Strategic Planning FY 2020-22

Impacting Social Determinants of Health
Mary Sajdak, COO of Integrated Care

February 27, 2019
Impact 2020 Recap

Status and Results

• Deliver High Quality Care
• Grow to Serve and Compete
• Foster Fiscal Stewardship
• Invest in Resources
• Leverage Valuables Assets
• Impact Social Determinants
• Advocate for patients
## Impact 2020

### Progress and Updates-Social Determinants of Health

<table>
<thead>
<tr>
<th>Name</th>
<th>Status</th>
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</table>
| Ensure continued access for uninsured patients | • Director of Carelink hired 11/18  
• Monthly meetings with joint agenda settings established  
• Carelink membership stable at 31,500  
• # of Carelink members in Care Coordination 326  
• Understanding admission reasons, ambulatory visits to refine care coordination approach |
| CCDPH data to plan intervention to improve population health | In Progress |
# Impact 2020

Progress and Updates—Social Determinants of Health

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| Partner with other organizations to impact social determinants of health | • Food as Medicine **Greater Chicago Food Depository** food trucks at 13 sites  
• Contract in process for nutritional support for at-risk CCH patients and CountyCare members with **Independent Living Systems**  
• Partnership established with **Black Oaks**, planning for 2019 underway  
• Completed housing 33 units for **Housing Forward**, 30 for **Illinois Housing Development Authority** (IHDA)  
• Training for care coordination for Coordinated Entry System and assessments  
• Securing 56 vouchers for **Housing Authority for Cook County** (HACC)  
• Outreach started on **Flexible Housing Pool** initiative |
| Develop Care Coordination | Developed, 200 care coordination team members in multiple sites |
## Additional Activities Linked to Social Determinants

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Activities</th>
<th>Results</th>
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</table>
| Linkages to Mental Health (MH)/Substance Use Disorder (SUD) Services | • Specialized discharge planning for those with medical complications of Opioid Use Disorder (OUD)  
• Access to outpatient services via Behavioral Health Access Line (BHAL)  
• Warm hand-offs for those in pretrial area at 26th and California with MH/SUD | • 60 patients per month  
• 500 to 600 BHAL referrals per month to ambulatory providers  
• Approximately 80 referrals per month to MH and SUD providers |
| Access to care | • Additional support for Patient Support Center through Chicago Lighthouse | • 277,279 primary and specialty care appointments were made in in 2018. (30,011 Chicago Lighthouse)  
• Initiation of concierge services for patients |
| Social Support | • Utility Assistance  
• Expansion of Community Health Worker activities of linkages to community based organizations | • $180,000 in grants, average grant size $250 to $500.
# Additional Activities Underway

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<th>Focus Area</th>
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<th>Results</th>
</tr>
</thead>
</table>
| Income/Economic Support  | • Legal Aid Foundation support to resolve Health Harming Needs  
|                          | • Access to public benefits  
|                          | • Application for SSI and SSDI                                               | 2018 Referrals  
|                          |                                                                            | 256 Public Benefits  
|                          |                                                                            | 44 Housing  
|                          |                                                                            | 36 Family Law  
|                          |                                                                            | 80 ADAPT  
|                          |                                                                            | 22 Disability Cases (SSI/SSDI)                                           |
| Transit                  | • Rides for discharged patients, ED patients, ACHN and methadone             | 110,000 rides since 9/17  
|                          |                                                                            | 95% on time arrival  
|                          |                                                                            | 27.4 minutes for on-demand rides  
|                          |                                                                            | 8821 bus passes for methadone treatment                                  |
Social Determinants

Facilitators

• A funding stream to enable this work this includes system resources as well as grant funds
• Health System willingness to engage for non-traditional service/support
• Staff willing to tackle the complexities associated with this work
• Willing external and internal partners
Health Risk Screening
Health Risk Screening

Identification

Screening for Social Determinants of Health
  - ED, Inpatient Units, Ambulatory Centers, Bond Court
Referrals from staff, physicians, CountyCare
Data review -- claims, utilization information

