Health Happens Here – Advancing The Need For Social Determinants of Health 2020:

The Impact of Social Determinants of Health on Nebraska's Health Outcomes

JULY 29, 2020

Key 

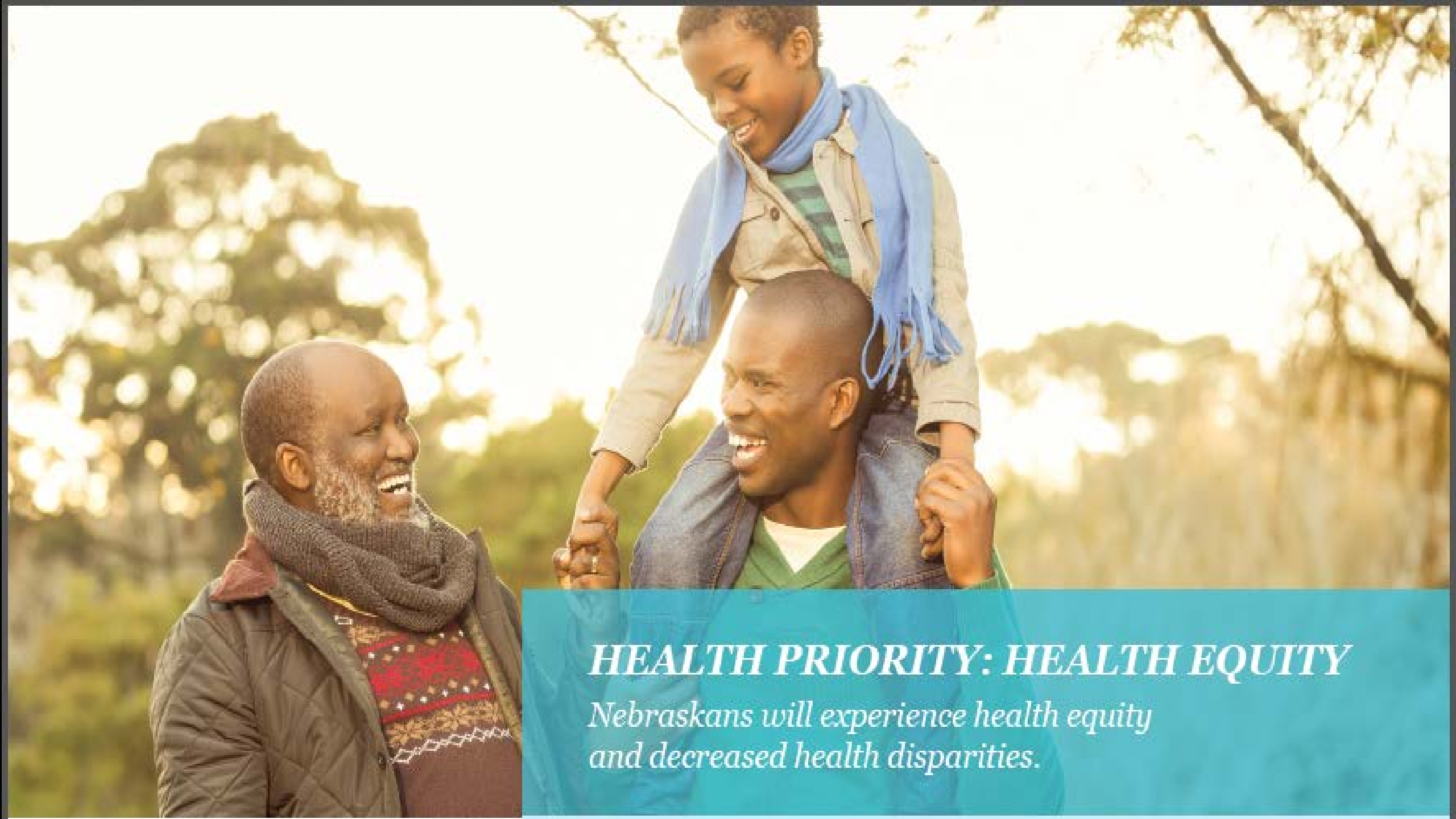
’s:

1. State Health Improvement Plan
2. Demographics of Nebraska
3. Why is Data Collection Key
4. Why & What is Social Determinants of Health?
5. Background, Needs and Stressors in our Health System
6. How Do We Know We Need It & What Works?
7. Models & Opportunities
8. Toolkit of Reference Resource Information


nebraska
SHiP
state health
improvement plan
Working together to improve the health
and quality of life for all individuals, families,
and communities across Nebraska.

SHIP Priority Areas & Objectives

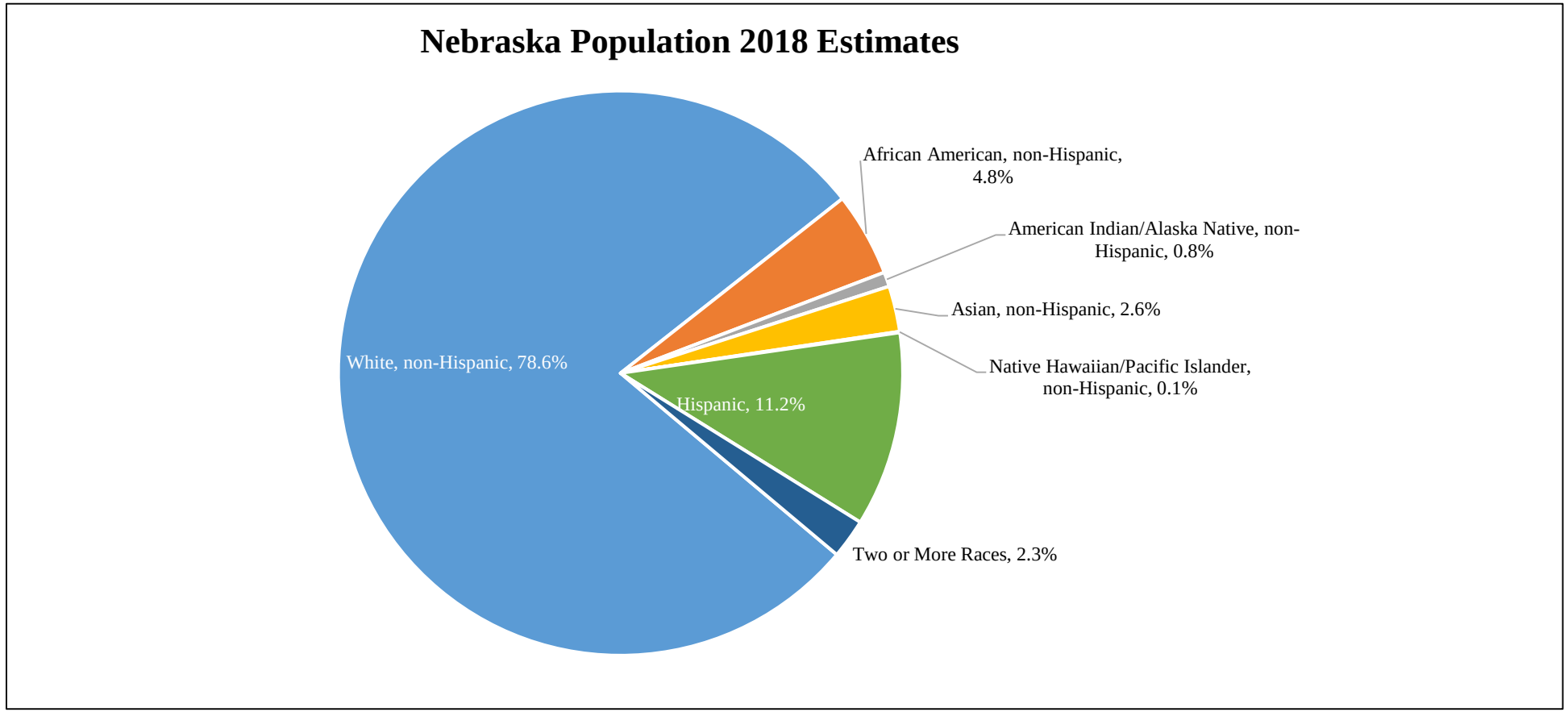
- **Integrated health system** – Address major determinates of population health among health system partners.
- **Depression and Suicide** – Promote collaboration to support prevention, education, and integration strategies.
- **Obesity** – Promote equitable access to healthy lifestyles by empowering communities and promoting effective use of local strategies and policies.
- **Utilization and Access** – Enhance culturally responsive healthcare with data driven decision making and increased coordination across preventive health systems.
- **Health Equity** – Support organizational capacity to address equity through systems, policy, and program efforts.



