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?

<table>
<thead>
<tr>
<th>Healthcare</th>
<th>Genetics &amp; Social Determinants of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>80%</td>
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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

"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

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.

Expenditure Reductions Associated with a Social Service Referral Program

Zachary Pruitt, PhD, MHA, Nnadozie Eniechiebe, MPH, Troy Quasi, PhD, Pammie Taylor, MHA, MBA, and Kristopher Bryant, MHA


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


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

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.
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
Beneficiary enters clinical delivery site

Screening for Health-related Social Needs

(+) Screen: Any health-related social need present

(-) Screen: No health-related social need

Usual Care

High Risk (>2 ED visits within 12 months)

Personal Interview

Tailored Community Referral Summary + Community Service Navigation + Usual Care

Lower Risk (<2 ED visits within 12 months)

Receives Awareness Intervention & Usual Care

PARTNER ALIGNMENT (QI)

Risk Stratification

Bridge Organization Responsibilities:
1. Data Sharing
2. Gap Analysis
3. Quality Improvement Plan

AHC Model Workflow Diagram

Usual Care

Tailored Community Referral Summary + Usual Care

Personal Interview

Receives Alignment Intervention & Usual Care
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
The project described was supported by Funding Opportunity Number CMS 1P1CMS331598-01-00 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.