Social Determinants of Health Survey Pilot

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Agenda

Overview of Social Determinants of Health

- What are Social Determinants of Health?
- Why do they matter?

Strategic Discussion

- Review SDoH pilot results to date
- Explore next steps and how to leverage insights gained from data collection

What are Social Determinants of Health?

Social determinants of health are socioeconomic factors that impact a person's health outcomes.

- For example, if someone does not have reliable transportation to get to doctor appointments, they are less likely to go, which can lead to negative health outcomes

By identifying and addressing these needs, we can drive positive health outcomes

- If we connect the person from our example with a non-emergency medical transportation organization, we are helping lower the barrier for the member to access the healthcare system

Pilot Rationale and Methodology

MAXIMUS and the West Virginia Department of Health and Human Resources wanted to leverage MAXIMUS EB infrastructure to *efficiently* create meaningful insights around SDoH impacting Medicaid members.

MAXIMUS, DHHR and our partner TAVHealth developed a broad set of social risk questions to be seamlessly administered as part of the enrollment process.

MAXIMUS and TAVHealth would present early results to DHHR to inform policy issues and to envision a way to potentially impact members upstream from a claim while yielding insights as to segment the social risk of those members attributed to MCOs.

Pilot Development

The primary goal of the pilot was to gather and analyze SDoH data for WV Medicaid recipients to determine what needs existed across the state and identify a path forward for driving positive health outcomes through addressing needs. We did that by:

1) Developing a survey tool to collect data
2) Implement a system to capture and analyze the data
3) Develop a robust reporting suite to help understand the data and what help direct future initiatives
4) Develop a community resource guide that lists all available resources to help address members' SDoH needs

Assessing Social Risk – Survey Questions

	Need	Questions
1	Income Support and Employment	In the past year, did lack of money ever make it hard for you to go to the doctor or dentist or pay bills such as water or heating bills?
2	Health Supportive Services	In the past year was there a time you needed health or dental care but were not able to find a doctor or dentist that could see you?
3	Food	Do you ever eat less than you feel you should because there is not enough food?
4	Employment	Do you have a job or other steady source of income?
5	Legal Services	Does a current or past legal issue make it hard for you to get a job or other steady source of income or get a better job?
6	Education	Would more education or training, such as getting a GED, going to college or learning a trade, help you get a job or better job?
7	Substance Use Disorder Services	Do you have a substance use issue that affects your activities and relationships?
8	Housing/Shelter	Are you now in stable housing that is a safe place for you to live?
9	Child Care Providers	Does getting childcare make it hard for you to work, go to doctor visits or go to school?
10	Local Transportation	Do you have a dependable way to get to work or school and to your appointments?
11	Material Goods	Do you have enough household supplies such as clothing, shoes, blankets, mattresses, diapers, toothpaste and shampoo?

Pilot Implementation

- Added the survey to our proprietary CRM (MAXeb) system to capture the responses
- Updated member enrollment packets to contain a survey form and instructions on why we were capturing this data
- TAVHealth configured their TAVConnect application to receive survey responses and member demographic data and provide detailed reporting around member needs
- TAVHealth developed a community resource guide that captured all the available CBOs and community resources that would be part of the outreach and addressing needs

Community Resources

MAXIMUS and TAVHealth curated a statewide resource guide of West Virginia Community Resources that address a variety of needs including, but not limited to:

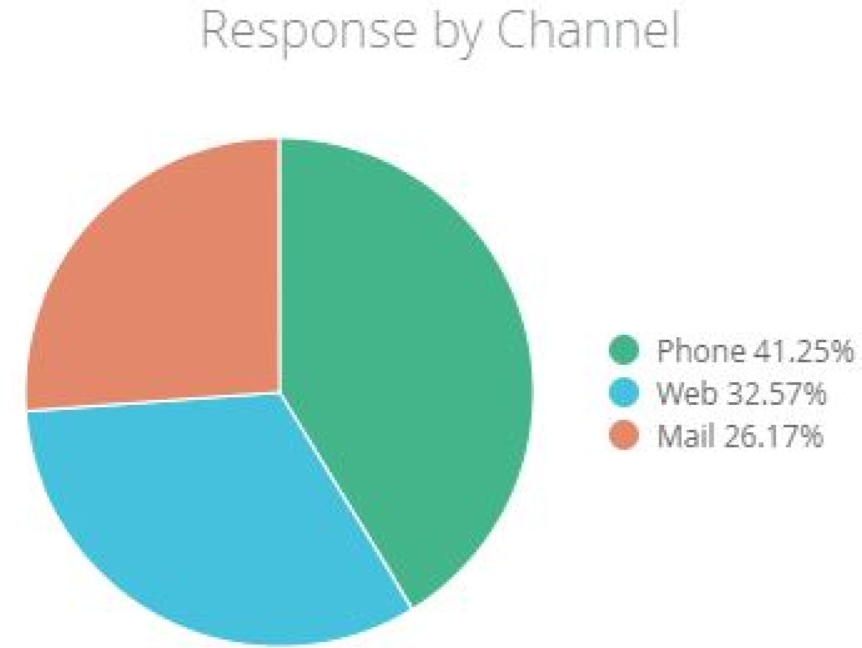
Progress Summary - Overview

18,153 surveys captured - 11/1/18 to 8/8/19
43,733 needs* identified

**A member's response to a given question indicates whether or not they feel they have an unmet need*

Progress Summary

- 65% of members we came in contact with completed the survey
- All channels (web, phone, mail) saw significant use
- Of the 18,153 responses received from November 2018 – August 2019
  - 810 responses indicated they were without identified needs
  - 17,343 responses averaged 3 needs per survey, with 43,733 needs in all



A balanced, multi-channel outreach campaign led to a high rate of response, with two thirds of polled members engaging. Those who responded overwhelmingly indicated some level of need.

Population and Member-Level Insights

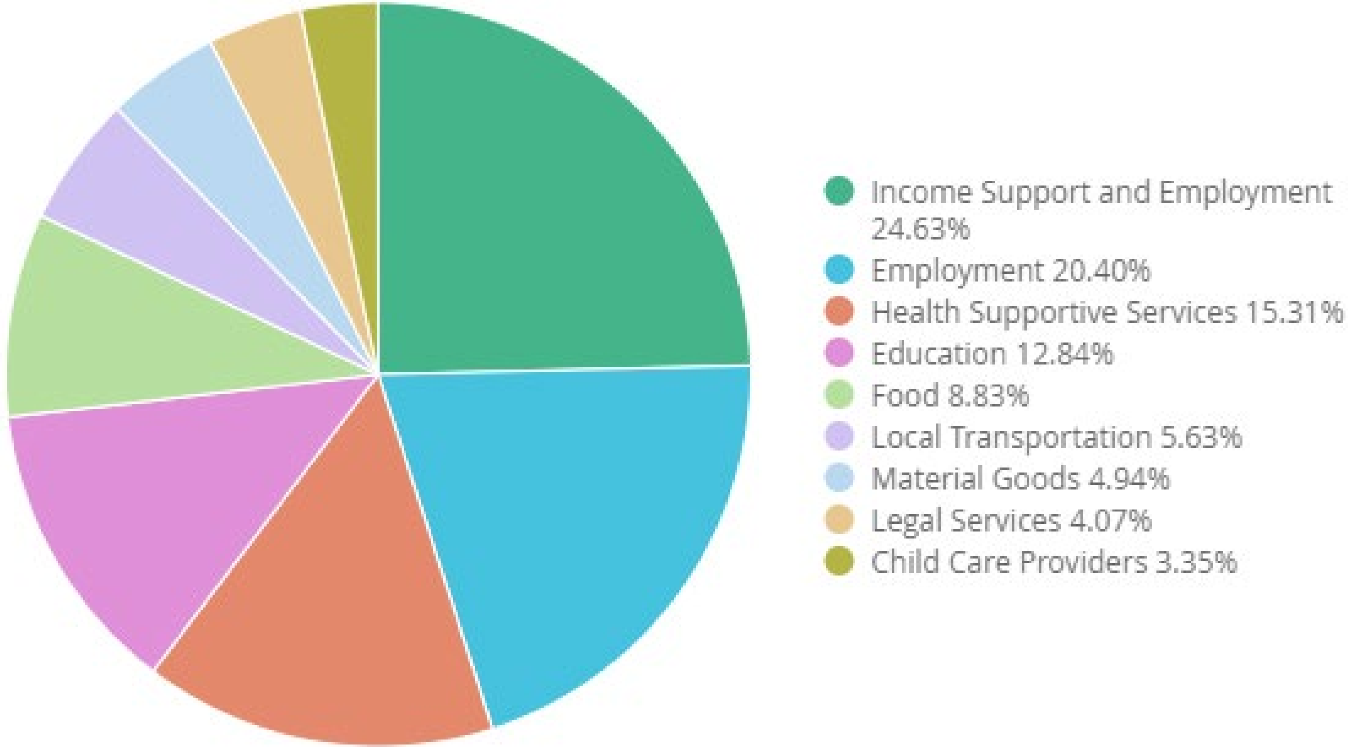
These insights help identify:

- Which needs are greatest
- Where help is needed the most
- Upstream social needs which create claims downstream
- Social risk profile of MCOs at the Plan and Program levels

Each response also indicates the ability to impact a person before a healthcare claim is generated.

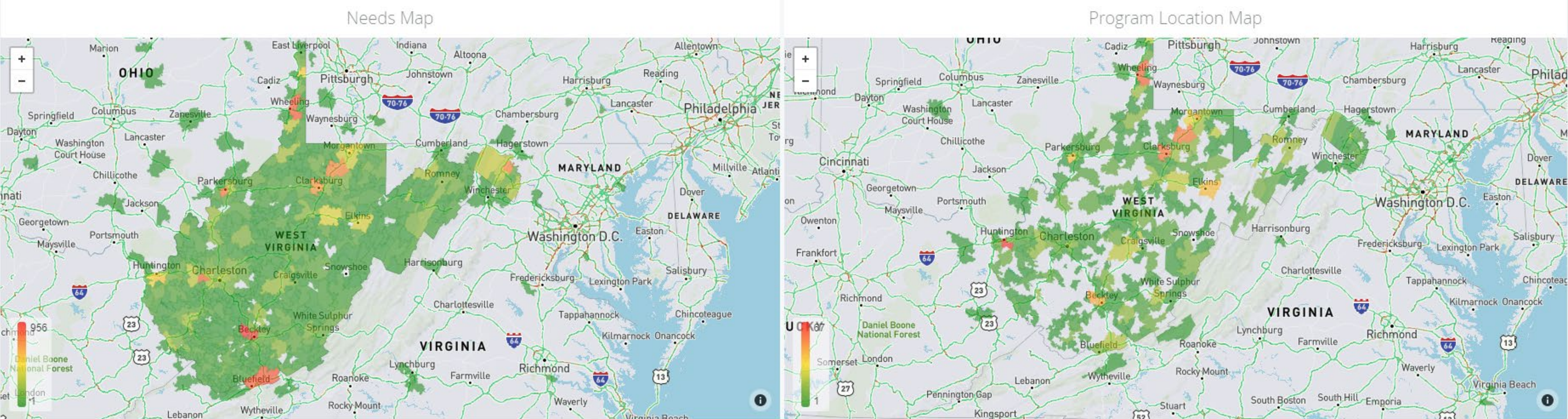
Report Findings – Initial Breakdowns

The highest need category reported is income support and employment (24.63%) which, while unsurprising, gives us a clear target when moving to Phase 2