HEALTH PRIORITY: HEALTH EQUITY

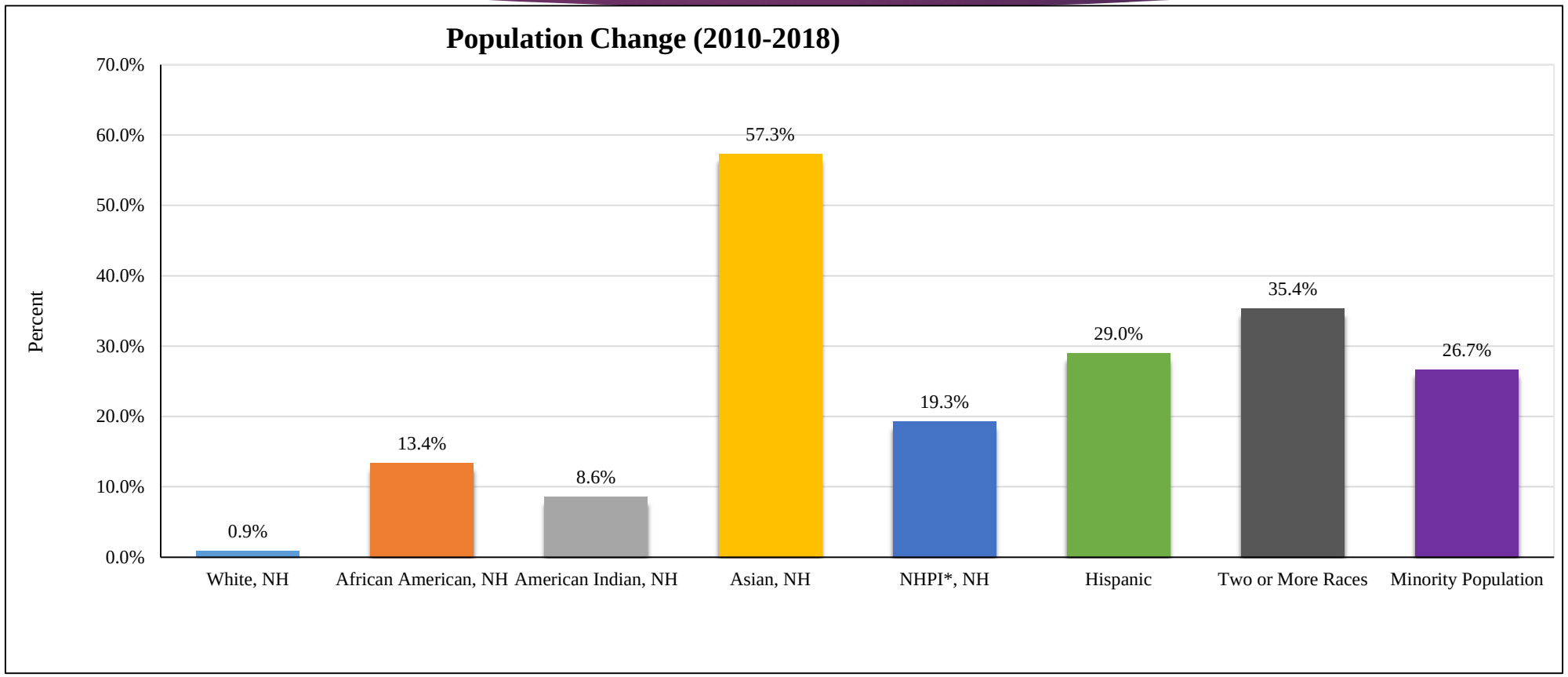
Nebraskans will experience health equity and decreased health disparities.

Percent Distribution of Nebraska Population by Race/Ethnicity, 2018



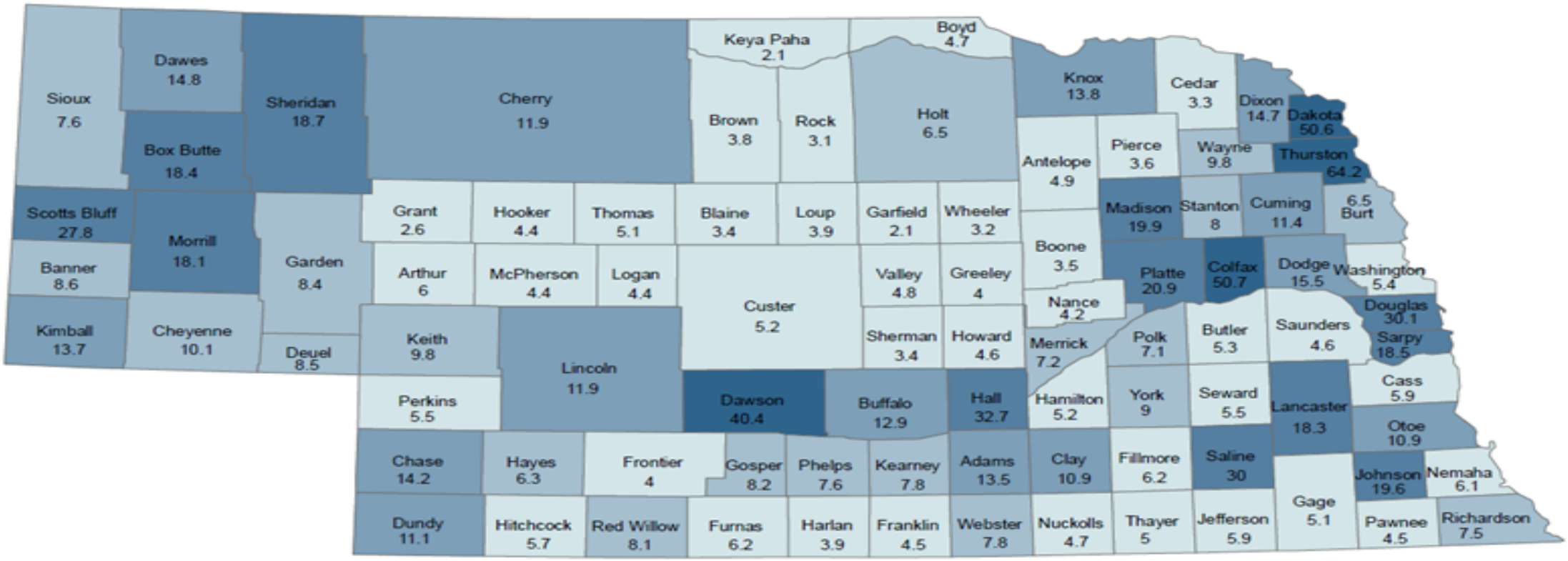
Source: US Census Bureau, Population Division. (2019).

