Social Determinants of Health Overview

Sunflower Health Plan – Project ECHO

April 2022

Objectives

- Understand the social determinants of health (SDOH) that may affect the populations receiving care in your practice or community, and how they may lead to health disparities and health inequity

- Learn about existing approaches to address SDOH barriers at the individual and community levels

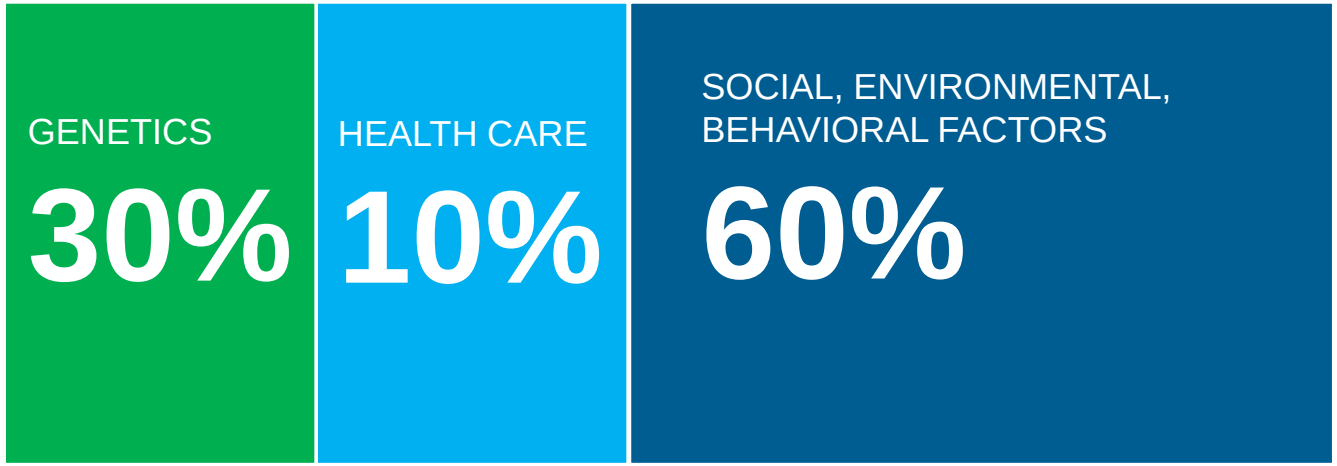
- Gain tools to identify and address SDOH in your community / practice

Defining Social Determinants of Health & Health Disparities

Defining Social Determinants of Health

- Health starts in our homes, schools, workplaces, neighborhoods, and communities
- Conditions in these places affect a wide range of health risks and outcomes
- These conditions are known as social determinants of health (SDOH)

Social, environmental, and behavioral factors drive the majority of healthcare outcomes

