Community Based Services:

IMPACT on Social Determinants of Health

Healthcare providers tend to think that people care about the same things they do – getting and staying healthy through a range of preventive care activities including annual well visits, chronic condition management, medication adherence programs, and health education. However, we need to acknowledge that the same things aren’t often on the minds of the typical healthcare consumer. For them, healthcare is one of many competing priorities, and it is often put on the back burner when compared with the long list of things that is really on their mind. (http://hms.com/about/)
SOCIAL DETERMINANTS OF HEALTH (WHO)

- Income level
- Educational opportunities
- Occupation, employment status, and workplace safety
- Gender inequity
- Racial segregation
- Food insecurity and inaccessibility of nutritious food choices
- Access to housing and utility services

SOCIAL DETERMINANTS OF HEALTH (WHO)

- Early childhood experiences and development
- Social support and community inclusivity
- Crime rates and exposure to violent behavior
- Availability of transportation
- Neighborhood conditions and physical environment
- Access to safe drinking water, clean air, and toxin-free environments
- Recreational and leisure opportunities

How to identify vulnerable populations

The Social Deprivation Index is used in the measurement and interpretation of socio-economic status of communities for a wide variety of contexts such as needs assessment, resource allocation, research and advocacy.

[Link to CDC page on Social Determinants of Health](https://www.cdc.gov/socialdeterminants/data/index.htm)
Area Deprivation Index NH

Area Deprivation Index RI

Area Deprivation Index VT
Community Health Needs Assessments - Local population health networks

Community health needs assessments (CHNA) and implementation strategies are newly required of tax-exempt hospitals as a result of the Patient Protection and Affordable Care Act. These assessments and strategies create an important opportunity to improve the health of communities. They ensure that hospitals have the information they need to provide community benefits that meet the needs of their communities. They also provide an opportunity to improve coordination of hospital community benefits with other efforts to improve community health. By statute, the CHNAs must take into account input from "persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health."

THE CASE MANAGER as COLLABORATOR

• Embedded in PCP practice
• Admissions for SNF, Rehab, Home Care, ED, Hospital
• Care Transitions
• Integrated PH/BH, SUD, Geropsych
• Outpatient and ambulatory services
• DME, O2, hospice, VNA
• Schools
• First Responders
• Assessment team
• Social Worker/Community Health Workers/Navigator

THE CASE MANAGER as COLLABORATOR

• Grass roots engagement with local shelters, food banks, churches
• Community leaders and cultural centers
• Networks and collaborations
• SOAP, treatment centers and outpatient SUD services
• BH clinicians, counselors
• Charitable organizations and funding sources (Easter Seals)
• Community Health Resources (Diabetes, Epilepsy)
• ESP, CBFS/ACCS, CBHI providers
• Social Worker/Community Health Workers/Navigator
Community Health Workers

CHWs are public health workers who apply their unique understanding of the experience, language and/or culture of the populations they serve in order to:

* Provide culturally appropriate health education, information and outreach in community-based settings, such as homes, schools, clinics, shelters, local businesses and community centers.
* Bridge and/or culturally mediate between individuals, communities and health and human services, including actively building individual and community capacity.
* Provide direct services, such as informal counseling, social support, care coordination and health screenings.
* Advocate for individual and community needs.

Community Health Workers

CHWs are distinguished from other health professionals because they:

* Are hired primarily for their understanding of the populations and communities they serve.
* Spend a significant portion of time conducting outreach.
* Have experience providing services in community settings.
* Assure that people access the services they need.

Navigators

Clinical navigators are nursing professionals who are specially trained to coordinate the clinical, educational and supportive needs of patients who are facing a significant medical diagnosis to help coordinate allied health needs, DME/VNA services, pain management, holistic health and family needs.

