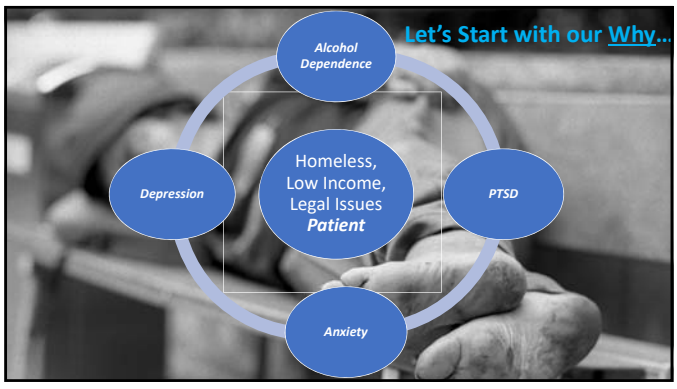
Uncovering the Value of Social Determinants of Health at Community Health Centers

Lucy Saenz, Assistant Director of Data Informatics
California Primary Care Association

Thursday, October 17 (3:00pm-4:30pm)



Current California Environment

342,422 individuals are **homeless**

30,974 patients have been identified with **substance use disorder**

304,750 individuals are considered **mental health** patients

3,857,524 patients identify as being at or below the **200% Federal Poverty Guideline**

2,948,742 patients identify as being at or below the **100% Federal Poverty Guideline**

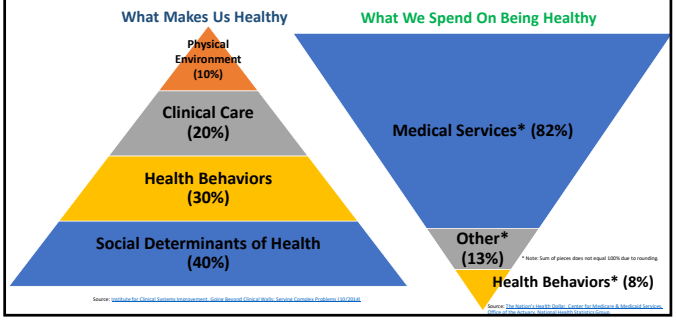
Source: *Health Resources and Services Administration; Uniform Data System (UDS); 2016 - 2018*

Intervention

- Behavioral Health Counseling
- Medication Management
- Referral to Housing, Medical Equipment and Furniture
- Referral to Legal Aid
- Referral to Sobriety Support Group

The Nation's Health Care Dollar, Where did it Go?

The Nation's Healthcare Dollar



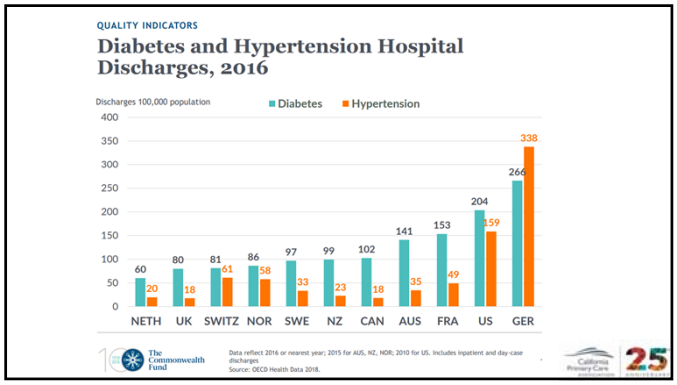
Source: Institute for Clinical Systems Improvement. Going Beyond Clinical Walls: Solving Complex Problems | 10/2018.

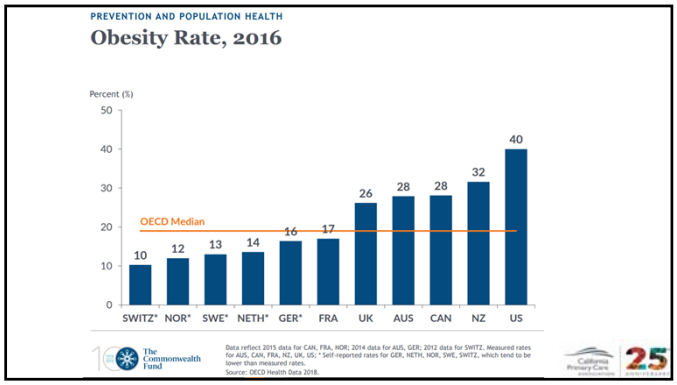
Source: The Nation's Health Dollar, Center for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

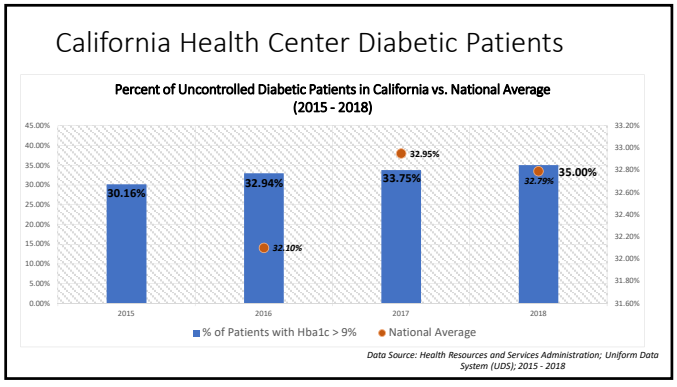
Sociodemographic characteristics for selected Organization for Economic Cooperation and Development (OECD) countries

	Life Expectancy (years)	Population older than age 65 (%	Poverty (%)	Unemployment (%)
Australia	82.5	14.9	13.9	6.2
Canada	81.9	16.1	13.7	7.0
Denmark	80.8	18.5	7.1	6.3
France	82.4	18.4	6.5	10.1
Germany	80.7	20.9	10.0	4.7
Japan	83.9	26.6	16.1	3.5
Netherlands	81.6	17.8	5.8	6.9
Sweden	82.3	19.5	9.3	7.6
Switzerland	83.0	17.7	8.9	4.9
United Kingdom	81.0	17.7	9.7	5.7
United States	**78.7**	**14.9**	**17.0**	**5.4**
OECD Mean	80.4	16.7	11.3	8.1

source Author's analysis of data from the following items: (1) For life expectancy, OECD.Stat, health status; (2) for population older than age 65, OECD.Stat, population and demography; (3) for gross domestic product (GDP), OECD.Stat, quarterly national accounts data; and Eurostat, (4) For poverty, Luxembourg Income Study, OECD.Stat, income distribution and poverty data; and Eurostat, (5) for unemployment, OECD.Stat, key short-term economic indicators. **extra** The data are from 2015


QUALITY INDICATORS
Diabetes and Hypertension Hospital Discharges, 2016
Discharges 100,000 population
Diabetes
Hypertension
400
350
300
250
200
150
100
50
0
60
20
80
18
81
61
86
58
97
33
99
23
102
18
141
35
153
49
204
159
266
338
NETH
UK
SWITZ
NOR
SWE
NZ
CAN
AUS
FRA
US
GER
The Commonwealth Fund
Data reflect 2016 or nearest year; 2015 for AUS, NZ, NOR; 2010 for US. Includes inpatient and day-case discharges
Source: OECD Health Data 2018.


PREVENTION AND POPULATION HEALTH
Obesity Rate, 2016
Percent (%)
50
40
30
20
10
0
OECD Median
10
12
13
14
16
17
26
28
28
32
40
SWITZ*
NOR*
SWE*
NETH*
GER*
FRA
UK
AUS
CAN
NZ
US
The Commonwealth Fund
Data reflect 2015 data for CAN, FRA, NOR; 2014 data for AUS, GER; 2012 data for SWITZ. Measured rates for AUS, CAN, FRA, NZ, UK, US; * Self-reported rates for GER, NETH, NOR, SWE, SWITZ, which tend to be lower than measured rates.
Source: OECD Health Data 2018.


California Health Center Diabetic Patients
Percent of Uncontrolled Diabetic Patients in California vs. National Average (2015 - 2018)
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
33.20%
33.00%
32.80%
32.60%
32.40%
32.20%
32.00%
31.80%
31.60%
30.16%
32.94%
32.10%
33.75%
32.95%
35.00%
32.79%
2015
2016
2017
2018
% of Patients with Hba1c > 9%
National Average
Data Source: Health Resources and Services Administration; Uniform Data System (UDS); 2015 - 2018

What are the SDOH?

Impact of Social Determinants of Health

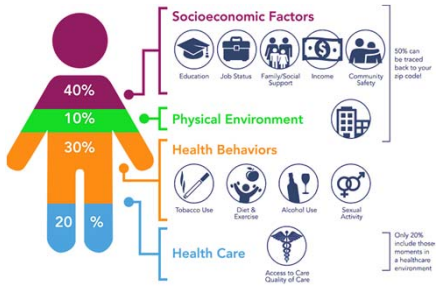


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Figure 1

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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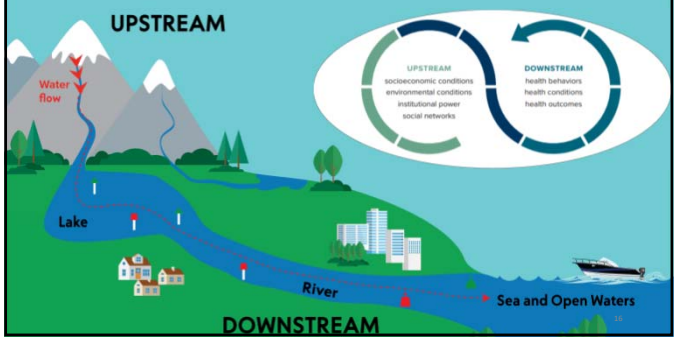
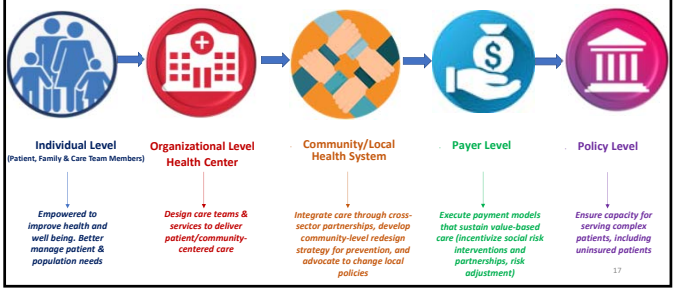
Why is it Important to Address the Social Determinants of Health?



Why Is It Important for Us to Collect Data on the Social Determinants of Health?



Business Case for your SDOH Work

- Quadruple Aim
  - Patient Experience
  - Better Health Outcomes / Population Health
  - Reducing Cost
  - Care Team Well Being
- Population Health
  - Data Integration
  - Risk Stratification
  - Measurement
  - Care Delivery System
  - Community Partnerships
  - Health Plan / Payers

California Primary Care Association 25 ANNIVERSARY

This is not New!

"The food you eat can be either the safest and most powerful form of medicine or the slowest form of poison."

~ Ann Wigmore

California Primary Care Association 25th Anniversary

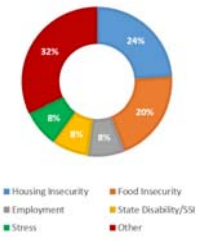
Data Integration and Analysis

SDOH Data Capture

- Integrated into the Electronic Health Record
- Standardized Screening Tool (PRAPARE, Health Leads, etc.)
- Workflow Development
- Reporting Capabilities
- Acting on Data

SDOH Focus for California Health Centers

TOP SOCIAL RISK NEEDS IDENTIFIED



*Other Category Includes: Income, Insurance, Literacy, Medical Care, Social Isolation, Transportation, Trauma Informed Care, Utilities/Clothing

Top 3 Needs Identified by CA Health Centers*

- Housing
- Food Insecurity
- Transportation

* Data Source: CPCA SDOH Learning Cohort Self Reported Data

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Where to Intervene – Food Security

Data Source; The Office of Statewide Health Planning and Development (**OSHPD**), 2017

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Where to Intervene – Transportation

Data Source; The Office of Statewide Health Planning and Development (**OSHPD**), 2017

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California Health Centers – Homeless Services, 2017

Data Source; The Office of Statewide Health Planning and Development (**OSHPD**), 2017

Where to Intervene – Transportation

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Reimbursement – Is there any?

L.A. Care Health Plan, Blue Shield Promise invest $146 million in community centers

MARIA CASTELLUCCI

Optima Health's Medicaid Addresses Food Security, Social Determinants

Payers roll out 2020 MA plans with increased focus on social determinants

Cigna, Humana Expand MA Plans to Cover Social Determinants of Health

Expanding coverage to address common social determinants of health demonstrates Cigna and Humana's commitment to tackling members' risk factors outside of traditional medical care.