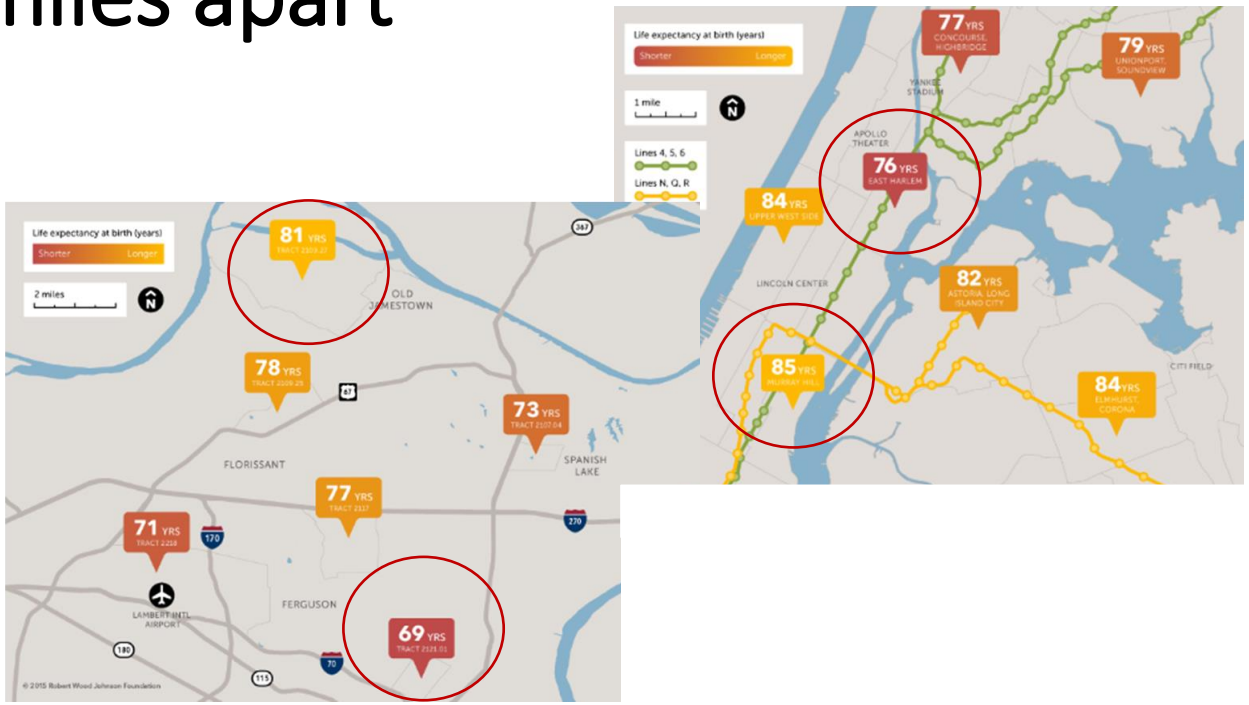


Source: Adapted from https://www.nejm.org/doi/full/10.1056/NEJMsa073350

Life expectancy can vary significantly between neighborhoods only a few miles apart

Why such stark differences between neighborhoods?

"Gaps in health across neighborhoods can stem from multiple factors, ranging from **scarce educational or income opportunities**, to **unsafe or unhealthy housing**, to **limited access to good hospitals and primary care**."



Source: Robert Wood Johnson Foundation https://www.rwjf.org/en/library/articles-and-news/2015/09/city-maps.html Accessed March 16, 2019

Addressing the social determinants of health enables improved health outcomes for individuals and communities

"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. . . .

The social determinants of health have an important influence on health inequities - the unfair and avoidable differences in health status seen within and between countries."

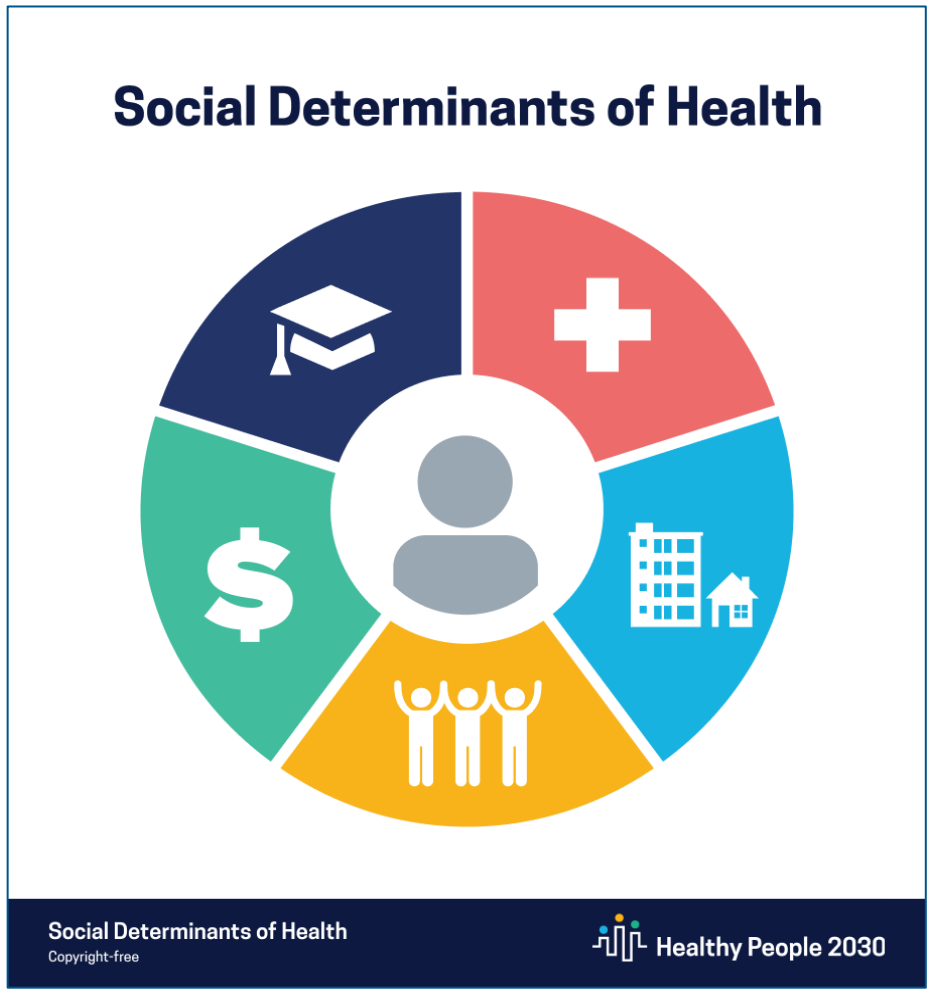
- The World Health Organization

CORE ELEMENTS

- Housing Instability
- Food Insecurity
- Transportation
- Employment
- Education
- Safety
- Social Isolation Supports
- Financial Security

Source: World Health Organization, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1, Accessed April 7 2022.

Healthy People 2030: Five Key Determinant Areas



	Economic Stability	Poverty Employment Food insecurity Housing instability
	Education Access & Quality	High school graduation Enrollment in higher education Language and literacy Early childhood education and development
	Health Care Access & Quality	Access to health care Access to primary care Health literacy
	Neighborhood & Built Environment	Access to healthy food Quality of housing Exposure to crime, violence Environmental conditions
	Social & Community Context	Social cohesion Civic participation Discrimination Justice-involved

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 2022 April 7, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Defining Health Disparities

A particular type of health difference closely linked with social, economic, and/or environmental disadvantage

Affect groups of people who have systematically experienced greater obstacles to health based on their:

- Racial or ethnic group
- Religion
- Socioeconomic status
- Gender, age
- Mental health
- Cognitive, sensory, or physical disability
- Sexual orientation or gender identify

Example of a health disparity:

Individuals with lower socioeconomic status (SES) have disproportionately higher cancer death rates than those with higher SES

