PROMEDICA: A NEW MODEL OF HEALTH CARE

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Social Determinants of Health
ProMedica
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CLINICAL AND SOCIAL CARE

NATIONALLY RECOGNIZED for Unmatched Clinical Care

13 ACUTE FACILITIES

National Leader in Managing SOCIAL DETERMINANTS OF HEALTH

EXPERTISE in Prevention, Diagnosis and Treatment of CHRONIC CONDITIONS

Nearly 70,000 Employees

2,600 PHYSICIANS & PROVIDERS with Privileges

HEALTH INSURANCE (PARAMOUNT)

Health Insurance Provider

MORE THAN 600,000 LIVES COVERED

PRODUCTS:

Medicare/Medicaid
Commercial
Dental
Workers Comp/
Employer Solutions

POST-ACUTE CARE (HCR MANOR CARE)

NATIONAL LEADER of Post-Acute Services

Reliable Partner to HEALTH SYSTEMS in 30 STATES

450+ Senior Care facilities

Hospice Patients AVERAGE 10,650/DAY

Home Care Patients AVERAGE 3,300/DAY

ProMedica
Food Insecurity

• Limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.” – USDA*

• Lack of access, at times, to enough food for an active, healthy life

• Food insecurity screenings – 284,942 in 2018

Our SDOH Journey
Health Care Approaches

Traditional healthcare

Collaborative healthcare
<table>
<thead>
<tr>
<th>We do …</th>
<th>But we don’t …</th>
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<tbody>
<tr>
<td>Ask about and encourage exercise</td>
<td>Ask about safety in neighborhoods</td>
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<tr>
<td>Ask about and encourage people to lose weight</td>
<td>Ask about their diet and ability to secure healthy food</td>
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<tr>
<td>Check vital signs</td>
<td>Screen for mental health</td>
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<tr>
<td>Check a child’s growth</td>
<td>Look for signs of toxic stress</td>
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<td>Physical examinations</td>
<td>Ask about their insurance information</td>
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<td>Provide education to patients</td>
<td>Ask if they can read</td>
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<td>Criticize patients who fail to show up for appointments</td>
<td>Ask if they have transportation</td>
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What Drives Health?

Only 20% of health and well-being is related to access to care and quality of services!

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)
Aligning Acute Care Navigation Approach with Naylor’s Transitional Care Model

- Shift from discharge planning to a transitional care planning approach
- Focus on patient activation and engagement
- Care is comprehensive
Comprehensive Risk Assessment by Care Navigators

- Looking beyond clinical care by addressing SDOH
- Executing the Transitional Care Planning Approach Assessment of Risk
- Predictive analytics
- Risk mitigation

ADDRESSING SDOH IN ACUTE CARE SETTINGS
SDOH Interventions

- Food as Medicine
  - Food at discharge
  - Food Clinics
- Depression Screenings
- Financial Opportunity Center
- Pathway HUB
  - Community health workers
  - Housing prescriptions
- Linkage to community and social resources
SDOH Outcomes – Food Insecurity

- **971,000** (194% of target) food screenings
- **7,248** Community Hub cases closed
  - 4,394 patients received SDOH intervention of some kind
- **31,302** people served by Food Clinic
- **947** meals provided at acute care discharge
- **809** employees received food
- **376,151** pounds of food reclaimed
- **131,145** customers served at Market on the Green

**OF 4,000 ADVANTAGE MEDICAID PATIENTS SCREENED AND REFERRED TO FOOD CLINIC:**

- Reduced ED usage (3%)
- Reduced readmission rates (53%)
- Increased primary care visit rates (4%)
- Reduced PMPM (15%)
Implications for Nursing Practice

- Transitional Care Management
- Competencies in the “Art of Nursing Realm”
- Promoting patient activation and engagement
- Top-of-licensure nursing practice/Supporting nursing students and staff
- Shifting from transactional to transformational leadership
- Embedding SDOH into nursing curriculum
- Cultural competency training and experiential learning in community settings
The Challenge

Overall Health and Well-being is Declining

• The U.S. spends more per person on health care than any nation with comparable incomes.

• More people die of preventable diseases in the U.S. than in any other developed nation.

• The U.S. has a significantly lower life expectancy than any other countries that spend less on health care.

The Strategy

National SDOH Institute

• Clinical – Treating the Whole Person
  • Screenings – Connected Care – Reducing costs

• Community – Beyond our Walls
  • Anchor Institution – Ebeid – Collective impact

• Research & Data – Measuring Impact
  • SDOH Research Center – Provider education – Root Cause Coalition

Highest cost doesn’t always equal highest outcome!