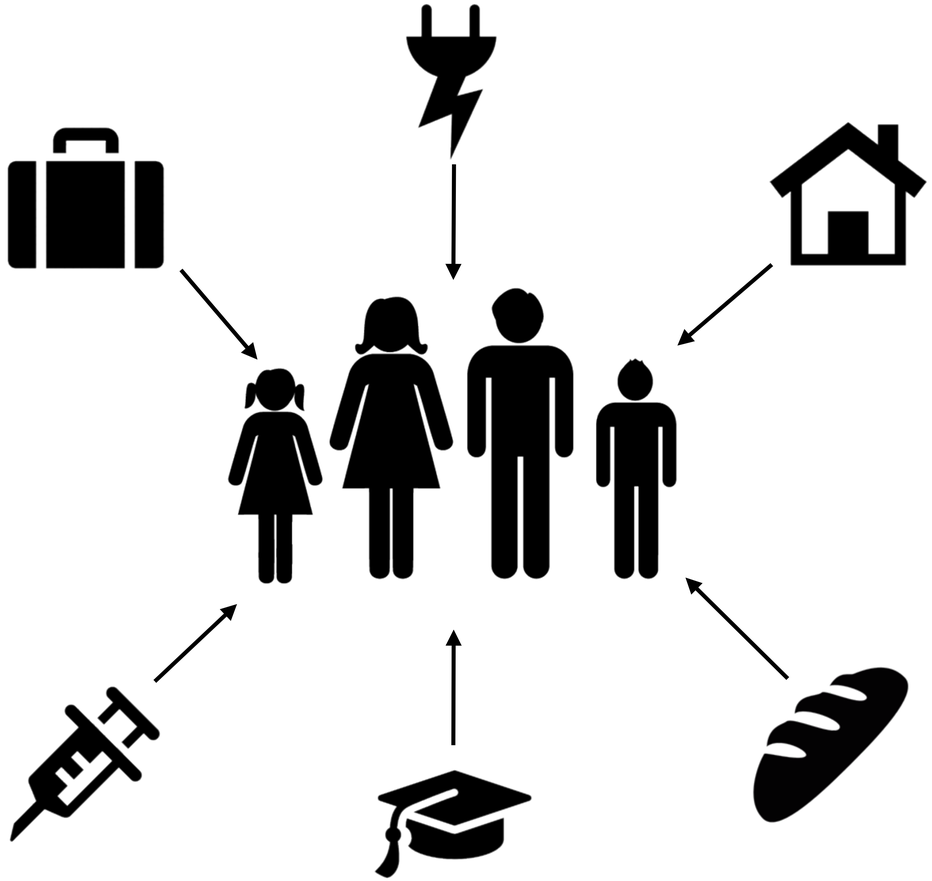
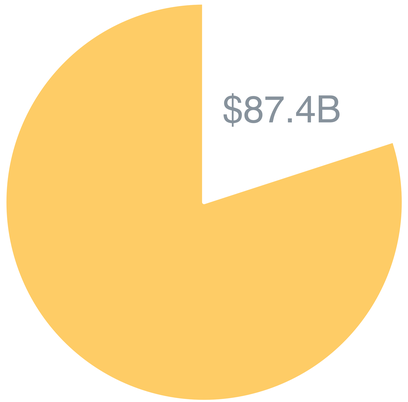