Health plan navigators answer questions about health plan options available through state and federal programs. Navigators can assist with the entire application and enrollment process.
**Resource Counselors**

**Options Counseling** is a service that provides people with disabilities of any age, as well as seniors 60 and over, with the information they need to live independently in their community. Options Counseling is available at no-cost, regardless of disability or income. Options Counselors are trained to work with consumers, family members and/or significant others to connect consumers to vital resources and services that fit their current situation and preferences and allow consumers to stay in their homes.

The **SHINE Program (Serving the Health Information Needs of Everyone)** provides SHINE counselors to offer free health insurance information, counseling and assistance and is available in each town through the ASAP/COA, town hall, or local library.

**Patient engagement**

- Pre-visit prep questions?? Could you think about…
- Gentle screening tool administered by skilled staff
- Patient-centered with family/caregiver involvement
- Trust, long term view
- Provide resources onsite if possible
- Cultural and language sensitivity

**A good place to start:**

- How do you think your health is?
- How confident are you in managing your health?
- What are your challenges?
  - nutrition (probe for scarcity, education)
  - does it make you worry/anxiety
  - do other things make your worry……
### Sample Assessment Tool

<table>
<thead>
<tr>
<th>Social Need Domain</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food insecurity</td>
<td>Limited or uncertain access to adequate &amp; nutritious food</td>
</tr>
<tr>
<td>Housing instability</td>
<td>Homelessness, unsafe housing quality, inability to pay mortgage, frequent housing disruptions, eviction</td>
</tr>
<tr>
<td>Utility needs</td>
<td>Difficulty paying utility bills, shut-off notices, disconnected services</td>
</tr>
<tr>
<td>Financial Resource Stress</td>
<td>Health insurance, emergency funds, financial literacy, medication overdue due to cost, benefit denial</td>
</tr>
<tr>
<td>Transportation</td>
<td>Difficulty accessing /affording transportation (medical or public)</td>
</tr>
<tr>
<td>Exposure to Violence</td>
<td>Intimate partner violence, elder abuse, community violence</td>
</tr>
<tr>
<td>Social Determinants</td>
<td>Race &amp; ethnicity, educational attainment, family income level, immigration status, language spoken</td>
</tr>
</tbody>
</table>

*These categories will likely require more highly clinical attention than other types of social needs.*

**Additional Resources:**

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### Sample Assessment Tool

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you feel emotionally close to someone?</td>
<td>Never, Sometimes, Always</td>
</tr>
<tr>
<td>Have you been in a situation where you feel you were not heard or respected enough?</td>
<td>No, Yes</td>
</tr>
<tr>
<td>Have you ever been told that your needs are not important?</td>
<td>No, Yes</td>
</tr>
<tr>
<td>Do you feel that others are not concerned about your health or well-being?</td>
<td>No, Yes</td>
</tr>
<tr>
<td>Do you feel that you have enough to eat?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Do you have access to clean water and food?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Do you feel that you have enough money to buy what you need?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Do you feel that you have a safe place to live?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Do you feel that you have enough money to pay your bills?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Do you feel that you have enough time to do the things you want to do?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Do you feel that you have enough time to take care of yourself?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Do you feel that you have enough time to do things you enjoy?</td>
<td>Yes, No</td>
</tr>
</tbody>
</table>

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### Assessment Considerations

- **Childcare**
  - Children's / preschool / after-school programs, prenatal support services, kids clothing and supplies, summer programs

- **Education**
  - English as a Second Language (ESL/ESOL), high school equivalency (HSE), college training programs, health literacy

- **Employment**
  - Under-employment, unemployment, job training

- **Health Behaviors**
  - Tobacco use, alcohol and substance use, physical activity, diet

- **Social Determinants**
  - Lack of family and /or friend network, minimal community contacts, absence of social engagement

- **Behavioral / Mental Health**
  - Stress, anxiety, depression, psychological assets, trauma
### SDoH Online resources

- HealthLeads- online assessment tools, coaching, social needs interventions. [https://healthleadsusa.org/](https://healthleadsusa.org/)

- Aunt Bertha- database to search by zip code for medical care, food, transit, residential care. [https://www.auntbertha.com/](https://www.auntbertha.com/)

- Healthify- helps healthcare organizations find community services, track social needs, and coordinate referrals with community partners. [https://www.healthify.us/](https://www.healthify.us/)

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### RESOURCES State & Federal programs

- **SSI**
- Department Transitional Assistance
- Medicaid
- Department of Developmental Services
- Department of Mental Health
- Department of Public Health
- Public Housing Commission

STATE 211 database contains detailed descriptions of programs and services provided by local community groups, social service and health-related agencies, government organizations, and others.

