

Social Determinants of Health

Louisiana Primary Care Association

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Delivering the Next
Generation
of Health Care

Social Determinants of Health (SDOH)

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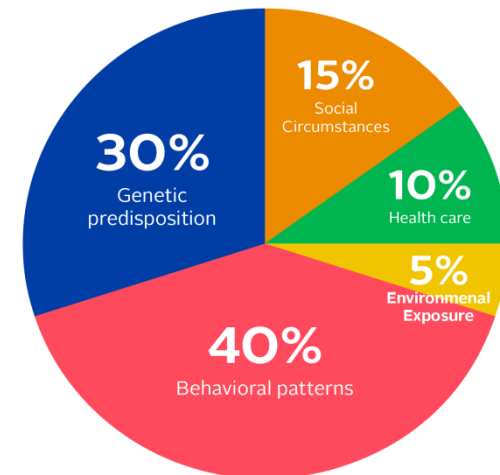
- Housing
- Education and/or literacy
- Food Security
- Employment
- Transportation
- Criminal Justice Involvement
- Intimate Partner Violence

Social Determinants of Health (SDOH)

“The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.”
(World Health Organization)

- Social determinants have a significant impact on health outcomes
- Social factors, including education, racial segregation, social supports, and poverty, accounted for more than a third of total deaths in the U.S. in 1 year.
- Social determinants disproportionately impact low-income individuals.
- Addressing social determinants of health (SDH) is important for achieving greater health equity.
- Medicaid and Medicare plans serving low-income individuals are uniquely positioned to identify and address social determinants.

Exhibit 1: Determinants of Health and Their Contribution to Premature Death



Source: Adapted from J.M. McGinnis, et al.⁴

<http://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>
<https://www.chcs.org/resource/measuring-social-determinants-health-among-medicaid-beneficiaries-early-state-lessons/>

Background

<p>Public Health: Historic champion addressing social determinants.</p>	<p>Health Policy and Payment: Heightened attention with health reform.</p>
<p><i>American Public Health Association, Robert Wood Johnson Foundation, Healthy People 2020, World Health Organization.</i></p>	<p><i>Affordable Care Act (ACA), IRS 990 community health needs assessment / community health improvement plan, Centers for Medicare and Medicaid Services state innovation model grants, National Quality Forum, IOM, health homes, meaningful use, state waivers.</i></p>
<p>Communities: Address social determinants however they can.</p>	<p>Providers: New emphasis, emerging models.</p>
<p><i>Government, community development corporations, social bonds, housing authorities, community justice, local community-based organizations (CBO), grants, and philanthropies.</i></p>	<p><i>ICD-10, National Association of Community Health Centers (NACHCs), state primary care associations, EMRs, HIEs, CMMI accountable health communities grant for social integration.</i></p>

Social Determinants of Health (SDOH)

- Integration of Physical Health and Behavioral Health
- Federally Qualified Health Centers
- Medicare reform
- Managed Care providing coverage for PH and BH

Adverse Childhood Experiences (ACE'S)

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- CDC-Kaiser Permanente investigation of the impact of childhood abuse, neglect and exposure to adverse life experiences to health and well being during adult life
- 1995-1997
- 13,494 HMO members in Southern California who had a physical exam were sent confidential surveys regarding current health status and health behaviors as well as a questionnaires documenting exposure to adverse childhood experiences
- 70.5 % response

Adverse Childhood Experiences (ACE'S)

- 2/3 of responders had at least 1 ACE
- Greater than 1 in 5 reported 3 or more ACE
- This study established a graded dose relationship between ACE's and negative health and well being across the life span
- The greater number of ACE's, the greater the risk for poor health outcomes

Adverse Childhood Experiences (ACE'S)

- Increased ACE's, increased risk for:
- SUD and/or illicit drug use
- COPD
- Depression
- Ischemic heart disease
- Liver disease
- STD's, multiple sexual partners

Adverse Childhood Experiences (ACE'S)

- Smoking
- Fetal death
- Poor work performance
- Risk for intimate partner violence
- Suicide attempts
- Risk for sexual violence
- Adolescent pregnancy or unintended pregnancies
- Poor academic achievement

Individuals with 4 or more ACE's, as compared to individuals with no exposure to an ACE, demonstrated a 4-12 fold increased risk for SUD, depression, suicide attempts.

