EL RIO HEALTH

Social Determinants of Health:
Building a Model that Supports the Quadruple Aim

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Chief Executive Officer

SDOH: Renewed Discovery by Multiple Groups

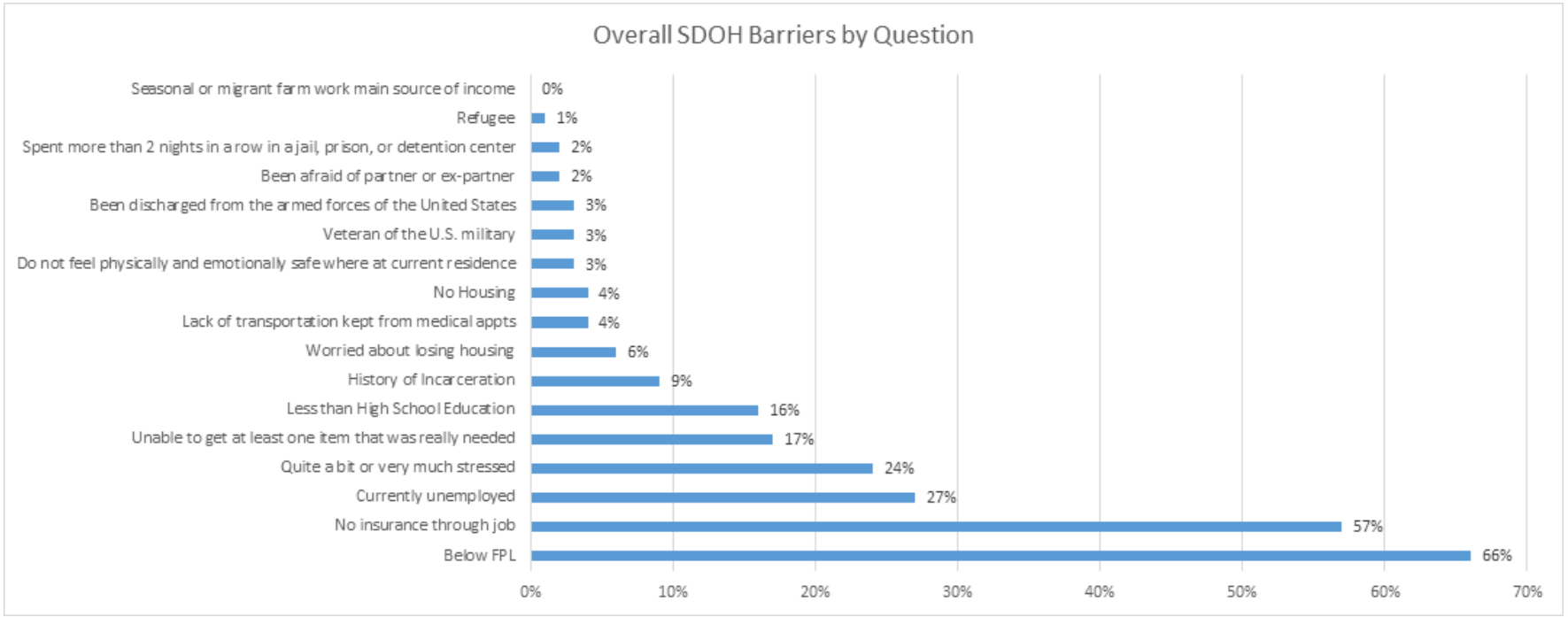
El Rio Current State and Journey Since 2017…

- Identification of SDOH via provider query and referral to Community Health Workers (CHWs)
- CHW address need internally or refer out to community organizations
- Need addressed?? Unknown if community organization closed the loop
- Unwieldy “Health Improvement” Codes with no linkage to ICD-10-CM Z codes

Then Comes PRAPARE and Kiosks/Tablets…

Data Collection January 2018 - July 2019

N = 9,401 Patients Screened; *1,321 Barriers Identified



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Patient-Centered Medical Home NCQA RECOGNIZED PRACTICE

THE JOINT COMMISSION NATIONAL QUALITY APPROVAL

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Crimson Workflow

1. 

Patient completes the PRAPARE survey on tablet at appointment check-in

2. 

An alert is generated on patient's EHR based on survey response, provider sends a referral to the appropriate staff

3. 

EL Rio staff (i.e. Behavioral Health or Community Health Advisor) meets with patient and connects them to a community partner or resource via Crimson referral or warm handoff

4. 

Community partner assists patient to help them meet their needs

5. 

El Rio and community partners communicate and coordinate to document outcomes through Crimson Referrals

6. 