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### RESOURCES Community Based Support and Information

- **Connecticut:** Aging and Disability Resource Centers
- **Maine:** Aging and Disability Resource Centers/AAAs
- **Massachusetts:** Aging Service Access Points (ASAPs) Area Agencies on Aging (AAAs)
- **New Hampshire:** Bureau of Elderly and Adult Services
- **Rhode Island:** Services for Seniors & Adults with Disabilities Resource Outreach Toolkit
- **Vermont:** Department of Disabilities, Aging and Independent Living
RESOURCES Waivers

Waiver programs provide financial assistance, resource location, housing, healthcare navigation

CT- Community Options Waiver
MA- Frail Elder Waiver
ME- MaineCare Elderly and Adults with Disabilities Waiver
NH- Choices for Independence (CFI) Waiver
RI- Home and Community Care Waiver
VT- Care Choice

RESOURCES Families

Parent to Parent USA
Emotional & informational support for families of children who have special needs. Parent to Parent programs offer parent to parent support as a core resource for families with children who have a special health care need, disability, or mental health concern.

Early Head Start/ Head Start/ Early Intervention through each state’s Department of Health and Human Services, is a source of information for parents, child care providers, early childhood educators, and others interested in the health and development of young children and their families.

United Ways of New England coordinated gateway to services for basic needs.

RESOURCES Community Action Committees

Through coordination with programs such as WIC, SNAP, job training, housing, food banks, fuel assistance, and financial assistance, Community Action Agencies tailor their services to meet the needs of the individuals and communities they serve. The “Community Action Program” (“CAP”) was established in 1964 by Congress as a centerpiece of the War on Poverty and is now part of the Community Services Block Grant. The program is carried out by a national network of over 1,300 designated Community Action Agencies (“CAAs”), which provide a diverse array of services to and advocacy on behalf of low-income individuals and families. Each CAA operates an average of 12 to 15 programs.
Case Study

52 yo female COPD, SOB, anxiety, recent arrival from PR hurricane

Presented to health center with acute asthma and was connected to a Navigator for Medicaid transfer; returned to ED with anxiety due to SOB

Navigator met patient and family in temporary housing (HUD hotel) and found patient unable to translate discharge summary, treatment plan and prescriptions. Provided coaching regarding care instructions, and referred to Action, Inc. Community Action. Family now on waitlist with expected occupancy October 1 in a housing unit. Patient meeting with transplant team at Lahey for potential bilateral lung transplant. Medications and education have impacted anxiety surrounding SOB and reduced ED visits

Do the right thing and good things will follow

Medicaid programs serve a diverse array of beneficiaries, some with complex needs, multiple chronic conditions, severe disabilities, or co-occurring behavioral and physical health conditions. These subpopulations account for a disproportionate share of Medicaid costs, and pose the greatest challenges to states in delivering coordinated, cost-effective care to achieve quality outcomes. Addressing these challenges requires innovations in the financing and delivery of care to meet the specific and often multidimensional needs of these beneficiaries.

Do the right thing, and good things will follow

Created in 2014, the Medicaid Innovation Accelerator Program (IAP) is a collaboration between the Center for Medicare and Medicaid Innovation and the Center for Medicaid and Children’s Health Insurance Program (CHIP) Services (CMCS) within the Centers for Medicare and Medicaid Services (CMS).
Superusers

The Agency for Healthcare Research and Quality references the top 1%, who account for 21% of health care expenditures in the United States.