Nebraska Population Change by Race/Ethnicity 2010-2018



Source: US Census Bureau, Population Division. (2019).
Note: *Native Hawaiian/Pacific Islander, NH: Non-Hispanic

Percent of Minority Population by County, Nebraska 2016



Legend

Percent of Minority

- 2.1 - 6.2
- 6.3 - 10.1
- 10.2 - 15.5
- 15.6 - 32.7
- 32.8 - 64.2

Data Souce: U.S. Census Bureau, 2016 Population Estimates.

NEBRASKA
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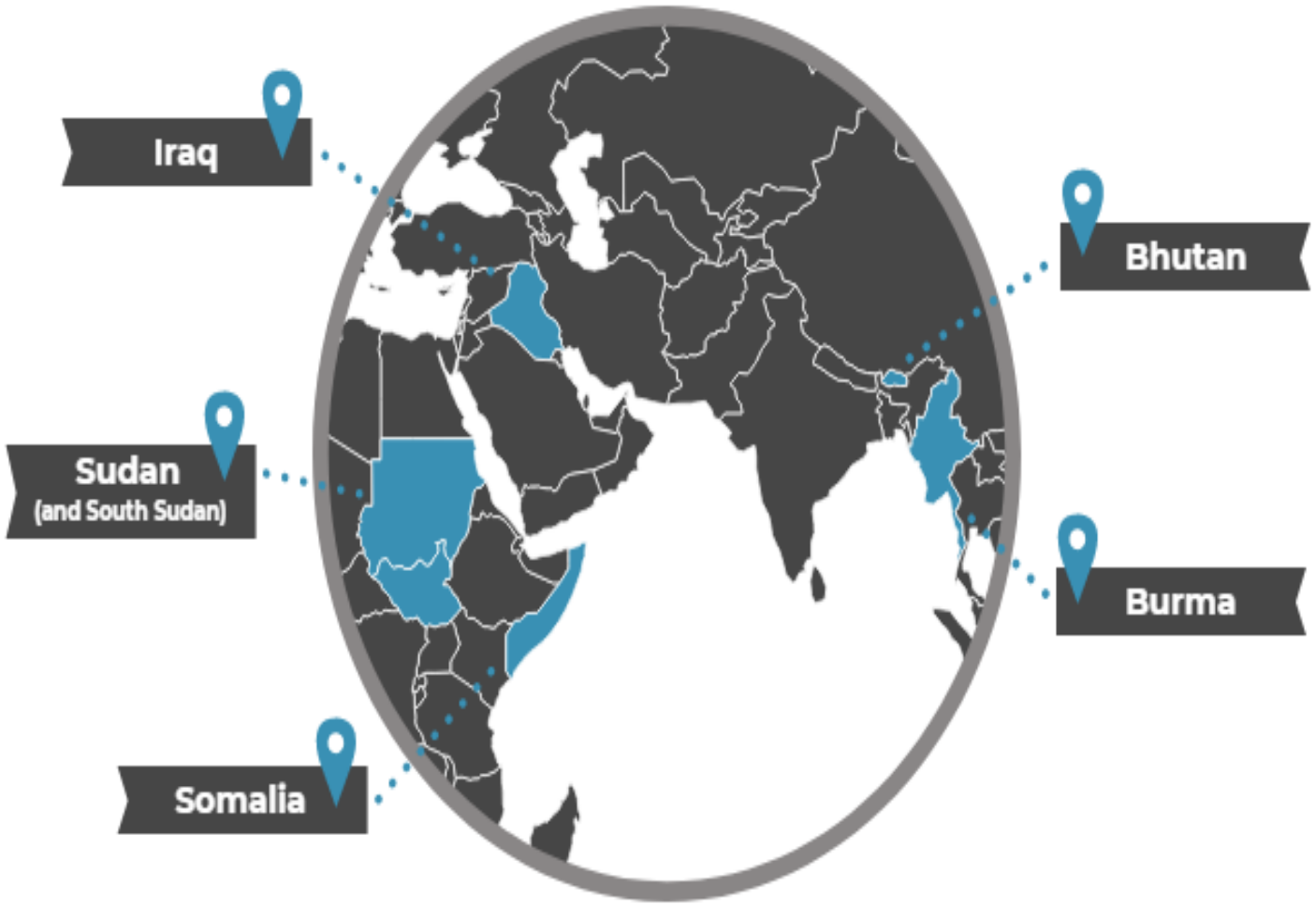
Top Refugee populations in Nebraska



- Burma (Myanmar): Burmese, Karen
- Bhutan: Dzongkha, Nepali
- Iraq: Arabic, Kurdish
- Somalia: Somali, Arabic
- Sudan: Arabic, English, Nuer, Dinka

Social Determinants of Health

Employment

4.3x

African Americans were less likely to be unemployed at 11.2% of the population, compared to Whites at 4.1%.

Household Income

2.1x

American Indians reported the lowest median household income at approximately $25,700, compared to Whites at $55,100.

Poverty

American Indians were most likely to be living in poverty at 40.5% of the population, compared to Whites at 10.9%.

Education

3x

Hispanics (10.1%) were less likely to have more than a Bachelor's degree, compared to Whites at approximately 30%.

How do social indicators affect health?

The conditions where individuals live, work and learn can have a large and lasting effect on health. For example, poverty can limit an individual's access to healthy food options, and education and stable housing have long been linked to better health. Understanding these social determinants of health and how they affect certain populations is important to improving health outcomes for all groups.

Office of Health Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services
Source: American Community Survey 2006-2015

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DHHS Division of Public Health Demographic Data Recommendations Report

- Provides recommendations for collection of demographic data for a core group of **six factors**

Race and Ethnicity

- Should be self-reported whenever possible

Primary Language

- Measure of English proficiency rather than language spoken

Gender

- Should be self-reported whenever possible

Age

- Collect date of birth whenever possible

Disability

- Focuses on the impact certain conditions may have on basic functioning

Geographic location

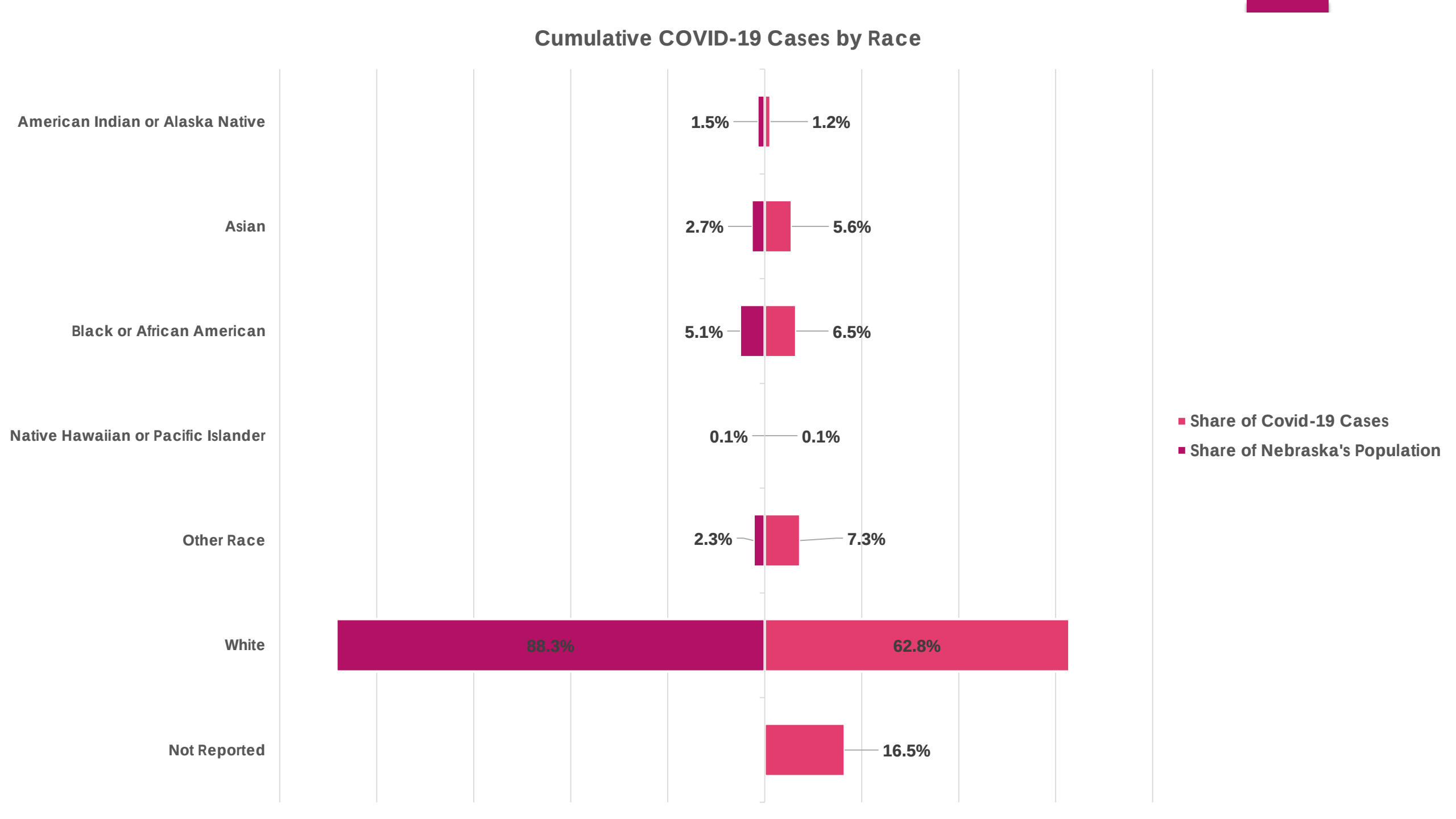
- Collect complete address (street address, city, zip, county) whenever possible

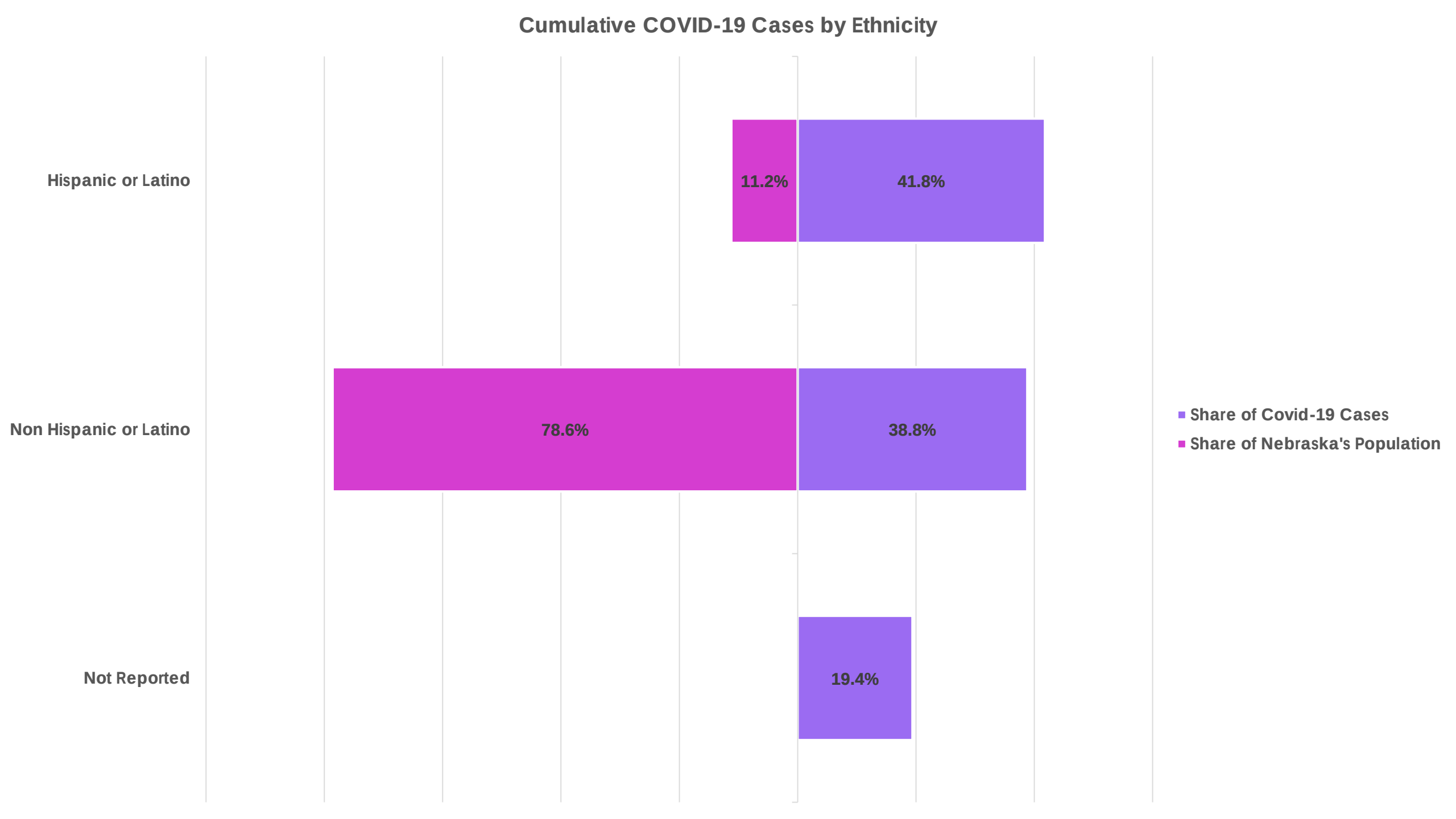
* Collection of other socio-economic data is recommended to identify other factors that influence health

Why is Demographic Information Important?

- Approximately 90 infectious disease are reportable to NEDHHS
  - Almost all of these conditions are diagnosed with a laboratory test

- Demographic Information
  - Used to describe the health status of the community that you serve
  - Used to help prioritize and target prevention and education efforts
  - Services can be given in a culturally responsive way
  - Barriers to accessing healthcare or other services can be identified
  - Can assist in identifying clusters and outbreaks
  - Helps local health departments and communities respond to outbreaks in a more timely manner


Cumulative COVID-19 Cases by Race
American Indian or Alaska Native
1.5%
1.2%
Asian
2.7%
5.6%
Black or African American
5.1%
6.5%
Native Hawaiian or Pacific Islander
0.1%
0.1%
Other Race
2.3%
7.3%
White
88.3%
62.8%
Not Reported
16.5%
Share of Covid-19 Cases
Share of Nebraska's Population


Cumulative COVID-19 Cases by Ethnicity
Hispanic or Latino
Non Hispanic or Latino
Not Reported
11.2%
41.8%
78.6%
38.8%
19.4%
Share of Covid-19 Cases
Share of Nebraska's Population

Collecting Demographic Information

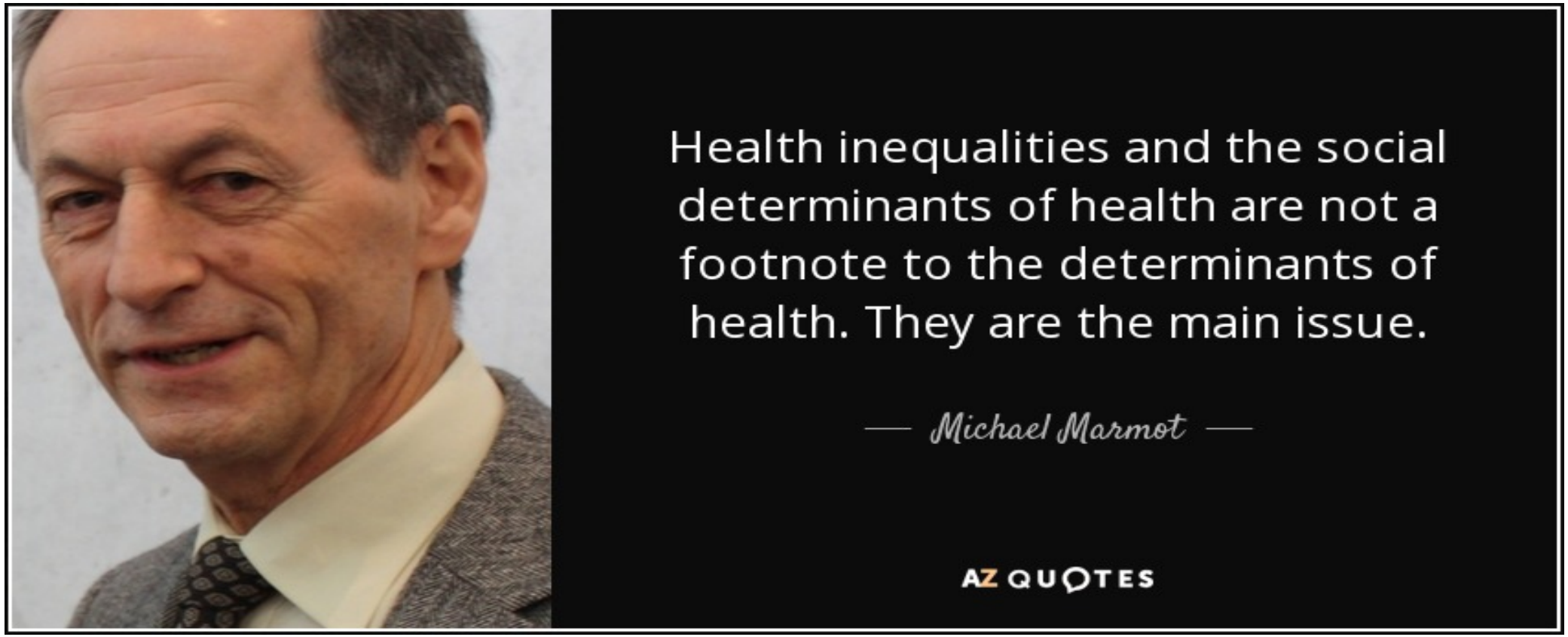
- Talk to your patients about
  - Why you are collecting demographic information
  - What your privacy policy is
  - How demographic data is used
  - How the information can be used by the community to benefit the community

Best Health for Everyone:

Greatest Health Care Driver not only asking their patients, *“what’s wrong,” but “what’s happening?”*

Providing Health Care, Not Just Sick Care, Means Treating the Whole Patient.

Global to Local: The Need Is Everywhere



Social Determinants of Health:

Healthy People 2020:

HealthCare is the Leader:

Figure 2

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

THE HENRY J. KAISER FAMILY FOUNDATION

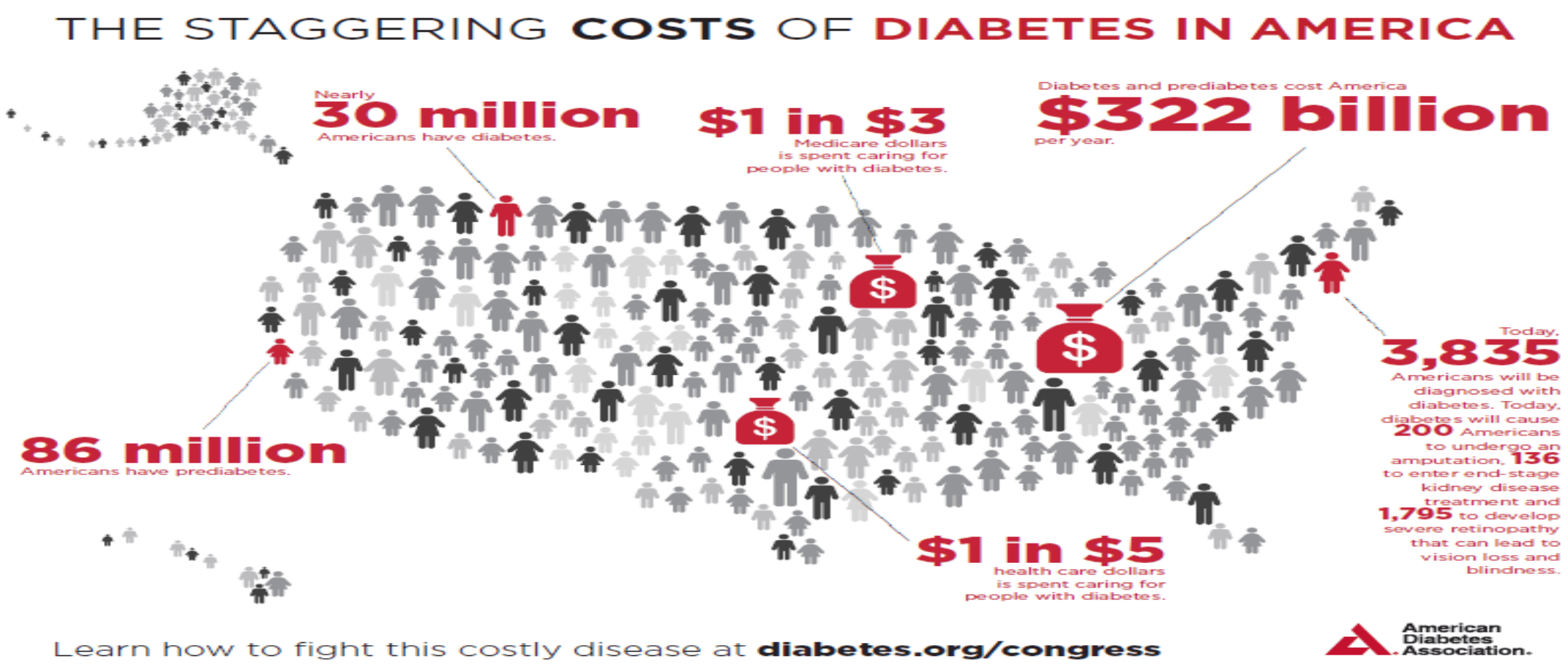
Increased

Factors:

1. Overweight & Obesity
2. Poor Diet
3. Older Age
4. Family History & Genetics
5. Race & Ethnicity
6. Historical Trauma
7. Natural Disasters/Stressful Circumstances
8. Behavioral Choices
9. Smoking
10. Lack of Physical Activity
11. Hypertension
12. High Cholesterol
13. High Blood Glucose

Minority Populations Health Risk Factors:

Opportunity to Manage Greatest Need:



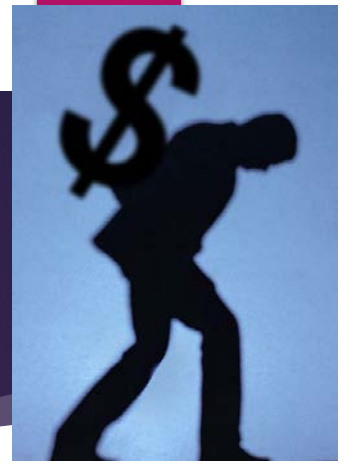
How Great Is The Need for SDOH:

- In 2019 Physicians Foundation survey found that **90% of U.S. physicians say at least some of their patients have a social condition** that poses a serious impediment to their health whether it be unemployment, lack of education or drug addiction.
- The survey shows more emphasis on **addressing social determinants of health** from food insecurity and transportation to affordable housing and have found that insurers like **Aetna, Cigna, Humana, UnitedHealth Group and Blue Cross and Blue Shield plans are paying for more ways to address them in 22 states.**
- **Only 1% of physicians said that none of their patients were affected by a social situation/need,** the healthcare industry appears to be on the right path in addressing social determinants of health, the Physicians Foundation analysis indicates.
- **2000+ Hospitals have noted that from direct patient care to C-Suite there is a need to incorporate surveys, assessments, collaborations to actively engage a 360 of patient needs. In a 2018, a Kaiser study found 52% of all hospitals are pursuing one social care need of physicians but there are still gaps to close**.
- **Medicaid Expansion unknowns are still "top of mind" in managing health and what does volume & need look like.**

Set The Stage: Social Determinants of Health Costs – Life & $

- According to the Kaiser Foundation: Population-level inequalities in health care result in **$309B** in losses to the economy annually and disproportionately affect disadvantaged populations.
- The cost to regain care is **$559B.**
- American College of Physicians analysis of studies measuring adult deaths attributable to social factors found that, in **2015, approximately 245 000 deaths were attributable to low education, 176, 000 were due to racial segregation, 162 000 were due to low social support, 133, 000 were due to individual-level poverty, and 119 000 were due to income inequality.**
- On average, there is a 15-year difference in life expectancy between the most advantaged and disadvantaged citizens; some research shows the disparity as high as 22 years.
- Generational – Negative Outcomes: **2-5 generational circumstances.**
- Interventions – Positive Outcomes: **Reset the circumstances.**

Risks:



- **Policy, Price of Insurance, Rural Hospital Closures, Opioid Epidemic, Physician Burnout, Retention, Lack of Nurses** and other specialty services **shortages** were already stressors.
- A 2019 study by the Permanente Medical Groups found that **1/2 of Americans are stressed to meet basic needs such as stable housing, adequate food, and reliable transportation.**
- More than one in four cites an unmet social need as a barrier to health. **PreCOVID 49% prioritize paying for food or rent over seeing a doctor or getting a medication.**
- **An unemployment rate of $50M+, indicates a future sharp indicator to close the gap in healthcare needs & to be determined from COVID.**

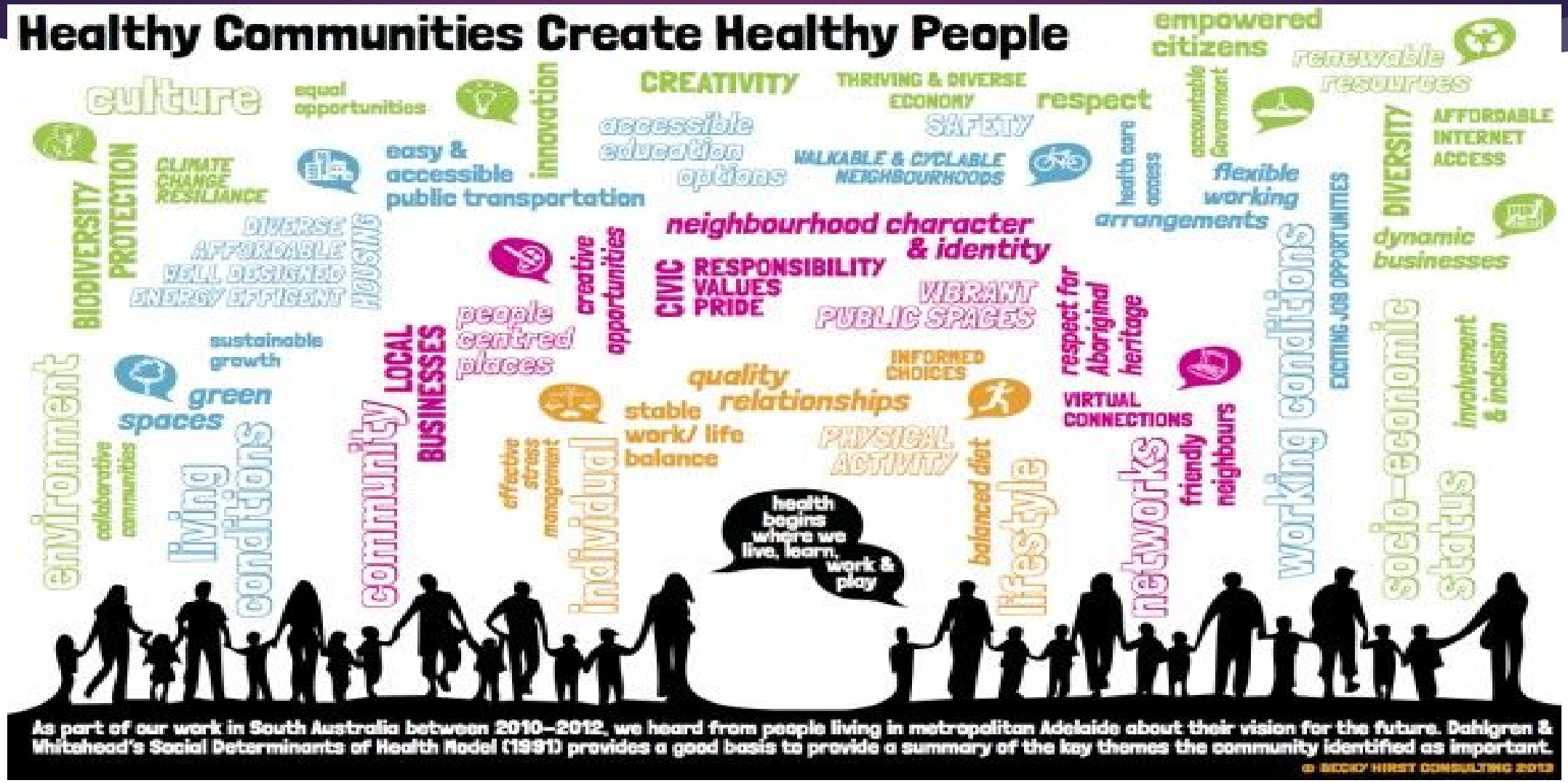
Hospitals Current State :

