

# Success Stories

## *Building Collaborative Contracts with Health Care: Central Ohio Area Agency on Aging, Molina Healthcare of Ohio and Aetna Better Health*

Since 2016, The John A. Hartford Foundation and USAgings Aging and Disability Business Institute (Business Institute) have recognized and honored the achievements of community-based organizations (CBOs) that partner and contract with health care entities. Their commitment is evident through The John A. Hartford Foundation Business Innovation Award,<sup>1</sup> a testament to their recognition of innovative and transformative approaches to addressing health-related social needs.

Central Ohio Area Agency on Aging (COAAA) in Columbus, Ohio is one of the runners-up for the 2023 award. COAAA's Social Drivers of Health Accelerator Program (SDOHAP) is a copyrighted program that pioneers screening and interventions for improved health equity and closing gaps in care. Foundational to the pilot program is the user-friendly social drivers of health (SDOH) screening tool, which was designed by the agency and is currently being validated by an external research firm.

This Success Story highlights the power of collaboration and excellence in instrument creation and underlines its transformative impact on the lives of older adults and individuals with disabilities in central Ohio. The innovative programming operationalizes the screening for social care needs, while also showcasing the leadership of area agencies on aging in this emerging field of work.

### About the Partners

#### Central Ohio Area Agency on Aging (COAAA)

COAAA was established in 1974 and plays a vital role in managing services for over 15,000 people and funding services for another 25,000 in eight counties in central Ohio. COAAA plans, funds and delivers services that help older adults and individuals with disabilities remain safe and independent in their homes. With the assistance of area providers, COAAA arranges and coordinates services to help individuals with activities of daily living such as homemaking, transportation, home-delivered meals, personal care and more. In addition, COAAA offers education and resources to caregivers, professionals and their community, and advocates for programs and policies that benefit older adults and individuals with disabilities.

### About the Partnership

The partnership between the COAAA and Molina Healthcare began in the fall of 2022 and Aetna Better Health became a partner in the fall of 2023. These organizations came together because of a mutual interest in health equity and SDOH factors on health outcomes and the desire to close the gap between medical and non-medical drivers of health.

According to the Centers for Medicare & Medicaid Services, the SDOH are the conditions in the environment where people are born, live, learn, work, play and age that affect a wide range of health, function and quality of life risks and outcomes.<sup>2</sup>

<sup>1</sup> The John A. Hartford Foundation Business Innovation Award- Aging and Disability Business Institute

<sup>2</sup> USING Z CODES (cms.gov)

## Z Code Categories

- Z55** – Problems related to education and literacy
- Z56** – Problems related to employment and unemployment
- Z57** – Occupational exposure to risk factors
- Z58** – Problems related to physical environment
- Z59** – Problems related to housing and economic circumstances
- Z60** – Problems related to social environment
- Z62** – Problems related to upbringing
- Z63** – Other problems related to primary support group, including family circumstances
- Z64** – Problems related to certain psychosocial circumstances
- Z65** – Problems related to other psychosocial circumstances

*This list is subject to revisions and additions to improve alignment with SDOH data elements.<sup>3</sup>*

In February 2023, COAAA launched the SDOHAP, dedicated to creating the common language, screening tool, processes and policies to meet the future of health equity. This partnership utilizes Community Health Workers (CHWs), Licensed Social Workers (LSWs) and Registered Nurses (RNs) to assign Z codes and then to provide education, referrals and connections. The COAAA team are also referred to as Social Care Clinicians: interdisciplinary professionals who screen and assess social drivers of health through empathetic engagement and provide support, education, information and referrals to assist in closing gaps in care. Social Care Clinicians are able to assign a Z code to needs identified through the screening tool. Z codes are ICD-10 diagnostic codes used to document SDOH factors influencing health status, such as housing, food insecurity and transportation.

The COAAA team operationalized the process for screening, assigning and tracking z-codes. The co-designing of these processes within a software system are laying the groundwork that will lead to a web-based social care billing system.

The following were the goals identified by the partners:

### Health Equity & Closing Gaps in Care

Identify gaps in care through SDOH screenings, listening sessions, area plans and SAFE/I-Team data. Develop innovative interventions to close the gaps in care and pilot for at least a year.

### Strengthening Partnerships

Work with health plans on projects to increase the familiarity of the AAAs strengths and abilities and enhance interest in working with AAAs to meet the needs of the community.

### Social Care Clinicians

Develop a multi-disciplinary team of RNs, LSWs and CHWs who are trained on tools and interventions to close gaps in care. Also, provide a career ladder for current staff members through leadership, analytics, business development, CHW certification and tuition reimbursement.

### Future Contracting

AAAs will become the “one-stop shop” and health entities first choice for partnerships. SDOH, care transitions and chronic conditions will be the focus for upcoming years. Scientific validation of COAAA’s SDOH screening tool, and continued work on Physician Fee Schedule community health integration (CHI) payments and Z code assignment billing will provide sustainable funds for future work.

<sup>3</sup> Ibid

## Funding

COAAA has a three-year financial commitment from Molina Healthcare and Aetna Better Health. This partnership has allowed for the development and validation of the SDOH tool, piloting of interventions and data collection of social needs in Central Ohio. COAAA anticipates additional partnerships to provide community health integration and Z-code billing by the end of 2025.

The SDOHP has a budget of \$600,000 each year for 2023, 2024 and 2025 to fund SDOH screenings, RN Home visits, in-home A1C and blood pressure testing and innovative interventions to close gaps in care.

