

# Social Determinants of Health Anchoring Our Communities



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# Social Determinants of Health

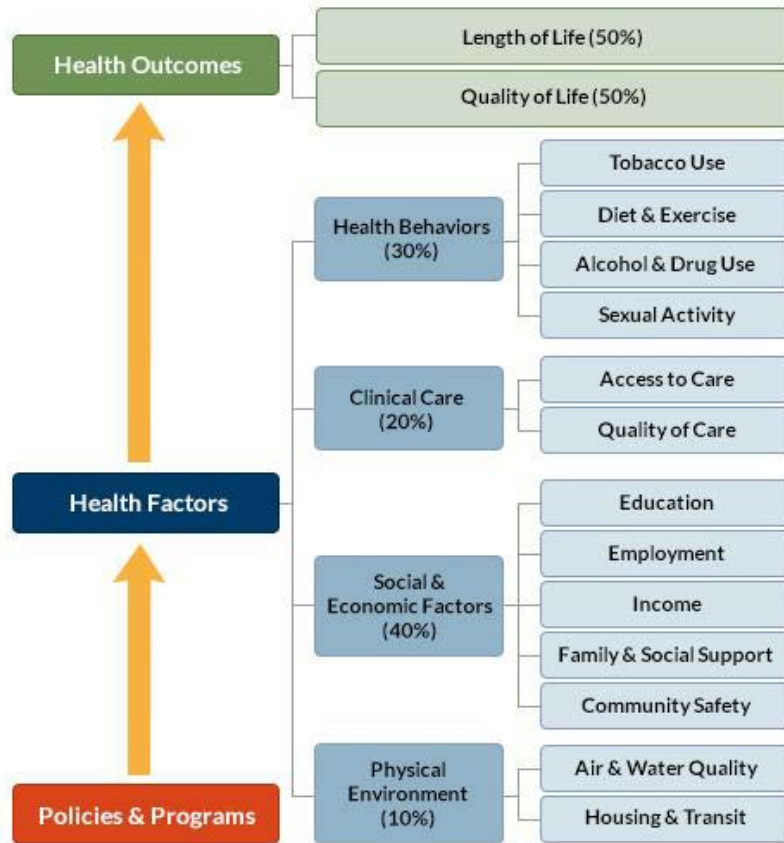
Economic Stability	Neighborhood and Physical Environment	Education	Nutrition	Community and Social Context	Healthcare System
<ul style="list-style-type: none"> <li>• Employment</li> <li>• Income</li> <li>• Expenses</li> <li>• Debt</li> <li>• Medical bills</li> <li>• Support</li> </ul>	<ul style="list-style-type: none"> <li>• Housing</li> <li>• Transportation</li> <li>• Safety</li> <li>• Parks</li> <li>• Playgrounds</li> <li>• Walkability</li> </ul>	<ul style="list-style-type: none"> <li>• Literacy</li> <li>• Language</li> <li>• Early childhood education</li> <li>• Vocational training</li> <li>• Higher education</li> </ul>	<ul style="list-style-type: none"> <li>• Hunger</li> <li>• Access to healthy options</li> </ul>	<ul style="list-style-type: none"> <li>• Social integration</li> <li>• Support system</li> <li>• Community engagement</li> <li>• Discrimination</li> </ul>	<ul style="list-style-type: none"> <li>• Health coverage</li> <li>• Provider availability</li> <li>• Provider linguistic and cultural competency</li> <li>• Quality of care</li> </ul>

## Health Outcomes

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

# The National Landscape

## *Impacting State Health Rankings- Learning from NY- 40<sup>th</sup> to 10<sup>th</sup>*



### New York State 2019-2024 Prevention Agenda Priorities

To improve health outcomes, enable well-being, and promote equity across the lifespan

•  
Focuses on addressing social determinants of health and reducing health disparities

•  
Incorporates a Health Across All Policies approach

•  
Emphasizes healthy aging across the lifespan

•  
Promotes community engagement and collaboration across sectors in the development and implementation of local plans

