ACOs Advancing Health Equity: AMITA Health

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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 include:

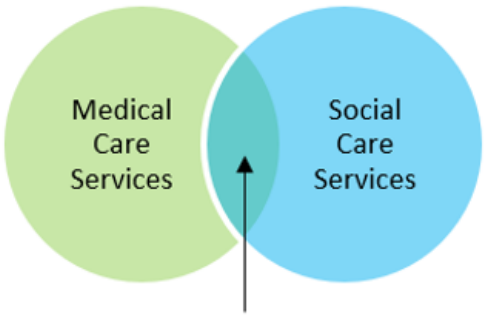
- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

— Adapted from Healthy People 2030

Bridging Medical and Social Needs

As a Medicare ACO since 2013, AMITA Health, a large faith-based health system serving greater Chicago, has focused on slowing costs and improving quality. So, when the Centers for Medicare & Medicaid Services launched the Accountable Health Communities Model in 2017, AMITA jumped at the opportunity to scale efforts to integrate screening and referral for social services into clinical settings (see Exhibit 1). Through the model, AMITA serves as a "bridge" organization to potentially screen and link more than 500,000 Medicare and Medicaid beneficiaries to needed social services, including housing, utilities, food, transportation, and interpersonal violence. "Being an ACO and moving toward value-based care in general, any opportunity we can find to decrease expenditures and improve quality of care, were going to take advantage of that," said Aleta Rupert, program manager of AMITA's model. "We saw ourselves as a fertile test ground for clearly what's emerging as a paradigm shift in health care."

Exhibit 1. Bridging Clinical Care with Social Needs



Health Equity Commitment Across AMITA

Participating in the model "certainly spoke to our commitment to health equity as an organization…. It's built right into our mission. If we have any prayer of giving whole care to an individual, we absolutely need to understand the social context of our patients," Rupert said. Through the model, AMITA has established more than 40 sites—primary care, emergency department (ED), and inpatient—where all Medicare and Medicaid beneficiaries receiving care are offered a screening to identify health-related social needs. High-risk patients—those with two or more ED visits in the last year and a reported social need—are then randomized into an intervention group and assigned a personal navigator to help link them to community resources and a comparison group that received only a list of community resources.

More than 2 in 3 beneficiaries completed the offered screening, and 1 in 4 reported at least one need with housing and food topping the list.

About 70% of beneficiaries accept and complete the offered screening, while 1 in 4 reported at least one need—the top reported needs are consistently housing, food, and transportation. Of beneficiaries eligible for navigation assistance, about 70 percent accept help, Rupert said. Navigators work with patients for up to a year or until the need is resolved, Rupert said, adding that the intensive follow up is the "secret sauce" that makes the difference. To date, early assessment found a 14% reduction in ED use among the intervention group receiving personal navigation assistance, while there was a 58% increase in ED use among the control group.

Key Lessons Learned

Engaging both patient and providers is critical in successful SDOH screening. "How to screen – delivery is everything, and it takes practice," Rupert said. Keeping providers informed about patients being assisted is essential to getting provider buy-in because clinicians are hesitant to raise social needs with patients unless they know assistance is readily available. The COVID-19 public health emergency also reinforced the importance of helping patients with social needs, Rupert. "The level of consciousness was just raised about how someone's social circumstances could change in 30 days," Rupert said.

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Building strong strategic relationships with community-based organizations also is crucial, and it takes time to build a workable navigation process that balances high-tech and high-touch approaches. AMITA is using the Aunt Bertha online platform to link people to community resources. "There are so many technologies coming out around this work, but there is no doubt that there is some human element to it and sort of balancing that out is something we are becoming aware as well," she said. Ultimately, the goal is to integrate electronic medical records with electronic social records to create a seamless referral system. At the same time, current payment models don't support integration of care delivery with meeting people's health-related social needs, making it challenging to sustain efforts to reduce health disparities and inequities.

Moving Forward

Already, AMITA is planning two offshoots of the Accountable Health Communities model—one for people with diabetes and the other focused on people with substance use disorders. "We're eager to continue testing this work and studying its impact on outcomes," Rupert said, adding, "We have a role to play…to bridge our patients…to where they need to be to resolve those social needs so that they can achieve optimal health and well-being."