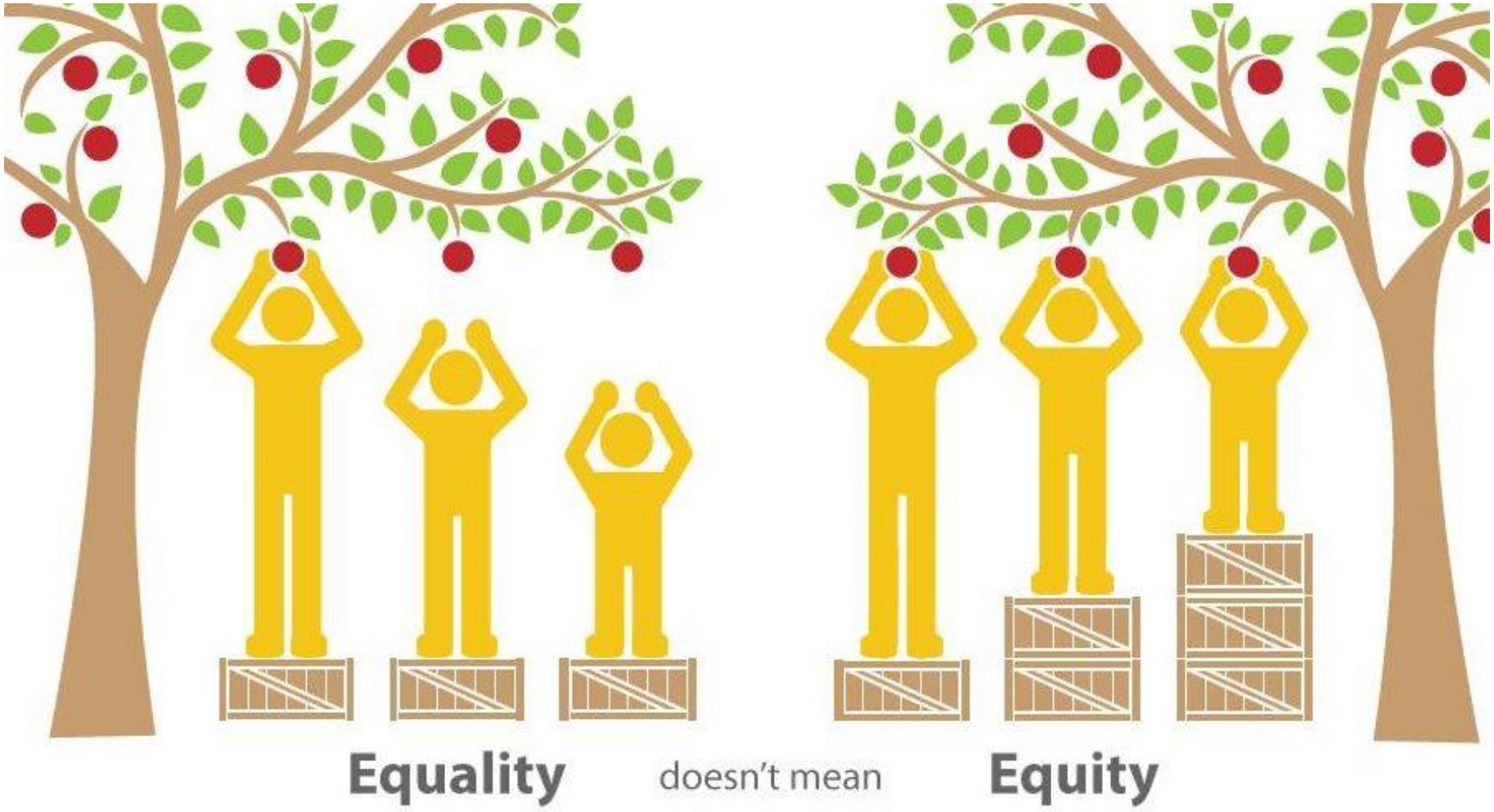
Defining Health Equity

The attainment of the highest level of health for all people

Achieving health equity requires:

- Valuing everyone equally
- Focusing on ongoing societal efforts to address avoidable inequities, historical and contemporary injustices
- Eliminating of health and health care disparities

Health Equality vs. Health Equity



Source: Saskatoon Health Region, https://www.communityview.ca/infographic_SHR_health_equity.html

Tools & Resources for Integrating SDOH Into Care Practices

Addressing SDOH through Managed Care: Sample Healthcare Benefits to Address SDOH

Medicaid Plan SDOH Benefits

Medicaid plans often offer a range of SDOH-related benefits, including but not limited to:

- Dedicated case management and/or care coordination support to navigate community resources
- Transportation benefits, including medical and/or non-medical (such as visits to the grocery store)
- Food benefits, such as access to medically tailored meal delivery or other grocery benefits
- Housing benefits, such as home modifications or utilities assistance
- Education and employment-related supports, including GED and job skills training
- And many others…