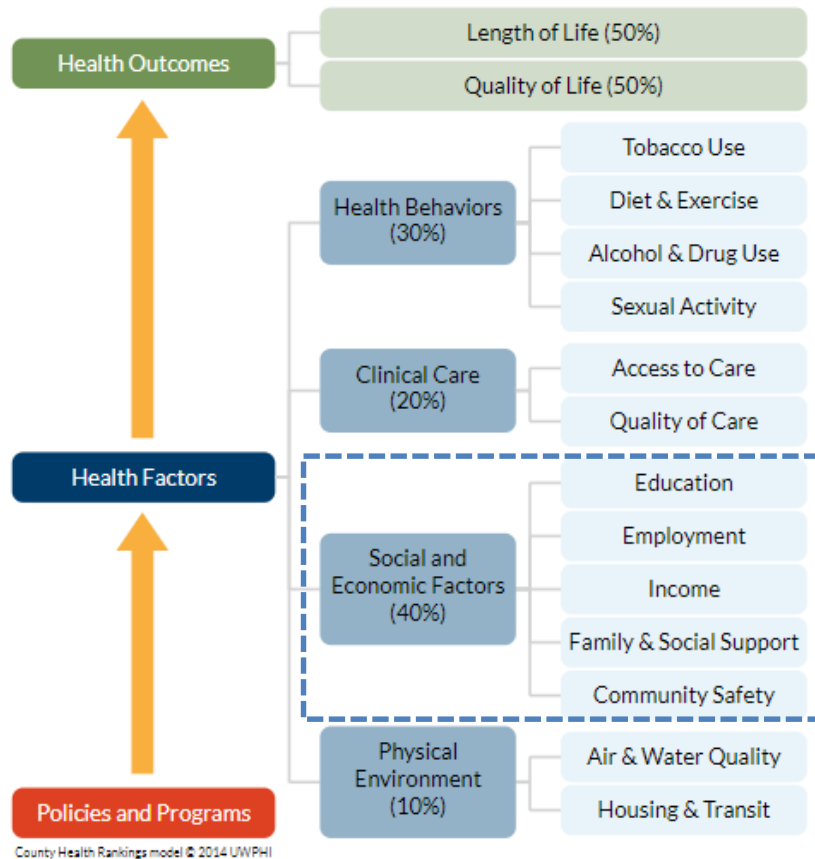
•  
Maximizes impact with evidence-based interventions for state and local action

•  
Advocates for increased investments in prevention from all sources

•  
Concentrates on primary and secondary prevention, rather than on health care design or reimbursement

# Patient Centered Care

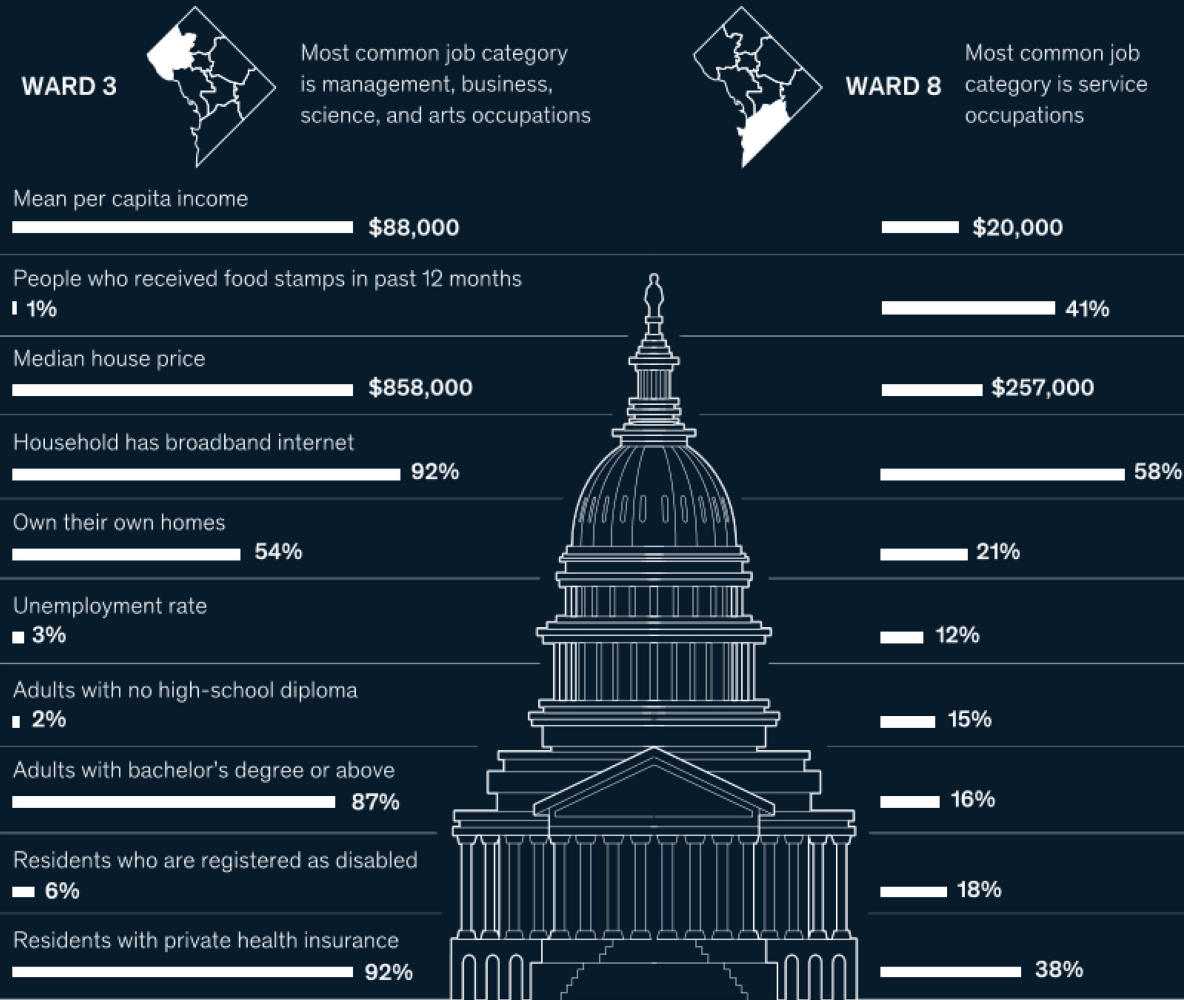
## Individual and Community Health



### Addressing Social Determinants of Health:

- New innovative partnership programs
- Social needs/mental health screening
- New technology to track and close-loop referrals
- Integrated services
- Investment in social service programs and co-location of services
- Centene Social Health Bridge™ Trust

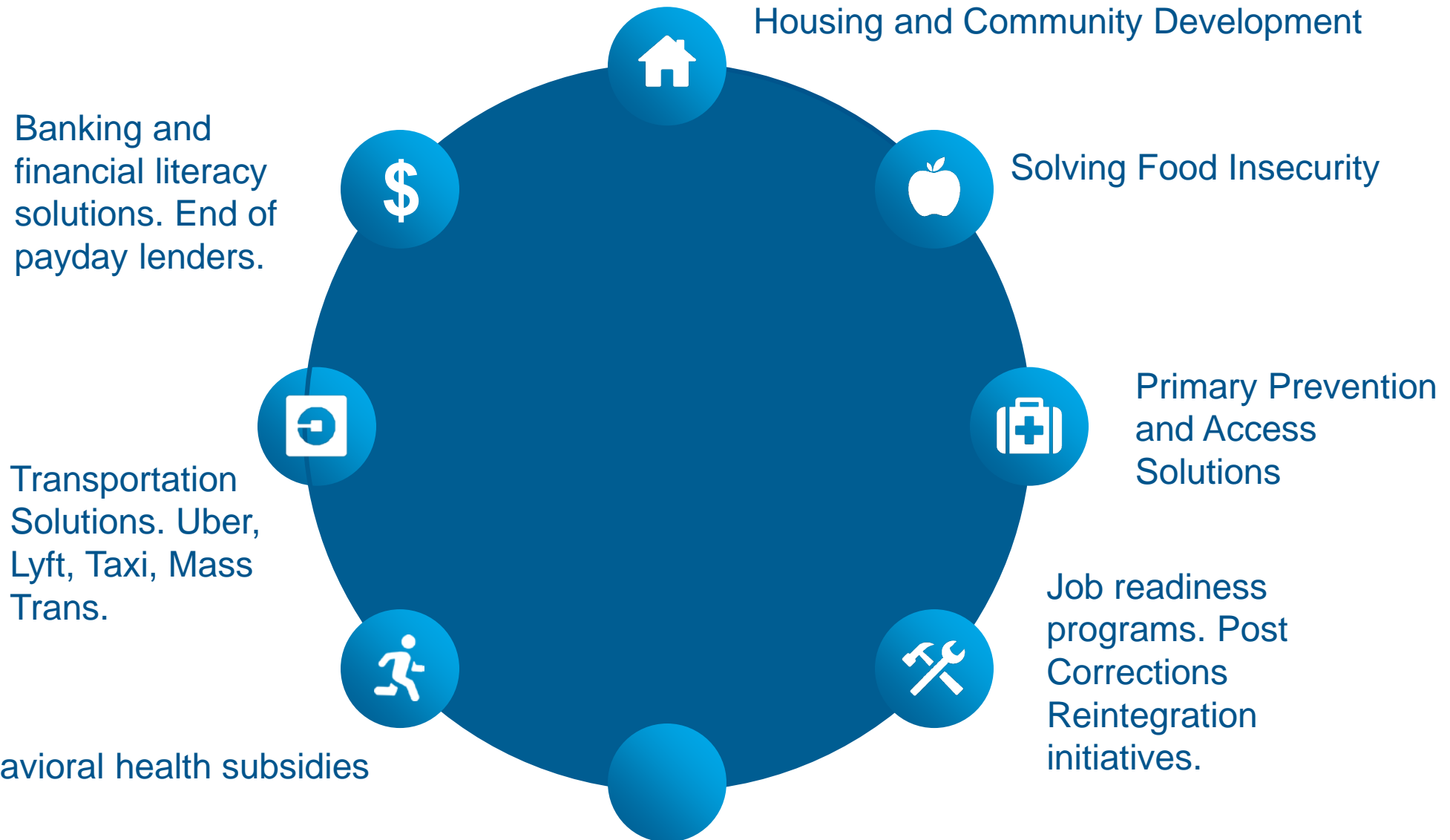
**Washington, DC, is one of the most unequal cities in the United States, as reflected in different outcomes for average residents of Ward 3 and Ward 8.**