- A recent study conducted in conjunction with Health Leads found that unmet health-related social needs are associated with:
- Higher risk of hospital readmission rates: Heart Failure & Pneumonia.
- ER High utilizers – Diabetes, Asthma, Mental Health
- About one-third of hospitals (35 percent) are tracking cost outcomes from their social needs investments. – Most hospitals do not have dedicated funds for all of the populations they want to target (72 percent),
- 50% are using Value-Based Care.
- 60 percent of health outcomes are determined by clinical care, yet clinical care accounts for most health care investments.
- The Centers for Medicare and Medicaid Services (CMS) launched its Accountable Health Communities Model to provide funding, over the course of five years, to dozens of providers to act as “bridges between clinical and community services.”

Closing Clinical Gaps – Completes Health Data Picture:

- Identify the patient's needs & risks – surveys/assessments; 360 Follow-up
- **Integration team** approach between health care providers and community resources and the technological connection to automate communications and track what has happened.
- Prevention can save **$3,500-$15,300 per person on average with other healthcare management showing savings of $100K+ per high utilizer patients.**

HealthCare Leadership Creates:



Models Selected:

- Close the Gaps - Advance Greater Opportunities for Equity of Care.
- Resolve Mass Critical Need
- Evidence Based, Clinical & Collaborative Driven
- Easy to Scale/Duplicate & Unique
- Fit within Rural & Underserved Populations/Needs
- Drive Cost Savings
- Create Patient Accountability

2020 SDOH Best Practices:

- CommonWealth Fund & Deloitte & Health Leads studies and surveys analyzed 500 hospitals across the nation to identify “best practices” of linking SDOH to HealthCare:
- **Chronic Disease Management:** **Geisinger’s Fresh Food Pharmacy** has educated and provided diabetes patients with fresh and nutritious food since 2016. Their goal is to “***deliver the gold standard of diabetes care by providing diabetes education and healthy food in a sensitive, caring and respectful manner.”***
- Patients with diabetes or pre-diabetes and who have been identified as “food insecure” receive a **Fresh Food prescription.** Following this prescription, **patients receive 20 hours of education with health coaches about diabetes, and a kitchen kit with measuring cups, recipes, and nutrition information.**
- Due to the proactive and preventive measures that were put in place, **over the first 18 months, there was an 80% decrease in costs for enrolled patients, or $48,000 in savings per patient per year.**

SDOH Hospital Best Practices:

- **Food Security: Northwest Permanente Medical Group in Oregon**, a new program "Thrive Local" enables physicians to seamlessly connect patients to geo-mapped community-based organizations for support.
- **If a patient cannot afford or access food, the physician can note this situation in the patient's electronic health record at the time of the exam or office visit.** This action automatically alerts the food banks closest to the patient's home. After one organization has completed the delivery, the program indicates to the other two that the need has been met. The result: the patient quickly receives the food, and there's no follow-up needed by the physician or staff.
- **A recent "Thrive Local pilot" resulted in more than 28,000 referrals for nearly 12,000 patients to 7,500 community-based organizations.** Participating organizations include medical support needs and access to transportation, utilities, housing, and food. In 2021, the program will be rolled out across all Kaiser Permanente medical groups across the nation.

SDOH Hospital Best Practices:

- **Healthy Children and Avoiding Adverse Childhood Events: Atrius Health** Massachusetts, hospital & clinic pediatricians focus on whole family health.
- At each **annual** pediatrics exam, a parent or caregiver completes an annual social determinants of health (SDOH) questionnaire. **The nine-question survey identifies individuals and families' potential concerns about permanent housing, employment, ability to pay utilities, as well as access to food, transportation, childcare, and mental health resources.**
- If the questionnaire indicates that the child or family may have issues in any of these areas, a provider will begin a conversation about these situations and connect them with a facilitator to pair them with community resources. **Goal- Patient leaves with 2 connections.**
- Atrius also adapts its clinic operations to help meet patients' needs combining multiple appointments into one visit, arranging transportation and helping families obtain SNAP benefits. **To date, they have helped 600+ families.**

SDOH Hospital Best Practices:

- **Travel: Essentia Health uses waivers and UBER services 60% of the time establishing a 97% patient appointment rate and 98% positive patient engagement satisfaction/commitment to care.**
- **Poverty: Geisinger Health System** relies on **Community Health Assistants (CHAs)** to help improve patient outcomes by addressing certain social needs, including social isolation and connection to community services – Meals on Wheels, Churches and Community Service Coalition support.
- **Interpersonal Violence Prevention: The Children's Hospital of Wisconsin** addresses family violence through a variety of activities Since 1980's using child advocacy centers to reduce violence, save lives and decrease health care costs.
- **Home Intervention: The Medical College of Wisconsin, and the Children's Service Society of Wisconsin. Project Ujima** Case workers identify patients' needs & provide immediate support during the hospital stay. The program also features a community-based home visitation model to follow hospital treatment. After discharge, a community liaison visits the patient's home within two weeks to develop a service plan. This provides teenager and other family members access services including medical, behavioral health, legal, school, and social services. **They have helped 6,000+ families.**

SDOH Hospital Best Practices:

- **Utilities**: **Boston Medical Center** wanted to help low-income patients who received treatment in the hospital but had to go back to apartments or housing that had no heat or electricity. They set up a "Protection Letter Program." ***During the program's first year, physicians wrote letters protecting 193 people from utility shutoffs.*** The program scaled up the following year with the opening of a new onsite legal clinic. It helps patients needing their utilities restored set up payment plans with utility companies and ensure future shutoff protection. **To date, they have helped 5,000 families.**

- **Education: WellCare Health Plans, Inc.,** a provider of government-sponsored health care, offers free General Educational Development (GED) testing for eligible Medicaid members. Recognizing that many social determinants factor into the health of an individual, family, and community, WellCare aims to help members remove financial barriers that may prevent them from furthering their education and employment opportunities. **WellCare first offered the GED benefit to Georgia members and have helped 100+ families.**