Healthify
CAR SERVICE

Problem



Social Determinants



1/5th of Healthcare Spending

+

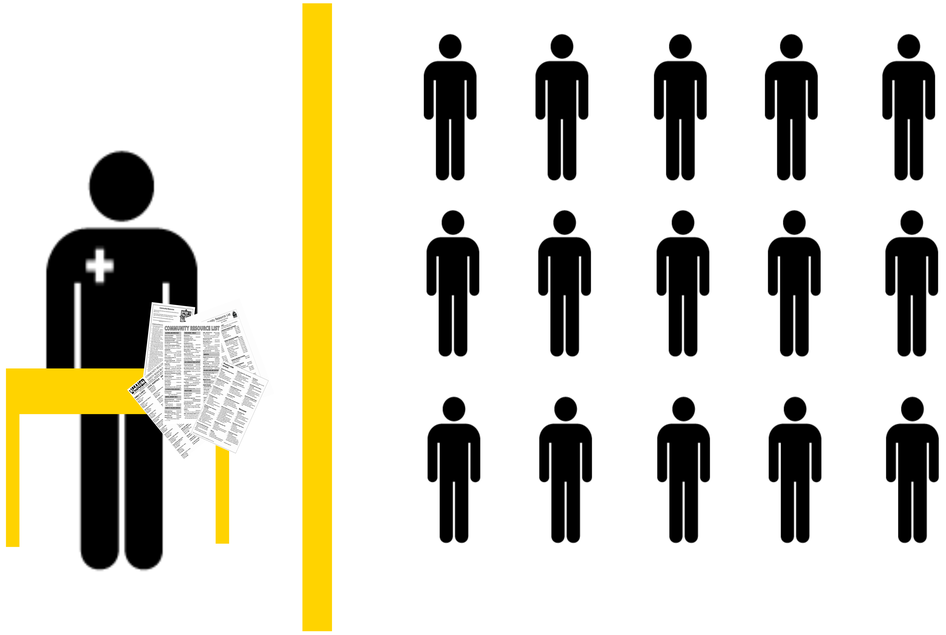
60%

60% of Health Outcomes

We address the social needs of members to reduce costs and improve population health

Current Solution?

Hire Ancillary Care Team (case managers, CHWs)



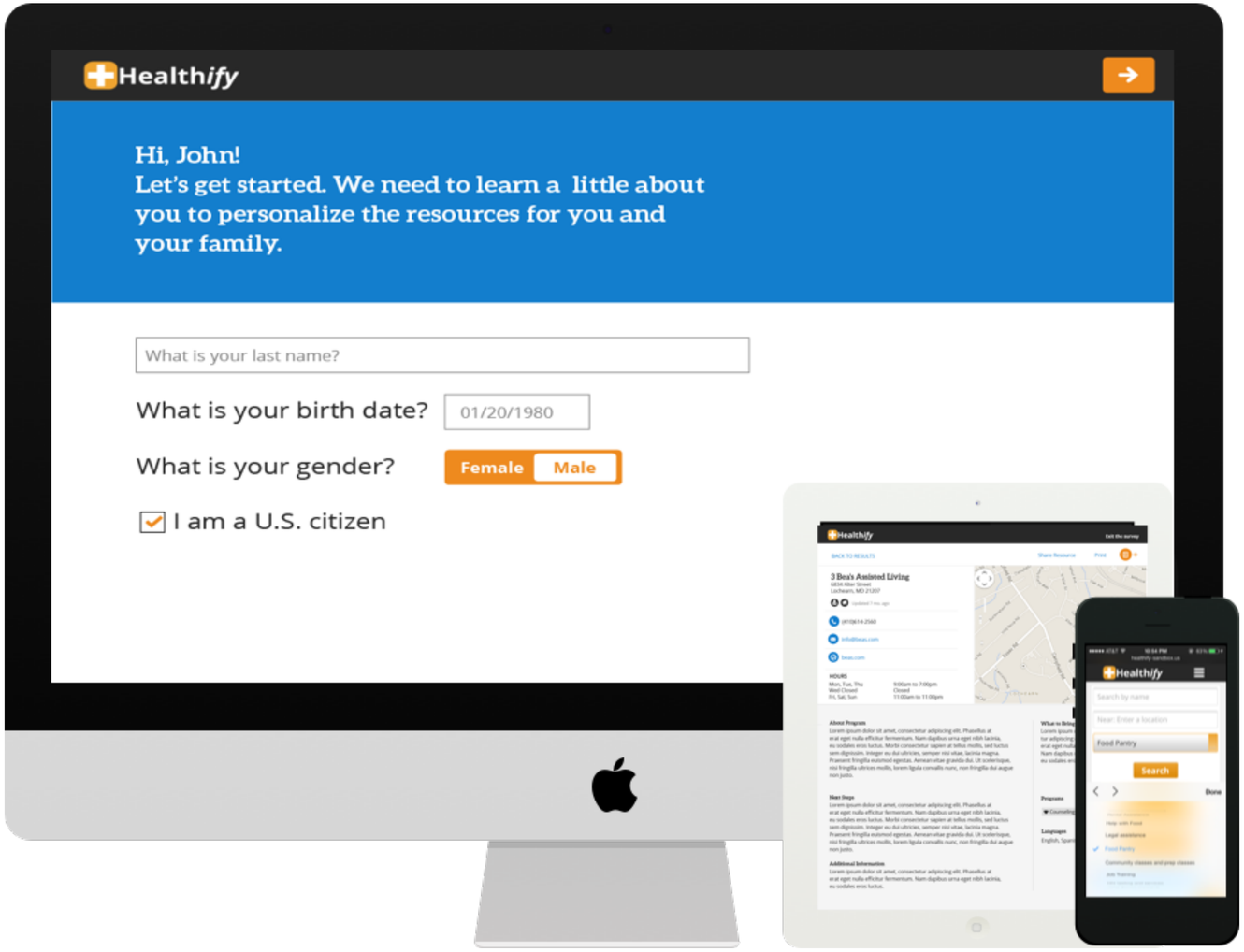
Team is understaffed and relies on paper based workflows to manage members, referrals to social services, and follow up. No standardization on workflows.