Meeting the Needs of SDOH

Social Determinants of Health (SDOH)

- Determined to be critical elements in determining poor health outcomes and high health care costs
- Need to establish a systematic and standardized method to collect, analyze, and use data to understand and develop responses to these health related social needs of our patients
- Design and implement interventions at targeted patient/member level
- Design and implement intervention strategies at the population level

Social Determinants of Health (SDOH)

- MCO's and CMM share a major interest in identifying and addressing selected unmet SDOH in the Medicaid and Medicare members
- Increased focus in Value Based Contracts to get providers to develop and implement cost-effective, non-clinical strategies in reducing SDOH to improve patient care and reduce avoidable costs

SDOH Programs Across the Nation

States with SDOH Programs

Several states have developed programs to access and address the SDOH in their Medicaid citizens

- Oregon: developed a provider-level food insecurity screening measure for its accountable care organization model; is developing a housing-related measure
- Washington: legislature requires the development of measures for housing, employment, criminal justice to later incorporate in to the state's clinically based Common Measures Set
- Massachusetts: “ neighborhood stress” measure related to home addresses. A neighborhood stress score is determined by income, education, employment, and transportation variables. The score helps determine risk-adjusted global capitated payments
- Kansas: incorporated BH and home and community based measures into its managed LTSS basic performance and pay for performance measures

States with SDOH Programs

- Michigan: collects data on employment, education, housing needs, and food security through in home visits by community health workers using a tablet based checklist. This information can electronically feed to a data base that can be accessed by authorized staff and providers
- Vermont: Collects information on low income seniors and adults with disabilities through an assessment tool that measures food security, substance use, tobacco use, and social isolation. The collected information is used to link these members to community based services and care coordination
- New Jersey: uses a standardized tool for a comprehensive needs assessment in its Medicaid members in collaboration with the MCO's. The MCO's are contractually required to collect data on SDOH

States with SDOH Programs

- Tennessee: requires the MCO's to assess SDOH through a needs assessment tool in the members who receive managed care long term services and supports. The MCO's are required to address any identified social need(s) plan in the member's care and provide reports to the state on state provided template
- New York: requires a functional assessment questionnaire at enrollment, annually and D/C for the participants in the Medicaid Health Home Program, designed for individuals with multiple chronic conditions. Data generated from the assessment is analyzed with claims data to evaluate utilization and quality of care

AmeriHealth's Response to SDOH



Choosing the Path Forward

To set the path for alignment with providers, springboard off work led by the National Association of Community Health Centers.

<http://www.nachc.org/research-and-data/prapare/>

What Is the PRAPARE Project About?