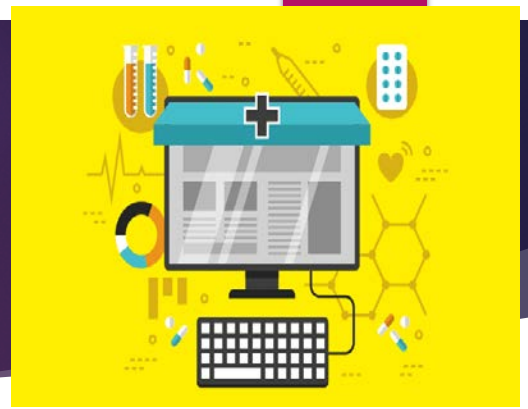
SDOH Hospital & Physician Opportunities:

- Shift to value-based care and toward value-based care models—such as accountable care organizations **(ACOs)** and bundled or capitated payments.
- Change your organization's mission and vision to completely align with addressing health-related social needs.
- Implementation of **MACRA., CPC & other CMS Innovation Programs Center** for Medicare and Medicaid Innovation and the Medicare Access and CHIP Reauthorization Act (MACRA) are helping more hospitals and health systems move away from fee-for-service (FFS) to value-based care models.
- Use **population health genetic tools** to help patients know what genetic predispositions they have diabetes, mental health, cardiovascular, oncology.
- Use **pharmaco-genomics for medication med management** to help patients in right drug, right time, right dosage.
- Use **EHR to manage wellness results** – Diabetes, Grant Participation, FitBit/Wellness Solutions etc.

SDOH Hospital & Physician Opportunities:

- **ICD-10-Z codes:** The ICD-10 classification scheme includes Z codes for describing factors that influence health status and contact with health services. These Z codes relate to potential hazards due to family and social circumstances impacting health status, including socioeconomic and psychosocial circumstances, problems related to education and literacy, employment and unemployment, housing and economic circumstances, and the social environment, to name a few
- **Break down inner siloes and consolidate resources.**
- **Hire patient advocates, navigators, social workers, &/or home health workers** to assist with patient coordination.
- Identify strategies to improve their ability to **track health and cost outcomes & adopt consistent definitions & metrics around addressing social needs.**
- **Sharing leading practices and data on other organizations' activities and strategies** to direct investments, and scale what is working.
- **Public Health** – Recognize they are central to the role.

SDOH Hospital & Physician Opportunities:



- **Listen to the patients** – patient centered care never stops.
- Sustainable funding can challenge the pursuit of social needs activities surveyed hospital stakeholders report a variety of funding sources for hospital social needs activities, with government – grants, **COVID funding, 340B,non-profit organizations grant partnerships. Centers for Medicare Services/Center for Medicare and Medicaid Innovation grants, funding through State Innovation Model (SIM) grants, waiver funding, Accountable Health Community grants State, local, and community funds.**

“7 National” TIPS & TAKE-AWAYS: HOSPITALS & PHYSICIANS :

- Payment risk-adjustment methodologies should include multiple variables representing social determinants linked to health outcomes.
- The incorporation of variables representing SDOH in APMs should be founded on evidence-based research methods.
- Evidence-based measurement of SDOH should be used by payers to provide resources to support additional services that patients with social risk may need.
- Measurement for payment adjustments should be made at a standardized geographic level, such as a census tract, census block group, or primary care service area.
- At a minimum, measurement should include the following: poverty, unemployment, household provider status, high-need age group (i.e., 17 years of age or younger; 65 years of age or older), education level, transportation, crowding, uninsured status, and race.
- Performance measurement should be risk-adjusted for SDOH when there is a clear relationship between social risk and health outcomes.
- Keep advancing digital technology and EHR systems: Health information technology (HIT) platforms should facilitate SDoH data collection from medical records and other sources to support improved clinical decision making, care coordination, quality measurement, and population health management.

Transformation Drivers:

1. Application of precision medicine managing all populations.
2. Look at Payer Groups as they focus on social determinants of health providing “Whole Care” like United – Diabetic Care, Waivers and Housing.
3. More CLAS Standards, Social Determinants of Health mainstream care.
4. ECHO Telehealth Programs – Lifestyle and Specialty Care
5. Adaption of ADOP for Oncology
6. Depression Screening, Sleep Studies, Cardio Testing
7. CMMI Innovation Center
8. Rural Health HRSA Grants

Strategies to Advance Population Health

- Increase knowledge about health disparities, health equity, and the factors that influence negative health outcomes
- Know the demographics of the population you serve and your community
  - Use the data collected to identify the health needs of population served and the other factors that influence their health outcomes
  - Identify language and literacy needs and provide services to meet these needs- ensure communicate at all points of contact within organization
- Address components of the National Standards on Culturally and Linguistically Appropriate Services (CLAS) by providing meaningful access

Strategies to Advance Population Health

- Create health equity leaders within your organization to assist with increasing organizational capacity and data collection efforts
- Participate in community needs assessment and efforts to improve the health of your community
- Partner with housing, education, work force development, city planning, and other system partners to address the needs of your community

Toolkit of Resource Information:

- https://www.cms.gov/Center/Provider-Type/Rural-Health -Clinics-Center.html
- https:www.cms/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html
- Care Management Services in RHCs and FQHCs - FAQs [PDF, 198KB]
- Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2020; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program
- https:www.CPC+/cms.gov
- https://www.cdc.gov/diabetes/data/statistics/statistics-report.html
- Rural Health Information Hub. www.Rhib.com
- https://innovation.cms.gov/initiatives/direction
- National Rural Health Association www.nrural
- https:/www.MyGenetx.com
- RAC Monitor Https:/racmonitor.com
- DHHS Health Disparity Data: http://dhhs.ne.gov/Pages/HDHE-Reports.aspx
- DHHS OMH Cultural and Linguistic Appropriate Services: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6

Summary of Other Models:
Need, Intervention & Results:

- **Rural Project Examples – FORHP Federal Office of Rural Health Policy -Rural Health Services Outreach Grant Program at least 100 of them**
- **1. RISE UP Program & Obesity Challenges - September 2018 & March 2019**
- **2. Child Maternal Health Remote Advancements October 2018 & April 2019**
- **3. One World Community Wellness – Psych October 2018 & April 2019**
- **4. One Community Wellness – Sept. 2017 & 2018**
- **5. Youth4Health – Sept. 2017 & 2018**
- **6. Sweet Dreams – January 2017 & 2018**
- **7. Vivir Mejor – June 2017 & 2018**
- **8. Healthy Early Learning Project (HELP) – May 2017**
- **9. Heartland Rural Health Network – January 2018**
- **10. Project ADPT – Applied Diabetes Education Program – January 2016**
- **11. Meadows Diabetes Education Program - Sept. 2016**
- **12. Chautaugua Health Connects (CHC) – Sept. 2016**
- **13. Healthy Outcomes Integration Team (HOIT) – Nov**
- **14. Downeast Maine Diabetes Prevention Program – Sept. 2015**

Toolkit of Resource Information:

- CDC Social Determinants of Health
- CMS
- 2020 Healthy People
- Secretary's Advisory Committee Social Determinants of Health Report
- MAP-IT Toolkit/MAP IT SDOH
- Resources: Deloitte Studies and Surveys
- The Physician Foundation
- Health Payer Intelligence
- Annals of Internal Medicine
- AHA & AMA Toolkits
- MD Edge Medical Society Tools
- AAPC – Academy of Primary Care & American College of Physicians
- Disparity Policies

We Are All In This Together: