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Advancing Health in America

Addressing Social Determinants of Health

CURRENT ENVIRONMENT

Social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put into place to deal with illness.

Each Year In The U.S...

- **1.48 million** individuals are homeless
- **3.6 million** people cannot access medical care due to lack of transportation
- **42 million** people face hunger, and
- **12.7 percent** of households are food insecure

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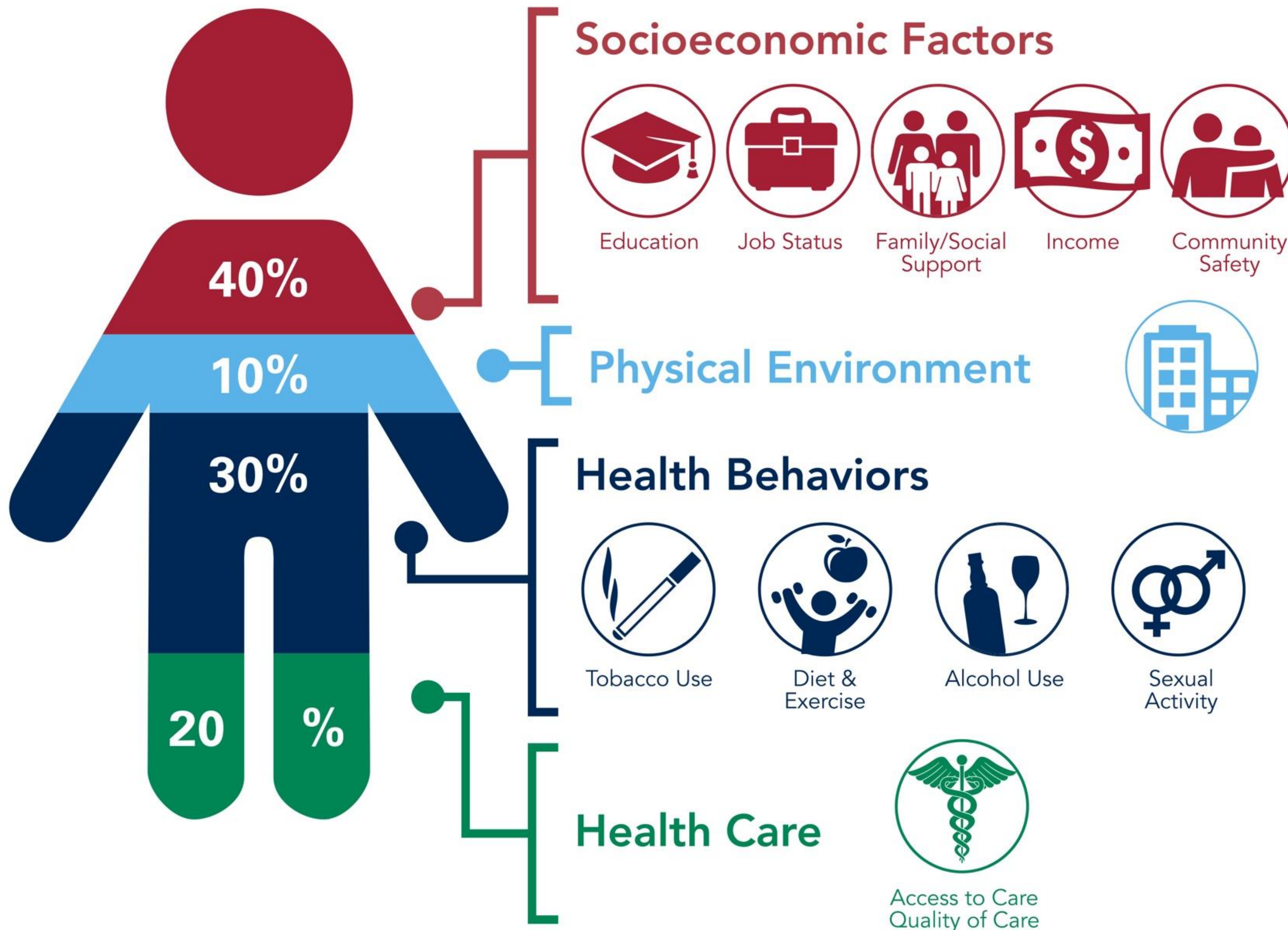
IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual's health regardless of age, race, or ethnicity.



SDoH Impact

- **20%** of a person's health and well-being is related to **access to care** and **quality of services**
- The **physical environment**, **social determinants** and **behavioral factors** drive **80%** of health outcomes

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Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.

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IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual's health regardless of age, race, or ethnicity.

Economic Stabilty:
- » Employment
- » Income
- » Expenses
- » Debt
- » Medical Bills
- » Support

Neighborhood & Physical Environment:
- » Housing
- » Transportation
- » Safety
- » Parks
- » Playgrounds
- » Walkability

Education:
- » Literacy
- » Language
- » Higher Education
- » Vocational Training
- » Early Childhood Education

Food:
- » Hunger
- » Access to Healthy Options

Community & Social Context:
- » Social Integration
- » Community Engagement
- » Support Systems
- » Discrimination

Health Care Systems:
- » Health Coverage
- » Provider Availability
- » Provider Linguistic & Cultural Competency
- » Quality of Care

Health Outcomes:

» Mortality » Life Expectancy » Health Care Expenditures » Health Status » Functional Limitations

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Source: Adapted from Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. November 2015.

