Redesigning Care Around the Social Determinants of Health:

A resource guide and introduction to the CMLN Social Determinants of Health Affinity Group

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Social Determinants of Health (SDOH) Affinity Group Series

The Center for Medicare & Medicaid Innovation (CMMI) models increasingly look beyond traditional medical care to improve patients' health and well-being, prevent avoidable hospitalizations, and reduce the cost of health care. Addressing social determinants of health (SDOH), such as housing, food security, and legal needs, can help CMMI models achieve the aim of better care for patients, smarter spending, and healthier communities.

The Cross Model Learning Network (CMLN) is launching an affinity group focused on addressing SDOH, exploring how health care organizations can move care upstream[1] to prevent disease and mitigate disease effects driven by social and environmental factors.

The CMLN invites you to join the SDOH conversation when the affinity group meets for the first time on May 23rd at 2:00pm Eastern. Participating in this group will provide you with robust opportunities to share questions, experiences, and ideas. Register today! If you have any questions, suggestions, or innovations you would like to highlight during this SDOH Affinity Group series, let us know by emailing CMLNSupport@lewin.com.

In support of this affinity group, the CMLN provides this summary about SDOH, identifying SDOH tools and resources, and highlighting some of the work of CMMI models in this area.

Why do Social Determinants of Health (SDOH) matter?

Exhibit 1: Components of SDOH

SDOH encompass the conditions in which people live, learn, work, play, worship, and age that profoundly shape their health status and quality-of-life (Exhibit 1).[2] Traditionally, health care organizations have focused exclusively on providing medical care to improve health, without seeking to address these critical factors directly. However, growing evidence shows that addressing social determinants can drive positive health outcomes and health equity.[3,4] While providers have long recognized that patients' conditions outside the clinical walls affect health outcomes, more health care providers now see themselves as essential partners that can play a substantial and valuable role in improving those conditions. Health care organizations need strategies and tools to address the social determinants of health without adding to administrative burden and provider burnout.

What available data address SDOH?

Understanding data that describe SDOH, such as income level, educational achievement, and employment status, can help health care providers tailor their efforts to improve community health. Many organizations seeking to develop a framework for addressing SDOH use geospatial analysis and community needs assessments to identify social and environmental factors affecting individual and

[1] Moving upstream is term describing the importance of addressing social determinants of health (e.g. upstream factors) such as housing, neighborhood conditions and increased socioeconomic status to improve the health of populations.
[2] U.S. Department of Health and Human Services. Social Determinants of Health. (2018, May 7). Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.
[3] The Accountable Health Communities Health-Related Social Needs Screening Tool. (n.d.). Retrieved May 7, 2018, from https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf.
[4] U.S. Department of Health and Human Services. Social Determinants of Health. (2018, May 7). Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.

community health.[5] The **CMS Office of Minority Health (OMH)** offers the Medicare Mapping Disparities Tool, which can help identify the areas of greatest need for the populations you serve. The Centers for Disease Control and Prevention (CDC) also offers data tools and resources that can help organizations identify and address SDOH. The Data Set Directory of Social Determinants of Health at the Local Level lists a number of sources that can give information on various social, economic, and environmental conditions. For additional information and tools, see the SDOH Resources Guide.

Do CMMI models identify and address SDOH?

In an effort to better identify and address SDOH, CMMI supports efforts to spread evidence-based interventions that strengthen partnerships between local healthcare providers, public health professionals, community and social service agencies, and individuals. Across the CMMI portfolio, organizations have formed multisector partnerships, using and sharing data to identify health trends and health disparities, improving access to health-related social services, and supporting beneficial policy and program change efforts. Exhibit 2 provides examples.

Exhibit 2: CMMI Models Addressing SDOH

(continued on next page)

Examples from AHC and ACO Models	Examples from SIM and Million Hearts Models
The recently launched **Accountable Health Communities (AHC) Model** aims to address SDOH by addressing a critical gap between clinical care and community services through screening, referral, and community navigation services.[6] The Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool can help providers determine patients' health-related social needs in five core domains that community services can help with: housing instability, food insecurity, transportation problems, utility help needs and interpersonal safety.[7]	The **Iowa State Innovation Model (SIM)** is working to develop and/or enhance referral networks that address social needs for individuals having or at risk of having diabetes. The state is investing in a standardized health risk assessment (HRA) tool that will identify SDOH and provide actionable data clinicians and patients can review together to address the patient's needs.[8]

[5] Heiman, H. J., & Artiga, S. (2016, March 29). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Retrieved May 8, 2018, from https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/.

[6] U.S. Centers for Medicare & Medicaid Services. Accountable Health Communities Model. (2018, May 3). Retrieved from https://innovation.cms.gov/initiatives/ahcm/

[7] Fichtenberg, C. (2017, June 02). CMS Health-Related Social Needs Screening Tool Now Publicly Available. Retrieved May 8, 2018, from https://sirenetwork.ucsf.edu/newsroom/news/cms-health-related-social-needs-screening-tool-now-publicly-available

[8] Iowa Department of Human Services. (2014, March). A Health Risk Assessment (HRA) Tool for Iowa Medicaid Members. Retrieved May 8, 2018, from https://dhs.iowa.gov/sites/default/files/HRA Whitepaper_03122014_Final.pdf

Examples from AHC and ACO Models	Examples from SIM and Million Hearts Models
Parkland Center for Clinical Innovation (PCCI), an AHC model participant, has achieved notable cost saving results because of an initiative that addresses SDOH, such as homelessness and access to food. Using an information exchange portal, PCCI works with community partners, such as homeless shelters and food pantries, to build a network that makes it easier for the hospital to refer people experiencing homelessness discharged from its emergency room to community based organizations. In December 2016, PCCI reported a decrease in average hospital visits by two-thirds or more, saving an estimated $12 million, less than two years after launch.[9]	**New York City Department of Health** established a cardiovascular disease prevention initiative focused on smoking cessation, as part of the Million Hearts Initiative. In 2002, the NYC Smoke-Free Air Act was enacted, prohibiting smoking in workplaces, restaurants, bars, and nightclubs. In 2011, the smoke-free ordinance was expanded to parks, beaches, public plazas, and boardwalks. These policy changes align with Million Hearts' aim to change the cardiovascular health of the nation by increasing community efforts to decrease exposure to secondhand smoke. According to early evaluations, changes to local laws, excise taxes, and media messages during 2002-2010 resulted in approximately 450,000 fewer smokers in NYC. [10]
The **Camden Coalition, an Accountable Care Organization (ACO) model participant,** addresses patients' health and social barriers to wellness through coordinated care and support. Their Housing First program reduces the patterns of high hospitalization and emergency room use among patients with chronic illnesses by connecting them to health, housing and other services.[11]	**Hudson River HealthCare (HRHCare) is a Million Hearts® Cardiovascular Disease (CVD) Risk Reduction Model awardee** and a Federally Qualified Health Center with a network of 31 sites throughout nine counties in New York State's Hudson Valley. To identify opportunities to address SDOH, HRHCare maintains an open dialogue with its board of directors, community leaders, key stakeholders, businesses and community-based agencies, and conducts surveys of patients, staff, and community members. After conducting a patient survey to identify barriers to coming to follow-up appointments and preferences for receiving information about blood pressure management, HRHCare partnered with Dutchess County to offer a "Hypertension 101" class that addressed healthy lifestyles and blood pressure self-management onsite at a HRHCare clinic site. To date, HRHcare has led several efforts to address SDOH such as promoting childhood literacy through Reach Out and Read and addressing housing needs through assistance with home purchases and necessary home improvements.[12]

[9] Allen, A. (2017, December 18). The 'Frequent Flier' Program That Grounded a Hospital's Soaring Costs. Retrieved from https://www.politico.com/magazine/story/2017/12/18/parkland-dallas-frequent-flier-hospital-what-works-216108
[10] Valderrama, A., Farley, T., DeMaria, A., Wright, J., Conway, P., Blair, N., . . . Popovic, T. (2012, December 21). CDC Grand Rounds: The Million Hearts Initiative. Retrieved May 14, 2018, from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6150a1.htm
[11] Yuen, A. (2018, May 03). Addressing addiction at the Camden Coalition. Retrieved May 8, 2018, from https://www.camdenhealth.org/addressing-addiction
[12] Association of State and Territorial Health Officials. (2015). Million Hearts Case Study. Retrieved May 14, 2018, from http://www.astho.org/Prevention/Chronic-Disease/Million-Hearts/Million-Hearts-Systems-Change-Case-Study--New-York/

SDOH Resource Guide

Definition and Background of SDOH

CDC: Social Determinants of Health: Know What Affects Health

This website provides social determinants of health resources from CDC, including tools geared towards practitioners for action, programs, and policy, to assess and improve the health and well-being of communities.

Healthy People 2020: Social Determinants of Health

Access to social and economic opportunities, as well as the quality of our neighborhoods, communities, schooling, water, food, and air, and even social interactions and relationships, in part determine health. "Create social and physical environments that promote good health for all" is one of the four overarching goals for Healthy People 2020.

National Academies: A Framework for Educating Health Professionals to Address the Social Determinants of Health

An expert committee within the National Academy developed a high-level framework for educating health professionals to address the SDOH, with the goal of promoting more effective strategies for improving health and health care for underserved individuals, communities, and populations. The committee's framework aligns education, health, and other sectors to better meet local needs in partnership with communities.

National Academy of Medicine: Social Determinants of Health 101 for Health Care: Five Plus Five

A discussion paper that considers what is known and what can be learned about social determinants of health, pursuant to the national quality strategy of better care, healthy people and communities, and affordable care. The title *Five Plus Five* alludes to five things the authors of the paper already know about the social determinants of health and five things organizations need to learn to adequately address the social determinants of health for the national quality strategy.

The Rich Live Longer Everywhere. For the Poor, Geography Matters

This New York Times article summarizes recent research findings showing that geographic location affects health the most for persons with the lowest socio-economic status. In the original research study on which the article is based, the authors concluded that reducing health disparities will likely require local policy and behavior change interventions.

Data Resources to Assist with the Identification of SDOH

CMS Office of Minority Health (OMH) Medicare Mapping Disparities Tool

A tool which can help identify the areas of greatest need for subgroups of Medicare beneficiaries. It is an excellent starting point for understanding and investigating geographic and racial and ethnic differences in health outcomes.

Commonwealth Fund Return on Investment (ROI) Calculator

The Commonwealth Fund has launched the new ROI Calculator for Partnerships to Address the Social Determinants of Health. This tool can help health systems and community-based organizations structure their partnerships in an equitable way by assessing the financial risks and rewards under various payment arrangements and terms.

Robert Wood Johnson Foundation (RWJF): Does where you live affect how long you live?

A zip code can be the most influential social determinant of health. With a 5-digit zip calculator, this site enables you to explore how life expectancy in America compares with life expectancy in US zip codes, and provides related resources.

RWJF: County Health Rankings

The goals of this website are to build awareness of multiple factors that influence health, including social determinants, and provide reliable data to help communities identify and address opportunities for improvement in a supportive network environment.

Singh Area Deprivation Index

The area deprivation index (ADI) represents a geographic area-based measure of the socioeconomic deprivation experienced by a neighborhood, using 17 different markers of socioeconomic status from Census data. The ADI can be used to explore and evaluate the relationship between socioeconomic factors and health. These variables can be used as risk adjusters and important contextual factors, and have been shown to be predictive of health care quality and health outcomes.

Screening for and Addressing SDOH

Advancing State Innovation Model Goals through Accountable Communities for Health

The new Accountable Communities for Health (ACH) model at CMMI are bringing together partners from health, social service, and other sectors to improve population health and clinical-community linkages within a geographic area. This brief reviews state efforts to develop and test ACH models within the federal SIM initiative, including an examination of how ACHs connect with broader population health and delivery system reform plans.

National Academies: Recommended Social and Behavioral Domains and Measures for Electronic Health Records

The Institute of Medicine's Committee on Recommended Social and Behavioral Domains and Measures for Electronic Health Records identifies domains and measures that capture the SDOH to inform the development of recommendations for electronic health records (EHRs).

Screening for SDOH in Populations with Complex Needs

This brief examines how organizations participating in *Transforming Complex Care*, a multi-site national initiative funded by the Robert Wood Johnson Foundation, are assessing and addressing SDOH (SDOH) for populations with complex needs. It reviews key considerations for organizations seeking to use SDOH data to improve patient care, including: (1) selecting and implementing SDOH assessment tools; (2) collecting patient-level information related to SDOH; (3) creating workflows to track and address patient needs; and (4) identifying community resources and tracking referrals.

Use of Community Health Workers to address SDOH

How States Can Fund Community Health Workers through Medicaid to Improve People's Health, Decrease Costs, and Reduce Disparities

This brief explains how community health workers improve people's health, reduce health care costs, and address barriers to care. They authors then discuss key questions regarding sustainable funding of CHW programs through Medicaid reimbursement for states that want to start or expand such programs. The authors present case studies of three states (Massachusetts, Minnesota, and New Mexico), detailing how these states fund, train, certify, and integrate CHW programs. Finally, the brief concludes with what state advocates need to know to move forward with building or expanding CHW programs in their state.

Prevention Research Centers Webinar: Engaging Community Health Workers

This webinar is the first of a three-part series highlighting how Prevention Research Centers (PRCs) partner with community stakeholders to translate research into effective public health programs

and how public health practitioners can use PRC tools and trainings to reduce health disparities. This webinar featured research and tools for engaging community health workers (CHWs) to prevent chronic diseases. Topics discussed include creating best practices for utilizing CHWs in clinical settings, developing community clinical linkages, and an example of how the national Million Hearts initiative integrated CHW and physician support models.

State Community Health Worker Models

The National Academy for State Health Policy created a map that highlights state activity to integrate CHWs into evolving health care systems in key areas such as financing, education and training, certification, state definitions, roles and scope of practice. The map includes enacted state CHW legislation and provides links to state CHW associations and other leading organizations working on CHW issues in states.

Federal, State and Community Tools and Resources

Aunt Bertha

With users in all 50 states, Aunt Bertha makes it easy for organizations, including health care organizations, to help people with social needs to find and make referrals to appropriate programs and services for social needs such as food, shelter, financial assistance and more to improve health outcomes.

Eldercare Locator

This free tool, provided by the U.S. Administration on Aging, helps find resources for older adults and their families in any U.S. community.

HealthBegins

HealthBegins helps health care professionals and systems improve health outcomes and quality of care by addressing SDOH, using evidence-based system and practice redesign processes and user-friendly clinical tools and technology. Their “Upstream Risk Screening Tool” is available upon request.

Health Leads

Health Leads works with healthcare organizations to create effective interventions that connect patients to community-based resources that impact the SDOH. Health Leads shares tools and expertise to positively impact not only the health and well-being of patients, but also to build the evidence base of best practices in healthcare pertinent to social determinants.

Independent Living Research Utilization (ILRU) Directory of Centers for Independent Living (CILs)

ILRU has a nationwide network of offices that can provide a number of services and referrals for people with disabilities. This map identifies Centers for Independent Living, non-residential, non-profit community based human service agencies focused on providing services and advocacy to empower individuals living with disabilities.

National Association of Area Agencies on Aging (n4a)

Areas Agencies on Aging (AAAs) are a network of approximately 620 organizations nationwide which serve the elderly populations (60+). Each AAA provides a different set of services such as: nutrition, caregiver support, long term care ombudsmen, insurance counseling, and transportation.

Social Interventions Research & Evaluation Network

SIREN acts as a central hub to promote and disseminate high quality research on efforts to address SDOH in care settings. They provide innovation grants, a research hub, and evaluation consultation services.

The National Center for Complex Health and Social Needs

The National Center works to promote and disseminate promising practices for patients with complex needs by linking clinicians, researchers, policymakers, and consumers who are developing, testing, and scaling new models of team-based, integrated care.

The National Partnership for Action (NPA) to End Health Disparities Toolkit for Community Action

The Office of Minority Health NPA has set goals to establish the priorities for a national strategy to eliminate health disparities using a community-oriented approach. This toolkit will help individuals, communities and organizations from the public and private sectors work together to implement programs and policies and engage with the NPA to reach that goal.

United Way: 2-1-1

Available to 94 percent of the US population, 2-1-1 provides confidential referral services to community resource specialists 24 hours a day, by phone or online. Service referrals may include: food/nutrition, housing, domestic violence, and behavioral health treatment.

United States Department of Agriculture (USDA) Nutrition Assistance

United States nutrition assistance programs increase food security and reduce hunger through access to affordable, healthy food and nutrition education. Most food assistance is provided by SNAP, WIC, and the Child Nutrition Programs.

Recent Publications

Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper (April 17, 2018)

The American College of Physicians uses this position paper to acknowledge the role of social determinants in health, describes their complexities, and provides recommendations to integrate social determinants into the health care system. The paper also addressed systemic issues hindering health equity.

2019 Medicare Advantage and Part D Rate Announcement and Call Letter, Fostering Innovation in Benefit Design: Expanding Health Related Supplemental Benefits (April 2, 2018)

Previously, CMS has not allowed an item or service to be eligible as a supplemental benefit if the primary purpose includes daily maintenance. However, in the final Call Letter, CMS discusses a reinterpretation of the statute to expand the scope of the primarily health-related supplemental benefit standard. Under this reinterpretation, CMS would allow supplemental benefits if they are used to diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization. This expansion will effectively increase the number of allowable supplemental benefit options and provide patients with benefits and services that may improve their quality of life and health outcomes.

Rule Change: "Screening for health-harming legal needs" is an Improvement Activity under CMS' Quality Payment Program (April 2, 2018)

A critical part of making sure that legal services are available as part of quality healthcare is ensuring that screening for legal needs is a recognized and reimbursable activity for health care providers. In the rule for the 2018 performance year of the Quality Payment Program, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Centers for Medicare & Medicaid Services included "screening for health-harming legal needs" as a recognized Improvement Activity (IA) under Medicare's Merit-based Incentive Payment System. Now eligible

clinicians who screen patients for legal needs will receive credit in the IA category, which could potentially lead to an increased Medicare reimbursement rate.

Health Affairs Blog: Physicians' Broader Vision For The Center For Medicare And Medicaid Innovation's Future: Look Upstream (March 2, 2018)

The authors assert that, "(h)istorically, our medical system and innovation environment have too often failed to account for patients' health-related social needs. When we do not fully consider the reality of patients' lives, it undermines their health, increases use and cost and contributes to physician frustration and burnout." The authors recommend a few specific next steps.

The Commonwealth Fund: Investing in Social Services as a Core Strategy for Healthcare Organizations: Developing the Business Case (March 2018)

This guidebook provides steps and practical approaches that may be applied by any organization (payer, provider, or even employer) that either currently bears risk or is in the process of moving to risk-based reimbursement models for a defined patient population.

The Commonwealth Fund: Using Community Partnerships to Integrate Health and Social Services for High-Need, High-Cost Patients (January 2018)

Innovative community-based programs coordinate services between health care providers and social service organizations to help patients with housing, food insecurity, transportation, and other issues. Challenges to these programs include financial sustainability, measurement of health outcomes and cost-savings, and integrated information technology. More research is needed to identify optimal payment models to support such efforts and move away from fee-for-service payment schemes.

The HHS Action Plan to Reduce Racial and Ethnic Health Disparities

This action plan outlines goals and actions the Department of Health and Human Services (HHS) will take to reduce health disparities among racial and ethnic minorities. The plan focuses on HHS iniatives and opportunities to reduce racial and ethnic health disparities.

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