Mastering Social Determinants of Health: Comprehensive Case Management

- Economic Stability
- Neighborhood & Built Environment
- Health & Health Care
- Education
- Social & Community Context

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Learning Objectives

• Define the Social Determinants of Health (SDH)
• Discuss the socio-political drivers to impact the progression of SDH
• Name and apply the steps of the Comprehensive Case Management Path© (CCMP)
• Apply the CCMP to attendee practice settings
Disclosure & Disclaimer

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What Are We Talking About?

- Prevailing theories
- Industry evidence
- Socio-political drivers
- Ethical impact
- Practical Realities
What Are We Talking About?

Social Determinants of Health (SDH):

• the conditions in which people are born, grow, live, work and age.

• shaped by the distribution of money, power, and other societal resources at global, national and local levels (World Health Organization, 2016a)
Five Categories of the Social Determinants of Health (Health Affairs and Robert Wood Johnson Foundation, 2014)

- Genetics
- Behavior
- Social Circumstances
- Environmental & Physical Influences
- Medical Care
Who Are We Talking About?

• You are the case manager for Jake, a 58 year old man who resides in a private house with his wife in Rockford, Illinois. The house has been in his family for 5 generations. The once thriving middle class community has been infiltrated by unemployment, and poverty.
• Most of Jake’s neighbors live below the poverty level, roughly $25,100 for a family of 4.
• Jake has had recurrent hospitalizations for emphysema and congestive heart failure. Dr. House, Jake’s hospitalist thinks Jake is not taking consistently taking his Lasix. Jake, tells the case manager, ‘Dr. House doesn’t need to worry about me. I may not do a lot of things I’m supposed to, but I always take those pills’. Dr. House orders home nursing at the case manager’s insistence.
• Your thoughts ??
Who Are We Talking About?

Overall Rankings in Health Outcomes

RANK 1 - 17 18 - 34 35 - 50 51 - 67 NOT RANKED (NR)

County Health Rankings, 2017
Who Are We Talking About?

Overall Rankings in Health Factors

County Health Rankings, 2017

RANK 1 - 17  18 - 34  35 - 50  51 - 67  NOT RANKED (NR)
Foundational perspectives of Social Determinants of Health
(Solar and Irwin, 2010)

Social selection
- Health determines socioeconomic position

Social causation
- Psychosocial factors and/or stressors: (e.g. living circumstances, social support, poverty, health literacy)
- Behavioral factors: (e.g. smoking, diet, substance use, adherence to physical and/or behavioral health treatment)
- The health system itself (e.g. access to care, program and service options)

Life course
- Recognizes how SDHs operate at each level of human development (e.g. infancy, early childhood, childhood, adolescence, adulthood), and
- How SDHs provide the basis for health or illness later in life
Erikson’s Psychosocial Stages (Ashford, LeCroy, Williams, 2018)

- Trust vs. Mistrust
- Autonomy vs. Shame/Doubt
- Initiative vs. guilt
- Industry vs. inferiority
- Identity vs. Role Confusion
- Intimacy vs. Isolation
- Generativity vs. Stagnation
- Ego Integrity vs. Despair
Structural and Intermediary Determinants

(Bryant, et. al. 2015; Guinto, 2012; Rajda and George, 2009, Solar and Irwin, 2010)

**Structural Determinants** - Socio-political contexts reinforcing stratification
- Governance
- Macroeconomic policies
- Social policies
- Public policies
- Culture and societal values

**Intermediary Determinants** - Factors shaping health choices/outcomes
- Material circumstances
- Behaviors and biological factors
- Psychosocial factors
- Health system

Impact on health equity & well being
Another Vital Dynamic

Power: ability to control people &/or things

Oppression: unjust or cruel exercise of power

any serious effort to reduce health inequities involves addressing the distribution of power in society, while also managing the presence of oppression (McGibbon, 2012)

Structural & Intermediary Social Determinants
What Does the Evidence Say?

• Clinical care was responsible for as little as 10% of the impact on health outcomes in some states.

• For ACOs, 68% reported their communities has inadequate resources to meet the challenge of improving health, including:
  – Inadequate funding for staffing and/or services
  – Data interoperability challenges (e.g. technology that was out of date, or not as expansive as needed).
  – Payer pressures

  (Anctil, 2017)
What Does the Evidence Say?

Impact of Different Factors on Risk of Premature Death

- 30% Genetics
- 40% Individual Behavioral Factors
- 20% Social & Environmental Factors
- 10% Health Care

(Schroeder, 2007)
What Does the Evidence Say?

Readmissions:

• Hospital readmissions have an annual cost of $26B
• Those residing in high poverty neighborhoods are 24% more likely to be readmitted to the hospital
• Safety Net Hospitals are especially impacted
  • 1:5 Medicare patients discharged is readmitted within 30 days
  • 77% of hospitals with the highest share of low income patients were penalized for excessive readmissions in 2014

(Davis, 2015; Reforming Health, 2014; Rice, 2014b)
What Does the Evidence Say?