By Emily Sokol, MPH

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Engaging Stakeholders and Partnership Development

Who needs to be engaged in your SDOH efforts?

- Clinic Leadership
- Community Partners and Leaders
- Staff
- Patients

Figure 13: Five Stage Stakeholder Engagement Framework
Redrawn from: Krick et al. (2005, 11)

Petaluma Health Center

Petaluma Health Center works to ensure access to high quality, prevention-focused health care for residents of Southern Sonoma County

The Homeless Picture Today

- There are 28,000 people in the Bay Area scattered in emergency shelters, temporary housing and on the streets making it the third-largest homeless population in the nation, behind New York City and Los Angeles.
- Nearly 70% of the nine- county region's homeless population is unsheltered — meaning they're living on the streets, in cars or tents — a number that's much higher than homeless in Washington, D.C., Boston and New York City.

We can improve health outcome comes together

- We can strengthen existing services for persons experiencing homelessness.
- Interventions can be used to bolster:
  - Financial feasibility of shelter based care
  - Strengthen shelter based coordinated care practices and services within the community
  - Grow the circle of care with collaboration .

Why Shelter Based Care?

- Meeting people where they are reduces barriers to care

Shelter Based Care

- FQHC Shelter Based Care is an opportunity to collaborate with shelter SDOH supportive systems.
- FQHC's improve access to care and establish the patient-provider relationships necessary for effective treatment

Sheltered clients

- Shelters have many clients with a variety of health care needs
- Infectious disease can spread rapidly
- Getting appointments with a PCP can be complicated
- Sometimes visits are just a Band-Aid or a question answered, hopefully

Individuals experiencing homelessness have high rates of acute and chronic illness

- Average life expectancy is 55 years and as low as 46 in some communities
- Emergency Departments are the primary care provider for many homeless people
- Shelter based clinics help to reduce ER use and offer preventative care.

Homelessness Is a Health Hazard

Petaluma Health Center

- Homelessness or unstable housing is a significant SDOH.
- Homeless patients may be predisposed to worse health outcomes due to:
  - Childhood and/or Adult trauma (ACE's)
  - Poor living conditions no running water or toilets
  - Excessive hot or cold weather
  - Food insecurity
  - Limited access to care

Path to Homelessness

- Sonoma County as an extremely tight housing market, which tends to squeeze out individuals with the greatest personal problems and the weakest support systems.
- Street homelessness often follows an eviction and temporary stays with relatives or friends.
- People with chronic health problems are particularly vulnerable to following this path into homelessness, especially if addictions or mental illnesses impair their

Mary Isaak Homeless Shelter Clinic

- Committee on the Shelterless (COTS) located at the Mary Isaak Center, provides a wide range of services that prevent and break the cycle of homelessness, for single adults.
- Petaluma Health Center and COTS have teamed up to better serve those in our

How do we do it ?

We do it together

Interdisciplinary teams –working together

- Interdisciplinary care is an effective solution for complex needs
- Teams work jointly from a variety of discipline specific theories, concepts and approaches:
  - We make plans of care together.
  - Patient's experience a continuum of care.
  - Team care brings stability to the patient.

Who is on our team?

Our shelter medical team includes

Medical provider –Exams, meds, counseling, case management, coordinates with shelter staff

Medical Assistant- insurance, intake , appointments.

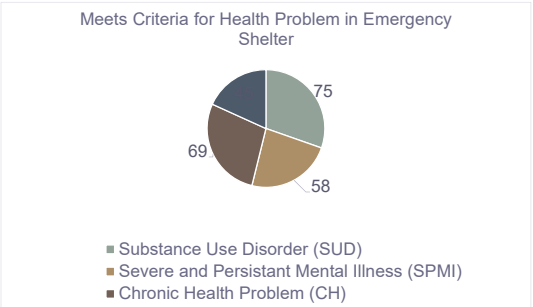
Navigator –transportation, specialty appointments, coordination with shelter staff

Who is on the shelter staff team?

- Disability Assistance
- Employment assistance
- Housing Case managers
- Housing specialists
- Healthy meal planners
- LCSW
- Street Outreach
- Substance abuse counseling
- Shelter bed manager

Shelter clients served 7/18-7/19

- 297 Clients sheltered at the Mary Isaak center
- 226 seen in our shelter clinic
- 79% or 178 identify their PCP at Petaluma Health Center
- 18% or 41 identify their PCP with another FQHC



Sober support and ED /Hospital Avoidance

- The Petaluma "Sober Circle" Community Collaborative project supports homeless struggling with addiction find help for recovery.
- .

Sober Circle

- This Petaluma pilot project builds on local efforts to connect homeless struggling with mental health and chronic intoxication.
- We partner with local services designed to help them get on and *stay on* a path to sobriety and good health.

Sober Support outreach program

- Our Sober Circle partnership includes:
  - Connecting clients to a medical home
  - Transportation to a safe in-patient detox
  - 30-90 day inpatient treatment

Cost savings with collaboration outreach

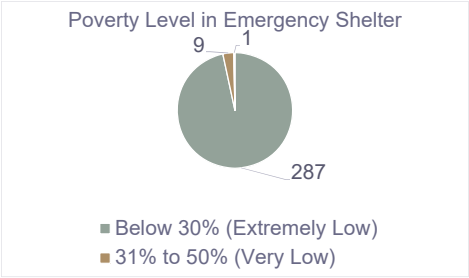
Innovative ways to engage our homeless community through outreach and engagement is a win for every one.

Clients …..Clinics.. ….Hospitals
EMS….. Law enforcement….. Community

Estimate of Cost Savings	Average per person	Total
Visits Pre	5.39	221.04
Visits Post	2.89	118.61
Visits Avoided	**2.50**	**102.43**
% Reduction in ED Visits	**46%**	**46%**
Average Cost of ED Visit*	$ 4,379	$ 4,379
Estimated Financial Impact of ED Visits	$ 23,608	$ 967,936
Estimated Savings from Reduced ED Visits	**$ 10,940**	**$ 448,525**

Poverty

- "Poverty is widely recognized as a major determinant of poor health, and this link has been extensively studied and verified.
- Despite the strong evidentiary link, little work has been done to determine what primary care health providers can do to address their patients' income as a risk to their health".



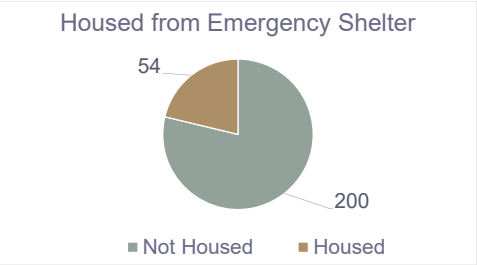
Housing

- Social Determinants of Health:
- Better Housing Linked to Healthier, Longer Lives

Recovery and healing are more difficult without housing

Stable housing provides:

- Privacy and safety
- A place to rest and recuperate from surgery, illness, and other ailments.
- A safe place to store medicine, clothing and supplies
- Decreases the worry about where to sleep or find a meal the following day.
- Opportunities for connection with health care and social services.



What you need to start a shelter based clinic?

- A shelter and community that is interested in collaboration and health care access
- Check with your agency on the requirements for a new access point, may require a change in scope.
- A site with potential exam room and storage
- Budget- Staffing and supplies
- Convenient hours for clients
- What services are to be provided (Start small)
- MOU's and procedures on how you will collaborate with

How do you keep persons, systems, and communities engaged in care?

Identify the impact homeless programs have on communities.

Run the data – one life saved is a success!

Frequent communication with immediate feedback and problem solving when problems arise.

Explain the barriers as they come up . Offer s

Invite success stories, our clients are skilled a

engagement and resilience.

Acknowledgments:

Petaluma Health Center UDS data and homeless tracking data.

COTS –Committee on the Shelterless, Mary Isaak Shelter

https://cots.org

St. Joseph Health Hospital System

Petaluma Health Care District

MCO- Partnership Health Plan

Sonoma County Task Force for the Homeless

Resources

- National Health Care for the Homeless Council
- https://www.nhchc.org/ A wide variety of studies and tools
- HUD
- https://www.hudexchange.info/housing-and-**homeless**-assistance/
- SAMHSA
- https://www.samhsa.gov/**homelessness**-programs-**resources**
- Sonoma County Coordinated Entry System (CES)

CONTACT INFORMATION

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