Results

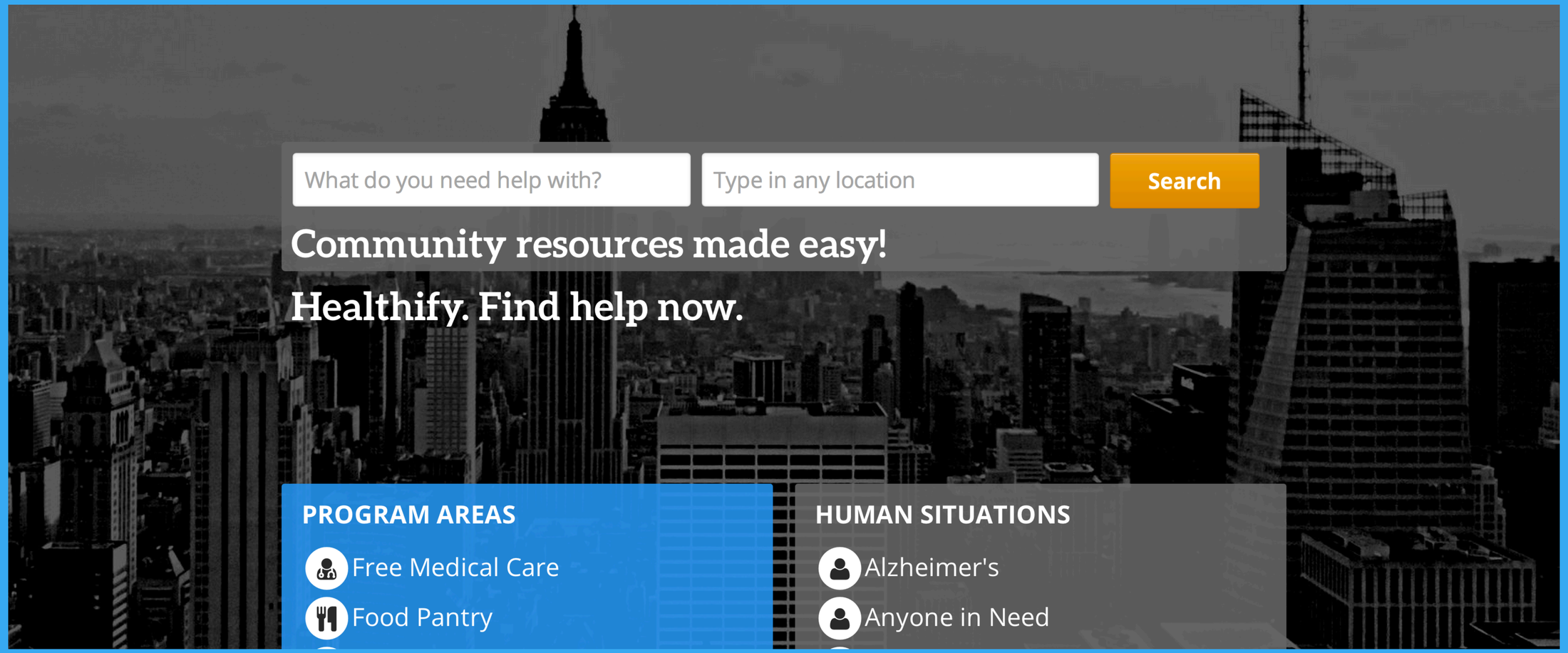
- **Poor Quality:** Less than 20% of members are routinely screened for social risks, like hunger, housing and child care support,[1] though 92% of those surveyed want to talk about these issues and report higher satisfaction if issues are addressed.[2] Four out of five physicians think patients' unmet social needs lead to worse health outcomes and are as important to address as medical conditions.[3]

- **High cost care:** Food-insecure diabetics are 27% more likely to be hospitalized in the last week of the month compared to the first week due to exhaustion of food budgets at month's end. Filling the food gap can reduce unnecessary hospitalizations.[4] Children who experience food insecurity or poor housing conditions are 30% more likely to be hospitalized by age three.[5, 6]

Healthify Solution

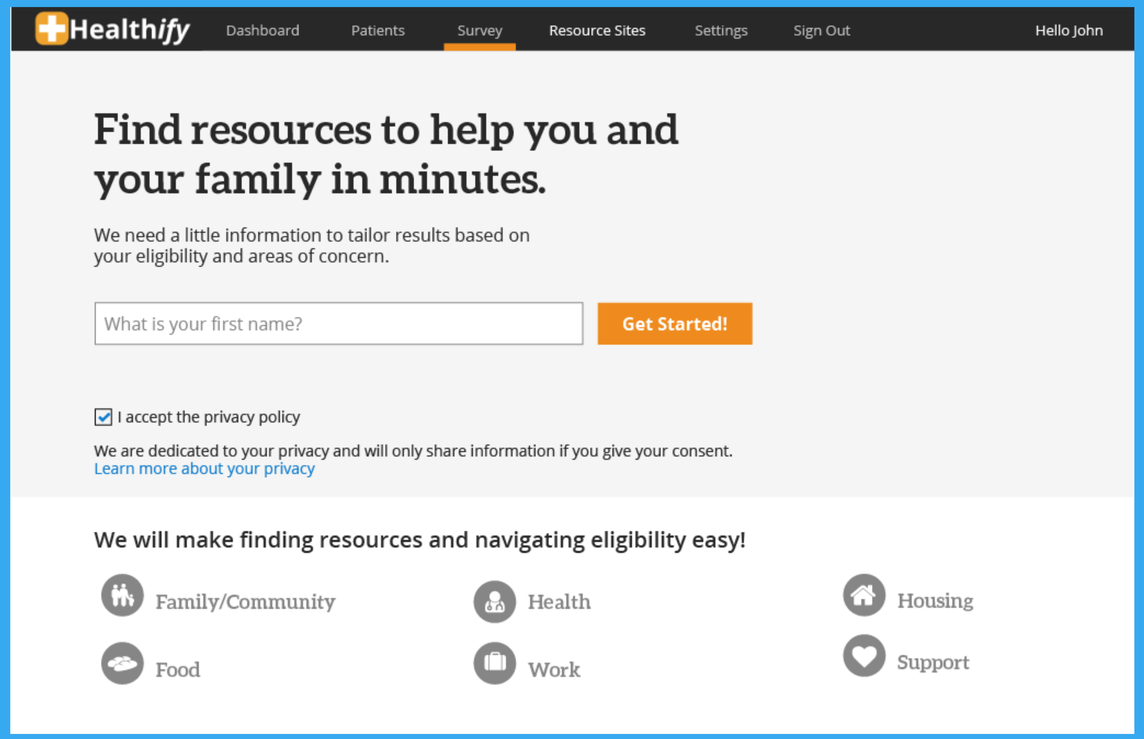


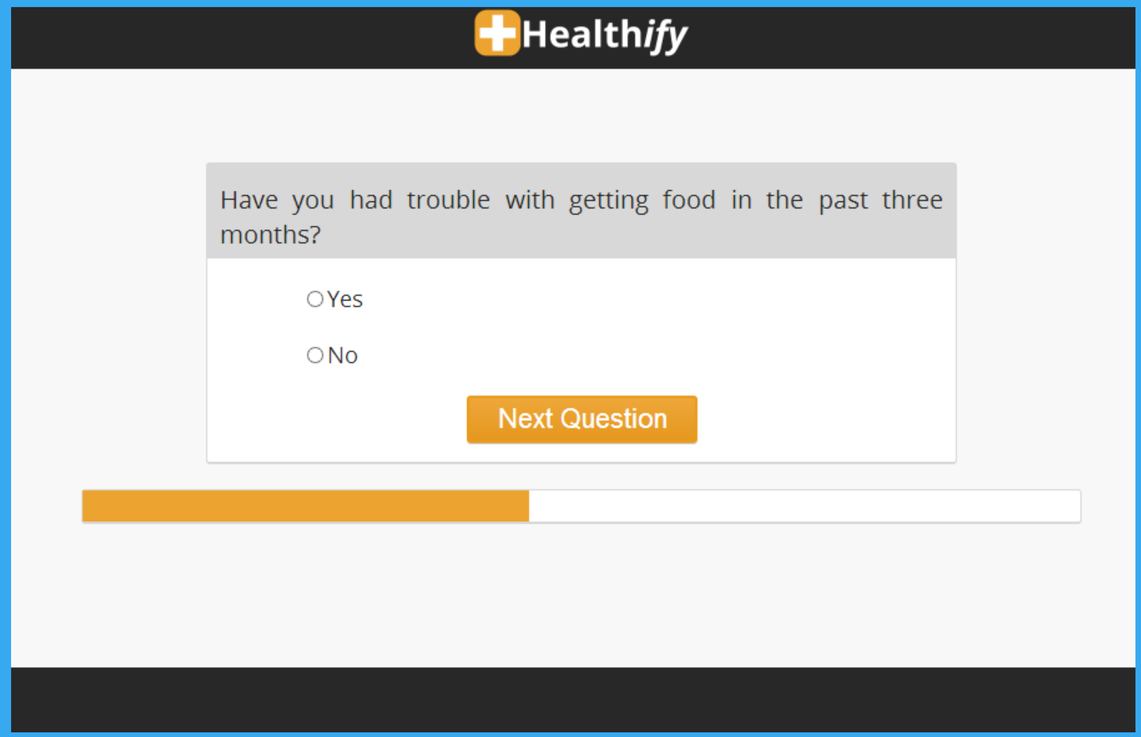
Access



Staff is given access to our resource platform on services to search, edit, modify, and rate resources

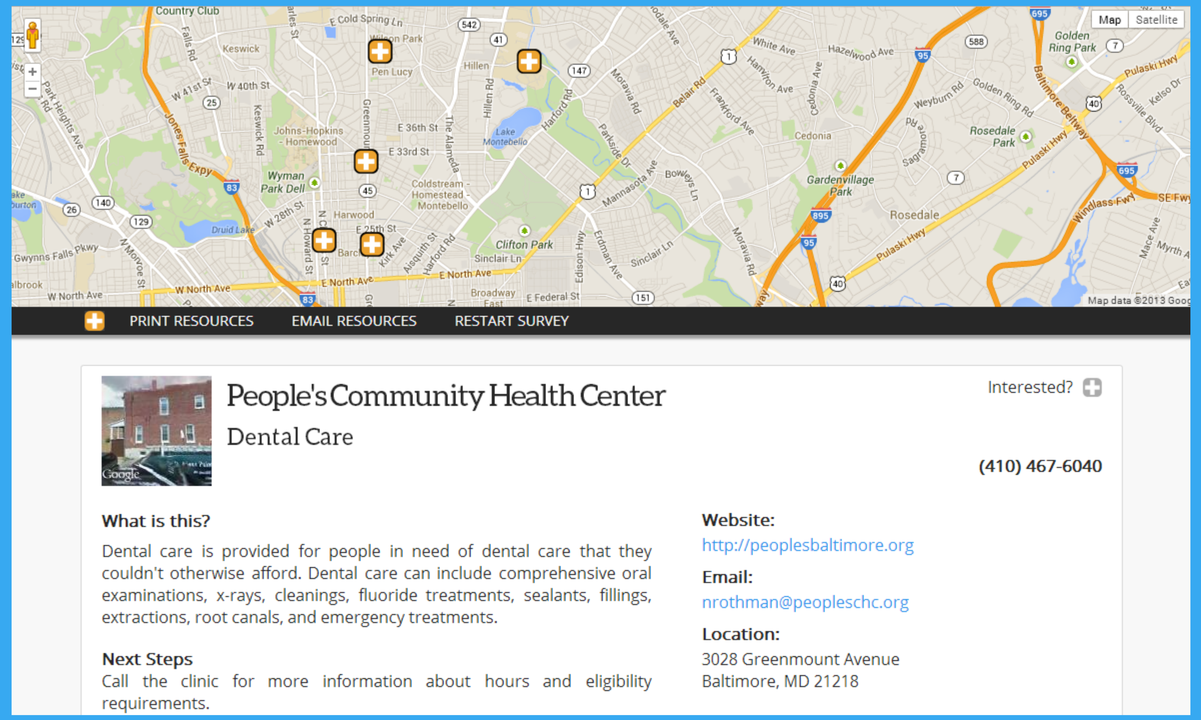
Screen





Members can take our web based screening tool on their own or with a staff member