## Impact and Outcomes

The SDOHAP started with the Medicare and Medicaid dually eligible population in a five-county region in Central Ohio (Delaware, Franklin, Madison, Pickaway and Union counties), and later expanded to Medicaid members in all eight counties in the COAAA service region.

To date, COAAA social care clinicians have conducted outreach to 2,350 individuals and have screened 800 plan members in Central Ohio with more than 560 members having SDOH needs affecting their overall health. Specific findings were:

- Forty-five percent have behavioral health needs.
- Twenty percent needed transportation to health care services.
- Forty-eight percent of those screened have housing insecurity.
- Fifty-eight percent lacked access to proper nutrition and were food insecure.

COAAA researched and developed interventions to improve health equity based on early trends through surveys and discussion sessions with staff to ensure pilot interventions met local needs using best clinical practices. COAAA combined public and private funding to create innovative interventions. These include behavioral health counseling, creative transportation partnerships, shallow subsidy housing intervention; RN visits with in-home A1C and blood pressure testing, diabetic-friendly food boxes and on-demand education programs.

COAAA identified and partnered with clinicians at Ohio State University (OSU) Wexner Medical Center's Department of Psychiatry to provide behavioral health counseling training to OSU students. This partnership includes a dedicated referral process for COAAA consumers, a significant decrease in average wait time for care, technical assistance with and provision of telecounseling when needed, and offers an opportunity for training students.

COAAA launched the first partnership in the U.S. between an Area Agency on Aging and UZURV, an Adaptive Transportation Network Company (TNC) that offers on-demand paratransit and assisted mobility services. UZURV's integrated approach to mobility combines the power of technology and a network of fully FTA-compliance drivers to achieve better performance, savings and service.

A pilot "shallow rental subsidies" program for case managed consumers who spend more than 50 percent of their income on housing was launched in July of 2024. COAAA is partnering with Ohio State College of Social Work's Age-Friendly Innovation Center (AFIC) in this randomized control trial, where half of the participants receive a monthly rental assistance payment aimed at reducing their housing cost burden. The evaluation will inform future SDOH housing insecurity screenings, with the goal of predictive analytics to prevent housing destabilization.

COAAA also developed a RN intervention to address the knowledge deficit and uncertainty surrounding diabetes and hypertension diagnoses. COAAA RNs mail or deliver A1C test kits and conduct a comprehensive home visit schedule to train patients and caregivers on using devices to obtain accurate screenings. RNs also work directly with physicians to communicate results and schedule follow-up care.

## Lessons Learned

Engaging members and developing trusting relationships is imperative to influencing change. SDOHAP has demonstrated that social care clinicians at COAAA and AAAs nationwide are the best option for making this impact. COAAA has been able to provide data to the health plans showing the exceptionally high engagement rates and ability to build the relationships necessary to impact change.

COAAA has demonstrated the importance of the multi-disciplinary approach and the value of adjusting and collecting data the health plans need to highlight their return on investment. It is imperative to provide reports that paint a clear picture of member needs and the interventions shown to improve health outcomes and reduce unnecessary medical costs.

## The Future

Social care is the future of health equity. COAAA will continue to demonstrate the value and importance of utilizing the experience and expertise of social care clinicians.

The SDOHAP is also expanding its target population and providing additional interventions. In late 2023, COAAA assisted Molina Healthcare with its medication adherence compliance metrics. This intervention was an additional revenue opportunity and demonstrated the expertise of AAA social care clinicians. The health plan continues to be impressed with the engagement rates and the impact this partnership has on members' lives.

COAAA envisions the 2024 Physician Fee Schedule as another opportunity to utilize its SDOH screening tool to continue its goal of breaking down barriers, impacting change and improving the overall health of its members. This is also a goal of the health plans, medical institutions and primary care physicians, and COAAA expects to provide Community Health Integration by 2025.

COAAA is currently undergoing a scientific validation and reliability testing of the SDOH screening tool and envisions this tool being integrated into assessment processes, outreach events, software and other

interactions across the state and AAA network. Validating the tool and creating training for future social care clinicians will create additional career pathways and encourage its expansive use to meet the social needs of older adults and people with disabilities.

“At COAAA, we are uniquely positioned to harness the talent and ideas of our staff, as well as our consumers, to implement a program that is rooted in meeting community needs,” said Katie White, COAAA administrator. “With exceptional, inclusive care as our foundation, we will pave the way for the future of meeting health equity through social care.”

“Our social care clinicians are the best in the business to address health-related social needs. Our interventions improve the quality of life for those we serve and reduce the cost of care for our healthcare partners,” said Melissa Gualtieri, Director of Clinical Innovations at COAAA. “We are committed and experienced at breaking down barriers and closing gaps in care to improve health equity in our communities.”

## About the Aging and Disability Business Institute

The mission of the Aging and Disability Business Institute (Business Institute) is to build and strengthen partnerships between aging and disability community-based organizations (CBOs), CBO networks and the health care system. Led by USAgging in partnership with the most experienced and respected organizations in the aging and disability networks, the Business Institute provides CBOs with the tools and resources to adapt to a changing health care environment, enhance their organizational capacity and capitalize on emerging opportunities to diversify funding. Funded by the U.S. Administration for Community Living, the Business Institute is the home of the Center of Excellence to Align Health and Social Care, which funds and supports community care hubs and the CBO networks that they lead. Learn more at [aginganddisabilitybusinessinstitute.org](http://aginganddisabilitybusinessinstitute.org).



SDOH Accelerator Program Funders:



SDOH Accelerator Program Partners:

