Social Determinants of Health:

Policy Drivers and Implications for Nursing

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Why a Landscape View of Policy?

Expert Nurse Informaticians Needed!

To Bridge the SDOH Gap

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Social Determinants of Health

- 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.
- These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.
- These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.
- The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

World Health Organization
http://www.who.int/social_determinants/sdh_definition/en/

Health Inequities – Person to Person, County to Country

Employment conditions

Measures to clarify how different types of jobs and the threat of unemployment affect workers' health.

WHO /D. Rodriguez

Social exclusion

The relational processes that lead to the exclusion of particular groups of people from engaging fully in community and social life.

WHO /D. Rodriguez

Public health programmes and social determinants

Factors in the design and implementation of programs that increase access to health care for socially and economically disadvantaged groups.

WHO /M. Dakin

Women and gender equity

Mechanisms, processes and actions that can be taken to reduce gender-based inequities in health by examining different areas.

WHO /A. Karl

Globalization

How globalization's dynamics and processes affect health outcomes: trade liberalization, integration of production of goods.

WHO/S. Volkov

Health systems

Innovative approaches that effectively incorporate action on social determinants of health.

WHO /R.B. Sorensen

Measurement and evidence

The development of methodologies and tools for measuring the causes, pathways and health outcomes of policy interventions.

WHO /A. Karl

Urbanization

Broad policy interventions related to healthy urbanization, including close examination of slum upgrading.

World Health Organization

http://www.who.int/social_determinants/sdh_definition/en/

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Who We Are Serving

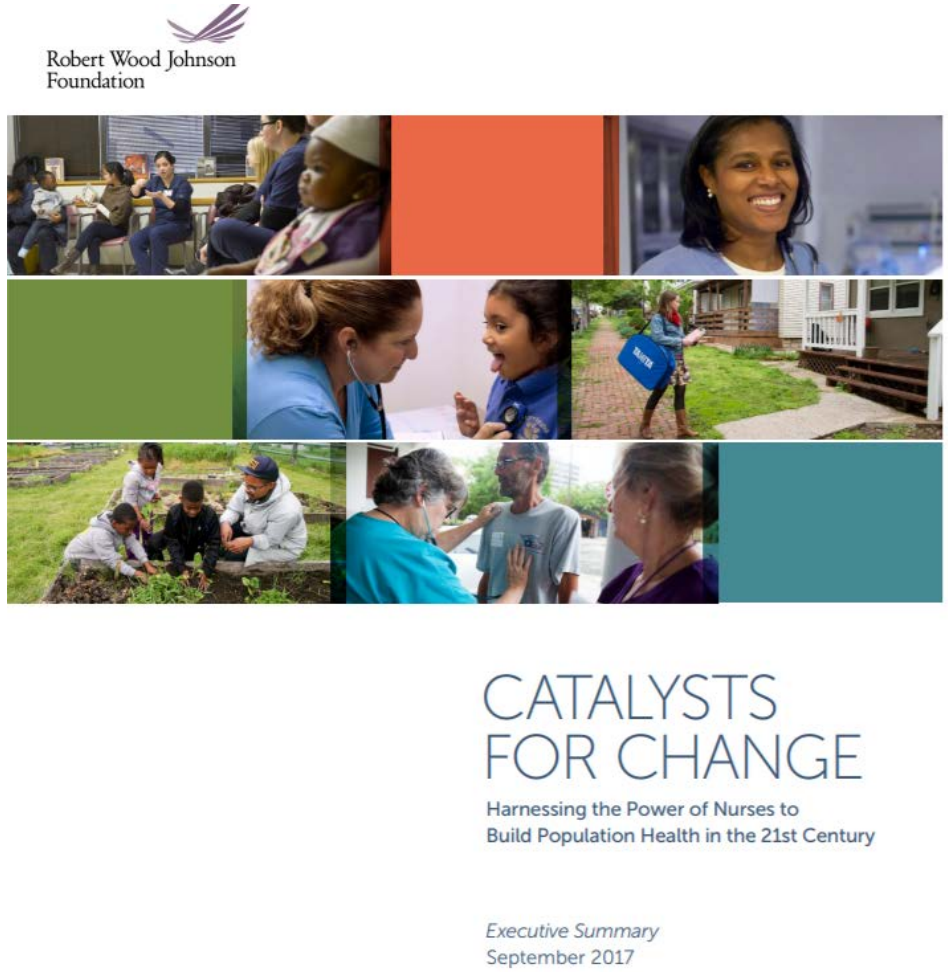
- One in five Americans lives in a neighborhood with high rates of crime, pollution, inadequate housing, lack of jobs, and limited access to nutritious food.
- The children of black high school dropout mothers are more than three times more likely to be born with a low birth weight than the children of white college educated mothers.
- Athsma is more prevalent in minority and low-income communities, affecting 11.2 percent of those below 100 percent of the poverty level, compared to 7.3 percent of those with incomes over 200 percent of the poverty level .
- A 2012 analysis found that households who spent more than 50 percent of their income on housing spent less on food and health care than similar households spending 30 percent or less of their income on housing
- People who are socially isolated have a death rate two to five times higher than people with close relationships to friends, family and community.

Harnessing the Power of Nurses
To Build Population Health in the 21st Century

How can nurses best help our nation reverse course on declining health of citizens and promote the health of the U.S. population in the 21st Century?

- Nursing education must be transformed
- Nursing practice must be transformed
- Concerted efforts must be undertaken to address national trends
- Continued support must be provided for research to advance the role of nurses in population health
- Continued support must be provided for advocacy

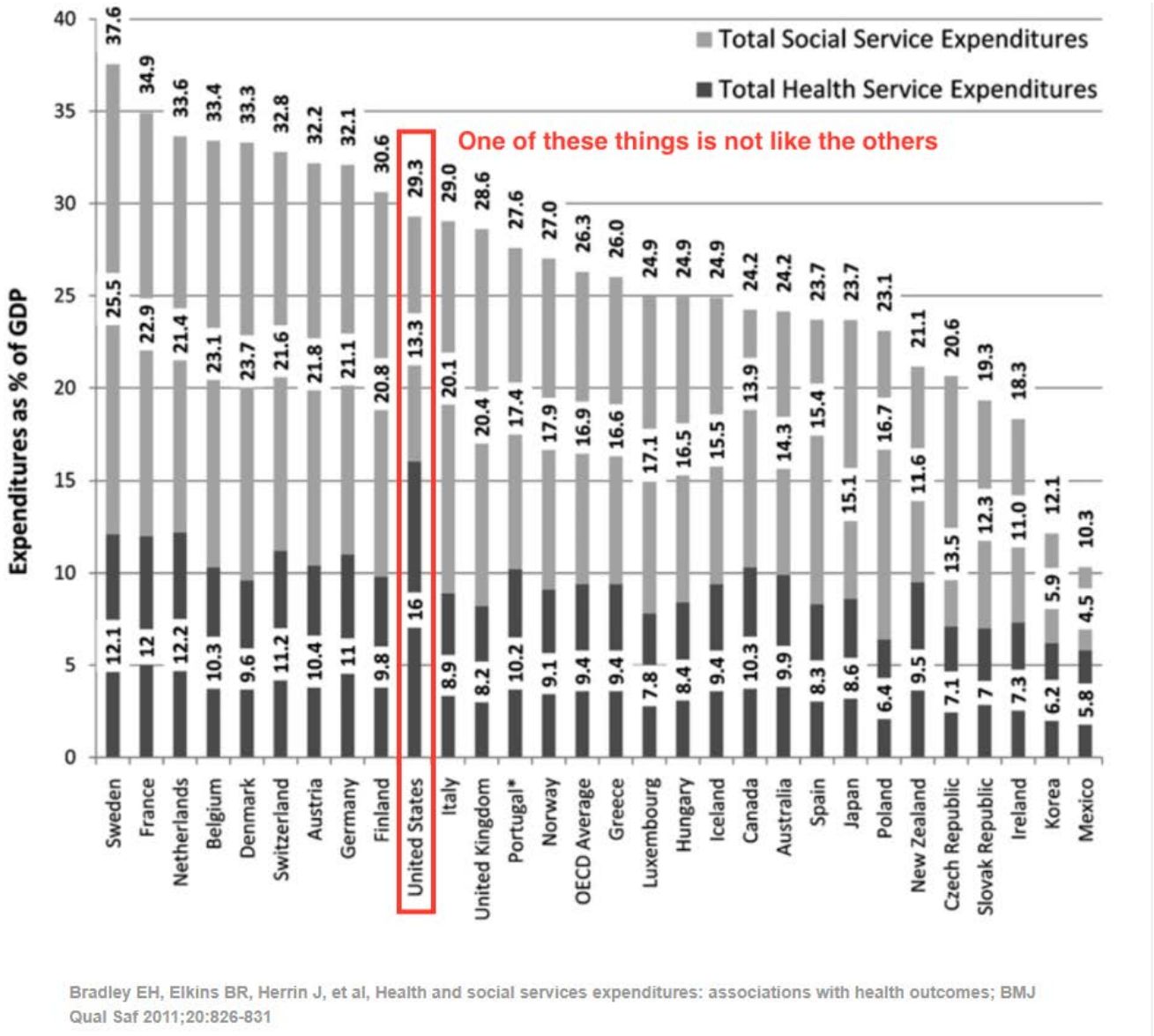
https://www.rwjf.org/content/dam/farm/reports/reports/2017/rwjf440286



Key Issues

1. What are the policy drivers for the maturity of technology-enabled SDOH infrastructure across healthcare provider, payer, public and community health?
2. How do we build out, and professionalize, and digitize, and integrate the social determinants as a partner to the health care system?
3. How do we achieve comparable shareable data that is person centric, longitudinal and actionable?

How Are We as a Nation Investing in Health?



Bradley EH, Elkins BR, Herrin J, et al, Health and social services expenditures: associations with health outcomes; BMJ Qual Saf 2011;20:826-831

On average, nations that are members of the Organization for Economic Cooperation and Development (OECD)

- Spend about $1.70 on social services for every $1 on health services

The U.S. spends just 56 cents.

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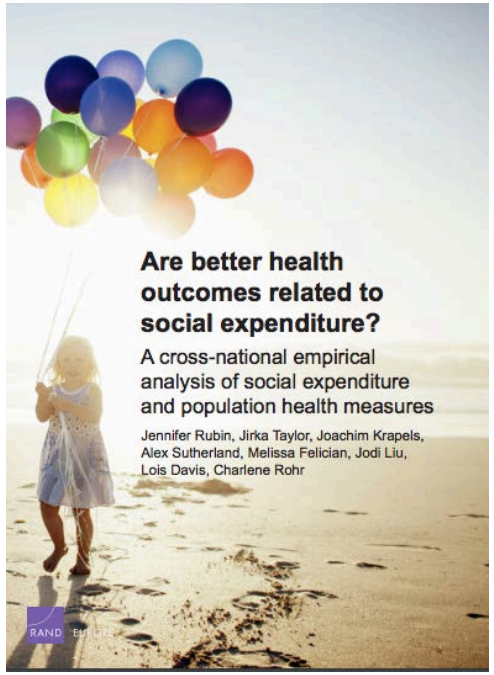
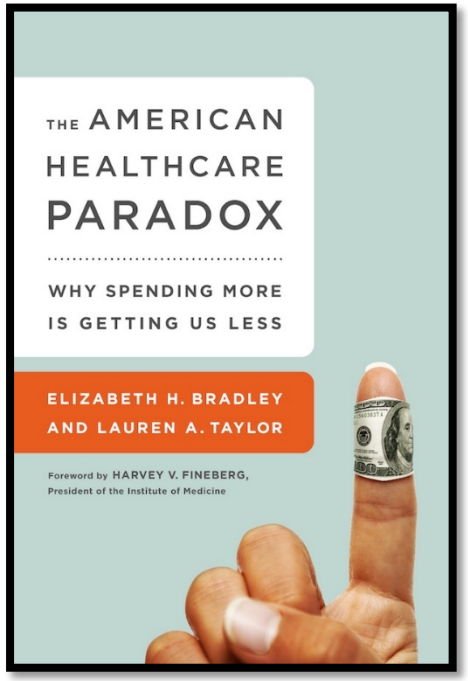
US Health Policy has Largely Ignored SDOH Until Now

The best available evidence suggests that a health policy framework addressing social and behavioral determinants of health would achieve better population health, less inequality, and lower costs than our current policies.

- Despite the powerful effects of social and behavioral factors on health, development, and longevity, US health policy has largely ignored them (Adler et. al., 2016).
- The United States spends far more money per capita on medical services than do other nations, while spending less on social services (Bradley et al., 2011).
- Residents of nations that have higher ratios of spending on social services to spending on health care services have better health and live longer (Bradley and Taylor, 2013; NCR and IOM, 2013a).
- The relative underinvestment in social services helps to explain why US health indicators lag behind those of many countries (Woolf and Aron, 2013).





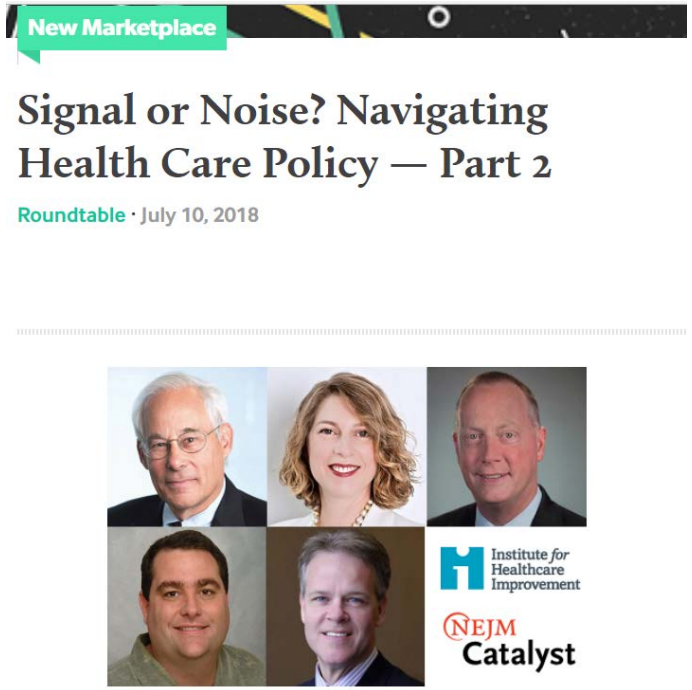
Addressing Social Determinants of Health and Health Disparities
A Vital Direction for Health and Health Care
Nancy E. Adler, University of California, San Francisco; **David M. Cutler,** Harvard University; **Jonathan E. Fielding,** University of California, Los Angeles; **Sandro Galea,** Boston University; **M. Maria Glymour,** University of California, San Francisco; **Howard K. Koh,** Harvard University; **David Satcher,** Morehouse School of Medicine
September 19, 2016

About the Vital Directions for Health and Health Care Series

Vital Directions for Health and Health Care
A National Academy of Medicine Initiative

This publication is part of the National Academy of Medicine's **Vital Directions for Health and Health Care Initiative,** which called on more than 150 leading researchers, scientists, and policy makers from across the United States to assess and provide expert guidance on 19 priority issues for U.S. health policy. The views presented in this publication and others in the series are those of the authors and do not represent formal consensus positions of the NAM, the National Academies of Sciences, Engineering, and Medicine, or the authors' organizations. Learn more: nam.edu/VitalDirections.

A Lot of Experimentation, Little Policy Influence



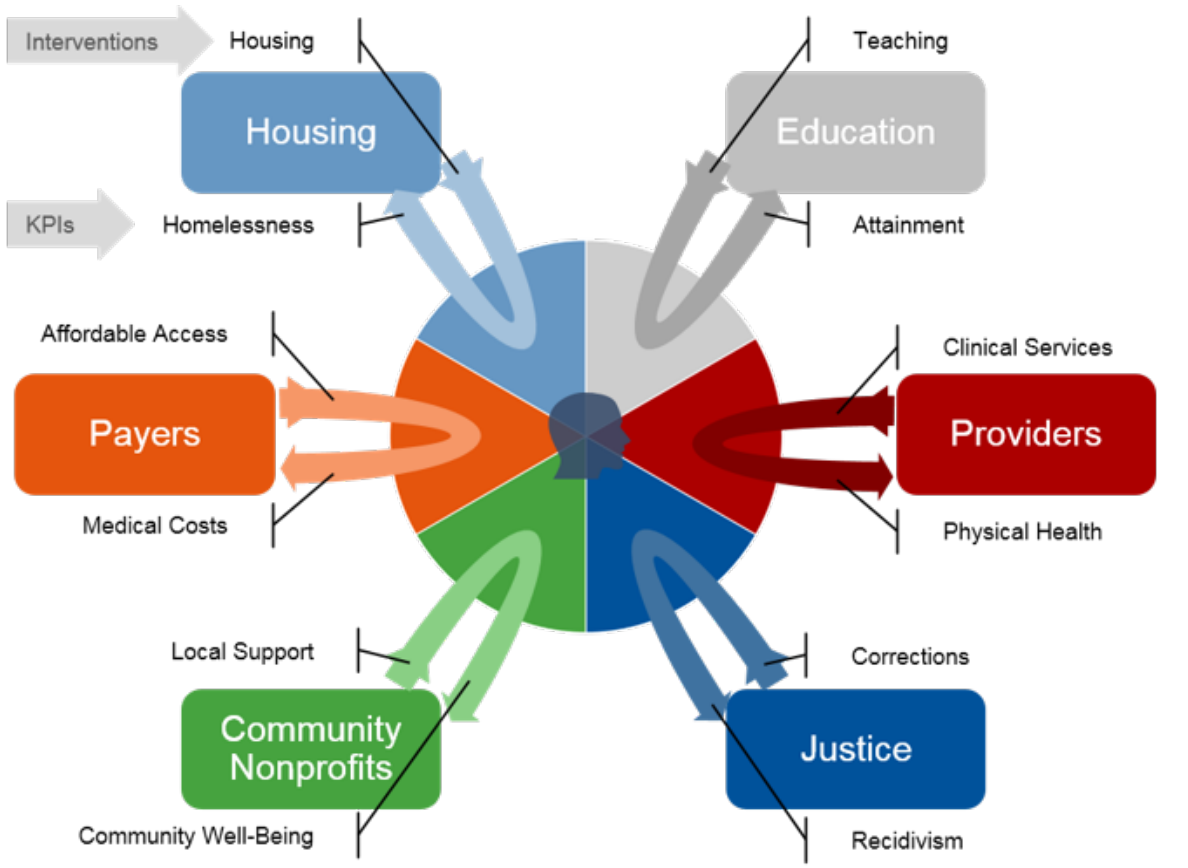
July 10, 2018

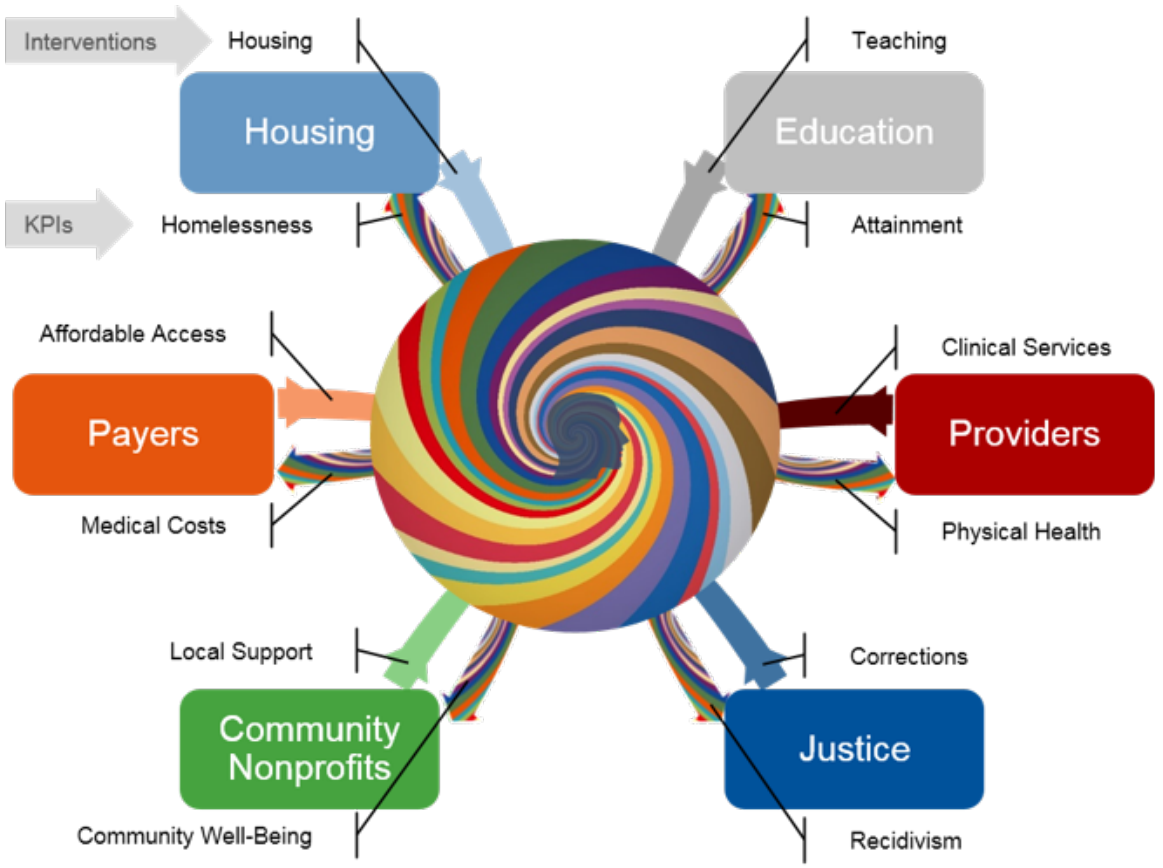
"There's innovation, experimentation in the market at different levels, and yet there's a lot of uncertainty about health care policy." Edward Prewitt

"Turn the QI "industrial complex" to the social determinants of health and population health issues. In addition to safety and harm and others, address suffering, vulnerability — these issues that have such a large impact on health and cost." Patrick Conway

"We look at our homeless population, which has made national news in Hawaii, although truly it represents 6,000 or 7,000 people across the state. But our adult tertiary care facility, they represent 30% of our most complex patients. Their average length of stay is almost 40% longer. Their mortality is almost 30 years less. They survive 30 years less than the rest of our patient population, and so this is a population in need." Raymond Vara

The Confluence of Interventions on Health and Well-Being





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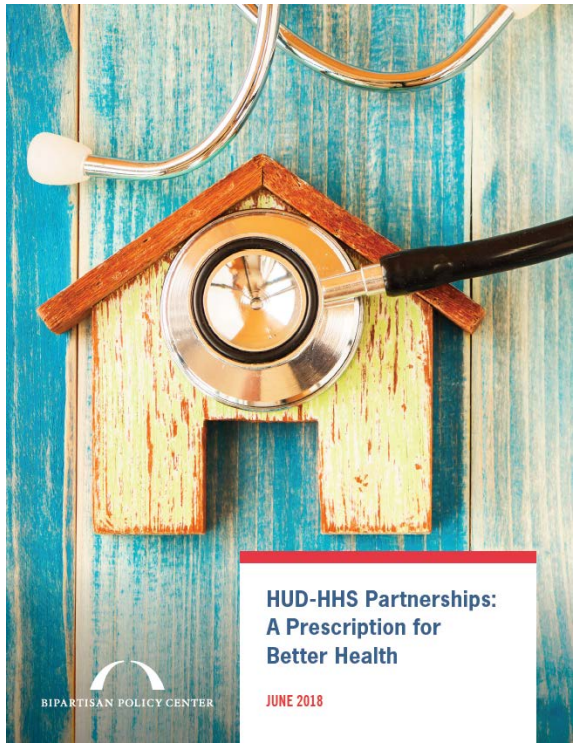
Recommendations Focus on Rebalancing Investments

1. Administration and Congress should *rebalance* federal spending patterns to adjust the current ratio of medical-to-social spending by shifting some current health care expenditures to investments in tackling “upstream” social factors with a bigger impact on health.
   - decreased hospital utilization
   - reduced spending by Medicaid and Medicare
   - while improving health outcomes.
2. The federal government should help *states* take the lead in this rebalancing, encouraging experimentation and cross state learning, building a needed body of evidence.
3. The federal government should review the evidence that social services are often the route to improved health, and agencies should work with health officials on ways to reprogram *funding,* with recommendation to work on housing.

USC-BROOKINGS SCHAEFFER ON HEALTH POLICY
Re-balancing medical and social spending to promote health: Increasing state flexibility to improve health through housing
Stuart M Butler, Dayna Bowen Matthew, and Marcela Cabello, **February 15, 2017**

Data Sharing across Federal, State and Local Agencies



HUD and HHS (2014) developed a pilot dataset

- **Linking HUD tenant data with Medicare and Medicaid claims to serve as a platform for managing the health services of low-income older adults**
  - 93 percent of HUD-assisted older adults matched to Medicare and 68 percent were dually enrolled in Medicare and Medicaid.
  - HUD-assisted, dually enrolled individuals had a higher rate of chronic conditions than the average unassisted dual individual.

Intra-agency HUD and HHS National Data Matching Initiative (2018)

- **Recommend the launch formal data collaboration initiative focusing on aligning and connecting local housing data with state Medicaid data.**
  - Expand on previous localized efforts to better evaluate both local and federal opportunities to match datasets that overlap the health and housing nexus.
  - Establish external Research Advisory Board of academics and stakeholders.

BiPartisan Policy Center, with funding support provided by Robert Wood Johnson Foundation

June 2018

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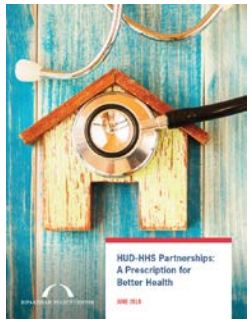
Healthy Homes: Lead Poisoning Prevention

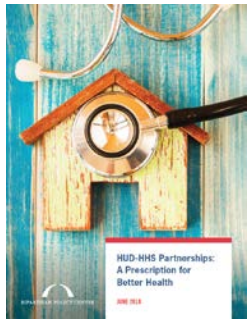


CDC's National Center for Environmental Health, CMS' Center for Medicaid & CHIP Services, and HUD's Office of Lead Hazard Control and Healthy Homes

Should begin a strategic dialogue to coordinate surveillance of lead poisoning, diagnosis and treatment of children with elevated blood lead levels, and prevention of lead poisoning. (last set 2000)

- Improve surveillance of housing conditions across all 50 states.
- Launch a public-private partnership to replace lead-contaminated windows in pre-1940 housing. HHS' Low Income Heating Assistance Program
- Work with state Medicaid agencies to submit timely and accurate data to CMS on the number of blood lead screening tests and positive blood lead screening tests; require Medicaid managed care plans to report on lead screening quality metrics; and support lead investigations, screenings, and follow-up services.
- Improve states' awareness of regulatory flexibilities to augment efforts.
  - **Rhode Island's Medicaid program** covers window replacement for children with lead poisoning - Section 1115 waiver
  - **Michigan's Medicaid program** pays for lead abatement services through a CHIP health services initiative
- Beyond waivers, state Medicaid agencies could also use value-based purchasing contracts with managed care plans to incentivize, finance and scale evidence-based healthy housing interventions; and/or pay for these interventions out of their administrative funds.

Healthy Homes: Asthma Prevention



CDC's National Center for Environmental Health, CMS' Center for Medicaid & CHIP Services, and HUD's Office of Lead Hazard Control and Healthy Homes

Should begin a strategic dialogue to coordinate activities for surveillance of asthma exacerbation "hot spots" & targeted remediation of homes to reduce environmental triggers

- HUD's Healthy Home grants should be coordinated with local public health and state Medicaid program efforts to reduce asthma environmental triggers. Case management of asthma cases should enable housing remediation when appropriate.
- CMS should develop an informational bulletin to clarify for states the various pathways to Medicaid reimbursement for pediatric asthma services. Options include:
- Use of 1115 waivers and CHIP amendments, Medicaid "health homes," social impact financing, managed care contracts that promote community-based asthma interventions, and new payment and delivery system reforms
  - **Massachusetts** is currently piloting a Children's High-Risk Asthma Bundled Payment Demonstration Program which allows for home visits, care coordination by community health workers, supplies to reduce environmental triggers (like vacuums, air filters, bedding, and pillows), and pest management supplies and services.
  - **Arkansas** is also allowing for non-clinical services through its bundled payment and medical home initiatives

CMS Redefining Health-related Supplemental Benefits

February 1, 2018

- **Medicare Advantage (MA)** plans in **2019** can expand the health-related benefits they offer
  - "Allow supplemental benefits if they compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable emergency room utilization."
  - Nontraditional MA benefits permitted if they "increase health and improve quality of life."
- Moving beyond benefits that have a primary purpose of preventing, curing, or diminishing an illness
  - To services that increase health and improve quality of life (e.g., coverage of non-skilled in-home supports, portable wheelchair ramps and other assistive devices and modifications)
  - Benefits could include things that are not normally thought of as "health care," (e.g., groceries, air conditioners for beneficiaries with asthma, provider organized Lyft and Uber rides to and from and medical appointments)

June 29, 2018

- National Alliance to Impact Social Determinants (NASDOH) advocates: Will CMS be willing to discuss expansion to traditional Medicare?

Supporting Social Impact Partnerships to Pay for Results

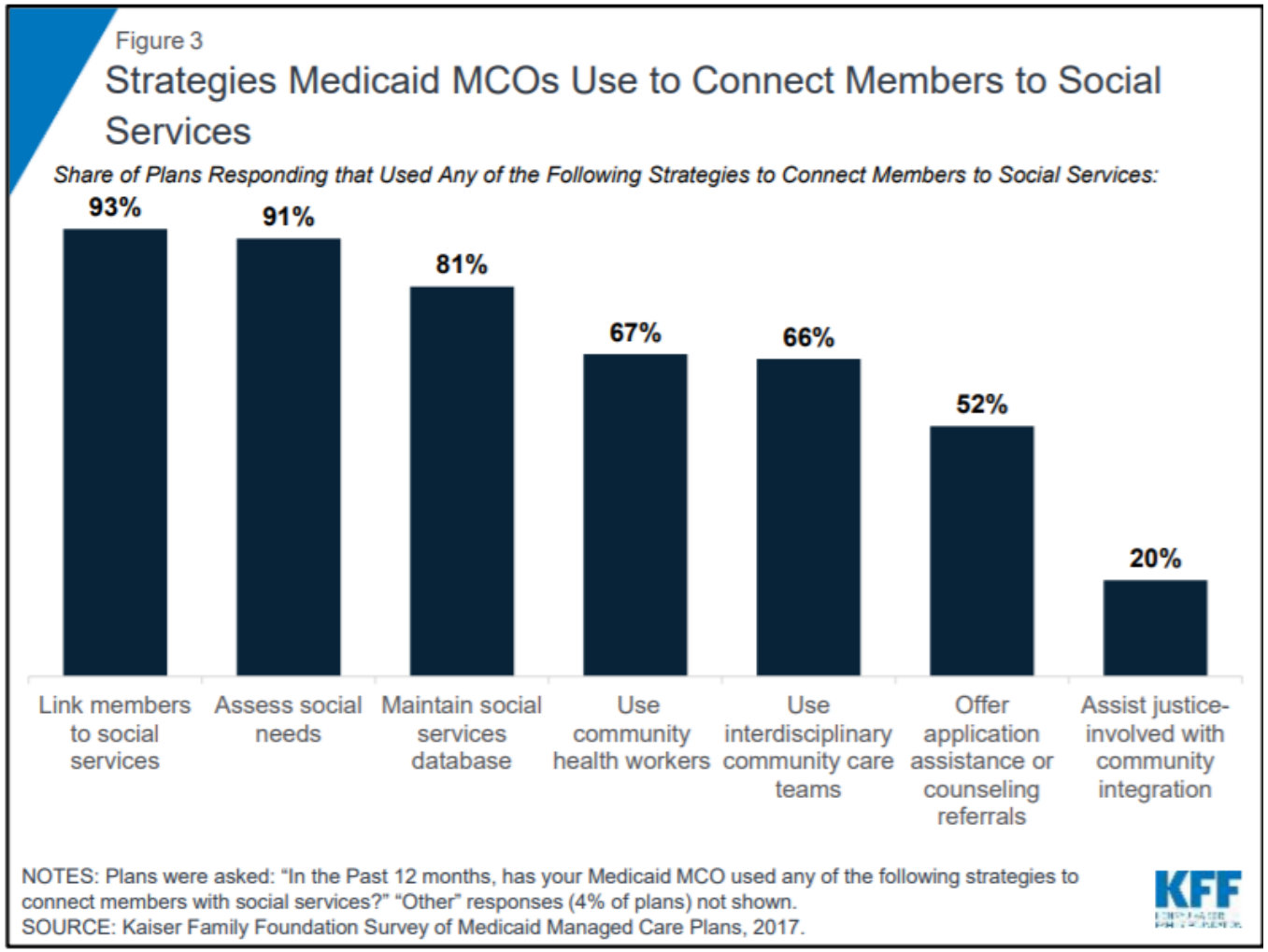
BiPartisan Budget Act of 2018, signed into law **Feb 9, 2018**, included Title VIII

- Bringing pay-for-performance to the social sector by establishing social impact partnerships
- Projects must demonstrate one or more of defined outcomes, e.g.
  - Reducing rate of preventable diseases ((asthma, diabetes) among low income families
  - Reducing rate of homelessness
  - Improved health and well being of those with mental, emotional, and behavioral health needs
  - Improved employment and well-being for returning US military members
- Governance and Process
  - Secretary of Treasury will publish RFP; awards to selected states and local governments within 6 months
  - Federal Intra-Agency Council (11 members)
  - Commission on Social Impact Partnerships (9 members)
  - **$100 million appropriated for 2018, made available through 2028**

Medicaid Managed Care Organizations (MCO) Stepping Up

Kaiser Family Foundation's 50 state Medicaid budget survey (2017)

- Growing number of states are requiring Medicaid MCOs to address social determinants of health as part of their contractual agreements
- 19 states require MCOs to screen beneficiaries for social needs and/or provide enrollees with referrals to social services
- 6 states require MCOs to provide care coordination services to enrollees moving out of incarceration; additional states planning for 2018
- Housing instability and nutrition/food security are top areas of focus



https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/ **May10, 2018**

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MassHealth 1115 Waiver Program

17 full-risk Medicaid ACOs were launched in January

- Massachusetts became the first state to pay more for members at higher social risk by incorporating indicators of unstable housing and neighborhood stress into its capitated payment model.
- MassHealth created a novel Community Partners program to help the ACOs coordinate services for the most complex members, which are often related to social determinants, through community-based organizations outside of the health systems.
- Pressure to produce savings within one year under these contracts keeps health systems and entrepreneurs focused on interventions that will yield results within a few months, rather than on strategies and investments that take longer to demonstrate ROI.

Policy Watch: Reduction in Resources for SDOH?

CMS has made **$157 million** in funding available to support 32 organizations attempting to bridge the gap between social and clinical services (ACH); CMMI State Innovation Models Initiative (SIM) has awarded over $**950M** to states to design and/or test innovation delivery and payment models.

CMS continues to increase penalties for re-admissions, expected to exceed ½ **billion dollars** in 2017, with new alignment to 21st Cures Act for 2018 methodology.

The Trump Administration is pursuing policies that may limit individuals' access to assistance programs to address health and other needs and reduce resources to address social determinants of health.

- Phasing out DSRIP programs
- Revising Medicaid managed care regulations; signaled reductions in funding for prevention and public health.
- Planning to change the direction of models under the CMMI
- Pursuing approaches to enforce and expand work requirements in public programs including Medicaid to "improve Medicaid enrollee health and well-being through incentivizing work and community engagement"

Kaiser Family Foundation "Beyond Healthcare: The role of Social Determinants in Promoting Health and Health Equity" , **May 10, 2018**

Key Issues

1. What are the policy drivers for investments and maturity of technology enabled infrastructure across healthcare provider, payer, public and community health?
2. How do we build out, and professionalize, and digitize, and integrate the social determinants as a partner to the health care system?
3. How do we achieve comparable shareable data that is person centric, longitudinal and actionable?

Business Driver: Radical Cost Escalation

Analyzing the Life Context of Healthcare Cost

Global healthcare and life science leaders face immense pressures to contain the unsustainable costs of care fueled by chronic disease, aging populations expensive drug therapies and complex unmet social needs.

- Identifying and addressing social determinants of health (SDoH) have long been the purview of government entitlement programs and public health practitioners.
- Traditionally, healthcare cost drivers for a defined population were tied to care access, utilization, administrative expenses and funding mechanisms.
- It's only recently that the broader healthcare ecosystem has awakened to the cost implications of these unmet social needs and the population health program value of community resource collaborations to address them.
- Research consensus indicates that SDoH and other external factors have significantly more influence on healthcare cost and outcomes than clinical interventions.
- Addressing these unmet needs requires an ecosystem of community partner collaborators.

What Prevents Widespread Collection & Use of SDOH Data?

1. **Lack of Knowledge and Consensus.** In the absence of standards or tools, and without knowledge about best practices, health systems, social services agencies, and community coalitions create home-grown initiatives. There is no systematic mechanism for sharing best practices, struggles, successes, or failures.
2. **Resource and Power Differences Between Social Services and Health Care Organizations**. While health care and social services systems share goals, they have different perspectives. Health systems need better understanding of their communities, and social service organizations need to be open to change.
3. **Lack of Effective Multi-Sector Collaboration**. These collaborations need to address not only who will collect data and how, but how it will be made available to health care providers; how they will act on collected data; and how they will link patients back to social service or other providers.
4. **Rigid Technology Systems**. The right technologies need to be identified and developed. Electronic health records may not be the right tool; cloud-based technology may work better. Either way, sharing data across sectors is a major challenge.

Robert Wood Johnson Foundation **(2016)**
Using Social Determinants of Health Data to Improve Health Care and Health: A Learning Report
https://www.rwjf.org/content/dam/farm/reports/reports/2016/rwjf428872

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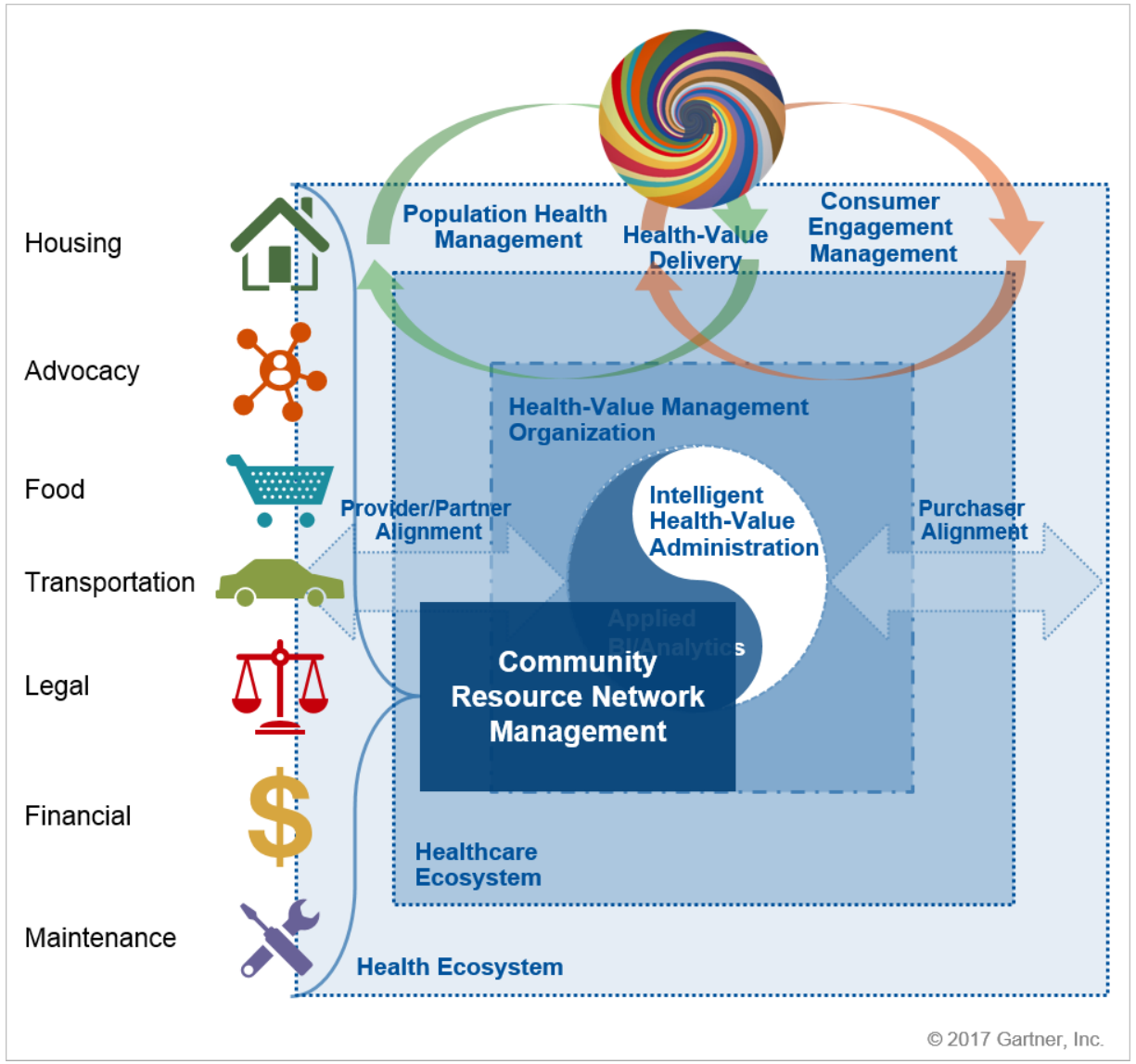
Community Resource Management Network

A New Enterprise Competency



Most regions lack reliable connections in technology and workflows that allow them to operate optimally as part of a network that supports health and well being – with providers, payers, social service and government agencies.

To reach those with highest needs and highest cost, policies must provide more flexibility to:

- Directly reimburse non-medical services,
- Use technology to coordinate care among medical and non-medical providers

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Critical Capabilities:
Community Resource Network Management

1. **Database of community resources** — A data asset, indexed for search, that contains a sufficient (ideally, comprehensive) listing of community resources, with key attributes such as location, hours and tax status, which is regularly updated for accuracy.
2. **Taxonomy of services** — An approach to categorizing the nonmedical services provided by community resources, with costs listed where applicable.
3. **Need-to-service matching** — Evidence-based recommendations of nonmedical, community services based on the profile of the individual and/or the unmet need.
4. **Real-time digital referrals and tracking** — The ability to refer an individual with an unmet need to a specific community resource for a specific service in a digital system that is accessible to all relevant parties.
5. **Real-time community resource capacity and scheduling** — The ability to display the availability of a community resource to provide a specific service.

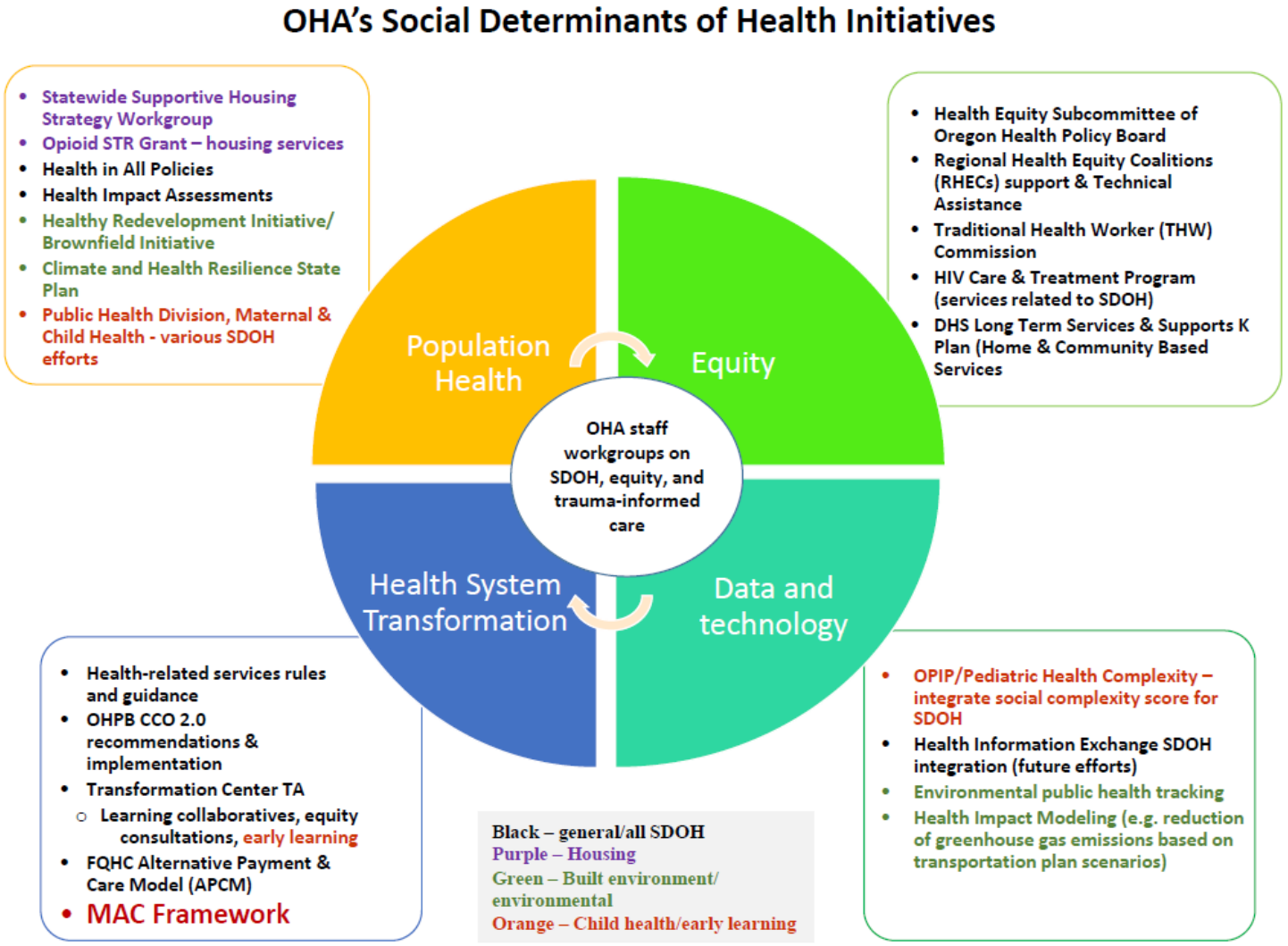
Critical Capabilities:
Community Resource Network Management

6. **Secure, bidirectional interoperability with adjacent workflow systems** — The ability to interoperate with the application in which the unmet need is identified (typically an EHR, care management workflow application or case management system) and the application that documents the service being provided to the individual by the community resource.
7. **Originator's access and workflow** — A web and/or mobile interface to the database, where a user can easily identify community resources and specific service offerings that address an identified need.
8. **Community resource access and workflow** — A web and/or mobile interface to the database, where a user affiliated with the community resource service provider can maintain organizational information, take referrals, report progress and make additional referrals.
9. **Individual access and workflow** — A web and/or mobile portal to a community resource service provider's information, personalized navigational assistance and appointment times, among other features.
10. **Reporting and analytics** — Used for timeliness, quality, satisfaction and outcomes.

States Continue to Collaborate Across Sectors

Oregon

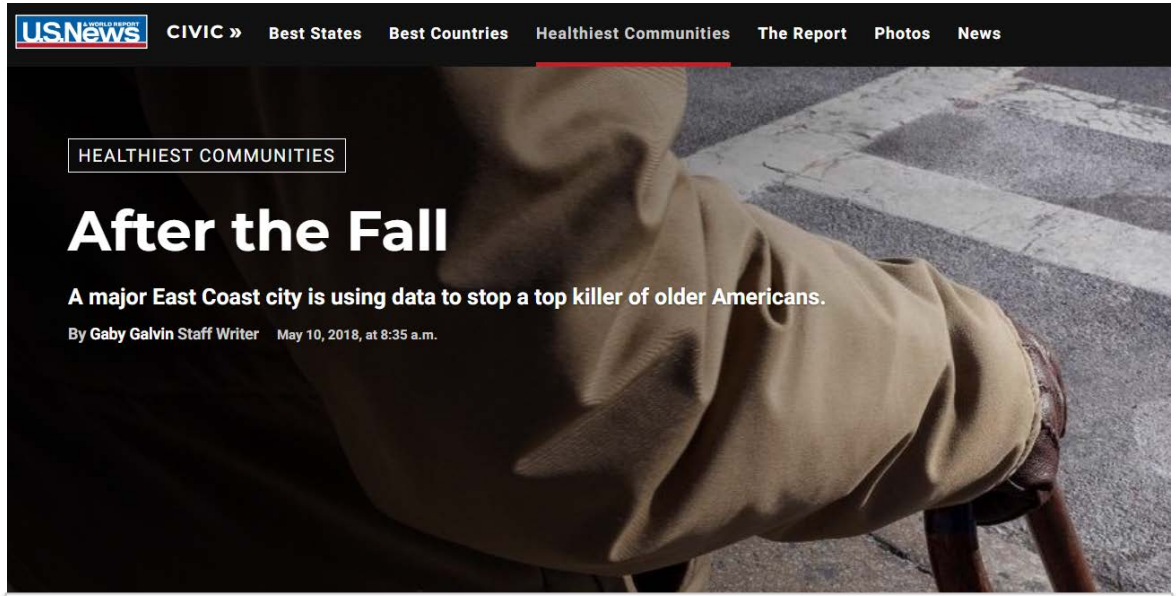
- Six hospitals and a Medicaid Health Plan in Portland will invest 21.6 million in new housing to help address the city's homeless population, and organize clinical and social services around housing
- The Oregon Health Authority leading statewide efforts to tackle SDOH through CCOs focusing on housing, the built environment, child health and early learning.



Utah Alliance for The Determinants of Health

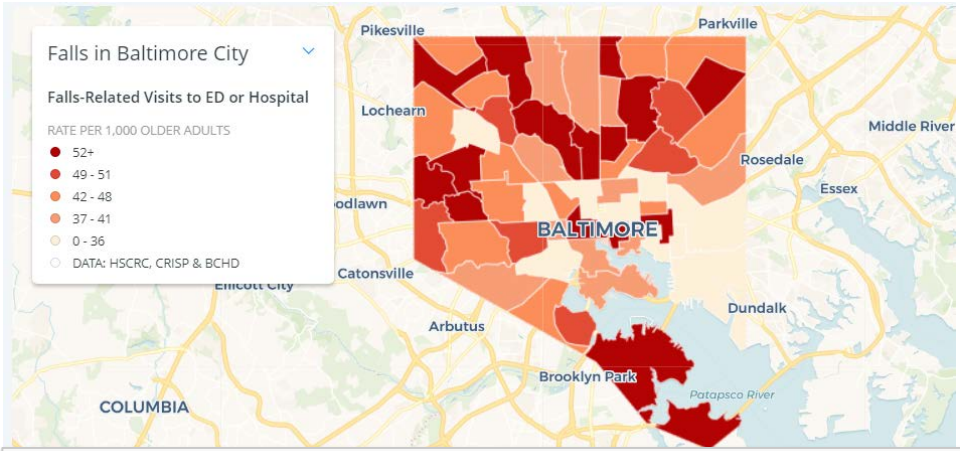
- Just announced June 27, 2018
- Focusing on the non-medical determinants, accounting for 60% of health outcomes
- Public and private sector collaboration involving city, county and state government agencies and community based organizations
- Intermountain will provide $12M in funding over next 3 years to support initial demonstrations, $2M annually in Ogden and St. George –in 4 zip codes

Communities Driving Pilots on the Built Environment



BALTIMORE IS BETTING ON data mapping to curb the leading cause of fatal injuries among older adults.

https://www.usnews.com/news/healthiest-communities/articles/2018-05-10/baltimore-seeks-to-curb-elderly-falls-with-data-initiative May 20, 2018



Baltimore City Health Department and CRISP

- By hot spotting falls, the health department has access to data on falls one week to one month after they happen (previously 18 months or longer)
- "We are not sharing (protected health information) with community partners," Mike Fried, chief information officer for the Baltimore City Health Department
- "We are not telling our friends who fell or where they fell. What we are doing is trying to guide the interventions that are happening."

Food is Medicine

Geisinger Health System Fresh Food Farmacy

How Geisinger Treats Diabetes by Giving Away Free, Healthy Food

Harvard Business Review, **DECEMBER 19, 2017**

https://diatribe.org/food-medicine-when-key-lower-a1c-access-healthy-food

April 6, 2018

Fresh Food Farmacy program LAUNCHED IN 2016

- identifies people who are food insecure and have type 2 diabetes with an A1c of greater than 8%
- 250 people - fresh, healthy food and nutrition education
- “Prescription” for healthy food -- enough food, menus, and recipes to prepare two meals a day for five days per week for themselves and their families
- Family of four -- 40 meals per week

Initial Results

A1c dropped by more than two percentage points: the average at the beginning of the program was 9.6%, which declined to 7.5% at the end of one year.

Other patients taking two diabetes medications are generally associated with a one-point drop in A1c levels.

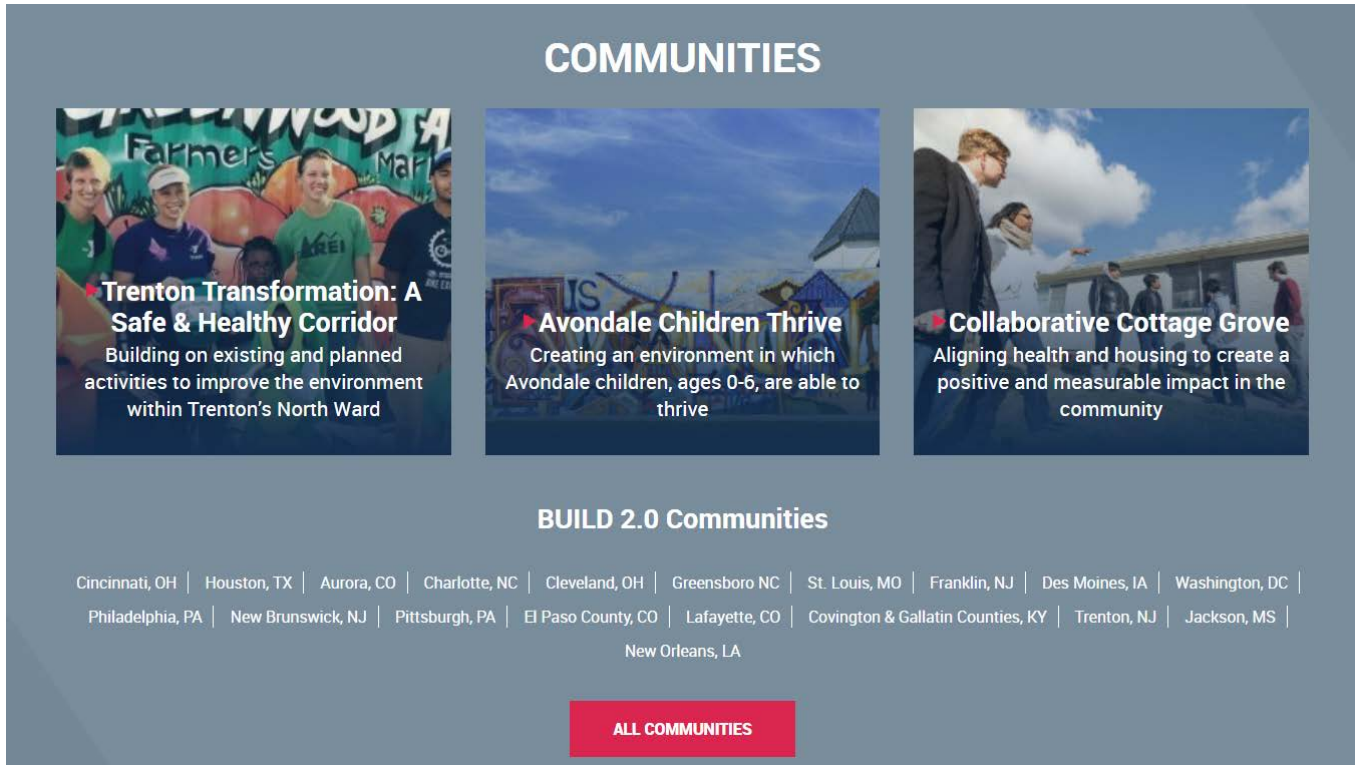
Investing in Housing: Build Health

What We Do

We strengthen partnerships—between community-based organizations, hospitals and health systems, and local health departments—with a shared commitment to moving resources, attention, and action upstream to reduce health disparities and create opportunities for improved community health.

The BUILD HEALTH Challenge

www.buildhealthchallenge.org



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Kaiser Permanente Investing $200 million in Housing

- Pledge: Up to $200 million over three years for programs to alleviate homelessness and expand access to affordable housing.
- Impact investment: “Residential developments that mix homeless services and market-rate housing.”
- in the markets where it operates already — eight states and Washington, D.C.

https://www.axios.com/kaiser-permanente-health-housing-54178933-bd6f-4702-9886-6f9d9302a4a5.html, May 22, 2012

Parkland and Dallas Community Demonstrating Results

https://www.politico.com/magazine/story/2017/12/18/parkland-dallas-frequent-flier-hospital-what-works-216108 December 18, 2017

- Parkland Center for Clinical Innovation (or PCCI)
- Partnering with hundreds of community-based social services around Dallas County
- On average hospital visits for some of the highest utilizers have been cut by two-thirds or more, saving an estimated $12 million.
- Less than two years after its launch, the PCCI portal contains 150,000-plus names and had been accessed nearly a million times by 98 community groups, including
  - The local community college, public school system, the city jail
  - The fire department (most of its calls are health care-related)
  - Goal to link 300 community groups by the end of 2018

"It would be so much cheaper to meet those needs outside the medical system than to pay for the consequences inside it."

Key Issues

1. What are the policy drivers for investments and maturity of technology enabled infrastructure across healthcare provider, payer, public and community health?
2. How do we build out, and professionalize, and digitize, and integrate the social determinants as a partner to the health care system?
3. How do we achieve comparable shareable data that is person centric, longitudinal and actionable – on local, community, regional and national scale?

Five Major Determinant Areas, Many Models & Frameworks

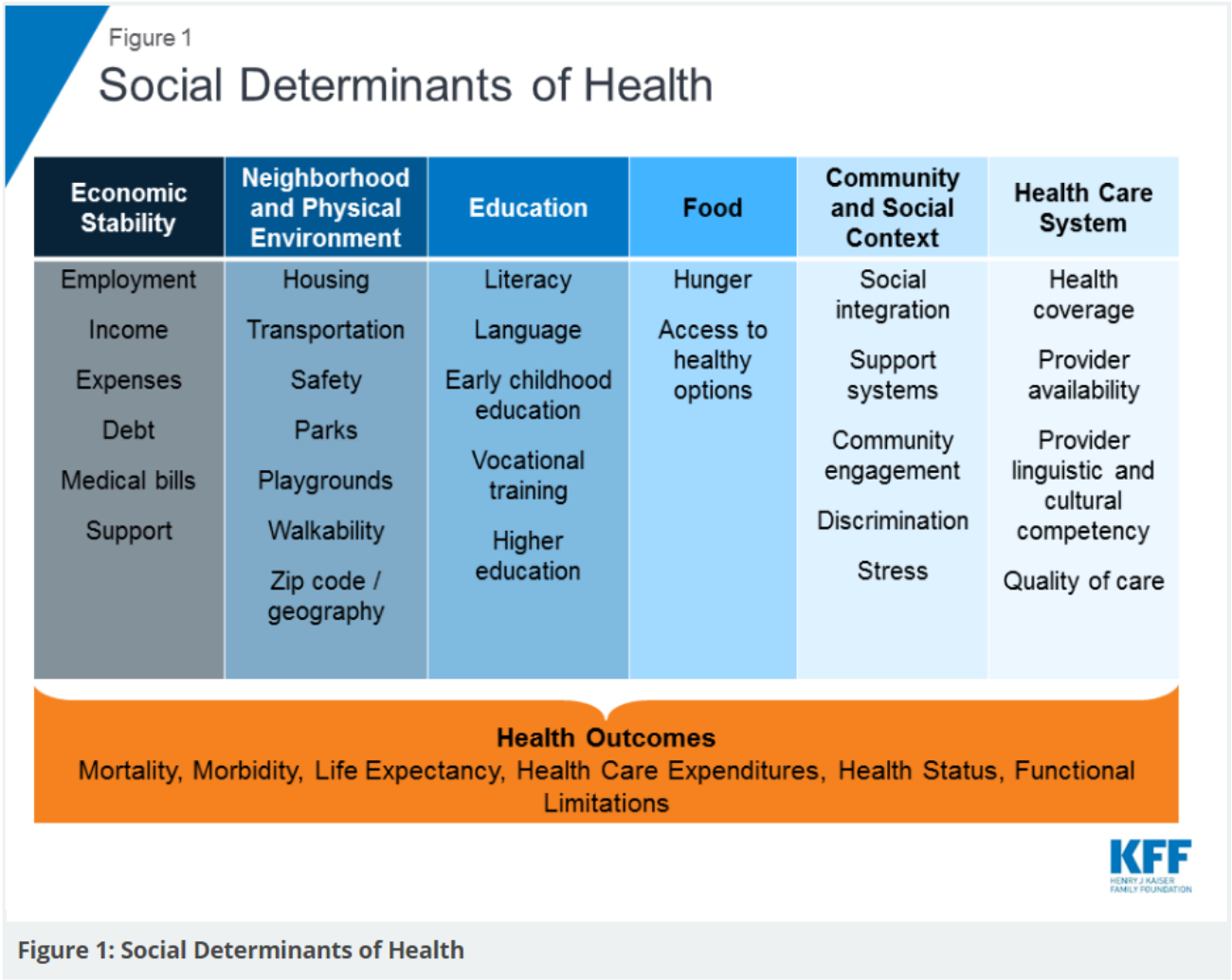
Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education		Stress	Quality of care
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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Figure 1: Social Determinants of Health

- Economic stability (poverty, employment, food security, housing stability);
- Education (high school graduation, enrollment in higher education, language and literacy);
- Social and community context (social cohesion, discrimination, incarceration);
- Health and health care (accessibility and health literacy); and
- Neighborhood and built environment (food deserts, quality of housing, safety) (source).
- http://www.who.int/social_determinants/en/

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Providers Adopting SDOH Tools for Targeted Populations

1. Deloitte Center for Health Solutions Survey (2017)

   N= 300 hospitals and health systems

   - 88% screen patients to gauge health-related social needs
   - 62% report screening targeted populations in systematic or consistent way

2. National Association for Community Health Centers PRAPARE tool

   - Tool mapped to UDS (HRSA reporting); ICD-10, IOM, Meaningful Use, CMMI ACH
   - Pilot results demonstrate patients (n= 2694) experience multiple SDOH risk factors (typically 4-7); positive correlation to hyperternsion
   - FREE EHR templates (eClinical Works, Epic, Next Gen, GE Centricity)
   - 750 health centers, hospitals, health systems, ACOs, health plans, and pop health vendors downloaded (as of January 2017)
   - Tool partially adopted by the CMMI Accountable Health Communities (n= 32 awardees)
     - Health Leads (non-profit, RWJF funded) developed social needs screening toolkit for providers; Borrowed 2 domains for its 5 domain risk screening tool

UCSF Siren Finds Immaturity in Adoption

SDH Codes Review

- NAM
- AHC
- PRAPARE
- Health Leads
- SEEK
- WE CARE

20 SDH Domains

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SDH Codes Review

ICD-10 TENTH REVISION INTERNATIONAL CLASSIFICATION OF DISEASES

LOINC®

SNOMED CT

cpt

Low use of Codes

Among 35.6 million discharges from inpatient care in 2013: 1.6% overall were assigned any ICD-9 social V Code

(Source: Torres JM, Lawlor J, Colvin JD, et al. ICD social codes: An underutilized resource for tracking social needs. Med Care. 2017)

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SDH Codes Review Results

133	Screening question panel codes
33	Screening procedure codes
686	Assessment/Diagnosis codes
243	Treatment/Intervention codes
1095	**SDH Codes**

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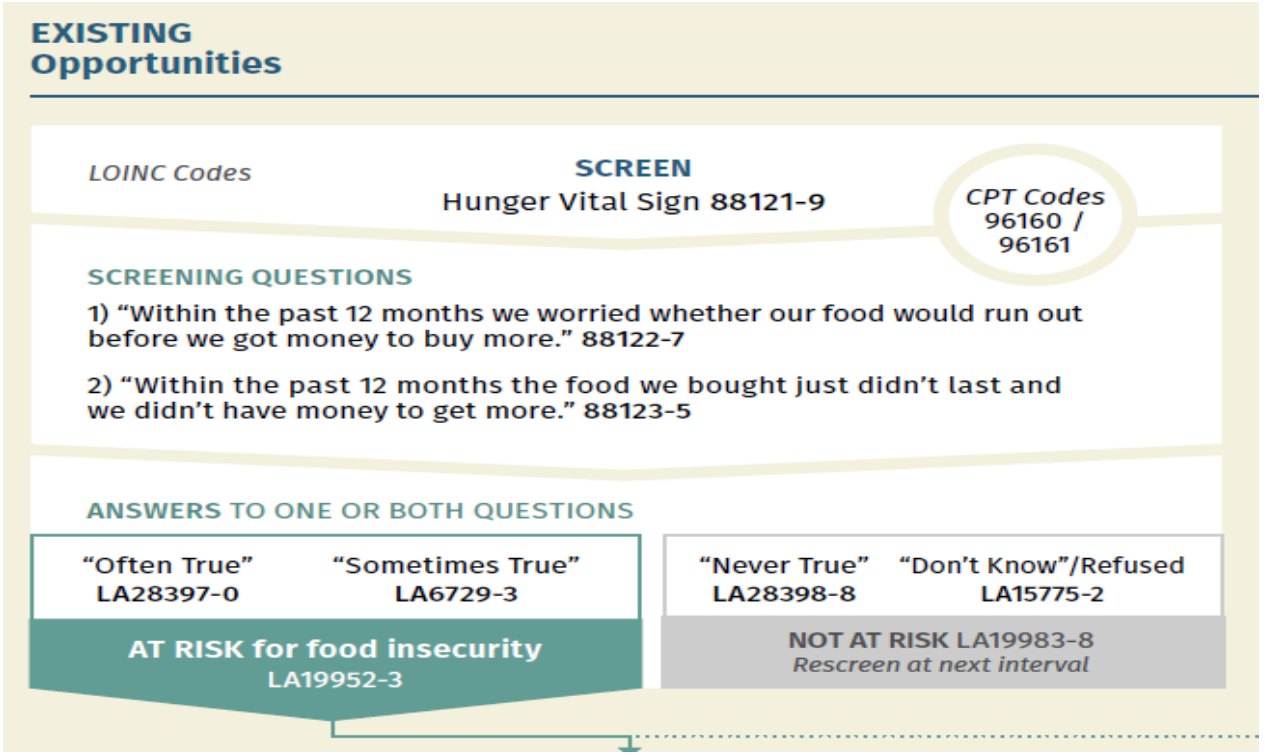
Integrating Data On Social Determinants Of Health Into Electronic Health Records

- As population health becomes more of a focus of health care, providers are realizing that data outside of traditional clinical findings can provide a broader perspective on potential drivers of a patient's health status and can identify approaches to improving the effectiveness of care.
- However, many challenges remain before data related to the social determinants of health, such as environmental conditions and education levels, are as readily accessible and actionable as medical data are.
- Key challenges are:
  - a lack of consensus on standards for capturing or representing social determinants of health in electronic health records
  - insufficient evidence that once information on them has been collected, social determinants can be effectively addressed through referrals or other action tools.
- To address these challenges and effectively use social determinants in health care settings, we recommend creating national standards for representing data related to social determinants of health in electronic health records, incentivizing the collection of the data through financial or quality measures, and expanding the body of research that measures the impact of acting on the information collected.

Michael N. Cantor and Lorna Thorp (April 2018). "Integrating Data On Social Determinants Of Health Into Electronic Health Records," Health Affairs, 37(4).

Nurse Lead Innovation: Hunger Vital Sign™



DeSilvey, S., Ashbrook, A., Sheward, R., Hartline-Grafton, H., Ettinger de Cuba, S., & Gottlieb, L. (2018). *An Overview of Food Insecurity Coding in Health Care Settings: Existing and Emerging Opportunities.* Boston, MA: Hunger Vital Sign™ National Community of Practice. Available at: http://childrenshealthwatch.org/foodinsecuritycoding/

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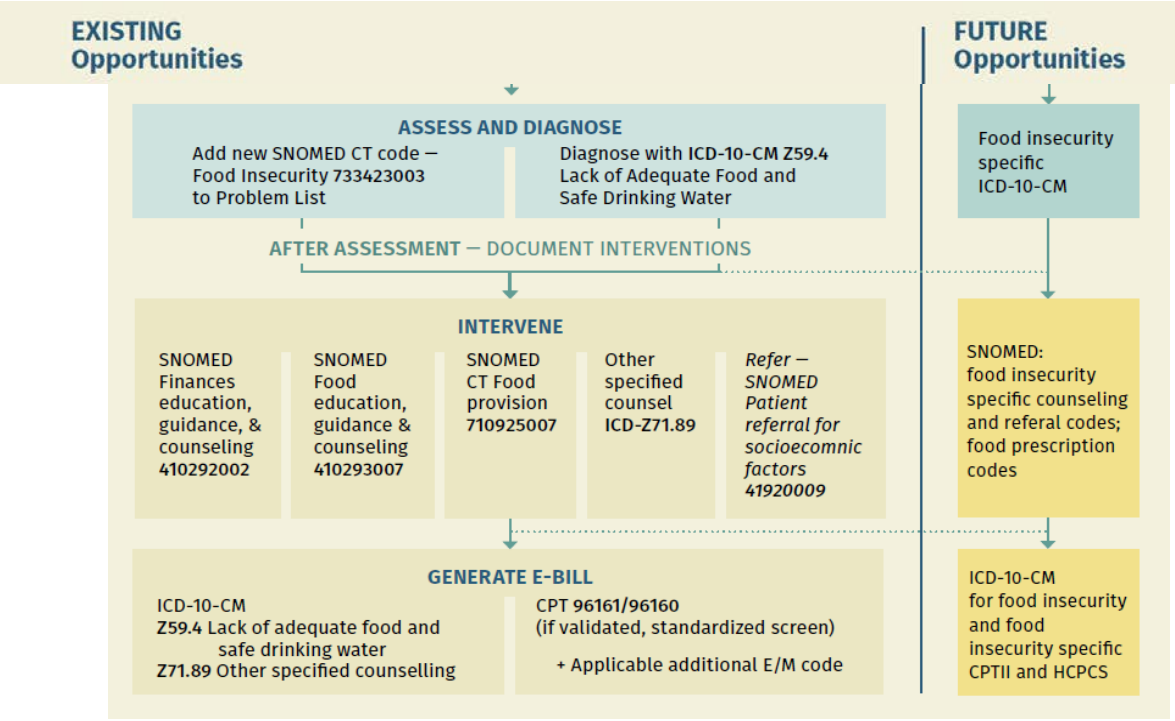
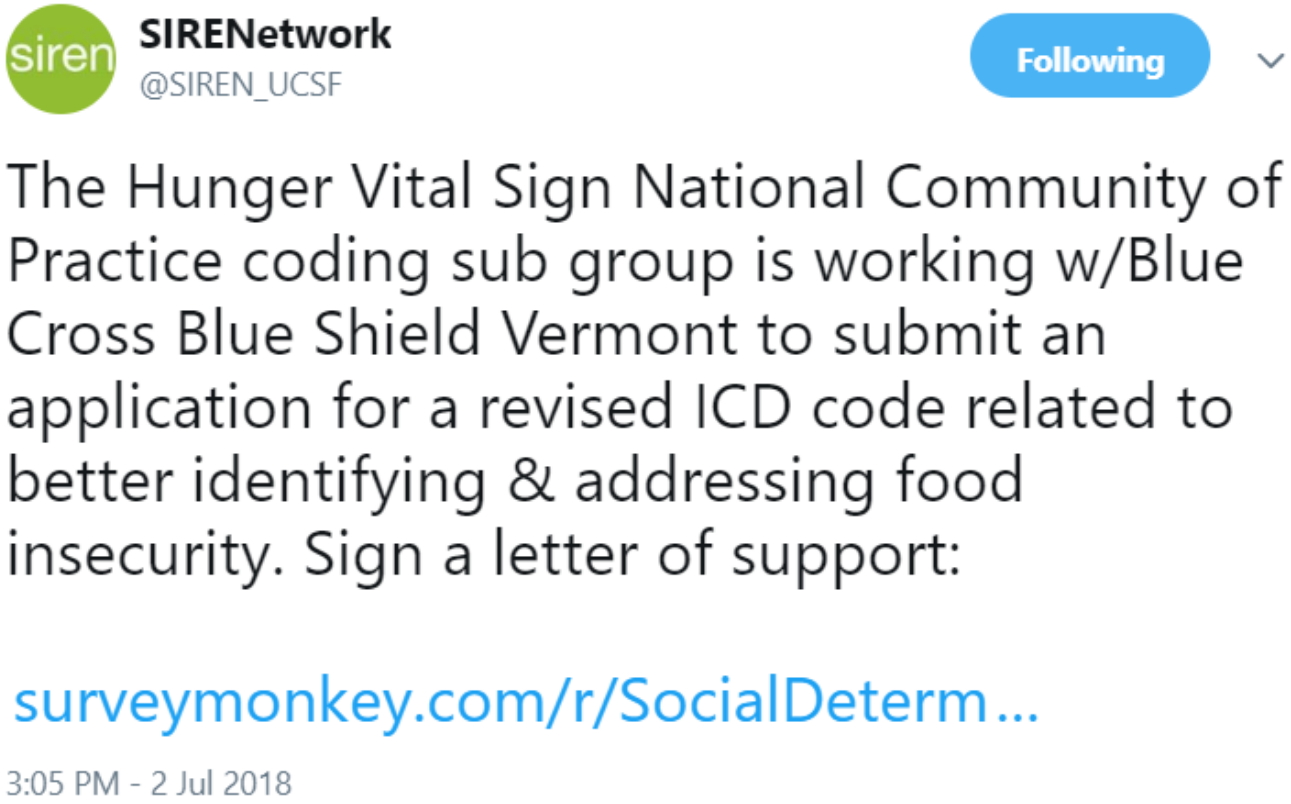
Assessment/Diagnosis, Intervention and Billing





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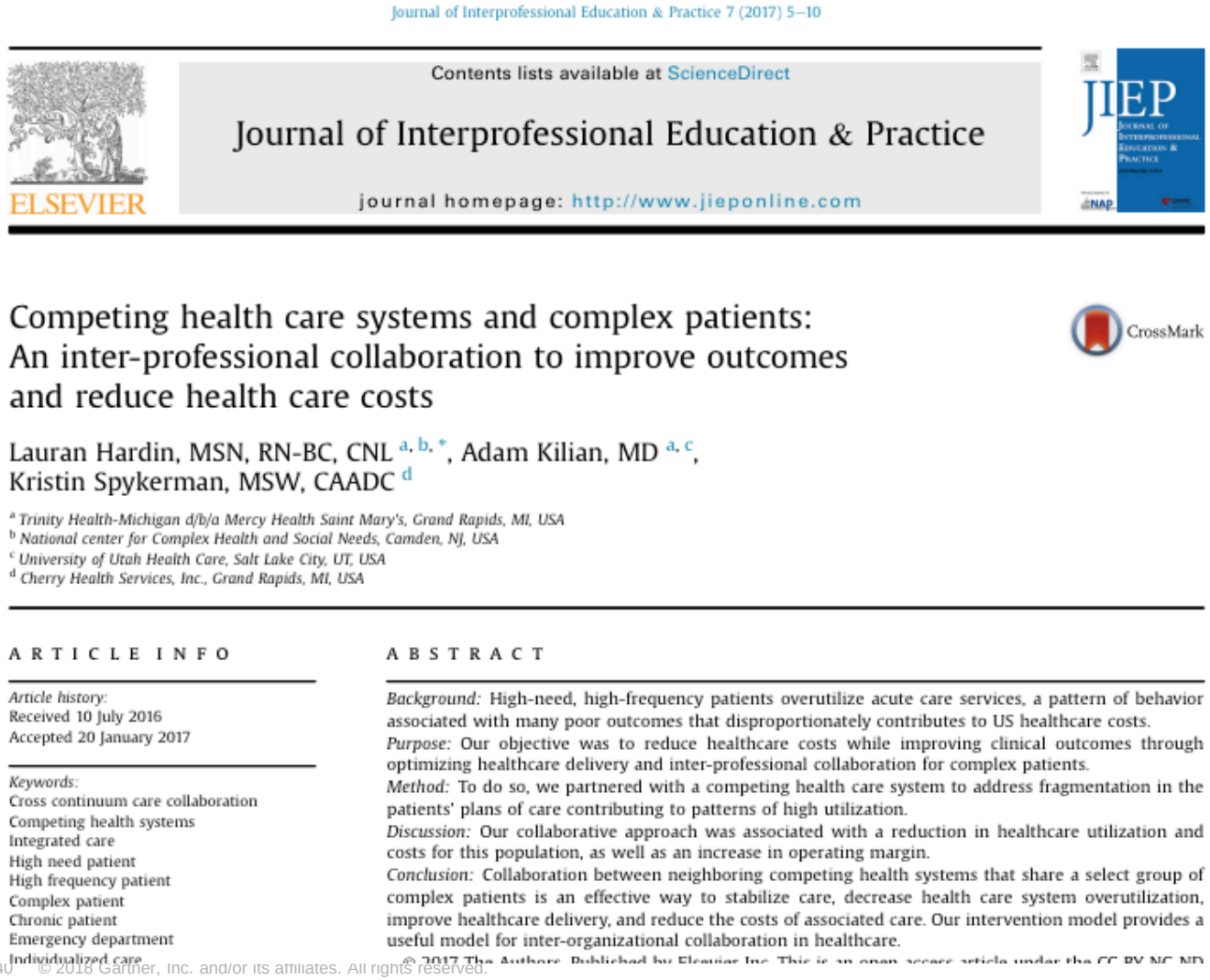
Nurse Lead Innovation: Complex Social and Health Care



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Competing health care systems and complex patients: An inter-professional collaboration to improve outcomes and reduce health care costs

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ABSTRACT

Background: High-need, high-frequency patients overutilize acute care services, a pattern of behavior associated with many poor outcomes that disproportionately contributes to US healthcare costs.
Purpose: Our objective was to reduce healthcare costs while improving clinical outcomes through optimizing healthcare delivery and inter-professional collaboration for complex patients.
Method: To do so, we partnered with a competing health care system to address fragmentation in the patients' plans of care contributing to patterns of high utilization.
Discussion: Our collaborative approach was associated with a reduction in healthcare utilization and costs for this population, as well as an increase in operating margin.
Conclusion: Collaboration between neighboring competing health systems that share a select group of complex patients is an effective way to stabilize care, decrease health care system overutilization, improve healthcare delivery, and reduce the costs of associated care. Our intervention model provides a useful model for inter-organizational collaboration in healthcare.

Shared Infrastructure for Cross-Continuum Collaboration

- Business Associates Agreement (BBA)
- Integrated patient consent forms for medical and behavioral health information sharing
- Shared Plans of Care
- Complex Care Map©

Call for Posters

Showcase your cutting-edge research at the State of the Science: A National Research Meeting on Medical & Social Care Integration

To complement presentations and panel discussions, poster sessions will enable participants to share and discuss their work. We welcome submissions related to **completed social and medical care integration research studies** across a range of settings and populations (unpublished data).

Deadline for abstract submission: July 31, 2018 at 5 P.M. Pacific Daylight Time

Click here to submit your poster abstract.

Recommendations and Top Actions

Monday Morning:

- *Choose a lens you are passionate about, and learn as much as you can about how your settings is leading work on social determinants.*
- *Initiate conversation and uncover the policy facilitators and barriers – as they relate to your role(s) in practice, education, research and technology innovation.*

Next 90 Days:

- *Get engaged in local and regional efforts to improve health, by focusing on the intersection of how we build out, and professionalize, and digitize, and integrate the social determinants as a partner to the health care system.*

Next 12 Months:

- *Find a nurse lead innovation, focused on new models of care and payment integrating social determinants that needs support to scale and spread.*
- *Partner bringing your nurse informatics support from the lens of practice, research, education, policy, technology innovation.*

Thank you

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