Outcome: Improved Patient Health and Well-Being

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Community Partners

- Community Food Bank
- Southern Arizona Legal Aid
- Interfaith Community Services
- Southwest Medical Aid
- DKA Advocates
- Arizona Youth Partnership
- Old Pueblo Community Services

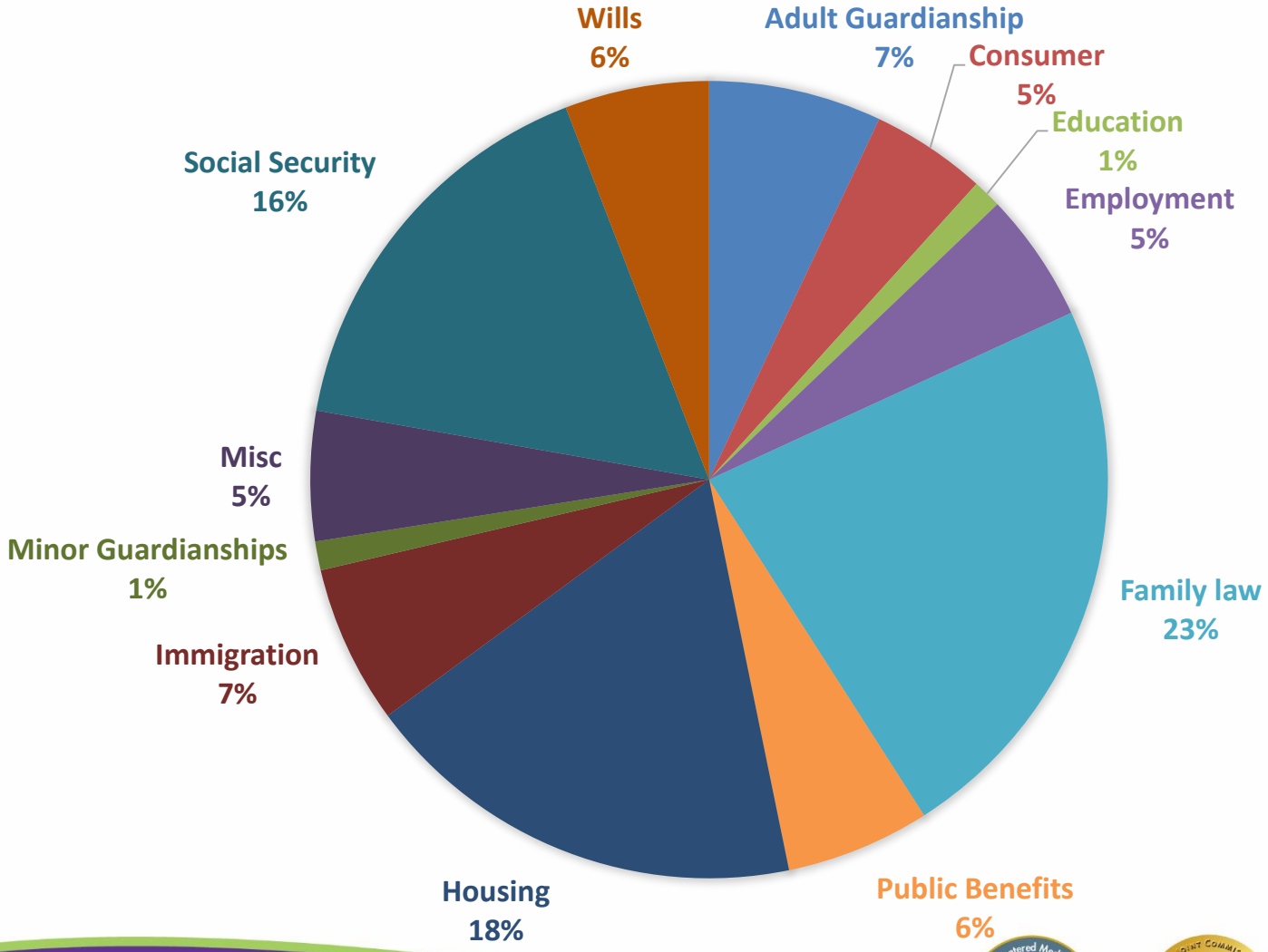
Partner Indicators

- 48 Responses to Referrals
- Documentation of Referral Completion/Close the Loop
- Upload documentation, screening tools, etc.

Community Partners

- Child Development Specialists
- Community Health Workers
- Health Builders Team
- Behavioral Health Consultants

Southern Arizona Legal Aid



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Collaboration with UnitedHealthcare AMA, NACHC & NCQA

Pilot 7/1/2019 – 7/1/2020

- Standardize how data is collected, processed and integrated in the health care system
- Creation of 23 new ICD-10 codes related to SDOH – if approved, available for use April 2020
- Remove barriers and improve health of vulnerable population

El Rio Data Set

- 20,000 unique United Medicaid lives
- Capturing all the SDOH referrals to design a social valuation model
- Assigning a dollar value

Data, Technology & Relationships to Address Social Determinants

2.5M

UnitedHealthcare beneficiaries self-identified social barriers to care collected

758K+

referrals provided for over 600K individuals

$826.9M value of critically important social services provided

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Framing the Challenges – Current Lean Project Underway