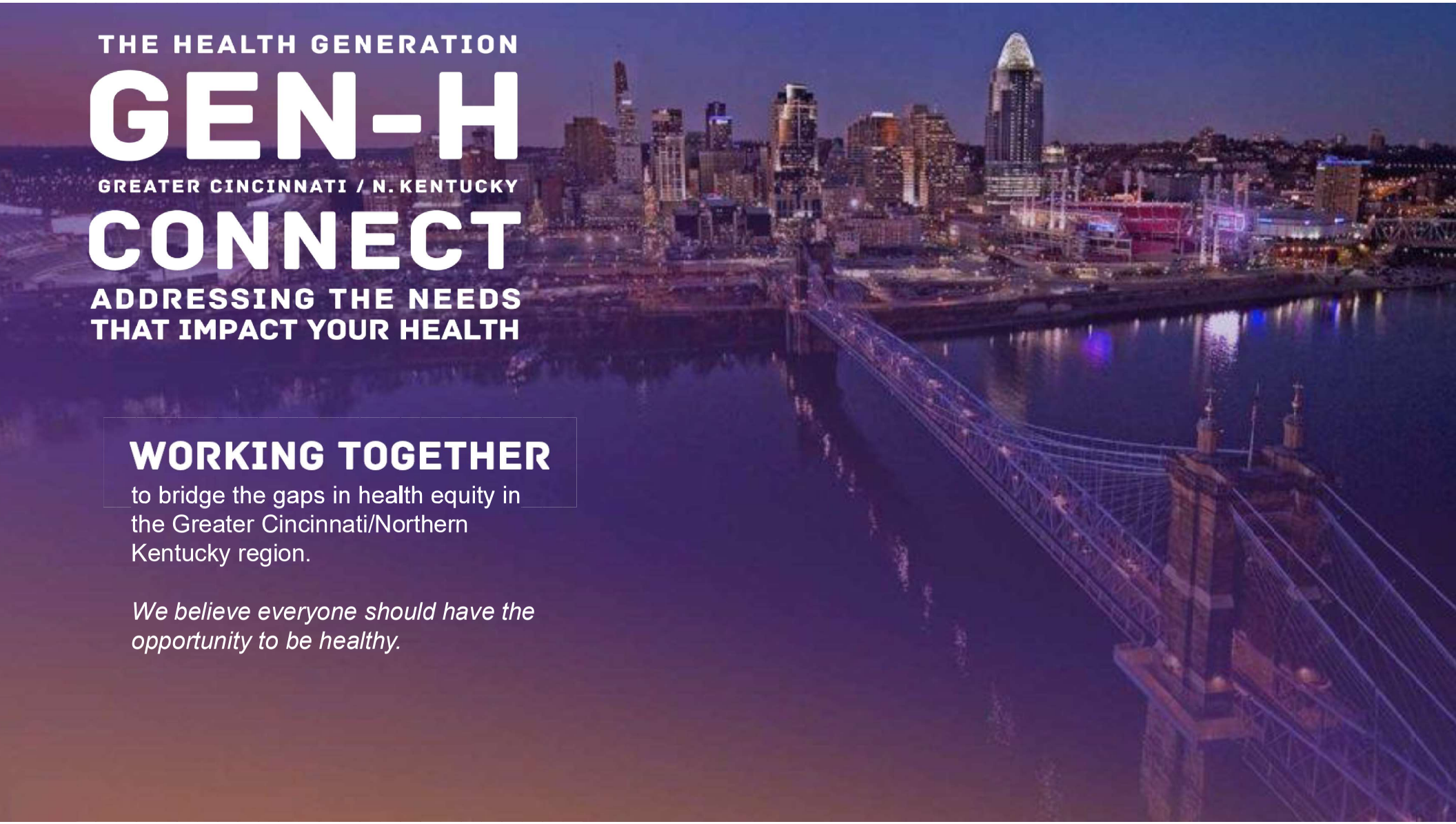
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GREATER CINCINNATI / N. KENTUCKY
CONNECT
ADDRESSING THE NEEDS
THAT IMPACT YOUR HEALTH
WORKING TOGETHER
to bridge the gaps in health equity in the Greater Cincinnati/Northern Kentucky region.
We believe everyone should have the opportunity to be healthy.

The Missing Health Link

80% of health is determined by factors outside of the healthcare we receive. The conditions where we live, grow and age are often more impactful than the medical care we receive when it comes to staying healthy and improving health outcomes.

These factors include **housing, transportation, utilities, hunger, and interpersonal violence**. As a community we are realizing the vital need to address health-related social factors in order to improve our overall health outcomes.

What Determines Our Health?

Designing Healthcare

Treating the whole patient means designing a healthcare system that is more accessible, coordinated, continuous, and comprehensive - a system where **value is based on the quality of care** provided and **rewards providers for both efficiency and effectiveness**.

The Case for Integrating Social Determinants

VIEWPOINT

Addressing Population Health Integrators in the Accountable Health Communities Model

"The Health Collaborative applies its expertise as a nonprofit, data-driven health care improvement organization to lead a broad coalition of community partners focused on improving the health of communities in Cincinnati, Ohio, where life expectancies can vary by more than 20 years across neighborhoods."

-Journal of the American Medical Association, November 2017

POPULATION HEALTH

Social determinants of health: The ProMedica story

Poor education, food insecurity, underemployment and inadequate housing all can harm an individual's — and community's — health.

September 11, 2017 | Ian Morrison

The health care community is showing a significant and growing interest in the social determinants of health. The rise of population health, providers' embracing risk, increased focus on community benefits and growing scientific evidence have all driven an appreciation that social factors such as income, education and food security can determine health status, health needs and health outcomes.

https://www.trusteemag.com/articles/1289-social-determinants-of-health-the-promedica-story

POPULATION HEALTH MANAGEMENT
Volume 00, Number 00, 2018
Mary Ann Liebert, Inc.
DOI: 10.1089/pop.2017.0199

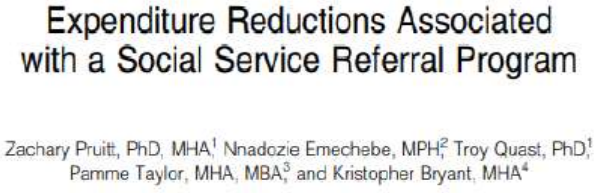
Original Article

Mapping the impact of social determinants of health

By Virgil Dickson | March 31, 2018

At UAMS Medical Center in Little Rock, Ark., clinicians are prompted by their electronic health record system to ask patients personal questions about their home life and eating habits. Those inquiries over the past few years helped reduce the hospital's overall readmission rate to 10% from 13.8% before it began gathering data on social determinants of health—factors that are profoundly linked to overall health.

http://www.modernhealthcare.com/article/20180331/NEWS/180339986



Expenditure Reductions Associated with a Social Service Referral Program

Zachary Pruitt, PhD, MHA,[1] Nnadozie Emechebe, MPH,[2] Troy Quast, PhD,[1] Pamme Taylor, MHA, MBA,[3] and Kristopher Bryant, MHA[4]

https://www.liebertpub.com/doi/pdf/10.1089/pop.2017.0196

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Connecting clinical care to social services

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ADDRESSING THE NEEDS THAT IMPACT YOUR HEALTH

Accountable Health Communities model

5-year demonstration project: May 2017 - April 2022

The Accountable Health Communities (AHC) Model will assess whether **systematically identifying the health-related social needs** of community-dwelling Medicare and Medicaid beneficiaries (CDB's), including those who are dually eligible, and addressing their identified needs, impacts those CDBs' **total healthcare cost** and their inpatient and outpatient **healthcare utilization.**

Complete **56,250** screenings and **2,187** navigations during Year 2 of the project.

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Participating Partners

Clinical Delivery Partners

Health Systems

- Cincinnati Children's Hospital Medical Center
- The Christ Hospital Health Network
- TriHealth
- UC Health

FQHC, Primary Care & Behavioral Health

- Centerpoint Health
- City of Cincinnati Health Department
- Crossroad Health Center
- Talbert House
- Warren County Combined Health District

Participating Partners

Community Partners

Navigation Partners

- CareSource
- Molina Healthcare of Ohio
- Healthcare Access Now
- Cincinnati-Hamilton County Community Action Agency
- Council on Aging of Southwest Ohio

Community Based Organizations

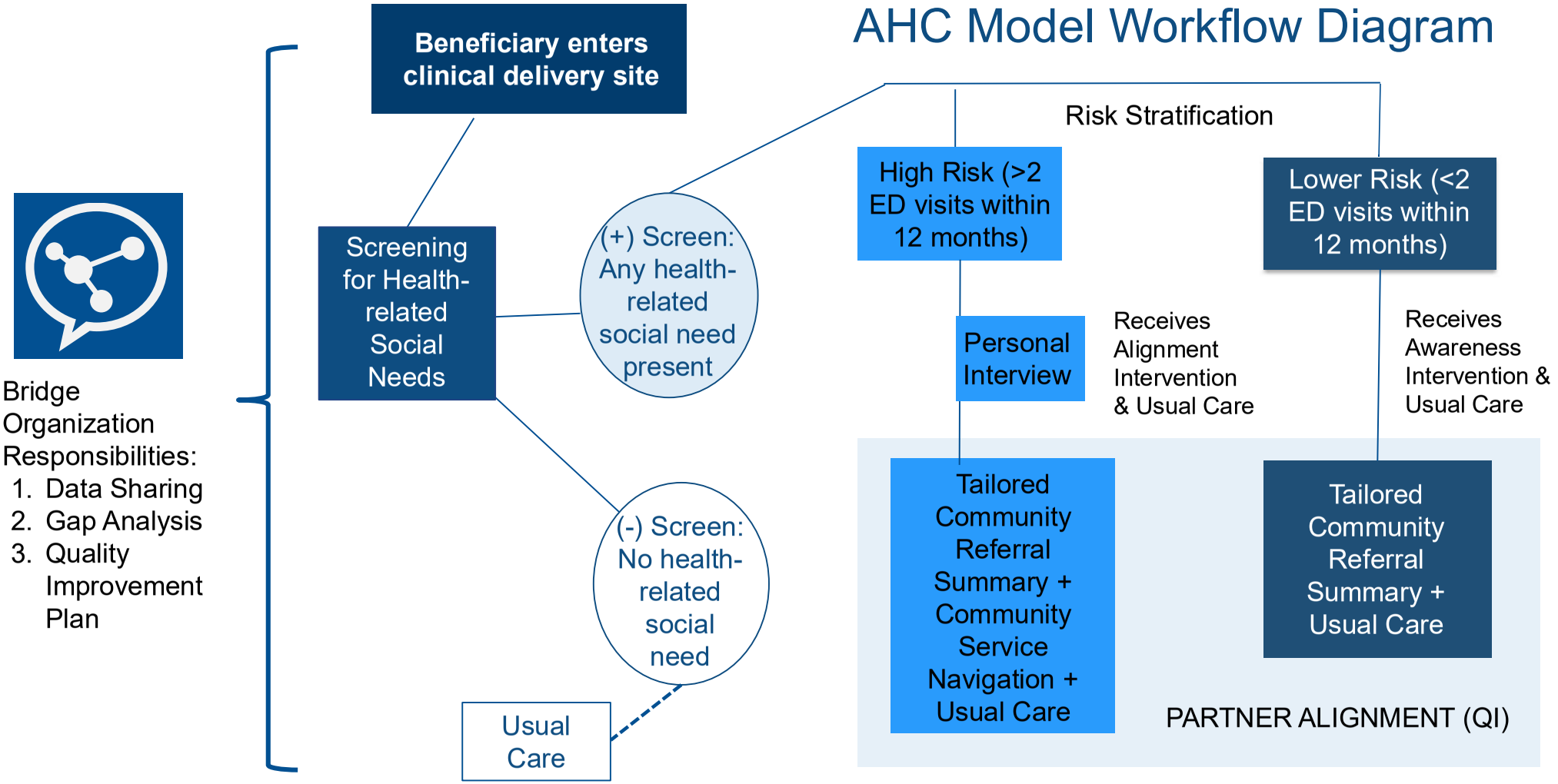
- United Way of Greater Cincinnati
- United Way of Greater Dayton
- Ohio Department of Medicaid

The Model

Participating clinical sites and community partners will implement the **four components** of the model via Healthify:

1. **Screening** to identify certain unmet health-related social needs (food insecurity, housing, transportation, utilities, and interpersonal violence)
2. **Referral** to increase awareness of community services
3. **Navigation** services to assist high-risk w/accessing community services
4. Encouraging **alignment** between clinical and community services to ensure services are available and responsive

AHC Model Workflow Diagram



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ADDRESSING THE NEEDS THAT IMPACT YOUR HEALTH

Screening Tool

Survey given to patients to identify health-related social needs:

- Developed by National Academy of Medicine
- Identify eligibility
- Risk stratification
- Administered via Healthify; software solution for connecting clinical and social services

Disclaimer

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