

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

MEASURES

MEASURE(S):

NCQA KM02 (Core) Comprehensive Health Assessment and Social Determinants of Health Assessment.

MEASURE(S) TRACKED BY:

NCQA, SDoH screening data beginning to be collected by AHI and ACO.

MEASURE STEWARD:

NCQA.

ALTERNATIVE MEASURES:

- Potentially preventable Ed Visits (PPV).
- Potentially preventable Ed Visits (PPV) for people with behavioral health diagnosis.
- Health Promotion and Education (ACO #5).
- Shared Decision making (ACO #6).

STANDARD SPECIFICATIONS

DESCRIPTION:

Social Determinants of Health is a core competency for NCQA certification. There is no recommended evidence-based screening tool or standardized referral process.

FUNCTIONAL MEASURE IDENTIFIED:

Screening for Social Determinants empowers providers, care teams, and community-based organizations with data that identifies specific social issues that can negatively impact health outcomes. Social determinants screening and follow up works most effectively when it is not the sole responsibility of the screener but rather a team-based effort with a strong referral process in place that manages the referral and follow up process.

BEST PRACTICE

SUMMARY:

A 2017 survey conducted by the American Academy of Family Physicians found that 83% of family physicians agree they should help with identifying and addressing social factors that influence patients' health outcomes, but 56% felt unable to provide solutions to patients to resolve unmet social needs. This study indicates an ongoing need for greater education and guidance to support healthcare providers' efforts in this arena. Our region is in the initial phases of implementing and standardizing processes to screen for social determinants of health and develop referral pathways between clinical providers and community-based organizations to address identified needs. This will enable healthcare providers to incorporate this information and resulting processes into clinical practice, outcomes measurement, and payment models. Below are recommended steps, informed by lessons learned through our regional initiatives along with recognized best practices, to guide providers in taking steps to address the role social needs play in their patients' and clients' health and wellness:

- Identify unmet social needs through screening. Select a screening tool that's most appropriate for your patient population and that will collect information meaningful to the individual and to the practice.
- Leverage patient-centered, culturally competent patient engagement strategies, such as motivational interviewing, to understand the root cause of the identified need and build rapport with the patient.
- Manage expectations around ability to address needs. Have a plan in place for responding to urgent needs and those that present an imminent safety risk to the patient or others.
- Refer patients to community-based service providers with capacity to address identified needs.
- Whenever possible, have standardized care pathways in place for addressing commonly identified needs, such as through an established partnership with a community service provider. For example, if access to healthy foods impacts many patients in your practice, consider opportunities for collaboration with food providers to create food prescription programs.
- Have a standardized referral and linkage process that includes monitoring and tracking referral outcomes (closed-loop referrals).

Collect and analyze data from screening and referral processes to better understand needs specific to your patient population as well as to contribute to a larger picture of population health in your region. Data can be used at the practice level to inform development of CBO partnerships and selection of interventions to implement. At the regional level, data collected can be used to advocate for policy change or to support requests for funding.

EDUCATIONAL TOOLS AND SUPPORTS

TITLES AND WEB LINKS:

- AHI Resources to Address Social Determinants of Health web page: [https://ahihealth.org/social-determinants-of-health/AHI Social Determinants of Health Screening Tool](https://ahihealth.org/social-determinants-of-health/AHI_Social_Determinants_of_Health_Screening_Tool)
- AHI Cultural Competency and Health Literacy web page: <https://ahihealth.org/ahipps/dsrip-infrastructure/cultural-competency-and-health-literacy/>
- Centers for Disease Control and Prevention (CDC): Tools for Putting Social Determinants of Health into Action: <https://www.cdc.gov/socialdeterminants/tools/index.htm>
- Health Leads Screening Toolkit: <https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/>
- NCQA Population Health Management Resource Guide: https://www.ncqa.org/wp-content/uploads/2018/08/20180827_PHM_PHM_Resource_Guide.pdf
- New York State Department of Health Medicaid Redesign Team: Social Determinants of Health and Community Based Organizations: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/index.htm
[New York State Department of Health Social Determinants of Health and Primary Care: A Deeper Dive](#)
[American Academy of Physicians' 2017 Social Determinants of Health Survey results](#)



1/24/2019

ADIRONDACKS ACO / AHI

POPULATION HEALTH COMMITTEE MEETING

Megan A. Murphy – Director, Partner Engagement, Adks ACO & AHI

Jessica Chanese – Community Engagement Manager, AHI

What are Social Determinants of Health (SDoH)?

- Social determinants of health (SDoH) are environmental and social factors, including housing, education, poverty, and nutrition, that drive medical utilization, cost, and health outcomes.



What are the impacts of SDoH?

| Economic Stability | Neighborhood and Built Environment | Education | Food | Social and Community Context | Health and Health Care |
|--|--|--|---|---|---|
| <ul style="list-style-type: none"> Employment Income Expenses Debt Medical bills Support | <ul style="list-style-type: none"> Housing Transportation Safety Parks Playgrounds Walkability | <ul style="list-style-type: none"> Literacy Language Early childhood education Vocational training Higher education | <ul style="list-style-type: none"> Hunger Access to healthy options | <ul style="list-style-type: none"> Social integration Support systems Community engagement Discrimination | <ul style="list-style-type: none"> Health coverage Provider ability Provider linguistic and cultural competency Quality of care |

Health Outcomes: Mortality, morbidity, life expectancy, health care expenditures, health status, functional limitations

SDoH in our Communities

Median Household Income

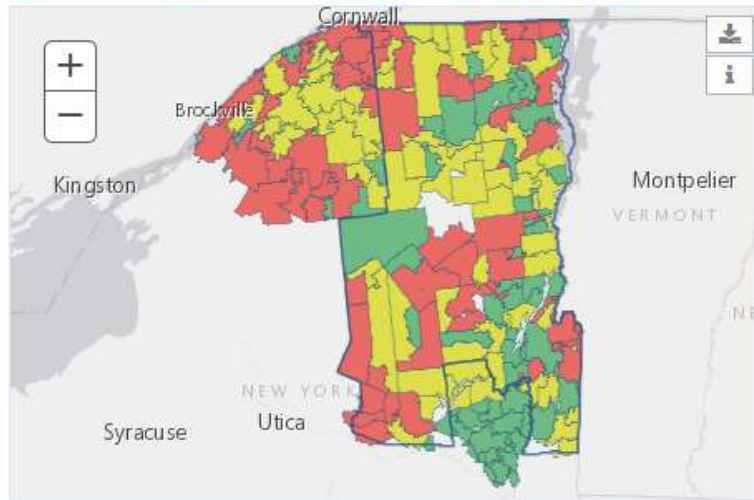
Select a Zip Code ▼

Measurement Period: 2012-2016 ▼

Filter: none (all Zip Codes)

SELECT A COMPARISON

- Grouped
- NY Zip Codes
- U.S. Zip Codes
- Prior Value
- Trend over Time




Worst Quartile
< \$47,615


25th to 50th Quartile
\$47,615 - \$57,561


Best 50th Percentile
> \$57,561


N/A

SDoH in our Communities

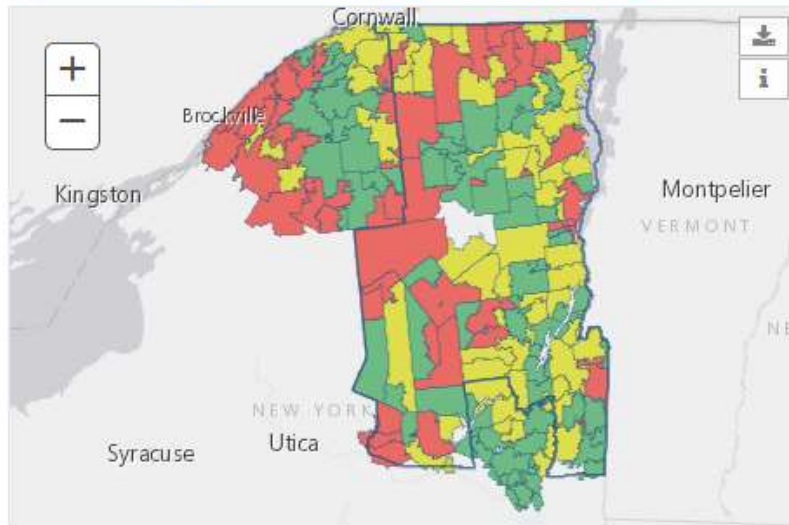
People 25+ with a High School Degree or Higher

Select a Zip Code

Measurement Period: 2012-2016

Filter: none (all Zip Codes)

Grouped NY Zip Codes U.S. Zip Codes Prior Value Trend over Time




Worst Quartile
< 85.9%


25th to 50th Quartile
85.9% - 90.8%


Best 50th Percentile
> 90.8%


N/A

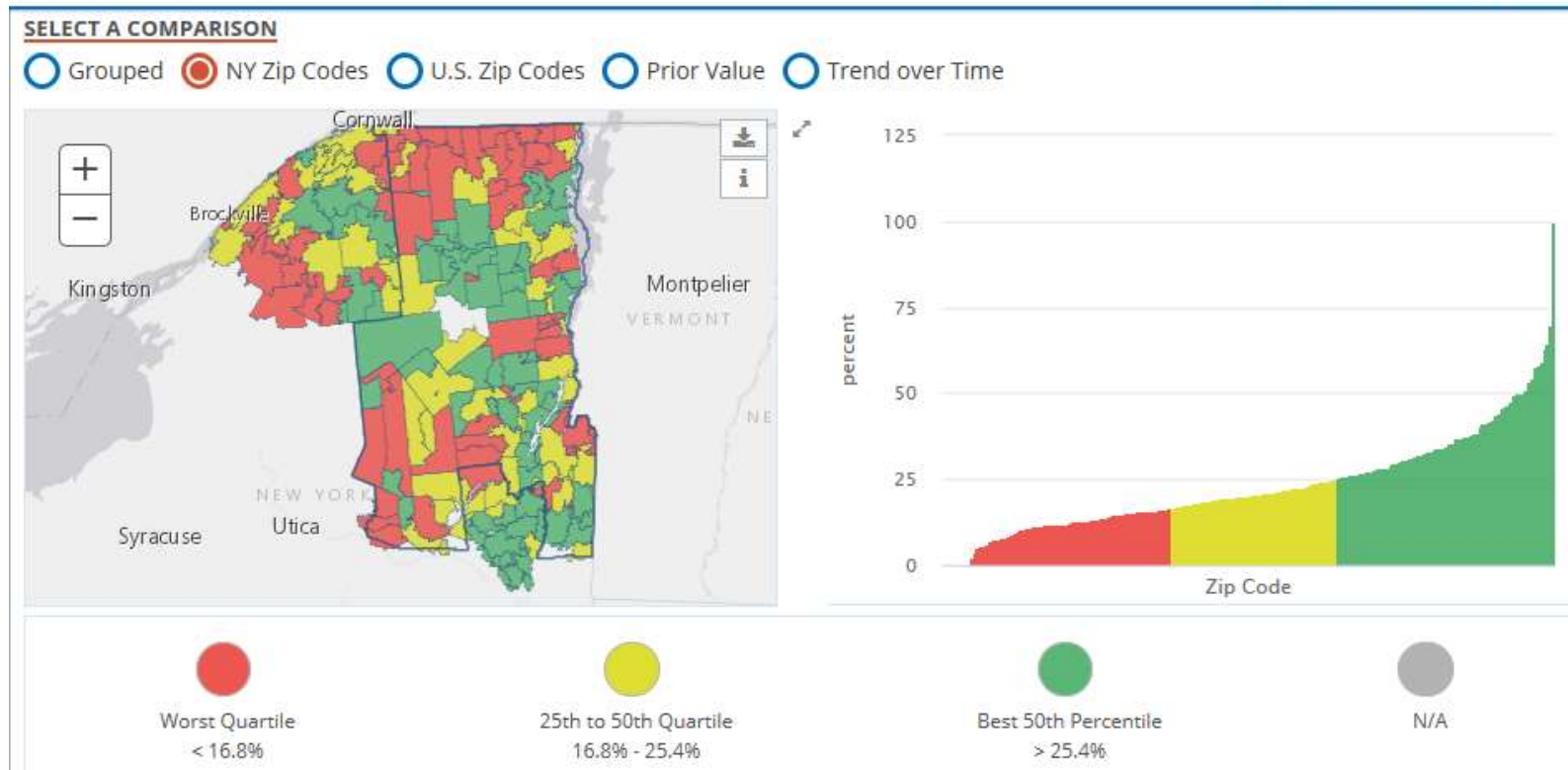
SDoH in our Communities

People 25+ with a Bachelor's Degree or Higher

Select a Zip Code

Measurement Period: 2012-2016

Filter: none (all Zip Codes)



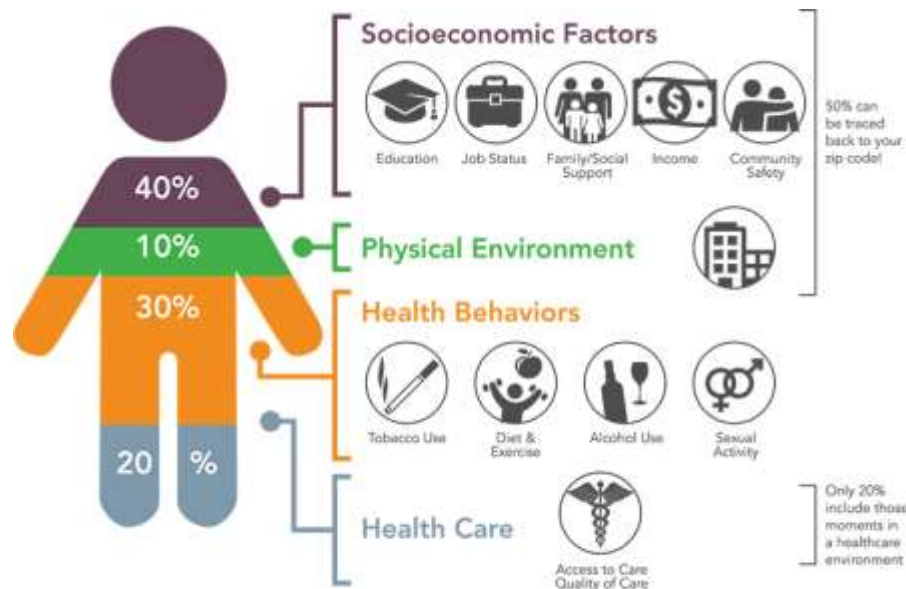
How do SDoH intersect with improving the Quality of Care?

- Patient engagement
- Outcomes
- NCQA requirements



Are you screening for SDoH?

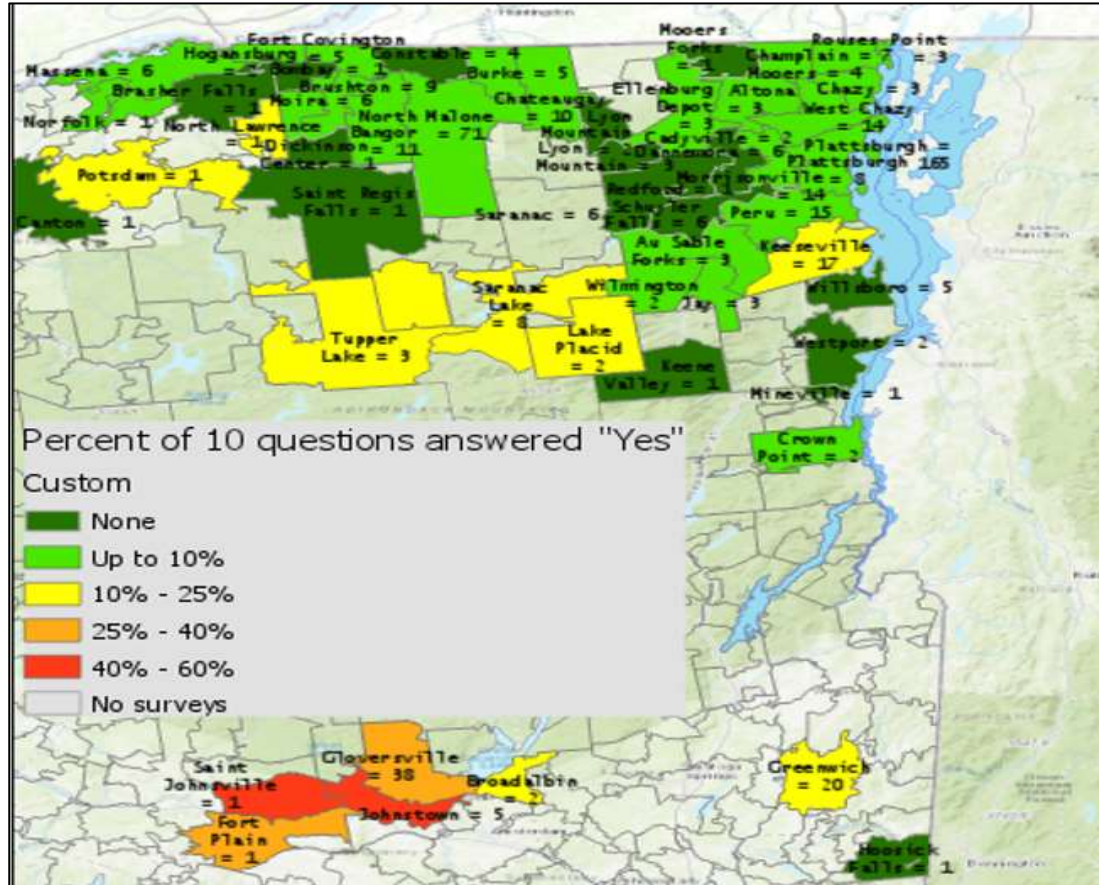
- What tool(s) are you using?
- Should providers, organizations, and agencies in our region be using the same tools for consistency?



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

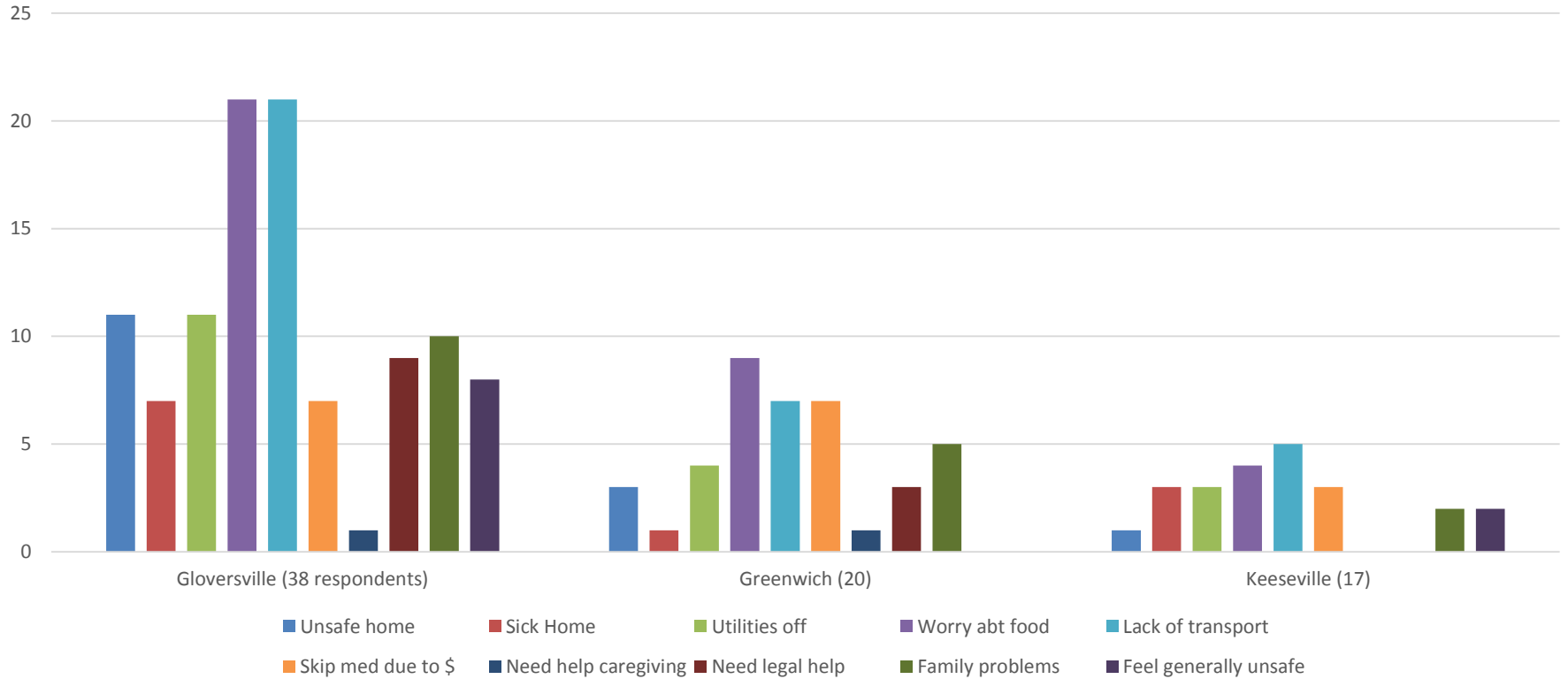
Preliminary Results

AHI Social Determinants of Health Screening Pilot (data as of 12/11/2018)



Screening Identifies Our Challenges

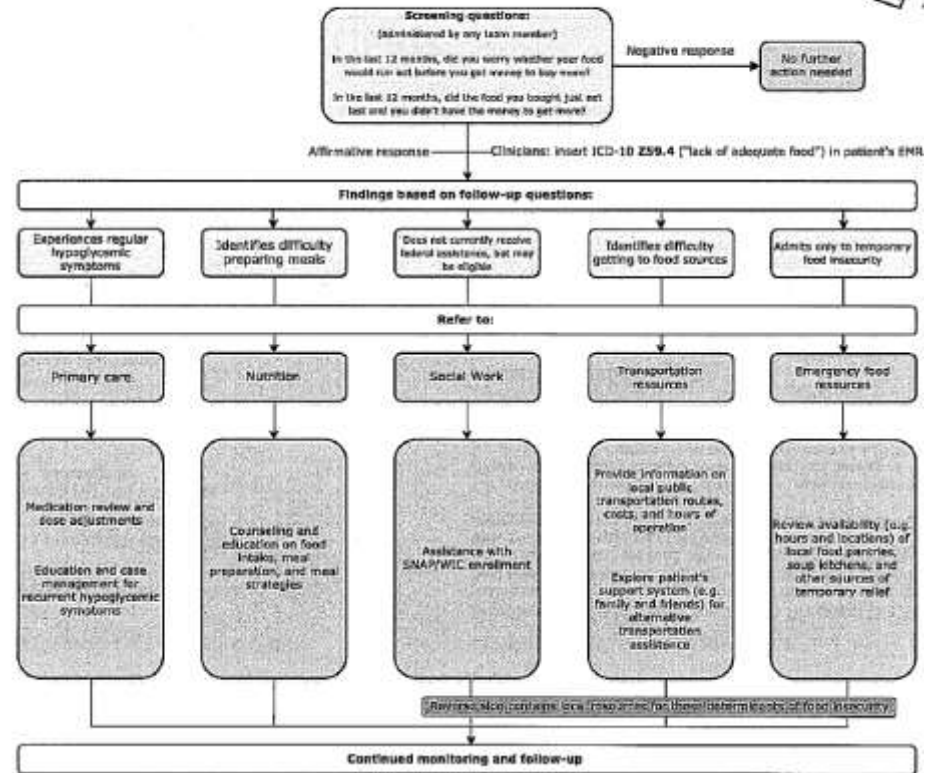
"Yes" responses to Social Determinants of Health survey in select communities