Centers for Medicare & Medicaid Services (CMS) Innovation Model: Value-Based Insurance Design (VBID)

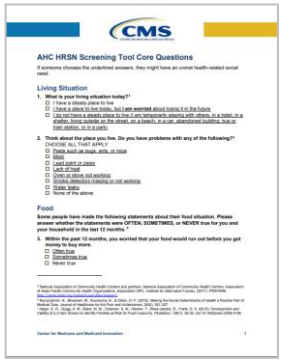
What it is	*CMS innovation model offering benefit design flexibilities to Medicare Advantage (MA) plans to test the impact on utilization, cost, and quality outcomes*
What's new for 2023	• Member eligibility for **expanded benefits (including SDOH-related services) can now be based on socioeconomic status**, not just limited to specific chronic conditions • Certain **community-based organizations (e.g., AAAs, CILs) can now qualify as "high-value providers"**
SDOH benefit opportunities	Sample health benefits may include: • food and produce; • meals (beyond the current allowable limits); • transportation for non-medical needs; • indoor air quality equipment and services; • access to community or plan-sponsored programs and events to address social needs (such as non-fitness club memberships, community or social clubs, park passes, family counseling, martial counseling, access to companion care, classes for enrollees with primary caregiving responsibilities, or events to address enrollee isolation and improve emotional and/or cognitive function, etc.); • complementary therapies (offered alongside traditional medical treatment); • services supporting self-direction (such as legal services to help establish decision-making authority for healthcare needs; access to courses on financial literacy, technology, and language; others); • structural home modifications; • general supports for living, which may include plan-sponsored housing consultations; • subsidies for rent or assisted living communities; • subsidies for utilities such as gas, electric, and water; and • pest control.

Source: Centers for Medicare & Medicaid Services, https://innovation.cms.gov/innovation-models/vbid, Accessed April 7 2022.

SDOH Screenings & Assessments

Identifying and addressing social needs in healthcare settings can lead to improved patient health, enhanced patient-provider trust relationship, and more effective care that treats the whole person

Sample SDOH Screening Tools


CMS

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. What is your living situation today?*
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but I am worried about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
2. Think about the place you live. Do you have problems with any of the following?* CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.*

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

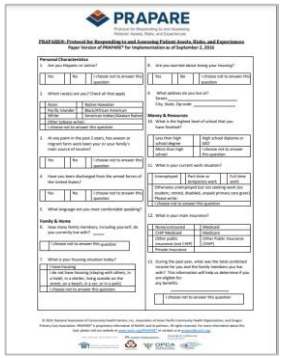
* National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association [illegible], Institute for Alternative Futures. [2017]. PRAPARE. [illegible]

* Billioux, A., Verlander, K., Anthony, S., & Alley, D. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/201705b

Center for Medicare and Medicaid Innovation

[Accountable Health Communities (ACH) Health-Related Social Needs (HRSN) Screening Tool]

- A standard screening tool developed by the Centers for Medicare & Medicaid Services (CMS)
- Includes 10 questions across 5 domains: housing instability, food insecurity, transportation, utilities, and interpersonal safety


PRAPARE

PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Paper Version of PRAPARE for Implementation as of September 2, 2016

Personal Characteristics

Family & Home

Money & Resources

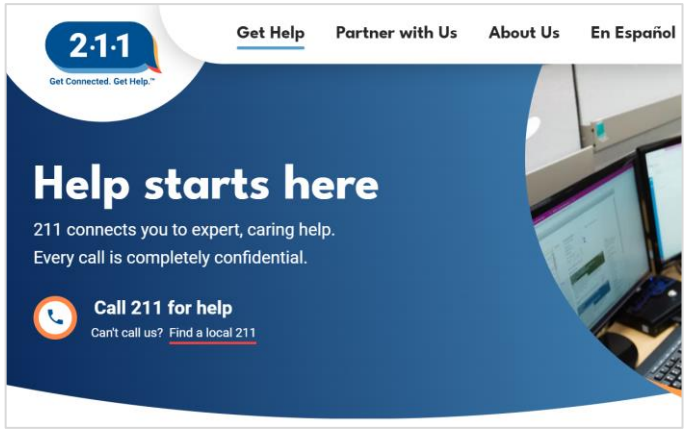
[PRAPARE Assessment Tool]