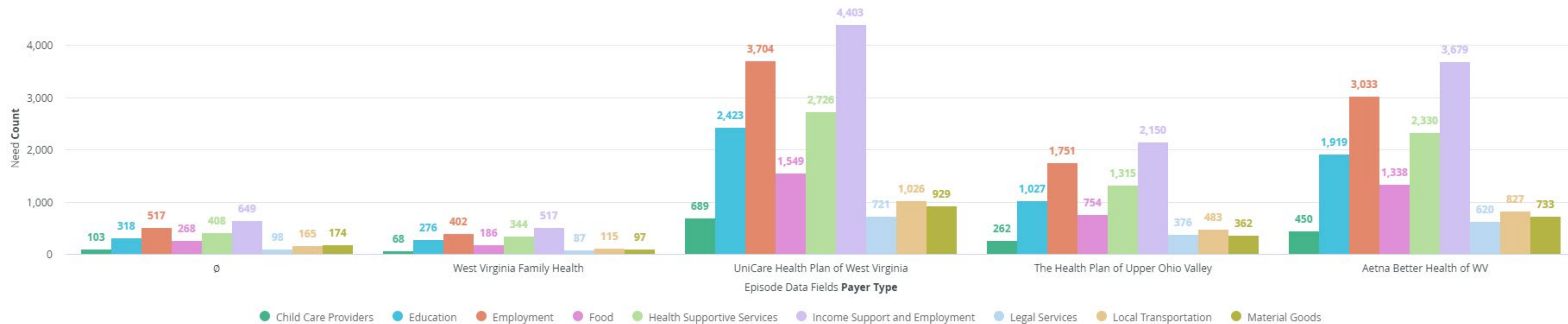
Report Findings – Assistance Availability

These heat map reports show needs reported relative to available programs across the state to identify underserved areas



Report Findings – HMO Impact

- Across all HMOs in WV, income support and employment is the highest need identified
- In WV, needs are reported to MAXIMUS prior to member enrollment which positions us to reach out to members when they are most vulnerable (i.e. newly in the program)
- By aggregating the data in one central system, MAXIMUS is able to follow the member through the process even if they move between health plans or in and out of the Medicaid Program



Note: The 0 category denotes members who have not chosen a plan or have not been auto-assigned yet

Leveraging Insights Into
Action and Outcomes

Cost of Unmet Needs

Need	Questions
Income Support	Energy insecure people incur an additional **$1800** in medical cost per year
Employment	Employment insecurity is measured by financial stress ($413) + depression ($993) = **$1406** additional medical cost per year
Health Supportive Services	Unnecessary ER Visits is an average cost of **$1233** per visit
Food	Food insecure people incur an additional **$1800** in medical cost per year
Local Transportation	Missing non-emergency doctor visits is estimated to cost **$2200** per person per year
Material Goods	Employment insecurity is measured by financial stress ($413) + depression ($993) = **$1406** additional medical cost per year
Child Care Providers	Missing non-emergency doctor visits is estimated to cost **$2200** per person per year
Housing/Shelter	Used all drivers – energy insecure, food insecure, ER cost, cost of missing appointments, financial stress, and depression which is **$8439** per year

Leveraging Insights Into Action

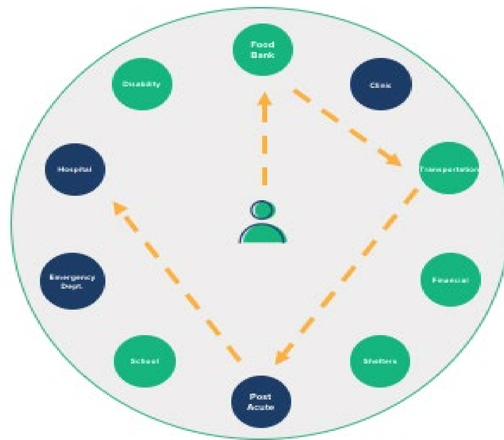
Opportunity to intersect with the member **before** they truly enter the healthcare cycle.

Provide ***Pathways*** to address member's needs, generate measurable outcomes, and create a longitudinal social record that follows the member through acute episodes and sporadic Medicaid enrollment.

Improve health outcomes and quality of care *[of distinct populations]* by building accountable and curated networks of community and health partners to safely collaborate and coordinate social services around West Virginians with heightened social risk **before they enter the healthcare cycle.**

Pathways: A series of organized actions in TAVConnect that drive towards pre-determined goals for a member population.

Longitudinal Social Records



Understand	**Build**	**Connect**	**Measure**
all social needs	social care plans	best resources	outcomes

Pathways: A series of organized actions in TAVConnect that drive towards pre-determined goals for a member population.

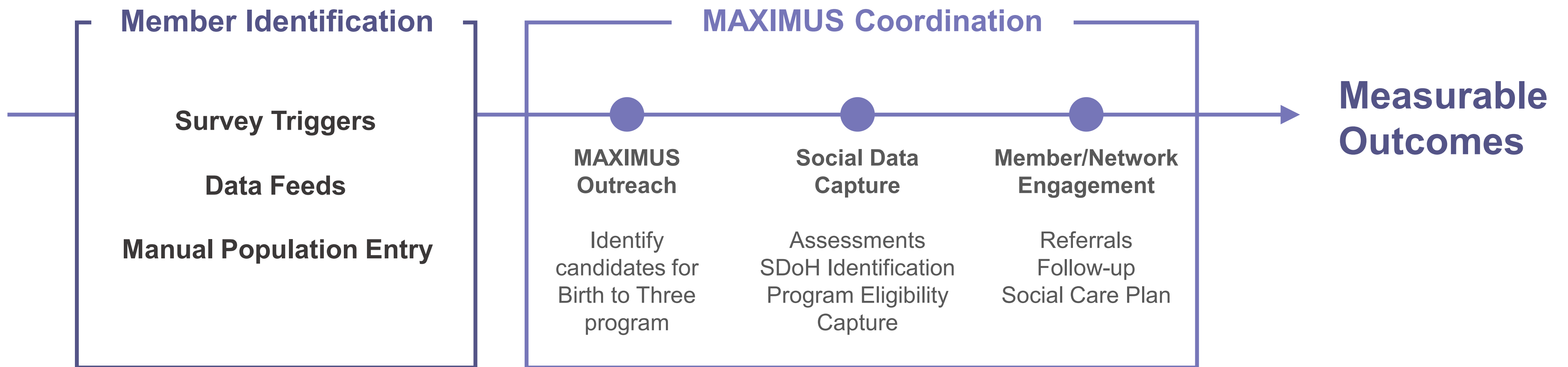
Longitudinal Social Records

- Collection of member data that track, among other things:
  - Healthcare interactions
  - SDoH intervention
  - Socioeconomic data points

- SDoH intervention can evolve as member needs change. If one need is met and an outcome is successful, another need may present itself. Tracking all of these data points in a single, centralized manner allows for improved SDoH interventions and better long-term outcomes.

How Pathways Work

From member identification to a coordinated care journeys, Pathways solve the SDoH that put outcomes at risk.



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Example: Mom and Baby Pathway

By defining the goals required to ensure a healthy pregnancy and quality outcomes, Pathways empower a community network to solve SDoH putting outcomes at risk.

Goals of Pathway	Identify Needs	Perform Tasks	Results	Pathway Outcomes Measured
• Reduce incidence of low birth weight • Reduce infant mortality	**Assessments to determine contributing SDoH:** • Transportation • Health Literacy • Food Insecurity • Basic Needs	• Capture program eligibility • Refer to community partners best suited to solve SDoH • Provide routine outreach & follow-up • Refer to State Programs as appropriate.	Transportation – **Solved** Health literacy – **Solved** Food Insecurity –**Solved** Basic Needs **– Solved**	**Reduced Costs** **Reduced NICU stays** **Increased Birth Weight** **Reduced infant mortality**

Next Steps

Next Steps

MAXIMUS and TAVHealth are developing a roadmap for Phase II services to bring back for DHHR consideration.

This includes:

- Demonstrate outreach and referral functionality within TAVConnect to DHHR
- Staffing to support member referrals and case management
- Outreach to CBOs to engage them in Pathways
- Extending the TAVConnect platform to MAXIMUS coordinators, CBOs, and members

Pilot Expansion

Now that MAXIMUS has collected all this data, we are proposing to expand the pilot and create actionable results from the survey data. This will include:

1) Developing **operational process flows** to track the members through the outreach process
2) Build a **network of community resources** that access TAVConnect to receive referrals and work with members to help get their needs addressed and drive positive health outcomes
3) Develop a reporting framework to **understand efficacy** of the outreach and **determine ROI** for performing the outreach

Summary

- Social Determinants of Health are critical socioeconomic factors that can serve as major drivers of health outcomes. By addressing these needs, organizations can positively impact health outcomes.

- In WV, MAXIMUS has collected data on the SDoH needs of Medicaid members; we are now in the process of developing a second phase of the pilot to outreach to members and help drive positive health outcomes, as well as realizing potential savings for the state

Questions?