

# Successfully Incorporating Social Determinants

Ideas for integrating service delivery to address environmental factors affecting health



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Our previous white paper on social determinants of health (“Advancing Integrated Service Delivery,” available [online](#)) discussed the idea that health is more than someone's disease state. Socioeconomic factors including housing, nutrition, mental illness, community environment, lifestyle and employment status can affect a person's health as well as their ability to access the care needed to improve it.

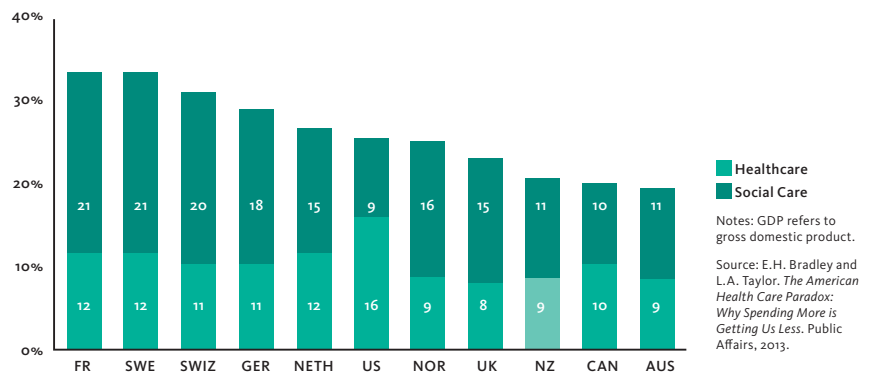
Addressing all the issues affecting an individual's health requires adopting a holistic picture of their needs and developing an integrated method for delivering the services they require. It takes organizing agencies to deliver integrated services, analyzing outcomes and continually improving management and delivery processes. And the effort can help states, counties and cities deliver better outcomes for citizens while controlling expenditures across programs.

This expanded view of individuals should be combined with a high-level view of the issues facing the groups in which individuals reside. These groups are communities, cities, states, ethnic or socioeconomic groups; they can even be users of a hospital, managed care organization or other healthcare delivery systems. Because our health is affected by the environment in which we reside, it is important to understand and improve the home and community environments.

Integrated service delivery – supported by an approach to healthcare that understands population health and addresses its needs – will further ensure that healthcare resources can promote better outcomes and reduces costs and health disparities over time. It's important to remember that population health is more than the overall health of a population; it also includes the distribution of health.<sup>1</sup> In an ideal delivery system, differences within the group are substantially eliminated or reduced. This moves the group as a whole toward improved health outcomes.

Assessments of healthcare delivery and outcomes in the United States reveal many opportunities for improvement. Pricing and per capita healthcare costs for health services are generally higher than in other industrialized nations. Yet we “devote a relatively small share of [our] economy to social services, such as housing assistance, employment programs, disability benefits and food security.”<sup>2</sup> At the same time, measures such as life expectancy and chronic disease levels in the US are some of the worst among developed nations. (For more information, see the accompanying chart.)

### Health and Social Care Spending as a Percentage of GDP



ACA funding has the potential to improve population health through initiatives such as Community Transformation Grants (community-level efforts to prevent chronic disease) and workplace wellness program incentives.



However, conditions have improved recently. A Commonwealth Fund issue brief<sup>3</sup> states that Federal and state policy environments appear favorable for integrating health and social services for many reasons. For one, there is the expansion of Medicaid (as of December 2015, 31 states and the District of Columbia have expanded, four states are discussing it and 16 have declined). There is also the Affordable Care Act's (ACA) focus on delivery and payment reform supported by the Center for Medicare and Medicaid Innovation within CMS; the Center's efforts often focus on coordinated, patient-centered care. Finally, more providers want to address patients' unmet social needs. Their support will continue to grow as providers bear more responsibility for health outcomes and financial results. This environment has provided a foundation for continued service integration.

The ACA also established the National Prevention, Health Promotion and Public Health Council and the Prevention and Public Health Fund. These groups help prioritize population-wide health concerns for healthcare programs across the country, including tobacco-free living, drug abuse prevention, healthy eating, active living, injury and violence-free living, reproductive and sexual health and mental and emotional well-being.<sup>4</sup>

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## State Examples in Action

Although seemingly a daunting task, integrated service delivery that addresses social determinants and population health is possible – and already being done successfully by multiple organizations.