Connect

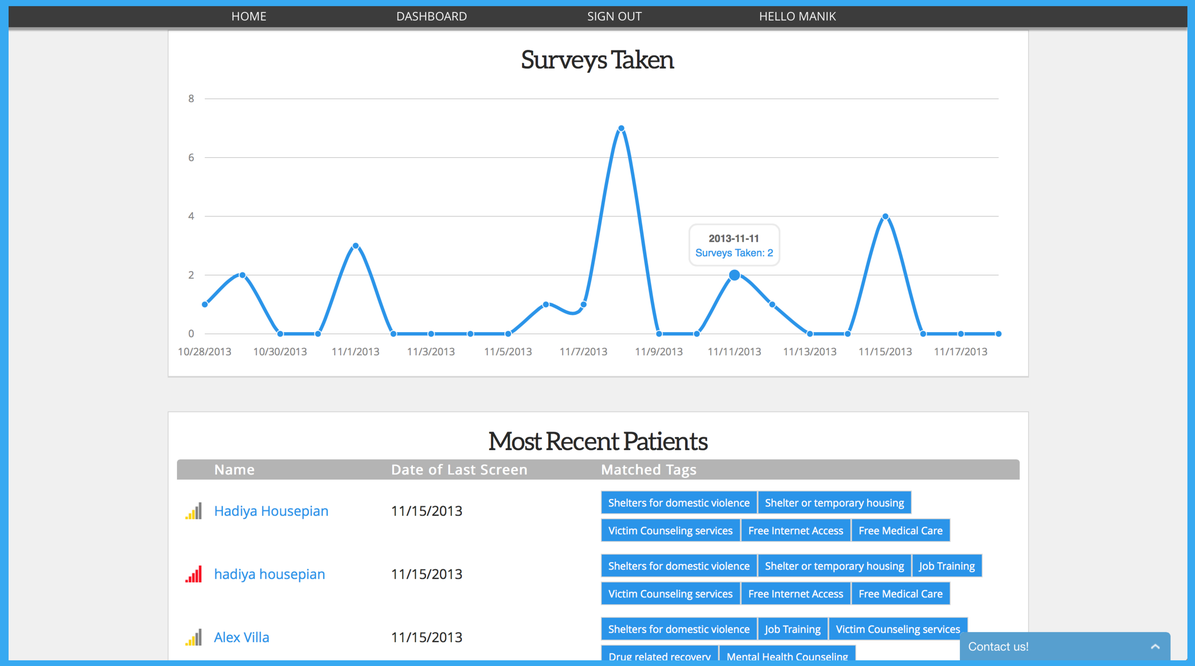


We automatically connect members to the resources they need based on how they responded

Engage

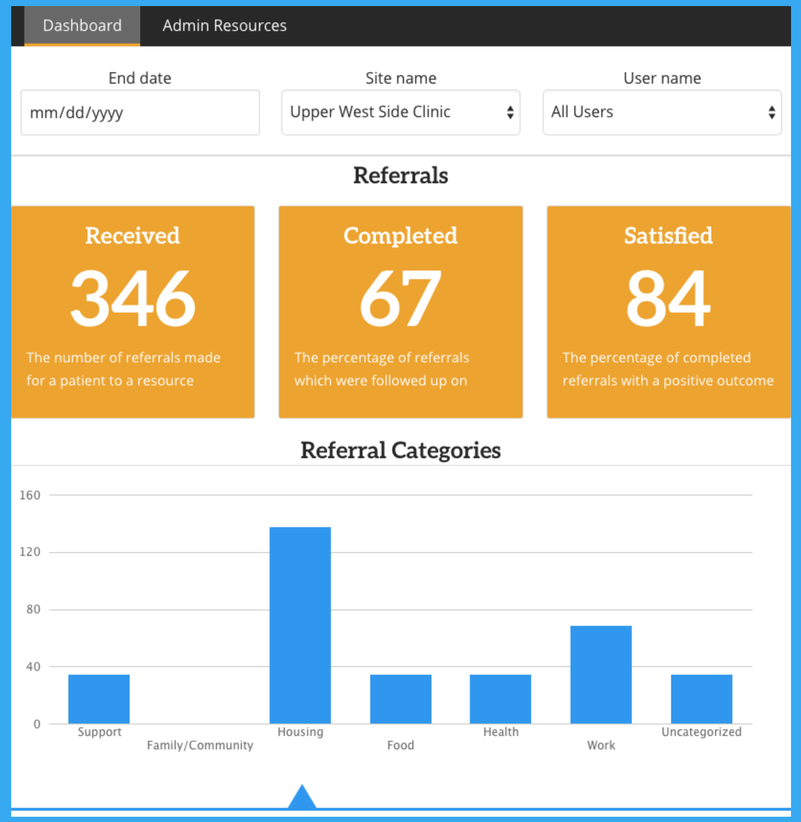
We engage around member needs with interactive texts

