Analytics teams support data capture & reporting; coaching teams support practice transformation efforts and standardized training

UNC Health Alliance SDOH Efforts: Screening

- Current focus: Increasing SDOH screening and building capacity to address nonclinical barriers to health and well-being
  - Highest-priority SDOH domains: Food, housing, transportation, financial barriers
  - Increasing SDOH screening tied to healthcare system performance goals, primary care quality improvement goals (both of which affect compensation)
  - Standardized training videos developed; over 500 completions to date
- SDOH screening mechanisms:
  - Paper-based during rooming process
  - Via care team conversations as part of clinical encounters (wellness visits, transitions of care visits, behavioral health visits, hospital discharge planning)
  - Electronic via patient portal (under development)
- SDOH screening efforts are universal and payer/population-agnostic to avoid introducing bias
  - However, improving health equity is a major driver of SDOH focus

UNC Health Alliance SDOH Efforts: Data

- Transitioning to use of SDOH module in Epic as source of truth re: SDOH needs
  - Questions based on validated assessment tools, e.g. Hunger Vital Signs
  - Individual results available on patient face sheet, cross-departmental longitudinal plan of care, patient history
  - Population-level results available in panel reports, practice & entity quality improvement dashboards
- Other key pop health data sources:
  - CDC Social Vulnerability Index score: Aggregated factors @ census tract level to predict social risk
  - Race, ethnicity, & language (REaL) data: Used in concert with SDOH and quality outcomes data to identify health inequities
  - Data from vendors, e.g. Arcadia, Experian

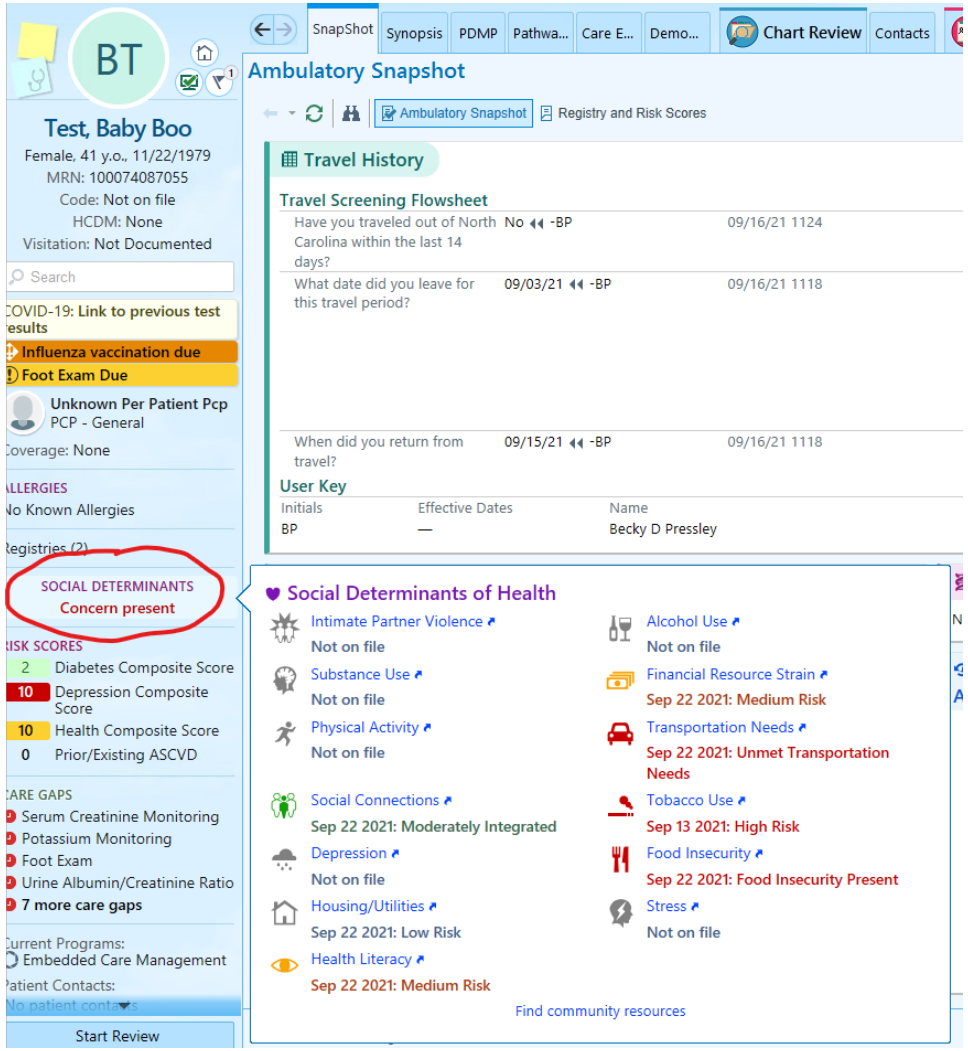


Image from a test chart, NOT a real patient

UNC Health Alliance SDOH Efforts: Community Partners

- Areas of greatest patient need: Housing & food insecurity
  - Highest-prevalence AND associated with increased healthcare costs, poor overall health, lower engagement in care
  - Housing is toughest resource need to address; more funding needed for affordable housing, eviction prevention, rent/utility assistance
- Key community partners: Food pantries, housing and legal aid organizations, senior centers/area agencies on aging, county departments of public health & social services
  - NCCARE360 is platform for referrals but has significant barriers
- COVID has accelerated urgency of building partnerships to address SDOH needs
- Funding sources for community collaborations:
  - Internal budget (e.g. CHW and care management programs; mobile COVID unit)
  - Grants & philanthropy (e.g. hospital-based food pantries)
  - Payer collaborations (e.g. food insecurity study with BCBSNC)