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SOCIAL DETERMINANTS OF HEALTH

We need to consider each factor to address the social determinants of health.

Housing

Food

Education

Transportation

Violence

Social Support

Employment

Health Behaviors

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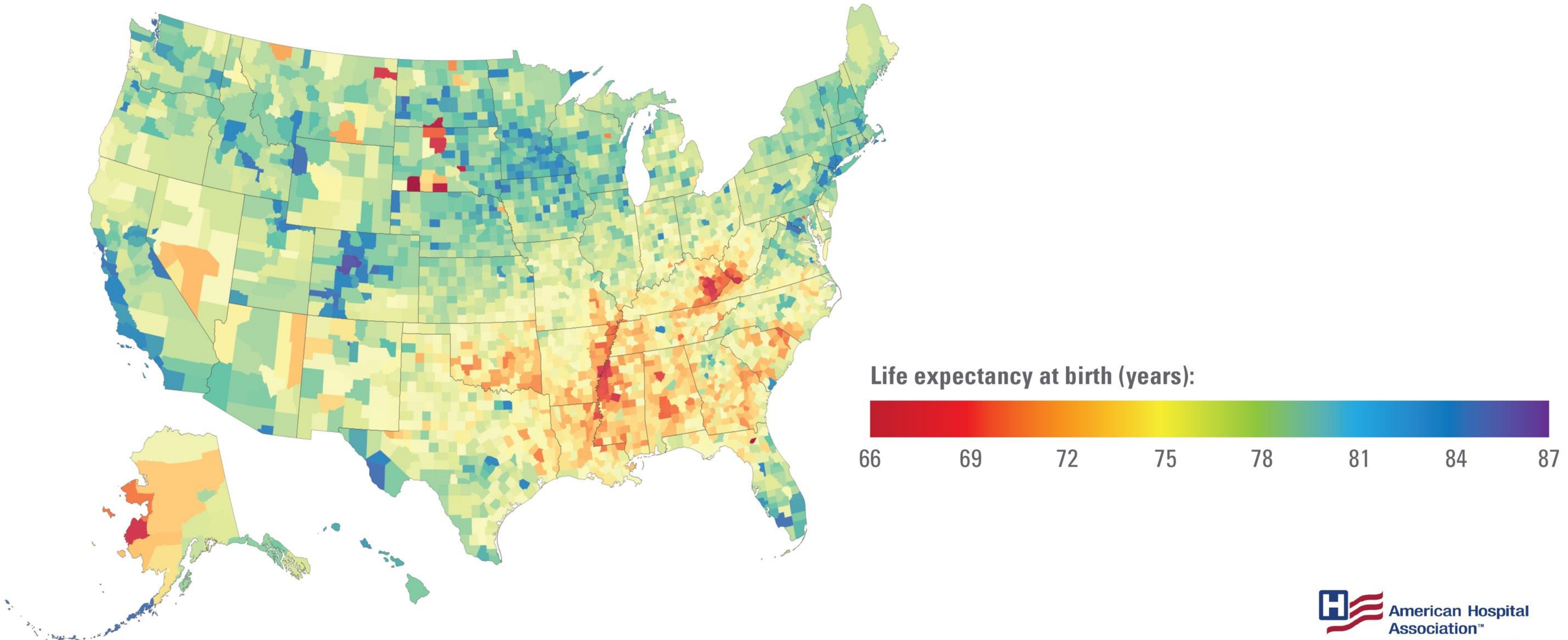
PLACE MATTERS

Where we live can determine how well we live and is a significant factor of life expectancy.



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Source: Institute for Health Metrics and Evaluation, University of Washington, 2014

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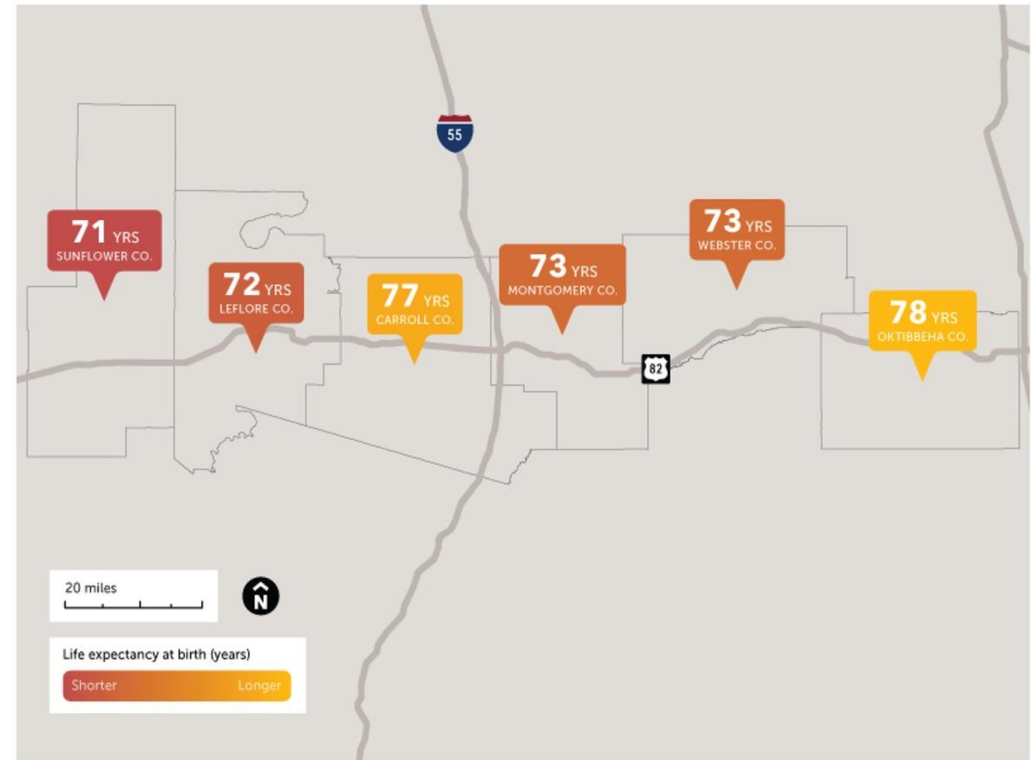
ZIP CODE MATTERS

Your zip code – where you actually live – also influences health.

Chicago, Illinois



Mississippi

Short Distances To Large Gaps In Health

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Source: Reprinted with permission from the VCU Center on Society and Health.

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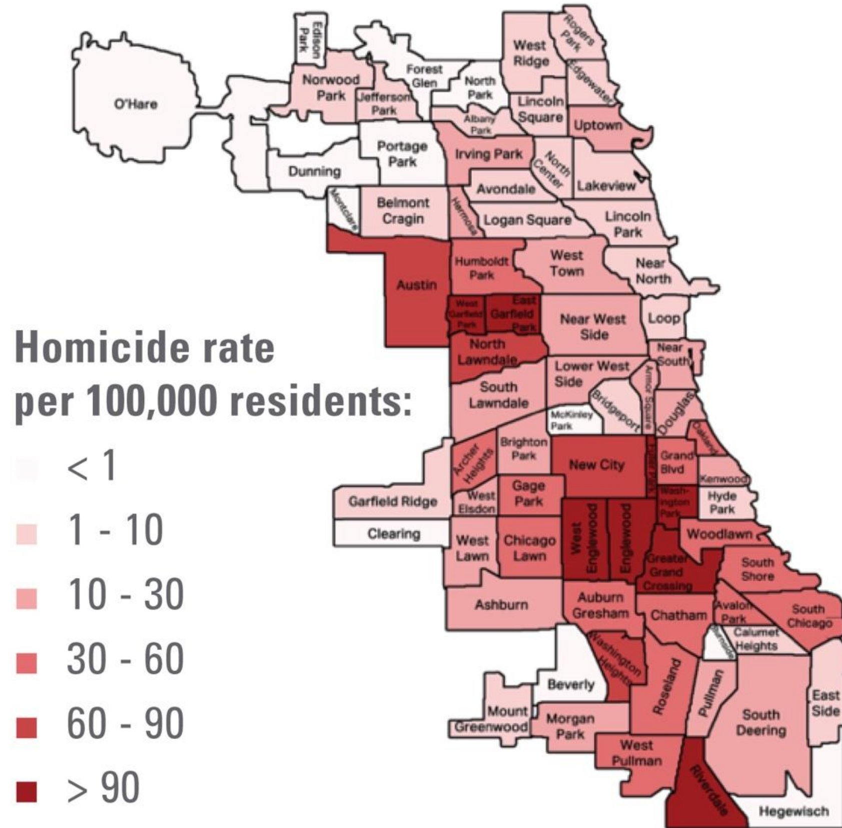
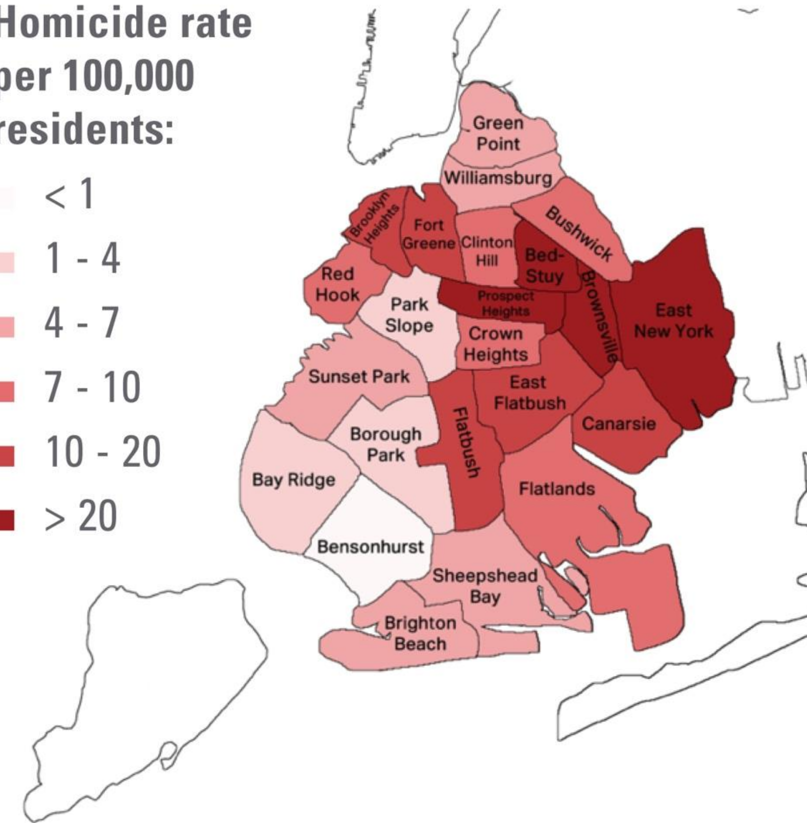
COMMUNITY MATTERS