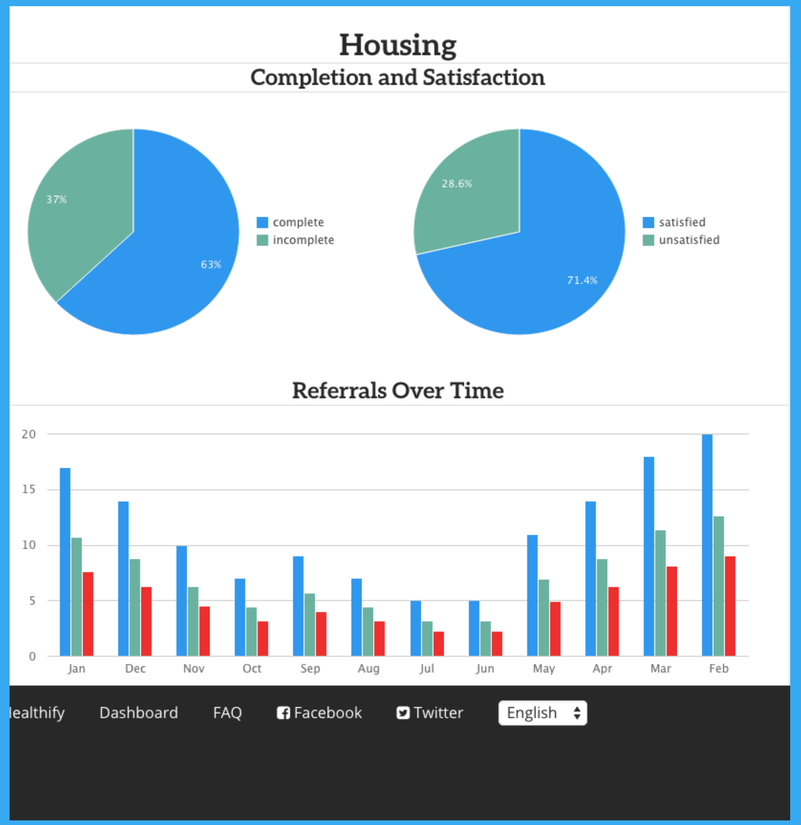
Manage



Our platform visualizes member data and provides staff tools to coordinate around population's social needs

Insight





We help understand referral patterns and how needs are changing in a population

Benefits

7x

Identify 7x as many members who are at risk[2]