### The State of California

California's Frequent Users of Health Services Initiative "promotes the development and implementation of innovative, integrated approaches to addressing the comprehensive health and social service needs of frequent users of emergency departments (EDs)."<sup>6</sup> The Initiative funds a program office within the Corporation for Supportive Housing along with six programs. 45 percent of the enrolled frequent users were homeless; more than a third were placed in permanent housing and 54 percent were placed in shelters, board and care homes or similar placements.

To improve nutrition and prevent obesity, Floyd County, Indiana, launched a project that encouraged eating home-grown fruits and vegetables.



The programs concentrated on connecting the participants to housing and understanding the impact of this connection for homeless clients and ED and inpatient outcomes. According to the Final Evaluation Report, “clients connected to permanent housing showed greater reductions in both ED use and charges compared to those who remained homeless or in less stable housing arrangements” (34 percent vs. 12 percent reduction in ED visits and 32 percent vs. 2 percent reduction in ED charges). Positive results in the number of inpatient days and charges were also reported.

### **Floyd Memorial Hospital**

Floyd County, Indiana (population 75,000) has low levels of poverty as compared with the rest of the U.S. However, it ranks 83rd out of 92 Indiana counties in tobacco use and has significant areas for improvement in all areas of lung health. Additionally, obesity rates are high (30 percent of the population are obese; 60 percent are overweight or obese). These issues have contributed to a high incidence of heart disease and high healthcare costs.<sup>7</sup>

To fight the problem, Floyd Memorial Hospital and Health Services focused on heart disease, obesity and cancer (lung, colon, breast). They implemented three community coalitions (Physical Activity, Nutrition, Tobacco) to tackle each priority. Over two years, the hospital’s community benefit platform has undergone a huge shift to align with these priorities. It completed a community health needs assessment, an action plan, focused priority areas and launched three engaged community coalitions (Physical Activity, Improving Nutrition and Tobacco Prevention and Cessation) and a grant-giving program.

The Floyd Memorial team reported several achievements, including funding mini-grants for physical activity programs, staging Fitness Days, a project that encouraged eating home-grown fruits and vegetables and creating an online student health magazine.

### **Conduent Client**

Conduent has adopted a care management model that empowers members based on social and environmental factors in assessments and care plans. We assess not only the person’s physical or mental symptoms and problems, but also their surrounding family, healthcare, community and social support structure. The person’s perceived gap of available resources and existing personal and support strengths form the basis for health improvement opportunities and collaborative care plans.

For example, one of our state clients’ program members was identified as a high user of emergency room (ER) services. The member often experienced chest pain that resulted in his caregivers taking him to the ER. Upon assessment, a care manager found that he lived with an overwhelming fear about his heart problem. He had a pacemaker to manage his condition as well as unique needs resulting from developmental challenges and living with limited access to specialist medical care. He did not understand the regulatory function of his pacemaker nor did he know how to manage his concerns and healthcare needs.

While the member lived in a suburban area with some access to care, his family lived in a rural area with very limited access to healthcare resources. As the member's condition worsened, the family no longer felt comfortable inviting him to their home for visits as they could not take him to an ER quickly. The feeling of isolation and lack of family support compounded the member's fear, escalating his number of ER visits.

The assessment of these factors and medical needs resulted in a care plan that involved the member's developmental disabilities case manager, his providers, direct caregivers, family, cardiologist and additional community supports. The collaborative care plan and health literacy education provided to the member, caregivers and family helped resolve the social and physical issues surrounding the member's care. The member did not have any ER visits during the next six months. He commented that he is much more comfortable, less fearful and is now able to visit his family more often.

## **How to Get Started**

To be the most effective, healthcare programs must account for the health of the patient, their family and support group, their social needs and their community. It's only then that programs can put the resources in place appropriately (both individually and at a community/group level) to achieve optimal individual and population health outcomes.

There is a long list of issues to address and programs may need to evolve in stages over time. But there are some initial steps that can be taken to begin addressing the social determinants of health:

- Determine how your state, county or city is currently organized and what structure or structural changes are needed to foster collaboration across programs/agencies
- Detail current internal and external funding streams and determine what changes need to be addressed
- Determine what programs and services should be addressed and prioritize their staging
- Develop Inter-agency agreements needed to foster integrated service delivery
- Determine how client cases would be managed across programs
- Address security and privacy issues
- Address workforce staffing and training issues and education of program members

Conduent can help you think through and plan strategies to help you incorporate population health management, integrated service delivery and social determinants of health into your program. Email [govhealthcare@conduent.com](mailto:govhealthcare@conduent.com) for more information.

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