Community also matters and plays a role in how long and how well you live.



Homicides by Chicago Neighborhood

As of December 12, 2016



Homicides by Brooklyn Neighborhood

As of October 2016

Source: *https://www.thetrace.org/2016/12/murder-inequality-neighborhood-homicide-rates/*

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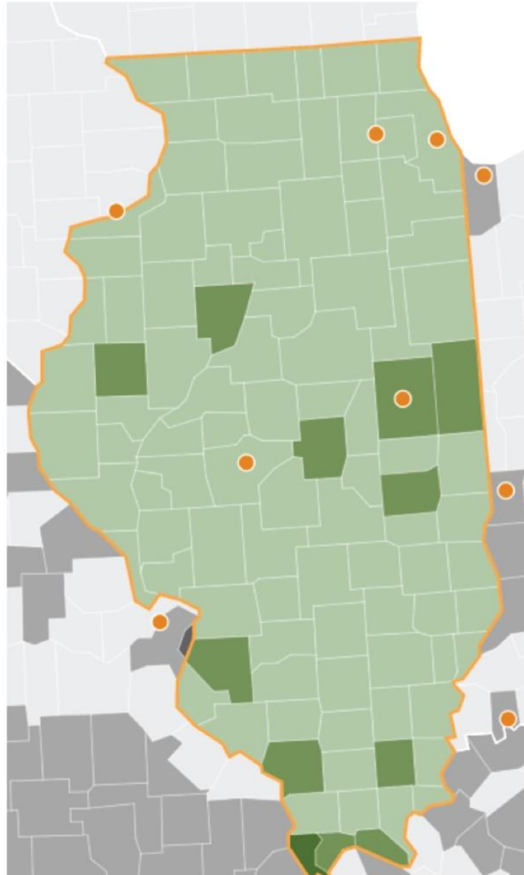
FOOD MATTERS

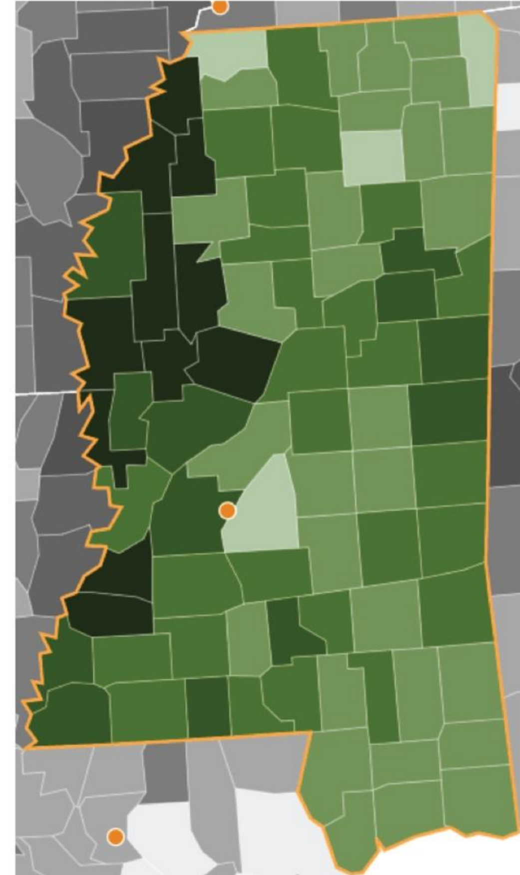
Food insecurity is a risk factor for various health issues, including chronic diseases, poverty, unemployment, homelessness, and developmental delays in children.



Illinois food insecurity rates:

- 4-14%
- 15-19%
- 20-24%
- 25-29%
- 30% +

11.7% are food insecure



Mississippi food insecurity rates:

- 4-14%
- 15-19%
- 20-24%
- 25-29%
- 30% +

21.5% are food insecure

Source: Feeding America, Map the Meal Gap. 2016

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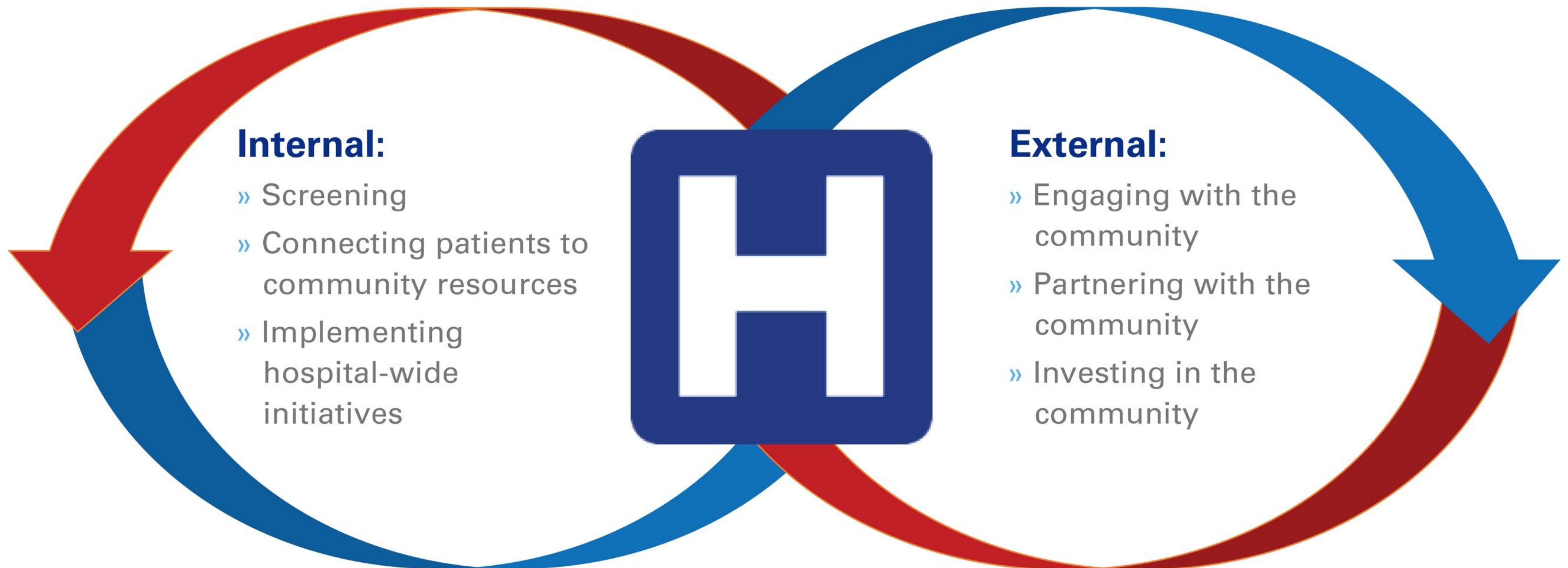
THE ROLE FOR HOSPITALS AND HEALTH SYSTEMS

There are multiple ways hospitals and health systems can address social determinants of health – both within their own walls and outside in the community.



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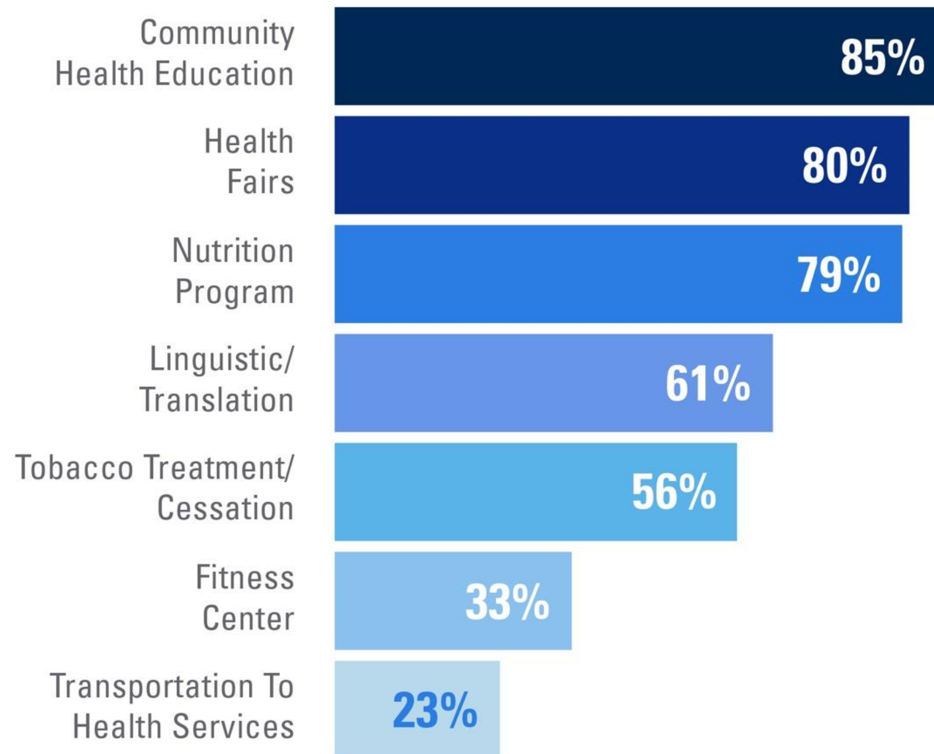
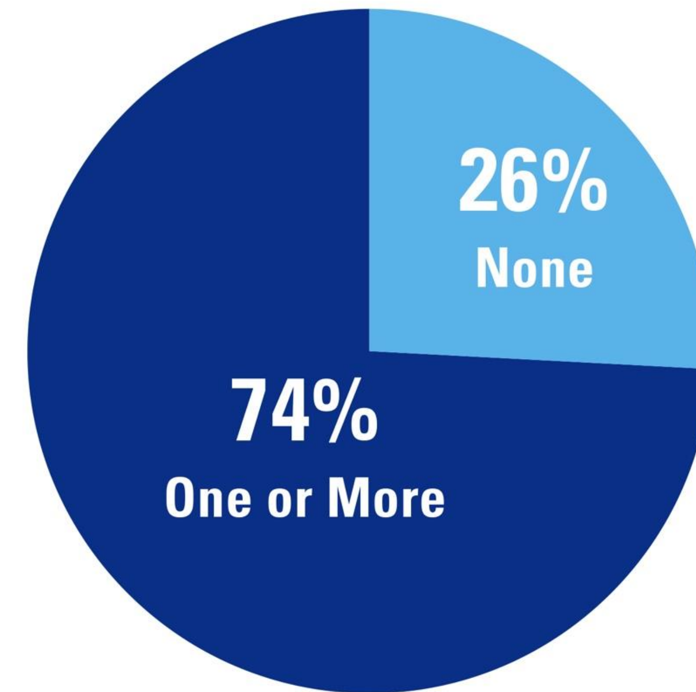
THE ROLE FOR HOSPITALS AND HEALTH SYSTEMS

We know many hospitals and health systems are already addressing the social determinants of health in their communities.



Hospitals that provide non-medical services



Hospitals that have entered into at least one type of community partnership

Source: AHA 2016 Annual Survey Data

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POTENTIAL NEXT STEPS

If a hospital or health system wants to move forward on their journey to address the social determinants, some examples of next steps include:

1. Know and engage with the community
2. Gather data
3. Develop organizational/internal engagement strategies
4. Integrate social determinants in strategic/financial plans
5. Explore funding options
6. Establish measurement strategies and evaluation tools

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AHA RESOURCES: THE VALUE INITIATIVE

Tools, resources and education to address social determinants as part of value, population health and health equity efforts.

THE Value Initiative

Members in Action: Redesigning the Delivery System

Meadville Medical Center – Meadville, PA

Care Coordination for Adults and Children

AHA's *Members in Action* series highlights how hospitals and health systems are implementing new value-based strategies to improve health care affordability. This includes work to redesign the delivery system, manage risk and new payment models, improve quality and outcomes and implement operational solutions.

Overview

The Meadville area, approximately 90 miles north of Pittsburgh, is nestled in the rolling hills of the lake lands in northwestern Pennsylvania. The population of Meadville and the surrounding area is approximately 35,000, with the hospital's service area covering about 75,000 residents. Meadville Medical Center (MMC) has 178 inpatient acute care beds and 32 skilled nursing beds. MMC reports annual inpatient admissions of approximately 7,600 and more than 242,300 outpatient visits. The emergency department (ED) sees more than 35,000 visits yearly, and approximately 650 babies are born at MMC each year. MMC has a medical staff of more than 100 physicians across 37 medical and surgical specialties, including an extensive primary care foundation.

Impact

The effectiveness of the Community Care Network is scrutinized carefully. Based on a review of the most recent utilization for CCN patients, readmissions declined by 45% and ED visits declined by almost 25%. On average, spending for CCN patients decreased about 28% per patient, ranging from $3,731 to $6,112 per patient, on average, depending upon payer type. While readmissions were reduced, use of outpatient services increased.

MMC views care coordination as an important aspect of fulfilling its mission as an independent community health system. Care coordination adds tremendous value to the community by assisting some of its most vulnerable residents, many of whom have complex health care and socioeconomic needs, which go far beyond the traditional scope of acute care services. In addition to advancing MMC's mission, care coordination provides an important framework for the future of health care delivery in the community as MMC evolves services to better align with the overall well-being of the population.

The Community Care Network (CCN) is an interdisciplinary team of dedicated clinicians who work with physicians, health care providers and other agencies to help manage chronic disease conditions, with a focus on meeting patients' health and wellness goals. Services offered in the CCN are provided at no charge and assist in the following areas: appointment adherence, nutritional support, medication reconciliation, prevention and risk, emotional support, community resource access, challenges of daily living, and education on health and well-being. The four diagnoses are hypertension, diabetes, hyperlipidemia and depression. Parenting classes also are part of the CCN. Programming is diverse and may be offered in schools, homes and physician offices.

The CCN has eight core members comprised of registered nurses, dietitians, social workers and counselors, who are augmented in the field by trained health coaches. The team is led by a medical director and works closely with community physicians. The CCN offers internships for graduate students, typically from Pennsylvania's University of Pittsburgh, Gannon University or Edinboro University. Students hired as interns, typically studying counseling,

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Hospitals and Health Systems See…

Increased cost associated with regulatory burden

Estimated Burden of Compliance with Regulatory Requirements for a Typical Community Hospital

Per-hospital estimate: Typical community hospital*	Staff FTEs	Up Front IT Cost	Staff Salaries	Vendors	IT-Related	Other (Training, Education)	Total Cost (By Domain)	% Of Total Cost
Hospital CoPs	23.2	$55,379	$2,600,846	$258,350	$67,605	$181,251	$3,108,052	41.0%
Billing & Coverage	17.2	$121,902	$1,229,161	$298,976	$69,382	$43,527	$1,641,046	21.6%
Meaningful Use	4.8	$410,687	$661,190	$28,353	$58,839	$11,307	$759,689	10.0%
Quality Reporting	4.6	$14,884	$605,541	$53,708	$19,197	$30,245	$708,691	9.3%
Privacy & Security	3.5	$140,553	$434,398	$35,651	$72,742	$26,680	$569,471	7.5%
Fraud & Abuse	2.3	$8,356	$277,417	$49,727	$8,800	$3,708	$339,652	4.5%
Program Integrity	2.8	$4,467	$263,533	$48,942	$12,004	$12,900	$337,379	4.5%
New Models of Care	0.6	$1,170	$82,578	$10,566	$7,117	$21,512	$121,774	1.6%
Total cost (by cost center)	59.0	$757,400	$6,154,663	$784,273	$315,687	$331,129	$7,585,752	
		% of total cost	81.1%	10.3%	4.2%	4.4%		

*Extrapolated to a typical hospital by scaling respondent responses to a per-bed figure and then multiplying by average number of beds among community hospitals (161 beds, according to 2015 AHA Annual Survey). Excludes costs related to PAC regulations.

Source: American Hospital Association, Regulatory Burden Service

Value Initiative

March 15, 2018

THE Value Initiative

THE Value Initiative

Issue Brief 1
Framing the Issue of Affordable Health Care

Affordability is one of the most important challenges influencing Americans' ability to access health care.[1] A number of factors affect the affordability of health care, including housing, transportation, education, personal choices, and the cost of health insurance, prescription drugs, and hospital services. Leaders from the American Hospital Association (AHA), hospitals, and health systems understand these challenges, have strategies to address them, and are deeply committed to ensuring that patients and consumers have access to affordable health care.

A wide range of stakeholders contribute to health care affordability – from payers to providers to pharmaceutical companies – and no single sector (or stakeholder) can solve the issue alone. Because of this complexity, a framework will be necessary to advance the affordability conversation forward without compromising access or quality. To this end, the AHA is developing a series of issue briefs that will:

- Discuss and frame the issue of affordability and why it matters;
- Explore the underlying factors that affect affordability;
- Examine the roles of various stakeholders in making care more affordable; and
- Share solutions and strategies that advance affordability.

Figure 1: Consumers are concerned about affordability

One in four Americans (25%) say the cost of health care is the biggest concern facing their family.[2]

One in three Americans (33%) report that they could not access care in the last year because of cost.[3]

Between 2011 and 2016, workers' out-of-pocket health care costs grew faster than their earnings.[4]

Roughly one in four people (26%) taking prescription drugs report difficulty affording their medicine.[5]

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You are invited to explore The Value Initiative at:

www.aha.org/TheValueInitiative

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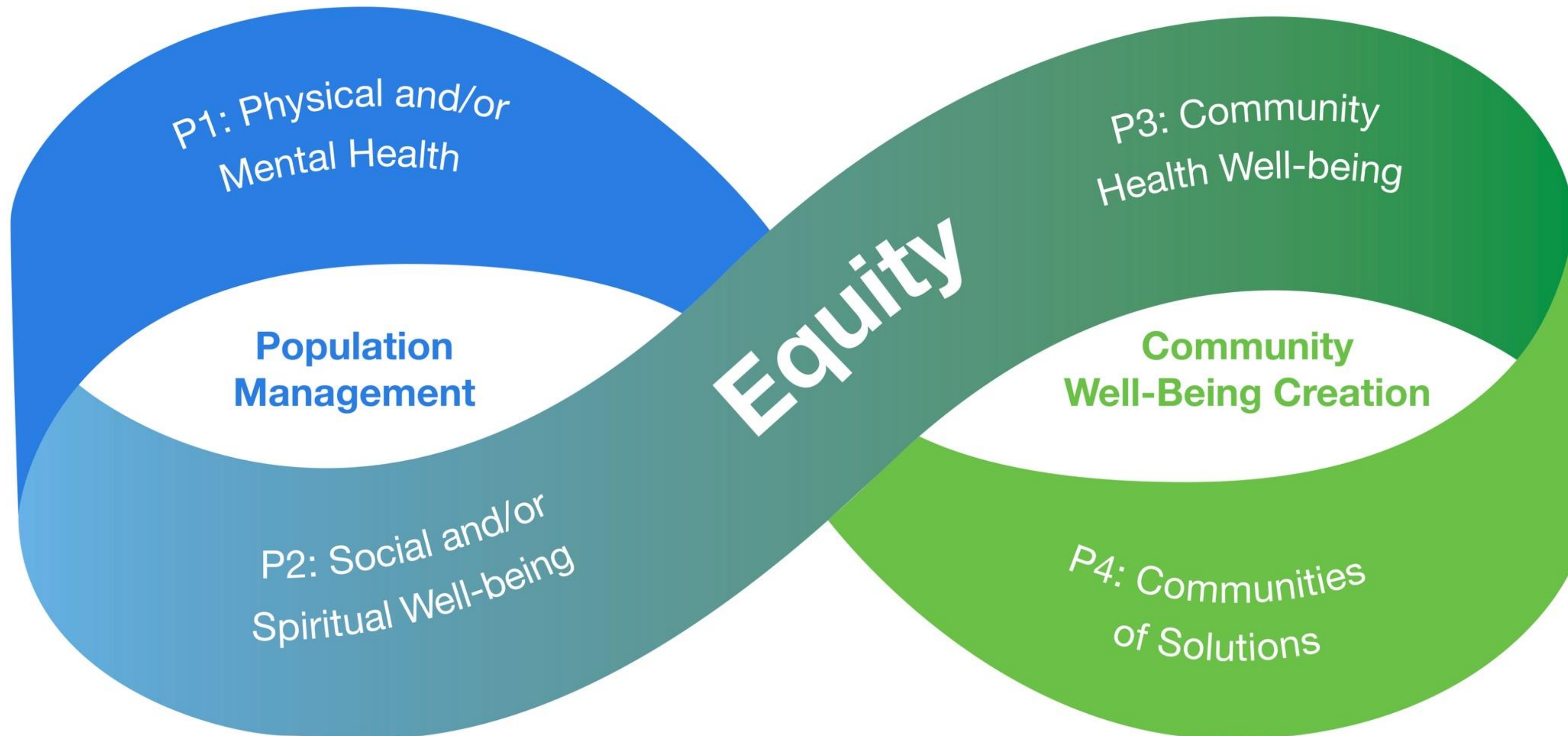
AHA RESOURCES: PATHWAYS TO POPULATION HEALTH

Tools, resources and education to address social determinants as part of value, population health and health equity efforts.



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Access tools and resources at: *www.pathways2pophealth.org*

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AHA RESOURCES: THE INSTITUTE FOR DIVERSITY AND HEALTH EQUITY

Tools, resources and education to address social determinants as part of value, population health and health equity efforts.

Institute for Diversity and Health Equity™

An affiliate of the American Hospital Association

"There can be no quality without equity. Promoting diversity and inclusion and building community are essential strategies for delivering equitable care."

www.diversityconnection.org

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MEMBERS IN ACTION: FIGHTING FOOD INSECURITY

Connecting individuals and families to health food sources and improving their health.

ProMedica

- More than **57,000 patients** were screened for food insecurity
- **1,100 food insecure patients** became food pharmacy clients
- Additional **4,000 Medicaid patients** referred to food pharmacy
- Food pharmacy patients **used ED 3% less**, had **53% fewer hospital readmissions**, and **primary-care visits increased 4%**

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MEMBERS IN ACTION: ADDRESSING TRANSPORTATION NEEDS

Creative solutions to help individuals keep needed medical appointments.

- **MedStar Health**
- **Ascension Health**
- **Denver Health**

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MEMBERS IN ACTION: ADDRESSING HOUSING

Providing chronically homeless individuals with stable housing and support services.

University of Illinois Hospital and Health Sciences System

BETTER HEALTH THROUGH HOUSING

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MEMBERS IN ACTION: ADDRESSING VIOLENCE

Connecting victims of violence with individual and family support to stop the cycle of violence.

Children's Hospital of Wisconsin

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MEMBERS IN ACTION: IMPROVING SOCIAL SUPPORT

Increasing physical activity and event opportunities for seniors to improve health and build community.

Northern Montana Hospital

- Activities include bus tours, picnics and fitness classes
- Built-in health screenings
- Diabetes prevention program resulted in decreased number of amputations

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MEMBERS IN ACTION: SUPPORTING YOUTH EDUCATION

The Tipping the Scale Program provides at-risk students job training, mentoring, and summer employment.

Baptist Health

University of Florida Health

- Ninth graders begin weekly training sessions on job interviewing, resume writing, money management, and accountability
- **1,700 students** each year
- **90%** graduate high school
- Majority attend college, join military or get a job

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MEMBERS IN ACTION: IMPROVING EMPLOYMENT AND HOUSING

SEED Program invests in a neighborhood to revitalize former vacant lots and turn around a poor retail market.

Bon Secours Richmond Community Hospital

- Initial investment - $50,000 a year with three-year commitment
- Established 14 business (still running today)
- Brought jobs to community and increased income
- Resulted in better housing opportunities

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BOARD DISCUSSION QUESTIONS

1. Which social determinants of health have the greatest impact on the communities we serve?
2. What sources of data and information (community forums, community health needs assessment results, etc.) does our hospital or health system use to understand and monitor the impact of social determinants on community health outcomes?
3. What actions is our health care organization taking to identify social determinants of health and to determine and address their impact on the patients and families we care for directly?
4. How is our hospital or health system partnering with other individuals and organizations to address social determinants of health across the communities we serve?
5. How is our organization integrating social determinants of health into its strategic and financial planning?
6. How should our governing board continue to keep apprised of the impacts social determinants of health are having on the communities we serve and how these impacts are being addressed?
7. What types of resources (issue briefs, reports, slide decks, case studies, etc.) from AHA and other sources could be most helpful to us in learning about the strategies and steps health care organizations are taking to successfully address social determinants and improve the health of the populations they serve?

Contact Priya Bathija at *pbathija@aha.org* with ideas for additional helpful resources.

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Addressing Social Determinants of Health