For statistical purposes, CMS defines superusers as frequent ED users (often defined as individuals with 4 or more visits per year) who comprise 4.5% to 8% of all ED patients across payers but account for 21% to 28% of all visits.
Superusers

Research shows that 60% of the factors leading to premature death are based on a combination of social and environmental issues and behavior.

Approaches

OneCare- Medicaid/Medicare eligible with complex medical/behavioral health needs work with a designated NP to coordinate care and services. [https://www.mass.gov/one-care](https://www.mass.gov/one-care)

Iora- holistic preventive model focused on keeping people out of the hospital to avoid additional health care complications. [https://www.iorahealth.com/](https://www.iorahealth.com/)

Stanford’s Coordinated Care program for high-needs employees and families focused on strong trusting relationships. [https://stanfordhealthcare.org/medical-clinics/coordinated-care.html](https://stanfordhealthcare.org/medical-clinics/coordinated-care.html)

Approaches

Baptist Hospital KY- algorithm to track social determinants, LOS, acuity and co-morbidity focused on d/c plan to incorporate SDoH. [https://www.baptisthealth.com/lexington/pages/default.aspx](https://www.baptisthealth.com/lexington/pages/default.aspx)

Camden Coalition- leader in establishing a pro-active approach to work with patients toward sustained behavior change, and to track progress in supporting patients to reach their goals. [https://www.camdenhealth.org/curriculum/intro-to-hotspotting/](https://www.camdenhealth.org/curriculum/intro-to-hotspotting/)
Case Study

50 yo male recent TBI falling off roof, seizure disorder, depression, sleep disruption, neuralgia

Complex needs led to patient missing appointments, frequent disruptions to treatment plan, frustration toward caregivers over lack of independence and ability to drive, repeated hospitalizations, medication complications and adherence challenges

Through connection to Adult Family Care benefit, patient referred to One Care; receives in-home PT, OT, dedicated NP for care coordination; application for TBI waiver through Mass Rehab Commission and MassHealth
### Results

Baptist Hospital KY- Three years after implementation, readmission rates for COPD had improved 14.5%, 7.2% for pneumonia patients


CMS reported that per beneficiary spending for consumers receiving chronic-care case management services fell by more than $200 over six months in 2016 to 2016


OneCare- Patients enrolled for 12 continuous months had 7.5% fewer hospital admissions and 6.4% fewer emergency-room visits. For those enrolled in the program for at least 18 months, hospital admissions dropped 20%.


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### Barriers

Provider concern regarding managing all factors contributing to a patient’s health in a value-based environment

Engaging patients with complex needs

Need for continuous evaluation as patients will cycle off and on based on their needs and health status

Information and data sharing

Caregiver burnout

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### Looking Forward

Digital solutions for improved communication, referrals, tracking

Experience will enhance workflow, coordination, and best practices

Long-term approach

BH/PH/SDoH integration represents a transformation in health care delivery

ICD-10 classification Z Codes related to potential hazards due to family and social circumstances impacting health status
We can bill for that?

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate material resources</td>
<td>276.8 Lack of adequate food and safe drinking water</td>
</tr>
<tr>
<td>Legal circumstances</td>
<td>250.8 Care received in civil or criminal proceedings without impairment</td>
</tr>
<tr>
<td>Other social factors</td>
<td>250.1 Problems related to social environment</td>
</tr>
</tbody>
</table>

Case Study

35 yo male SUD, diabetes, recent below knee amputation, homeless

Following several ED visits for cellulitis, and amputation, care transitions team was unable to secure shelter due to his complex medical needs

ACO Navigator was able to coordinate MassHealth benefits, and patient was placed in temporary shelter in state hospital

During a CHNA Systems of Care meeting, the CM from the hospital case conferenced with ESP team who was able to find an inpatient treatment center for SUD and medical needs
Workshop

Tell us your problems!
Pick a recent challenge
Share the barriers
What have you tried?
What, if anything, worked?
DISCUSS

Resources are out there- ask, collaborate, get to know your community