- Accompanied by an *Implementation and Action Toolkit* compiling best practices from health centers implementing SDOH assessments
- Includes 21 questions across several domains; currently translated into more than 25 languages

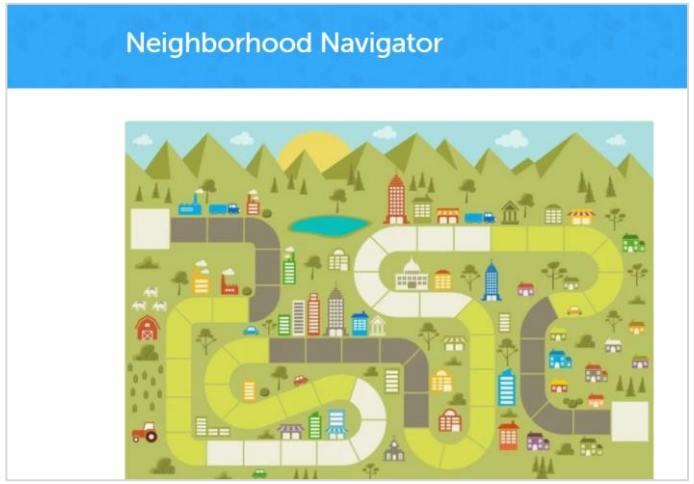
SDOH Referrals & Community Resource Navigation

Beyond health plans and direct care coordination support, several free resources can support community resource navigation

Sample Community Services Websites

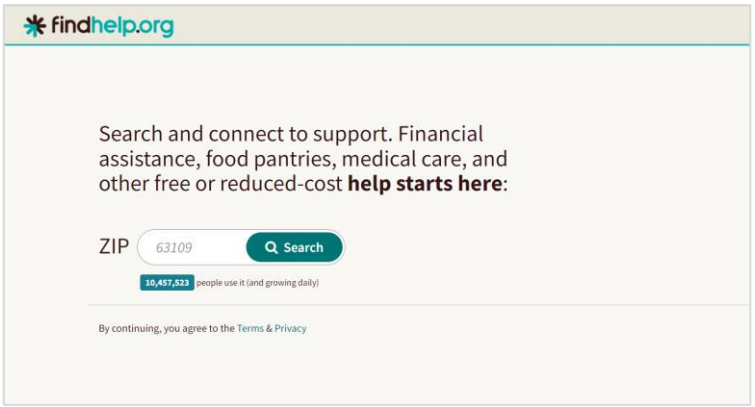


https://www.211.org/



https://navigator.aafp.org/

See also: https://www.aafp.org/family-physician/patient-care/the-everyone-project/neighborhood-navigator.html