Results

• 17,093 CountyCare members were screened during 2018
### Health Risk Screening

**Self-Reported Data**

<table>
<thead>
<tr>
<th>Question</th>
<th>Potential Risk</th>
<th>Question</th>
<th>Potential Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last PCP visit &gt;1 yr</td>
<td>(5%)</td>
<td>Abuse history</td>
<td>(3%)</td>
</tr>
<tr>
<td>Lack of transportation for medical appts</td>
<td>(20%)</td>
<td>Afraid of family member</td>
<td>(.6%)</td>
</tr>
<tr>
<td>Problems obtaining or paying for meds</td>
<td>(9%)</td>
<td>No one to help you for a few days</td>
<td>(26%)</td>
</tr>
<tr>
<td>Overall health</td>
<td>Fair (22.6)</td>
<td>Need help getting food</td>
<td>(18%)</td>
</tr>
<tr>
<td></td>
<td>Poor (8.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence of MH condition</td>
<td>(17.1%)</td>
<td>Help with housing</td>
<td>(10.9%)</td>
</tr>
<tr>
<td>Presence of SUD</td>
<td>(2.9%)</td>
<td>Help with utilities</td>
<td>(15.3%)</td>
</tr>
<tr>
<td>Unstable Living Situation</td>
<td>(2.0%)</td>
<td>Help with clothing</td>
<td>(12.1%)</td>
</tr>
</tbody>
</table>
## Health Risk Screening

Frequency of Risk Indicators

<table>
<thead>
<tr>
<th></th>
<th>1-3 Indicators %</th>
<th>4-6 Indicators %</th>
<th>7 or more Indicators %</th>
<th>Population Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic MH</td>
<td>43.3 %</td>
<td>39.7%</td>
<td>16.8%</td>
<td>2,446</td>
</tr>
<tr>
<td>Chronic SUD</td>
<td>26.4%</td>
<td>43.0%</td>
<td>30.4%</td>
<td>702</td>
</tr>
<tr>
<td>MH/SUD</td>
<td>16.0%</td>
<td>40.8%</td>
<td>43.0%</td>
<td>411</td>
</tr>
<tr>
<td>Total Population</td>
<td>80.4%</td>
<td>16.0%</td>
<td>3.5%</td>
<td>17,093</td>
</tr>
</tbody>
</table>
FY2020-2022 Opportunities
Impact Social Determinants/Advocate for Patients
FY 2020-2022 Strategic Planning Recommendations

2018 Opportunities

• External partnerships are only partially defined; not clear how well they work/support the patients or members
• Engagement of physicians and medical home team members regarding CCH capabilities
• Being able to evaluate what really works for whom
Impact Social Determinants/Advocate for Patients
FY 2020-2022 Strategic Planning Recommendations

Integrated Care Short-Term Plans

• Meet or exceed targets for all funded projects related to housing, opioid abuse, linkages to treatment for SMI

• Secure ongoing funding for MH/SUD activities when grant funding expires e.g. recovery coaches, AOT Assisted Outpatient Treatment (AOT) program, etc.

• Catalog existing activities regarding tobacco cessation, nutritional support, exercise and risk reduction for scalability and ease of referrals

• Identify top 3 social/community needs of CCH supported patients and identify strategy(ies) to meet needs

• Partner with CCDPH on one mutual project (housing for children at risk)

• Develop an understanding of patient approach and related successful interventions

• Develop and present a housing model for CCH patients
Impact Social Determinants/Advocate for Patients
FY 2020-2022 Strategic Planning Recommendations

Organizing for Impact and Sustainability

• Create a coordinating committee -- success will depend on cross-department collaboration and coordination

• Identify working definitions for social determinants of health, which ones may be in the purview of CCH departments and strategies for others that may have significant impact
  • Complete gap analysis and provide recommendations
  • Document resource requirements, training etc.
  • Enter into discussions to support collaboration

• Review information from cataloging existing programs and determine next steps

• Complete implementation of social service data base
Thank You