Elevated costs of care:

- 50% of adults with diabetes experience financial stress
- 20% experience financial insecurity specific to health care + food insecurity
  
  (Patel, et. al., 2016)

- $35M in excess health care costs
- $200B in premature deaths

  (Ayanian, 2015; Rice, 2016)
What Does the Evidence Say?

Technology

• 60% of US Smartphone owners use phones to manage their health
• 58% use their phone to communicate with a medical professional.
• 50% have a fitness, health, or medication-tracking app, and
• 83% use fitness or workout apps at least once weekly.

(Mack, 2016)
What Does the Evidence Say?

Technology

– The SDH digital divide

  • Portal use and remote health access are significantly lower across race, gender, and socioeconomic status

  • Lower electronic health record adoption for non-Hispanic black vs. non-Hispanic white patients.

  • Decreased personal health record registration by African American vs. Caucasian managed care subscribers

  (Gibbons, 2011)
What Does the Evidence Say?

Population Health

– Race related disparities and socioeconomic status:
  • Diabetes
  • Obesity
  • Chronic Kidney Disease

– Members of racial and ethnic minority groups are:
  • less likely to have access to mental health services, and
  • use community mental health far less
  • more likely to obtain needed care from emergency rooms, hospitalizations, and
  • Receive lower quality care

What Does the Evidence Say?

**ENVIRONMENTAL IMPACTS ON HEALTH**

**WHAT IS THE BIG PICTURE?**

**FACT:** 23% of all global deaths are linked to the environment. That’s roughly **12.6 million deaths** a year.

**WHERE IS IT HAPPENING?**

- **3.8 million** in South-East Asia Region
- **3.5 million** in Western Pacific Region
- **2.2 million** in Africa Region
- **1.4 million** in European Region
- **854,000** in Eastern Mediterranean Region
- **847,000** in the Region of the Americas

(World Health Organization, 2017)
Socio-Political Drivers: Legislation

H.R. 5273-Helping Hospitals Improve Patient Care Act of 2016

• Value-based reimbursement initiatives penalize hospitals financially for excessive readmissions.

• 3% less in Medicare reimbursement if 30 day readmission rates are higher than expected for certain diagnoses (e.g. heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease, hip and knee replacement).

• Value based penalties would be determined through comparison of hospitals with similar Medicare & Medicaid patient populations, and

• Provide a more level playing field across safety net hospitals and other health systems.

• The Act has passed the House of Representatives and continues to advance in Congress. https://www.congress.gov/bill/114th-congress/house-bill/5273

(Belliveau, 2016)
Socio-Political Drivers: Legislation

- The Patient Protection and Affordable Care Act (P.L. 111-148), and
- The Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)

- Expanded Medicaid to millions of low income Americans, and
- Children’s Health Insurance Program (CHIPS)
- Many prone to SDH
- States passing Medicaid expansion with the largest # of adults in the coverage gap:
  - Texas: 26%
  - Florida: 18%
  - Georgia: 12%
  - North Carolina: 8%

2.6 Million People
Medicaid Expansion (Kaiser Family Foundation, 2018)
Socio-Political Drivers: Immigration

84.3M immigrants in the US: 27% of the population
(Zong and Batalova, 2017)

- The acculturation process
- Legal status
- Separation from family and socio-cultural norms
- Employment
- Poverty
- Financial and administrative hurdles
- Health insurance
- Health literacy and language
- Dietary adjustment
- Adherence to medication and other treatment regimes
- Annual prevention screenings, and
- Overall access to health and behavioral health care.
80% of payers to address SDH by expanding value-based reimbursement + focusing on consumer engagement
• Using Medicare/Medicaid status as a factor in the calculation for their value based purchasing programs:
  – **Accountable Health Communities Model**
    • Will identifying health-related social needs of recipients impact:
      – Care costs?
      – Reduce health care utilization?
    • 32 organizations participating
      [https://innovation.cms.gov/initiatives/ahcm/]
Wait There’s More... ICD 10 Codes

American Hospital Association (March 2018)

• Documentation from non-physicians (e.g. social workers and registered nurses) will be considered justification to account for the SDH.

• Codes Z55-66 (AKA, the ‘stress codes’) reflect stress at individual, family, – relationship, – environment, – community, – difficulty learning, – difficulty at work, – economic stress, or caregiver burden. (Iverson, 2018)

A vital factor in the scope of value based initiatives and reimbursement moving forward
“The crucial interweave of sociopolitical influences on communities, populations, and individuals is a mandate for the success of any industry provider moving forward, whether health and/or behavioral health”
Back to Jake......