https://www.findhelp.org/

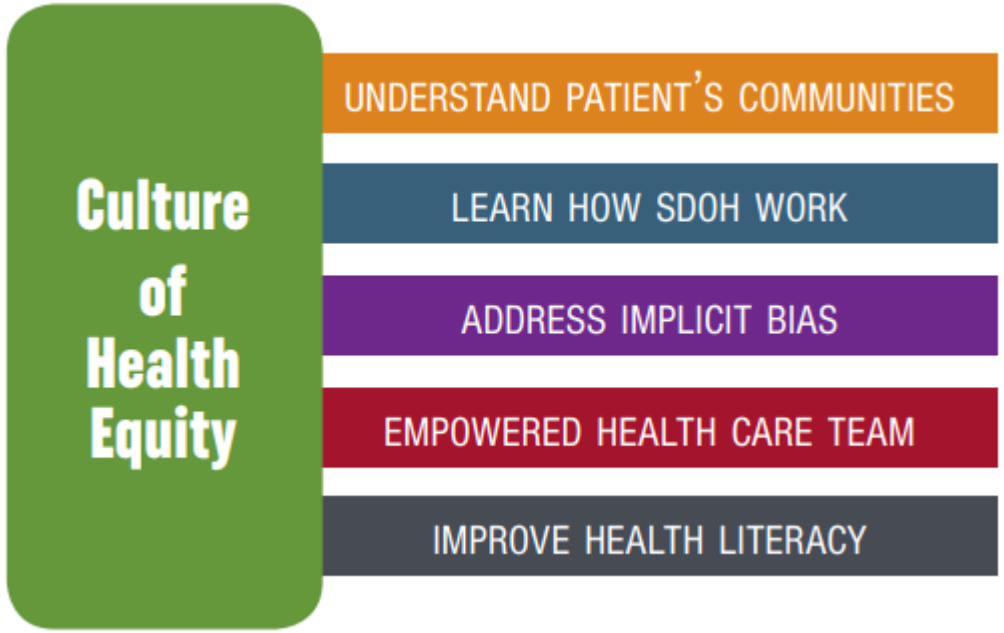
Additional Resources to Integrate SDOH into Clinical Care Practice

The EveryONE Project™

Advancing health equity in every community

Addressing Social Determinants of Health in Primary Care: A Team-Based Approach for Advancing Health Equity

Implementation guide for physicians and practice teams aiming to better address their patients' social determinants of health and advance health equity



Sample Patient Visit Flowchart	
Step	**Actions and Considerations**
Patient checks in ↓	Posters are available in the waiting room that prompt patients to discuss their social needs.
Patient sits in waiting room ↓	Social determinants of health (SDOH) screening tool is distributed to patients at check-in to be completed in the waiting room.
Height and weight checked in hallway ↓	Nurse or medical assistant confirm social needs with patient and provides information to office clerk to cross reference social needs with available community resources.
Remaining vital signs checked in exam room ↓	Posters are available in the waiting room that prompt patients to discuss their social needs.
Patient meets with clinician ↓	Clinician discusses social needs with patient and available resources and works to develop a plan to address the patient's SDOH.
Patient meets with counselor ↓	Nurse or medical assistant finalizes plan to address patient's SDOH and referrals to community resources.
Patient stops at billing/scheduling station ↓	Office staff schedules follow-up appointment.
Patient leaves ↓	

Source: American Academy of Family Physicians (AAFP, The Everyone Project, https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/team-based-approach.pdf, Accessed April 7 2022.

APPENDIX: SDOH Resources

Key SDOH Resource List

Introduction to Social Determinants of Health (SDOH)

Healthy People 2030
https://health.gov/healthypeople/priority-areas/social-determinants-health

General Framework

SDOH Objectives

Additional Resources: Websites & Newsletters

The Root Cause Coalition
https://www.rootcausecoalition.org/

Annual RISE SDOH Conference
https://www.risehealth.org/event-center/rise-events

Building Healthy Places
https://buildhealthyplaces.org/

The Gravity Project
https://thegravityproject.net/

SDOH Data Sources to Explore

County Health Rankings Model - https://www.countyhealthrankings.org/
Enables lookup of specific communities to understand the social and environmental aspects contributing to overall health

Social Interventions Research & Evaluation Network (SIREN) – Evidence Library - https://sirenetwork.ucsf.edu/tools/evidence-library
Highlights peer-reviewed publications & other resources that demonstrate effective practices for integrating medical and social care

Healthy People 2030 – SDOH Literature Summaries - https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries
CMS Healthy People 2030 database spotlighting recent research on various social determinants of health