Addressing SDoH Needs in Clinical Settings

- Screen
- Engage the patient
- Determine why
- Make the referral
- Follow up

FOOD INSECURITY SCREENING ALGORITHM
For Clinton County Health and Social Service Providers





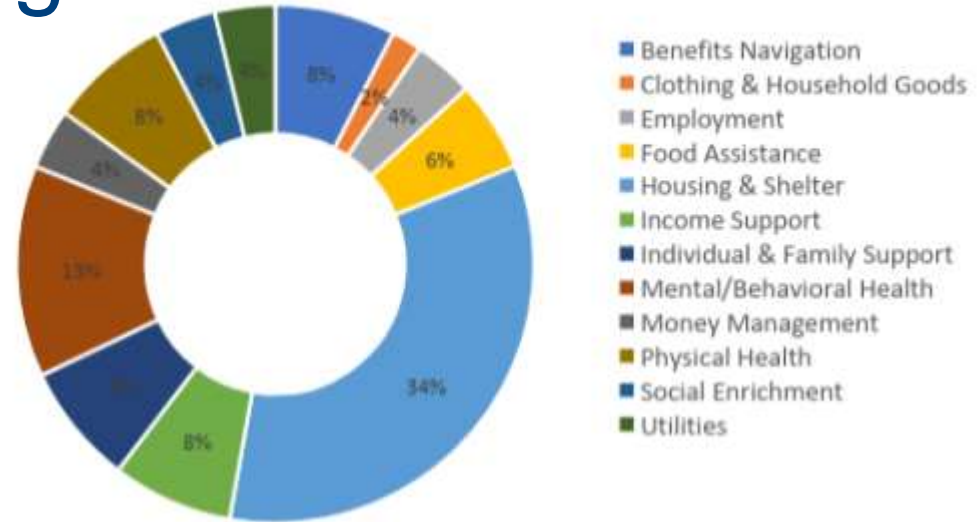
ADK Wellness Connections

- Collaborative referral coordination and resource navigation network in Clinton, Franklin, Essex, Fulton, Franklin, Saratoga, St. Lawrence, Warren, and Washington counties.
- Intended to increase access to resources and services to address social and medical needs.
- Promotes screening for social needs across settings and provides a tool for providers to strengthen linkage to services to address identified needs.
- Data source for identifying regional social needs, service gaps, and referral efficiency.

What are we finding?

Breakdown of Service Episodes by Service Type

| Service Type | # of Service Episodes |
|-----------------------------|-----------------------|
| Benefits Navigation | 4 |
| Clothing & Household Goods | 1 |
| Employment | 2 |
| Food Assistance | 3 |
| Housing & Shelter | 18 |
| Income Support | 4 |
| Individual & Family Support | 4 |
| Mental/Behavioral Health | 7 |
| Money Management | 2 |
| Physical Health | 4 |
| Social Enrichment | 2 |
| Utilities | 2 |



| | |
|--------------------------------------|-----------|
| Housing & Shelter | 18 |
| Emergency Housing | 8 |
| Housing Applications/Recertification | 3 |
| Permanent Housing | 3 |
| Home Expense Assistance/Repairs | 1 |
| Rent/Mortgage Payment Assistance | 3 |



QUESTIONS?

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