80%

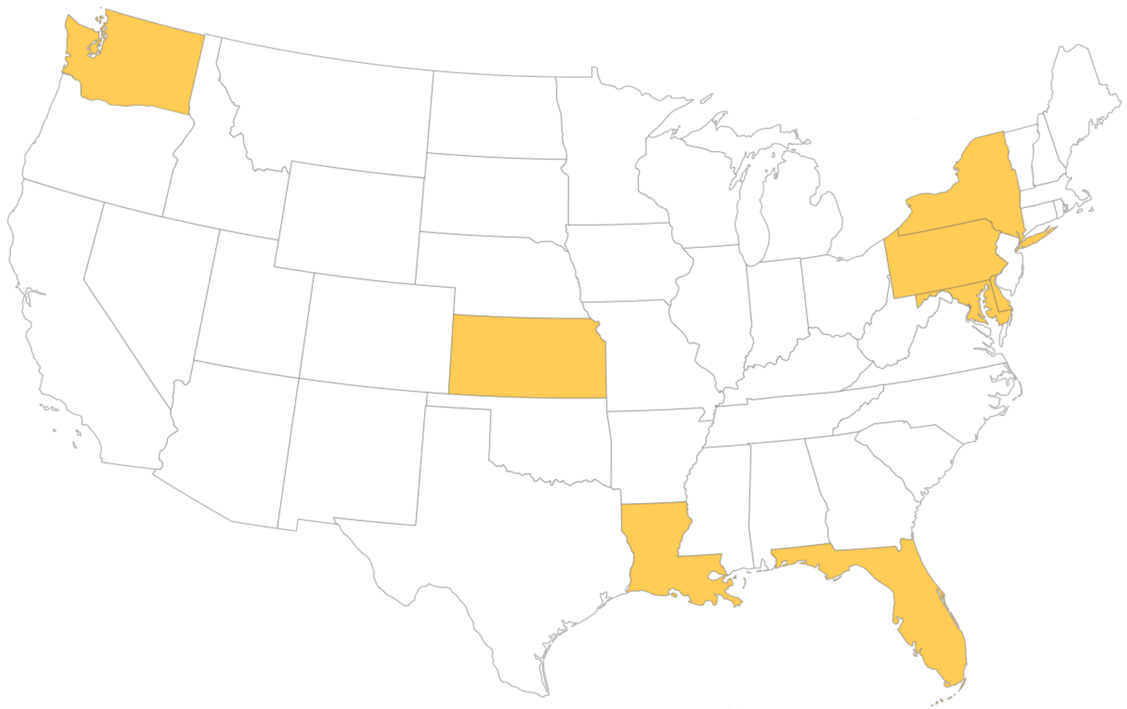
Over 80% of staff found Healthify more useful than previous workflow

Increase case management and referral capabilities by 4x[1]

LONG TERM

- Reduce costs by ~2%
- Collect enhanced member data
- Build a referral network

Progress?



- Live in 8 States
- >500 healthcare staff using platform
- Three ongoing research studies supported by PCORI and AHRQ

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

THE HSC HEALTH CARE SYSTEM

Banner Health

PHILIPS

VILLAGECARE
FOR BETTER HEALTH AND WELL-BEING

Client Use Cases

Johns Hopkins Healthcare: Caregivers in Baltimore City and Baltimore County are screened, risk stratified, and connected to relevant resources and support materials. In addition, wide amount of staff have access to share information about resources. This is part of the J-CHiP initiative to integrate team based care for high-risk patients who receive primary care from sites in certain zip codes surrounding Johns Hopkins and patients discharged from Johns Hopkins Hospital.

VillageCare: Health Home model. High risk and high need with very low payments. 50k in NYC Health Home care management but will probably expand to 1 million more under Medicaid Redesign in NYC. Sustainability is crucial. Operational efficiencies and referral success rate are being measured via an RCT trial.

Project CONNECT: Hyper local referral and follow-up system from hospitals/clinics to community partners for high-risk adults with chronic conditions. Outcome metrics are change in number of ED visits + hospital days, self-reported access to care, self-efficacy for obtaining services and satisfaction of care.

HSC Healthcare: Special needs Health Plan in DC using Healthify for full screening, follow-up, and referrals with their outreach staff.

Large Insurer: Community Health Worker program referring to services in the field with heavy smartphone usage.

Lessons – It's the Wild West

Marketplace

- **MCO and IDNs seemed less receptive** than FQHC/Health Homes/PCMH but still were main clients.
- Initiatives around **SDOH** are a great way for **MCOs to work with providers.**
- Seeing more **brick and mortar clinics** from the payer side.

Adoption

- **Texting** always has legal hurdles.
- **Screening** can intrude on other screening assessments in use.
- **Legacy** systems **hinder** integration and data capture.

Process

- **Feedback loop** is crucial but at the end of the day needs participation from CBOs.
- Each **geography has different needs**. Not much time spent on designing workflow or education materials to help patients with these needs.

Coordination

- **CHW models** are some of the **best** way to address these needs.
- Staff can be champions when talking about these needs. Patients are **more engaged** when needs are brought up.

Contact Us

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Research Account
http://bit.ly/1wAtPHo

References

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