Source: "2013-2017 ACS 5-year estimates," US Census Bureau, March 2019, census.gov; McKinsey Global Institute analysis

**McKinsey  
& Company**

# How to Address Social Determinants of Health?



# Food Insecurity Realities

**1 in 4**  
**Medicaid**  
**members**  
**food insecure<sup>1</sup>**

- **50M** Number of Americans receiving SNAP benefits <sup>2</sup>
- **2-3 weeks** Average time for SNAP benefits to run out every month<sup>3</sup>
- **79%** Percent of families who purchase inexpensive, unhealthy food when SNAP benefits run out<sup>4</sup>

1,3 Envolve Lab: Louisiana Member Needs Assessment; August 2017.

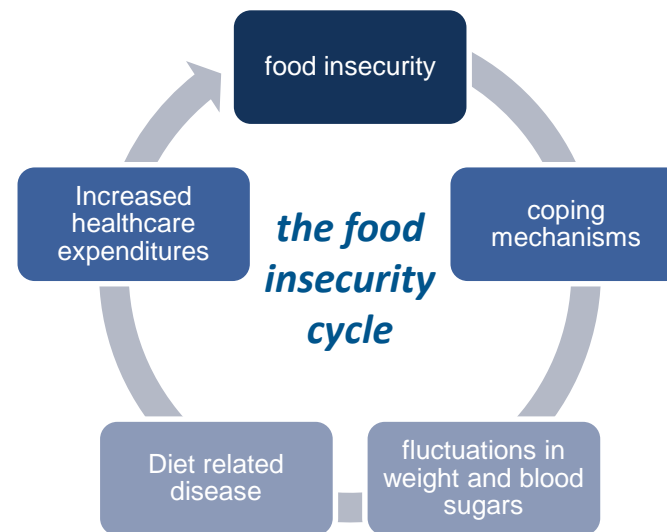
2 <https://www.snaptohealth.org/snap/snap-frequently-asked-questions>

4: <https://www.feedingamerica.org/sites/default/files/research/hunger-in-america/hia-2014-executive-summary.pdf>

# Health Consequences of Food Insecurity

# \$1,863

Additional  
healthcare  
spend per year  
for the food  
insecure



- **\$5,144** Add'l HC spend for food insecure adults with Heart Disease compared to the food secure
- **\$4,414** Add'l HC spend for food insecure adults w/diabetes compared to food secure



# Food Security Interventions: Potential Savings Opportunities

12-15% ▼

ER reduction potential for hypoglycemia by increasing SNAP benefits<sup>1</sup>

176M ▼

WIC Program Net Savings of Federal and state Medicaid dollars<sup>2</sup>

109M ▼

Medicaid cost reduction potential by increasing meal delivery by 1% to the homes of older adults<sup>3</sup>

30% ▼

Percent reduction of food insecurity through the SNAP program<sup>4</sup>

\$30 ▲

Additional SNAP benefit dollars needed to met the needs of the food insecure<sup>5</sup>

30% ▼

Percent reduction in medication non-compliance for elderly adults on SNAP vs. non-SNAP elderly adults<sup>6</sup>

1. Heflin, C., Hodges, L. Mueser, P., "SNAP benefits and ER Visits for hypoglycemia," Public Health Nutrition, May 2017.

2. Foster, Jiang, & Gibson-Davis; 2010; Khanani et al., 2010; Hoynes, Page, & Stevens, 2009; Lazariu-Bauer et al., 2004; El-Bastawissi et al., 2007; GAO, 1992; Muhajarine et al., 2012.

3. Thomas & Mor, 2013a; Thomas & Mor, 2013b; Thomas & Dosa, 2015.

4, 6: <https://www.cbpp.org/research/food-assistance/snap-is-linked-with-improved-nutritional-outcomes-and-lower-health-care>

5: <https://www.cbpp.org/research/the-relationships-among-snap-benefits-grocery-spending-diet-quality-and-the-adequacy-of-low>

## Identify the Barriers

*Work with the communities and members we serve to identify barriers that impede health outcomes.*




# Case Study: Baltimore-Asthma

- Baltimore 21223 zip code. Asthma flare ups 4X the rate of neighboring zip codes. 2<sup>nd</sup> highest Asthma Admissions
- Within 3 miles of Johns Hopkins and 1 mile of University of Maryland Medical Center
- These two institutions collected ~\$84 million in 3 years to treat Baltimore Asthma patients
- Asthma admissions now are medically ~ 90% avoidable
- Yet Asthma is the most common childhood condition. Affecting 50% of families living in poverty. 500,000 admissions per year, 2 million ER Visits. Thousands of Deaths Annually
- Baltimore each ER visit paid ~\$871, inpatient stay \$8698. In a 3 year period \$6.1 million spent for treating just 50 inpatients (high utilizers 10 stays each)
- Johns Hopkins' own research showed shifting dollars from hospitals to improve housing through providing half the cost of one admission could improve outcomes. Yet they did little to nothing.
- Total Annual Cost of Asthma Care in US: 50 Billion

Health & Science

## Hospitals find asthma hot spots more profitable to neglect than fix

By Jay Hancock, Rachel Bluth of Kaiser Health News and Daniel Trielli of Capital News Service  
December 4, 2017



**Most Read World**

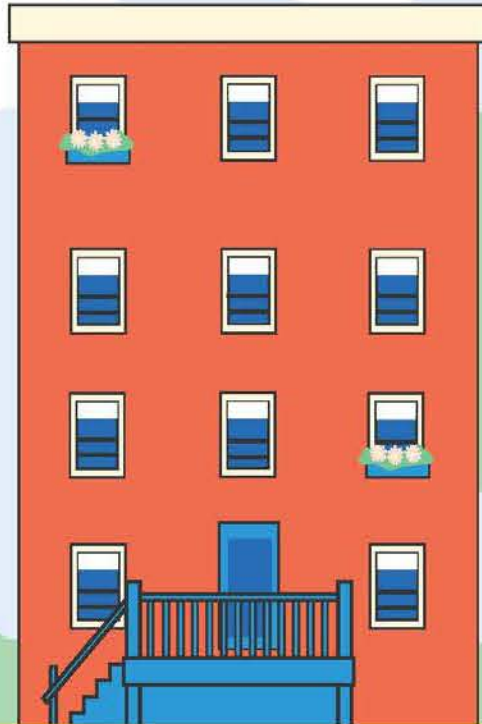
- 1 NSA's top talent is leaving because of low pay, slumping morale and unpopular reorganization
- 2 Analysis Tens of thousands of people have protested in Iran. Here's why.
- 3 Former Taliban captive Joshua Boyle arrested and charged with sexual assault, death threats
- 4 At least 48 dead when bus plunges onto rocky beach in Peru



## Does your patient need an asthma home visit referral?

**BPHC offers 2 FREE home-based services for Boston residents with asthma**

**Help your patients keep their asthma under control**



## Healthy Homes Asthma Home Visit Program

Visit by CHW includes:

- Asthma education (& review medications)
- Visual assessment for asthma triggers
- Cleaning & pest management supplies
- Additional resources and referrals

Download Referral Form: [www.bphc.org/asthma](http://www.bphc.org/asthma)

Attach Asthma Action Plan & Allergy test results if possible

Fax to 617-534-2372

## Breathe Easy at Home Program

Boston Inspectional Services Department (ISD) inspectors will:

- Identify asthma triggers that are covered by the MA sanitary code
- Work with landlords to correct these poor housing conditions

Referral login: [www.cityofboston.gov/isd/bmc](http://www.cityofboston.gov/isd/bmc)

Login support & Info: 617-534-2485

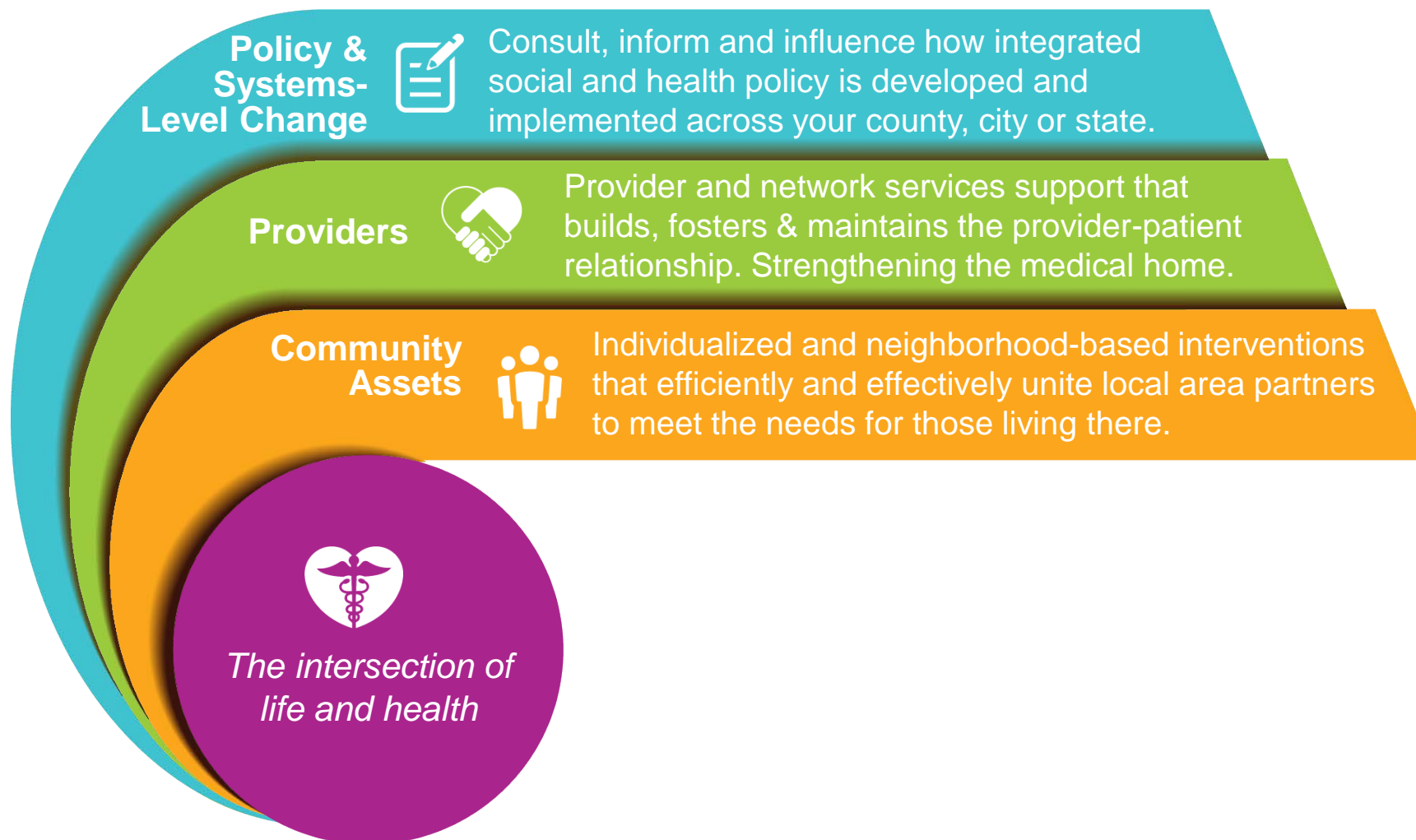
## How to make a referral

1. Check eligibility (Boston resident, qualifies per referral form)
2. Obtain patient consent
3. Fill out forms completely and submit referral



Building a Healthy Boston  
Mayor Martin J. Walsh

# Building a SDOH Framework



# Let's Talk!

