New Jersey DSRIP Learning Collaborative Presentation
June 8, 2017
Social Determinants Of Health
Impact on SDOH

Key Findings...
Physician notes contain valuable information on social risk factors that put patients at high risk for 30-day all cause unplanned hospital readmission. A study found that analyzing physician notes within electronic health records can identify social risk factors more completely than administrative data, enhancing a hospital’s ability to identify patients at risk of readmission.

Studies revealed seven (7) social risk factors (tobacco use, alcohol abuse, drug abuse, depression, housing instability, fall risk, and poor social support) identified in medical records can serve as predictors of readmission.

Of the seven (7) factors, adjusting for demographic and clinical factors, four (4) of the seven selected social factors were significantly associated with increased readmission risk:

- **Housing instability** increased risk of readmission by 25%
- **Depression** increased risk by 21%
- **Drug Abuse** and **Poor Social Support** increased risk by 20%

The Implications:

Patients with social risk factors are substantially more prevalent than currently identified through billing codes or EHR data alone, and are at a higher risk of returning to the hospital within 30 days of discharge with certain social determinants / risk factors.

Clinical notes may lead to better identification of patients at risk for readmission.

Four social characteristics were more frequently identified through analysis of physician notes as compared to billing codes alone, or billing codes together with structured EHR data and were stronger indicators of readmission risk.
Core Medicaid Experience

Gender Distribution:
- Female: 55%
- Male: 45%

Medicaid by Age (as of February 2017):
- Adults (20-64): 47.0%
- Adults (over 65): 4.4%
- Children (under 19): 48.6%

HNJH Members by County:
- 1 to 10,000
- 10,001 to 30,000
- 30,001 to 50,000
- 50,001 to 70,000
- 70,001 to 90,000
- 90,001 to 110,000
Managed Long Term Support Services Experience

MLTSS MEMBERS BY COUNTY

- 1 to 200
- 201 to 400
- 401 to 600
- 601 to 800
- 801 to 1,600

ETHNICITY (AS OF FEBRUARY 2017)

- Caucasian: 8,070 (54.6%)
- Other: 3,211 (21.7%)
- African American: 2,434 (16.5%)
- Hispanic/Latino: 1,006 (6.8%)
- Native American: 47 (.3%)

AGE

- (65+): 10,440 Members (71.54%)
- (0-20): 175 Members (1.20%)
- (21-64): 4,153 Members (28.4%)

GENDER

- Female: 9,889 (67%)
- Male: 4,879 (33%)
Combined Medicaid Experience

**LANGUAGES SPOKEN**
(Source: Analytics, February 2016)

- Unknown: 32.94%
- English: 57.43%
- Spanish: 8.08%
- Chinese: 0.10%
- Arabic: 0.25%
- Persian: 0.38%
- All Other: 1.2%

**ETHNICITY**
(AS OF FEBRUARY 2017)

- Caucasian: 30.75%
- Other: 25.29%
- African American: 22.12%
- Hispanic/Latino: 21.56%
- Native American: 0.28%
Health Services  Core Functions

✓ Medical Management
  ▪ Medical Directors

✓ Clinical Operations
  ▪ Utilization Management
  ▪ Care / Case Management
  ▪ MLTSS Clinical Operations
  ▪ NICU / GEMS Program
  ▪ Clinical Training & Quality

✓ Quality Management Operations and Performance Improvement Reporting
  ▪ Quality Management Operations
  ▪ Performance Improvement Reporting: Medicare Stars / HEDIS Reporting

✓ Dental Operations
  ▪ Network Development and Partnership
  ▪ Dental Utilization Management and Quality Improvement

✓ Pharmacy Operations
  ▪ Pharmacy Benefit Management (PBM)
  ▪ Prior Authorization Program (PA)
  ▪ Pharmacy Network Management
Health Services

Core Functions

- Responsible and accountable for management medical and dental costs and ensuring appropriate health care delivery

- Uses Enterprise analytics and informatics

- Operates on a 24 hour basis to respond to authorization requests for emergency and urgent services for members and is available during normal working hours for inquiries and authorization requests for non-urgent health care services
Clinical Operations – Care/Case Disease Management

Field Staff

- Region based clinical staff. Referrals from internal and external customers
  - Meet members at: FQHC’s, soup kitchens, and drop off centers

Member Support Unit

- Horizon NJ Health has developed and implemented the Member Support Unit to address the immediate needs of members that are not assigned to a Case Manager.
  - Triages calls that come from Member Services
  - Internal complaints
  - External complaints
Members with complex medical conditions CM incorporates the continuum of both care management and disease management. HNJH defines complex care management as all members who have been stratified as level 3, regardless of disease state or co-morbidity.

Members with diagnosis of but not limited to diabetes, asthma, congestive heart failure (CHF), hypertension, chronic obstructive pulmonary disease (COPD); use of nationally recognized evidence-based standards of care.
Clinical Operations - Utilization Management

**Concurrent Review**
- Notice of Admissions and Concurrent review
- Utilize benefits, MCG guidelines and policies for decision making
- Referral of high risk members to Case Management
- Refer any identified concerns to Quality

**Post Acute Facility**
- Manage member transitions from acute care setting to acute rehabilitative and lower skilled level of care
- Perform concurrent review and apply MCG guidelines
- Refer to medical directors
- Send field RN to SNF nursing home facilities to perform validation reviews

**Prior Authorization**
- Review PA requests for medical necessity using MCG guidelines and policies
- Approve or forward to Medical Director for determination
MLTSS Clinical Operations – Core Functions

- Eligible members are assigned a RN/SW or BH Care Manager
- Perform face-to-face visits with each member to initiate care planning and monitor members status
- Create a member centric plan of care addressing the physical, social, behavioral and long term needs of the member

Case Management

- MLTSS program provide services and supports to allow members to safely remain in the least restrictive setting, for their long term care needs.
- Long term care needs can be met in the community; in private homes and in Alternative Residential Settings and in Nursing Facilities on the program. Members are able to transition from one level to another when support needs change.

Provide Support
1. **Emergency Room Outreach**
   Identification of patients at high volume ERs. Set up follow-up appoints with PCP, Dentist, Social Work, BH Therapist

2. **In-Home Intensive Programs**
   Patient-centered in-home models that develops care plans, addresses gaps in care and improves care coordination. Behavioral health specialists can be included if needed

3. **Post-Acute Transition of Care Programs**
   Transition support services to reduce 30-day readmissions

4. **Complex Care Management Programs**
   In-home and telephonic care model that stabilizes health status, closes gaps in care and facilitates care transitions.
Engage your high-risk members - Use a multi-level contact method – call, email, text, mail and visit door to door

Face-to-face contact with patients - Frequent face-to-face contact with patients (~1/month)

Small enough caseload (e.g., 50-80) - Continuous assessments, training and feedback to care managers

Rapport with physicians and members - Face-to-face contact, regular hospital rounds, accompanying patients on physician visits, care coordinators assigned to patients

Culturally sensitive patient education - Provide evidence-based patient education / intervention, including how to take Rx correctly and treatment adherence

Manage care setting transitions - Timely, comprehensive response to care setting transitions (most notably from hospitals)

Medication management - Comprehensive Rx management, involving pharmacists and/or physicians

Address psychological issues - Staff with expertise in social supports for patients who need it

Source: Care Coordination For The Chronically Ill Alliance- Healthcare Reform Briefing- Randy Brown, Mathematica Policy Research Aug 2011
### Medicare Advantage:
Top Admitting and Readmission Diagnoses, February 2017

#### READMISSION FROM HOME

<table>
<thead>
<tr>
<th>Diagnosis first admission</th>
<th># of discharges</th>
<th>% of discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia, unspecified</td>
<td>3</td>
<td>7.89%</td>
</tr>
<tr>
<td>Acute kidney failure, unspecified</td>
<td>2</td>
<td>5.26%</td>
</tr>
<tr>
<td>Heart failure, unspecified</td>
<td>2</td>
<td>5.26%</td>
</tr>
<tr>
<td>Chest pain, unspecified</td>
<td>2</td>
<td>5.26%</td>
</tr>
<tr>
<td>Pneumonia, unspecified organism</td>
<td>2</td>
<td>5.26%</td>
</tr>
<tr>
<td>Unspec atrial fibrillation</td>
<td>1</td>
<td>2.63%</td>
</tr>
<tr>
<td>Other specified heart block</td>
<td>1</td>
<td>2.63%</td>
</tr>
<tr>
<td>Postprocedural fever</td>
<td>1</td>
<td>2.63%</td>
</tr>
<tr>
<td>Chron obstr pulm dz w/acut lwr resp</td>
<td>1</td>
<td>2.63%</td>
</tr>
<tr>
<td>Chro obstruc pulm dz uns</td>
<td>1</td>
<td>2.63%</td>
</tr>
</tbody>
</table>

#### READMISSION FROM REHAB

<table>
<thead>
<tr>
<th>Diagnosis first admission</th>
<th># of discharges</th>
<th>% of discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortness of breath</td>
<td>1</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

#### READMISSION FROM HOME

<table>
<thead>
<tr>
<th>Diagnosis - readmission</th>
<th># of discharges</th>
<th>% of discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart failure, unspecified</td>
<td>11</td>
<td>28.95%</td>
</tr>
<tr>
<td>Chest pain, unspecified</td>
<td>3</td>
<td>7.89%</td>
</tr>
<tr>
<td>Pneumonia, unspecified organism</td>
<td>2</td>
<td>5.26%</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>2</td>
<td>5.26%</td>
</tr>
<tr>
<td>NSTEMI</td>
<td>2</td>
<td>5.26%</td>
</tr>
<tr>
<td>Noninfective GE &amp; colitis, unspecif</td>
<td>2</td>
<td>5.26%</td>
</tr>
<tr>
<td>Acute systolic(congstv)heart failure</td>
<td>1</td>
<td>2.63%</td>
</tr>
<tr>
<td>Nontraumatic subdural hemorrhg,uns</td>
<td>1</td>
<td>2.63%</td>
</tr>
<tr>
<td>Dehydration</td>
<td>1</td>
<td>2.63%</td>
</tr>
<tr>
<td>Cellulitis of left lower limb</td>
<td>1</td>
<td>2.63%</td>
</tr>
</tbody>
</table>

#### READMISSION FROM REHAB

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<tr>
<th>Diagnosis - readmission</th>
<th># of discharges</th>
<th>% of discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent NSTEMI</td>
<td>1</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

| Grand Total                                            | 1               | 100.00%         |
Healthcare Value Transformation

Focus on Quality

Improve Quality

Enhance Patient Experience

Lower Costs

Provider Partnerships

Population Health

Member Engagement
Maternal / Child Health Initiative

Description

Project goal is to improve maternal / child health outcomes

- Challenges to be addressed are:
  - Decrease in C-section rates
  - Early identification of pregnant women for prenatal care
  - Improve postpartum care
  - Reduce the incidence of low birth weight babies
  - Potential use of contraception to prevent future pregnancies

- Measurable metrics:
  - Increase in gestational age
  - Decrease in NICU days per 1000
  - Improvement in HEDIS measures
Questions