• Lani is the new homecare nurse assigned to Jake. Her colleagues tell her. “You won’t be leaving early today. Jake will need to be readmitted, and the inpatient case managers will be furious! He says he takes his meds, but don’t believe him. He probably eats fried foods. All these folks are the same”, say the colleagues.

• Lani reads the information in Jake’s EMR, then enters the house. Her goal is to do an objective assessment. “My colleagues may think they know him, but....”

• She realizes it’s freezing in the house; colder than outside. Lani introduces herself, then asks, “Jake, do you have the heat on?” Lani sees a thermostat that says 80 degrees, but she isn’t convinced.

• Jake says, “that thing hasn’t worked for months. I can’t afford to pay those guys to fix it; not on my disability.”.

• Lani asks Jake if he filled his prescriptions since his discharge from the hospital. “Ms. Lani, I’m always able to, but had an unpaid bill at the pharmacy, so they won’t give ‘em to me.”

• Lani thinks, I wonder what other things interfere with Jake taking care of himself..????
What do the Codes and Standards Say?
What do the standards and codes say?

NASW
National Association of Social Workers

Code of Ethics for Nurses
with Interpretive Statements

CMSA
CASE MANAGEMENT SOCIETY OF AMERICA

CCMC
Commission for Case Manager Certification
What do the Standards and Codes Say?

Standard B: Client Assessment

- The professional case manager should complete a thorough individualized client centered assessment that takes into account the unique cultural and linguistic needs of that client including the client’s family or family caregiver, as appropriate:

- **How demonstrated:** The assessment may include, but is not limited to the following components
  - Medical
  - Cognitive and Behavioral
  - Social
  - Functional

Standard K: Ethics

- The professional case manager should behave and practice ethically, and adhere to the tenets of the code of ethics that underlie his/her professional credentials
  - Recognition that a primary obligation is to the client cared for..
What do the standards and codes say?

Preamble

• The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty.

• The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession’s history, are the foundation of social work’s unique purpose and perspective:
  – service
  – social justice
  – dignity and worth of the person
  – importance of human relationships
  – integrity
  – competence.
What do the Standards and Codes Say?

• **Provision 1:** The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.

• **Provision 2:** The nurse’s primary commitment is to the patient, whether an individual, family, group, community, or population.
What do the Standards and Codes Say?

• **Principle 2:** Board-Certified Case Managers (CCMs) will respect the rights and inherent dignity of all of their clients.

• **Principle 3:** Board-Certified Case Managers (CCMs) will always maintain objectivity in their relationships with clients.

• **Principle 4:** Board-Certified Case Managers (CCMs) will act with integrity and fidelity with clients and others.
Case Management’s Reality
Critical Thinking
The switch to trigger the mental calisthenics to engage in the case management process (Treiger and Fink-Samnick, 2016)
The Case Management Process

Client identification/selection

Assessment & problem identification

Develop a case mgmt. plan

Implementation & coordination of care

Evaluation of the case mgmt. plan & follow up

Termination of the case management relationship

Follow up post discharge/transition from health care encounter

(Tahan in Treiger & Tahan, 2017)
Comprehensive Case Management Path©
(Adapted from Treiger & Fink-Samnick, 2016; Tahan in Treiger & Tahan, 2017)
Consider this.....

• Mona is the case manager for Rhianna, a 17 year old who delivered her first child one month prematurely. She was also diagnosed with gestational diabetes towards the end of her pregnancy. Her newborn daughter, Isla is scheduled to be discharged home on nebulizer treatments.

• Rihanna and Isla have moved in with her older sister, Kiki, who has longstanding congestive heart failure. She’s had repeated hospitalizations for pneumonia and fluid overload. The threesome reside in Kiki’s 2 room apt, a 4 story walk-up.

• Isla’s father, Drake promised to support Rhianna and the baby. Drake was attending community college at night, working by day for a local mechanic. However, Drake was recently laid off. Since he worked off the books Drake is ineligible for unemployment and unable to provide any financial support to Rhianna or Isla.
• Mona calls Rihanna a week after discharge. She’s depressed, but denies suicidal ideation or intent. “I’d like to go back to school and get my GED, maybe work, but I don’t see how, Ms. Mona”, says Rihanna.

• “Things are tight, my Auntie K. now rents a room of the apartment to a friend. He has women in and out of here at all hours. The cigarette smoke is awful, but I’ll deal” says Rihanna. It’s better than what I left, and I’m not going to the shelter. Besides, Drake will come through with something for us”. Mona is struck by how sad Rihanna sounds. “We are from tough stock, Ms. Mona. we got this so don’t worry!”.