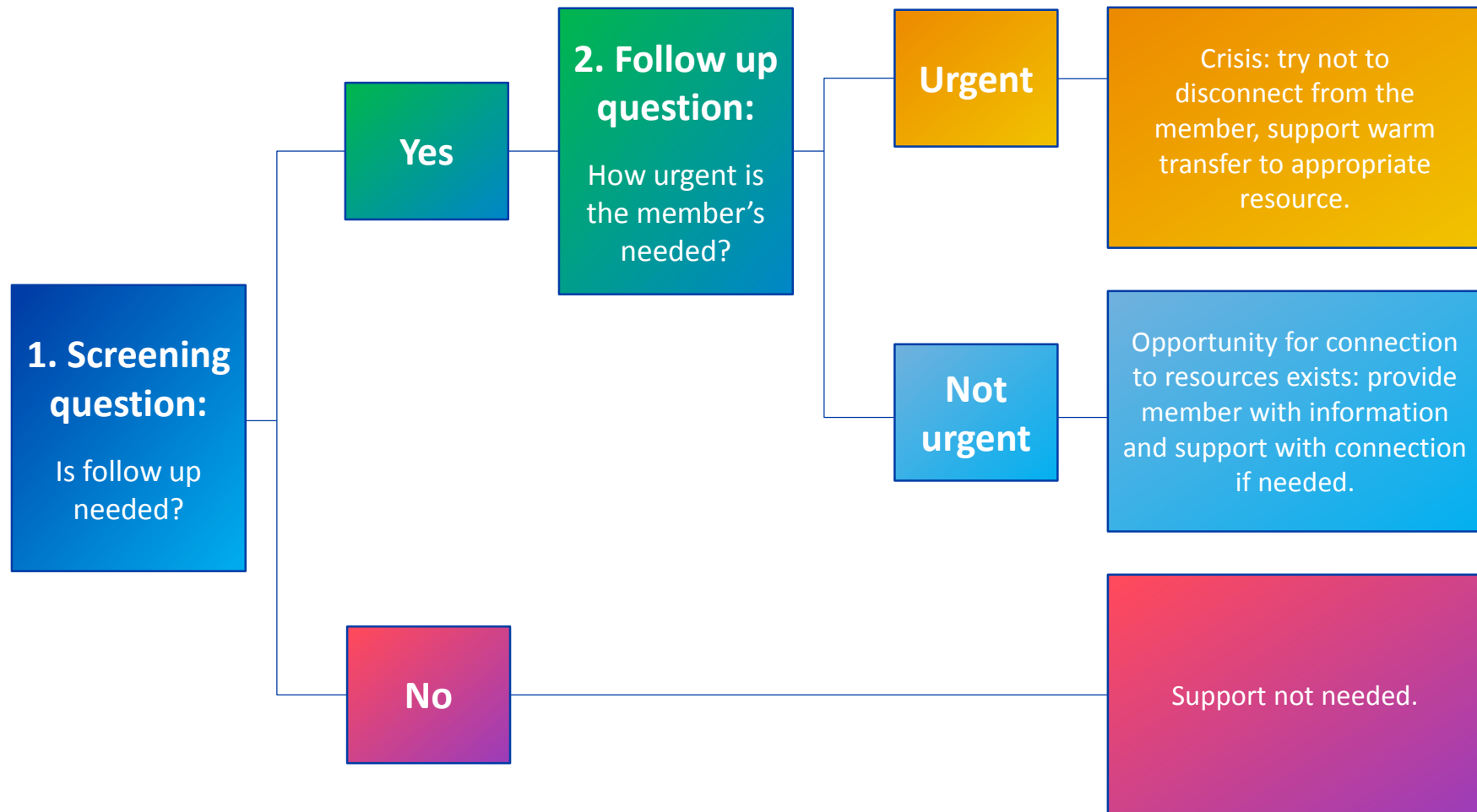
PRAPARE: Protocol for responding to and assessing patient assets, risks, and experiences.

Overall Project Goal: To create, implement/pilot test, and promote a *national standardized patient risk assessment* protocol to assess and address patients' social determinants of health (SDH).

In other words, position health centers to:

- Document the extent to which each patient and their total patient populations are complex.
- Use that data to:
 - Improve patient health.
 - Affect change at the community/population level.
 - Sustain resources and create community partnerships necessary to improve health.

Screening and Risk Stratification Approach



Domains

Education.

Health literacy.

Transportation.

Material security (food, utilities, child care, clothing, phone, and household needs).

Housing.

Aunt Bertha

Aunt Bertha

- Austin –based social service search and referral software platform
- Database of food banks, emergency shelters, childcare services, healthcare, employment, etc.
- AmeriHealth Caritas, as a corporate entity, has purchased access to Aunt Bertha to co-brand with the different LOB, will refine the search algorithm to meet the specific needs of each LOB, will allow access to each staff’s and member’s search history to help better define the biggest needs as well as gaps in resources

www.auntbertha.com

Poverty Simulation

What is a Poverty Simulation?

Community Action Poverty Simulation is an experiential exercise designed to sensitize participants to the realities faced by low-income families.



What is a Poverty Simulation? (continued)

- Participants assume the role of a low-income family member living on a limited budget.
- The experience is divided into four 15-minute sessions, representing one “week” over the course of a “month” in which participants must provide for their family and maintain their home.
- Fifty to 88 participants are assigned new identities, filling the roles of 26 different families facing poverty.

Goals of the Simulation

Raise awareness of realities of poverty

- Break down stereotypes and misconceptions.
- Cultivate community connection to systematic problems of poverty.
- Highlight social determinants of health.
- Generate action toward change.
- Instill the message of community responsibility.

Poverty Simulation

The Community Action Poverty Simulation was created by the Missouri Association for Community Action and is conducted across the nation.

The focus can be tailored to your specific audience.

<http://www.povertysimulation.net/about/>



AmeriHealth Caritas Louisiana's Wellness Center



AmeriHealth Caritas Louisiana's Wellness Center

- Shreveport location
- Staffed by ACLA associates
- Member walk-in capacity
- Offers opportunity for on-site member support and education: classes for DM care and diet, BH and PH support groups, housing of a State Medicaid eligibility staff, exercise classes
- Plans for a Wellness Center in New Orleans for 2018

More than
30 YEARS
of making
care the heart
of our **work.**

