ACOs Advancing Health Equity: Southwestern Health Resources

September 2021

Defining Equity and Disparity

Healthy People 2030 defines ***health equity*** as "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." A ***health disparity*** is "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage."

Social determinants of health (SDOH) are the conditions where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

— Adapted from Healthy People 2030

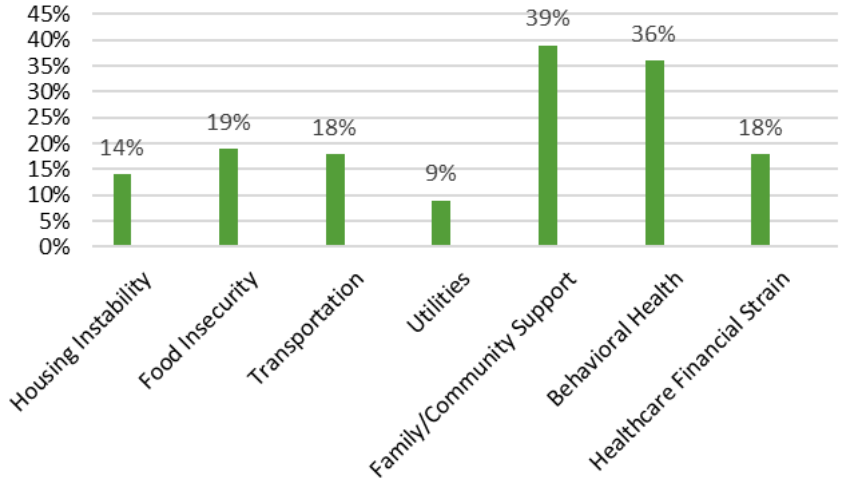
Identifying Social Needs to Advance Equity

Anchored by the University of Texas Southwestern Medical Center, Southwestern Health Resources (SWHR) includes a network of 29 hospital locations and more than 5,000 physicians and other providers serving people across 17 counties in North Texas. In total, SWHR coordinates care for approximately 700,000 patients across commercial health plans and Medicare, including 100,000 beneficiaries attributed to a Medicare Next Generation ACO, which was the nation's top performing ACO for savings in 2019—$52 million. A key element of the ACO's success is identifying and screening complex, high-risk beneficiaries for social needs like food and housing insecurity, according to Yolanda Rodriguez, R.N., SWHR vice president of care and disease management.

SDOH Team Targets High-Risk Beneficiaries

SWHR launched a social determinants of health (SDOH) program in 2018 with a goal of increasing quality of care and patient satisfaction while reducing utilization and overall costs. Through the SDOH team, which includes licensed social workers and community health workers, the ACO screens beneficiaries receiving care management services for housing instability, food insecurity, transportation problems, utility assistance, family and community support, behavioral health, and healthcare financial strain. Of the more than 3,500 patients screened between June 2019 and March 2021, about 1 in 7 experienced housing instability, 1 in 5 faced food insecurity, and more than 1 in 3 experienced a behavioral health need (see Exhibit 1).

Exhibit 1. Patients Screening Positive for Social Needs



After identifying a social need, the SDOH team taps a database of community resources to assist patients in meeting their needs. The SDOH team follows each patient for 90 days, and before completion, evaluates whether the patient's identified social needs were met.

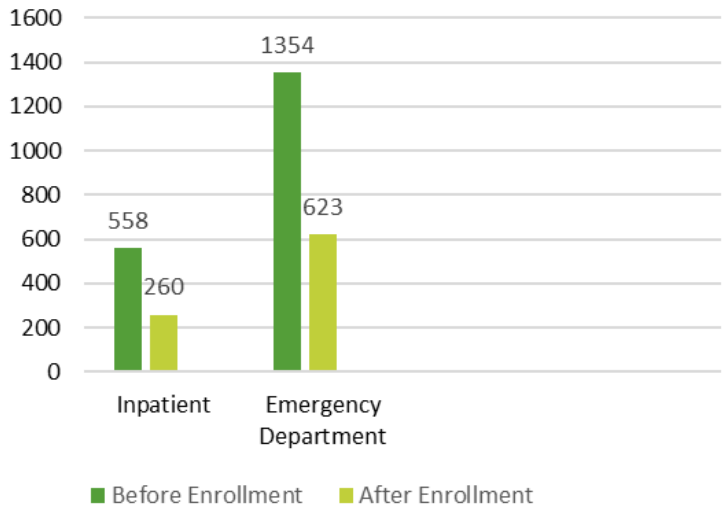
Most of the time patients reported their needs were met for housing (60%), food insecurity (77%), and transportation (73%), utilities (74%), family and community support (64%), behavioral health (61%), and healthcare financial strain (61%), according to Rodriguez.

SDOH Impact Linked to Lower Inpatient and Emergency Department Utilization

To understand impact on utilization, SWHR evaluated 1,078 patients enrolled in the SDOH program between June 2019 and March 2020 by looking at their rate of inpatient admissions and emergency department visits 6 months before enrollment compared to 6 months after enrollment. The analysis showed a 53% drop in inpatient admissions and a 54% drop in emergency department visits (see Exhibit 2).

Moreover, the reduced inpatient and ED utilization translated to a 57% reduction in costs, from $11.3 million for the 6 months before SDOH enrollment to less than $1.9 million in the 6 months after enrollment, according to Rodriguez. "It all goes back to the value of how these programs can make such an impact not only for our members and our providers but also for our payers," she said.

Exhibit 2. Utilization 6 Months Before SDOH Enrollment and 6 Months after Enrollment



Winning Over Clinicians and Patients…and the C-Suite

Initially, both clinicians and patients were sometimes reticent about asking and answer questions about food and housing insecurity and other social needs, Rodriguez said. But over time, and with the assistance of social and community health workers trained in motivational interviewing techniques, seeking information about social needs that pose barriers to care has been incorporated into practice. "It really was a learning process… now the providers understand and they are really looking to us to help with some of these things—that if a member can't come into the office for a visit, they know we can help with that … and I think it's just going to get to more normalcy as it develops," she said. Similarly, monitoring and evaluating outcomes have helped build the case for expanding investments in advancing equity by responding to social needs and SDOH, Rodriguez said, adding, "We've been able to provide financial information that when we do that type of advocacy and are able to fund those types of programs for expansion that it does provide us good ROI." Next steps for the SDOH team include expanding efforts to partner with community-based organizations, such as Meals on Wheels, to address food insecurity issues and address patients' behavioral health needs.

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