• Mona returns to her office overwhelmed. “How do I untangle this mess?”
Implement the Case Management Path ©

- Suspend Judgment
- Develop CM plan
- Implement & coordinate care
- Reflect
- Evaluate CM plan
- Terminate CM relationship
- Deconstruct
- Follow-up & discharge/transition from health care encounter
- Synthesize

Client identification/selection
Assessment & problem identification
EFS Supervision Strategies, LLC © 2018
Moving Forward: Successful Programs & Initiatives

Integration of Community Health Workers (CHWs)

• Frontline public health workers
  – Licensed & unlicensed
• Often from the community being served
• Liaison between health/social services & community, facilitating:
  – Access to services
  – Improving quality & cultural competence of delivery of care across chronic illness (e.g. diabetes, hypertension, asthma)
City Health Works Components  

**Personalized Health Coaching**
- One-on-one coaching sessions to implement realistic, culturally appropriate lifestyle & routine changes
- Session held in home or community
- Medication & care plan education to decrease barriers to adherence
- Continuous evaluation toward goals via phone check-ins
- Assess support system: engage household members & care givers

**Clinical Integration and Coordination**
- Regular communication & care planning between CHW’s Clinical Care Manager & Primary Care Clinicians
- Early identification of complications. Escalation of urgent medical, medication, & psychological issues to avert Emergency room and hospitalization
- Compare med lists with actual patient usage; inform clinicians to align lists and address barriers to access (e.g. cost)

- 78% of clients had decrease in A1C
- A medical issue was found for 50% of clients, otherwise unknown to the medical provider.

**Coordination with Non-Clinical Services**
- Referrals to social service providers, Health Homes to address legal, employment, housing & related socio-economic needs
- Depression care planning under supervision of Depressive Care Specialist social worker & CM using Collaborative Care Model;
- Identify & engage individuals who are ‘lost to follow-up”, or not connected to clinical care through community partners.
Moving Forward: Successful programs & initiatives

Asset Mapping

• Provides information about the strengths & resources of a community
• Fosters the ability to help uncover solutions
• Assets include:
  – Capacities & abilities of community members.
  – Physical structures or places. (e.g. school, hospital, church, library, recreation center, or social club)
  – A business that provides jobs & supports local economy.
  – Citizens’ Associations (e.g. Neighborhood Watch, Parent Teacher Association)
  – Local private, public, & nonprofit institutions or organizations.
Moving Forward: Successful programs & initiatives
Moving Forward: Successful programs & initiatives

Healthy People 2020: a program for improving the nation’s health

- A framework of 5 key areas to categorize the social determinants of health (HealthyPeople.gov, 2017)
# Moving Forward: Successful programs & initiatives

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*(Healthy People 2020, 2017)*
Moving Forward: Successful programs & initiatives

Oregon Community Health Information Network (OCHIN)
- Documentation of the patient’s SDH in the EHR
- Creation of EHR tools to review SDH, identify referral options, order referrals, and track past referrals

Methodist healthcare Ministries of South Texas & the Texas health information exchange (HIE)
- Integration of SDH to include clinical, social, and behavioral risks
- Think of the promise for involved Case Managers!

SDH included in EHRs
1.7% in 2012
7.9% in 2014
25.2% in 2016

(Monica, 2018)
Moving Forward: **Successful programs & initiatives**

**Blue Cross Blue Shield Institute: The Zip Code Effect**

- Will work with business partners to address populations at risk of the SDH
  - Improve care access
  - Treatment adherence, and
  - Outcomes
- **Lyft and Uber:** to reduce the transportation gap
- **CVS and Walgreens:** Increase access to pharmacy services
- **2019:** Expansion to fitness and nutrition services

(Minemyer, 2018)
Moving Forward: Use Successful Messaging

1. Health starts—long before illness—in our homes, schools and jobs.
2. All Americans should have the opportunity to make the choices that allow them to live a long, healthy life, regardless of income, education or ethnic background.
3. Your neighborhood or job shouldn’t be hazardous to your health.
4. Your opportunity for health starts long before you need medical care.
5. Health begins where we live, learn, work and play.
6. The opportunity for health begins in our families, neighborhoods, schools and jobs.

(Robert Woods Johnson Foundation, 2017)
Moving forward: Career implications for Case Management

“the need for qualified case managers is expected to grow in order to address the increasing elderly population, a growing number of patients suffering from chronic illness, and the impact of managed care and additional regulation.” (Commission for Case Manager Certification, 2016).
Moving Forward: Be Strategic

At the end of the day, the only constant is change......
Moving forward: Resources

- Community Commons: Community Health Needs Assessment: https://www.communitycommons.org/chna/
- County Health Rankings and Roadmaps: http://www.countyhealthrankings.org
- Healthy People 2020: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources
- Virginia Commonwealth University, Center for Society & Health http://www.societyhealth.vcu.edu/work/the-projects/the-health-of-the-states.html
- UCLA Center for Health Policy Research http://healthpolicy.ucla.edu/Pages/home.aspx
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