CURRENT ENVIRONMENT

Social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put into place to deal with illness.

➡️ Each Year In The U.S...

➡️ 1.48 million individuals are homeless

➡️ 3.6 million people cannot access medical care due to lack of transportation

➡️ 42 million people face hunger, and

➡️ 12.7 percent of households are food insecure
IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual’s health regardless of age, race, or ethnicity.

- 40% Socioeconomic Factors
  - Education
  - Job Status
  - Family/Social Support
  - Income
  - Community Safety

- 30% Health Behaviors
  - Tobacco Use
  - Diet & Exercise
  - Alcohol Use
  - Sexual Activity

- 20% Physical Environment

- 10% Health Care
  - Access to Care
  - Quality of Care

SDoH Impact

- 20% of a person’s health and well-being is related to access to care and quality of services
- The physical environment, social determinants and behavioral factors drive 80% of health outcomes

Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.

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IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual’s health regardless of age, race, or ethnicity.

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<td>Employment</td>
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<td>Safety</td>
<td>Higher Education</td>
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<td>Community Engagement</td>
<td>Provider Linguistic &amp; Cultural Competency</td>
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<td>Parks</td>
<td>Vocational Training</td>
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<td>Quality of Care</td>
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<td>Early Childhood Education</td>
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<td>Support</td>
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<tr>
<th>Health Outcomes:</th>
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<tr>
<td>Mortality</td>
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<tr>
<td>Life Expectancy</td>
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<tr>
<td>Health Care Expenditures</td>
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<tr>
<td>Health Status</td>
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<tr>
<td>Functional Limitations</td>
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SOCIAL DETERMINANTS OF HEALTH

We need to consider each factor to address the social determinants of health.

- Housing
- Food
- Education
- Transportation
- Violence
- Social Support
- Employment
- Health Behaviors
PLACE MATTERS

Where we live can determine how well we live and is a significant factor of life expectancy.

Source: Institute for Health Metrics and Evaluation, University of Washington, 2014
ZIP CODE MATTERS

Your zip code – where you actually live – also influences health.

Short Distances To Large Gaps In Health

Chicago, Illinois

Mississippi

Source: Reprinted with permission from the VCU Center on Society and Health.
COMMUNITY MATTERS

Community also matters and plays a role in how long and how well you live.

Homicide rate per 100,000 residents:
- < 1
- 1 - 4
- 4 - 7
- 7 - 10
- 10 - 20
- > 20

Homicides by Chicago Neighborhood
As of December 12, 2016

Homicides by Brooklyn Neighborhood
As of October 2016

Source: https://www.thetrace.org/2016/12/murder-inequality-neighborhood-homicide-rates/

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FOOD MATTERS

Food insecurity is a risk factor for various health issues, including chronic diseases, poverty, unemployment, homelessness, and developmental delays in children.

Illinois food insecurity rates:
- 4-14%
- 15-19%
- 20-24%
- 25-29%
- 30% +

**11.7%** are food insecure

Mississippi food insecurity rates:
- 4-14%
- 15-19%
- 20-24%
- 25-29%
- 30% +

**21.5%** are food insecure

Source: Feeding America, Map the Meal Gap. 2016

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THE ROLE FOR HOSPITALS AND HEALTH SYSTEMS

There are multiple ways hospitals and health systems can address social determinants of health – both within their own walls and outside in the community.

**Internal:**
- Screening
- Connecting patients to community resources
- Implementing hospital-wide initiatives

**External:**
- Engaging with the community
- Partnering with the community
- Investing in the community
THE ROLE FOR HOSPITALS AND HEALTH SYSTEMS

We know many hospitals and health systems are already addressing the social determinants of health in their communities.

- Community Health Education: 85%
- Health Fairs: 80%
- Nutrition Program: 79%
- Linguistic/Translation: 61%
- Tobacco Treatment/Cessation: 56%
- Fitness Center: 33%
- Transportation To Health Services: 23%

Hospitals that provide non-medical services

- Hospitals that have entered into at least one type of community partnership: 74%
- None: 26%

Source: AHA 2016 Annual Survey Data

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POTENTIAL NEXT STEPS

If a hospital or health system wants to move forward on their journey to address the social determinants, some examples of next steps include:

1. Know and engage with the community
2. Gather data
3. Develop organizational/internal engagement strategies
4. Integrate social determinants in strategic/financial plans
5. Explore funding options
6. Establish measurement strategies and evaluation tools
AHA RESOURCES: THE VALUE INITIATIVE

Tools, resources and education to address social determinants as part of value, population health and health equity efforts.

Value Initiative

Members in Action: Reengineering the Delivery System

Meadville Medical Center – Meadville, PA
Cane Coordination for Adults and Children

AHA Members in Action: series highlights how hospitals and health systems are implementing new value-based strategies to improve health care affordability. This includes work to reduce the delivery system, manage risk and reduce payments, improve quality, and outcomes and implement operational solutions.

Overview
The Meadville area, approximately 90 miles north of Pittsburgh, is marked in the rolling hills of the blue lands in northwestern Pennsylvania. The population of Meadville and the surrounding area is approximately 75,000. With the Meadville Medical Center (MMC) for 179 inpatient acute care beds and 28 skilled nursing beds, MMC reports several important additions of approximately 1,380 and more than 30,000,000 patient visits. The emergency department ESI 2 more than 33,000,000 patient visits. Approximately 1,200 cases are involved in each MMC, and MMC has a medical staff of more than 150 physicians across 27 medical and surgical specialties, including an inpatient primary care foundation.

MMC views care coordination as an important aspect of tailoring its mission as an independent community health system. Care coordination also provides immediate value to the community by addressing some of its most vulnerable residents, many of whom have complex health care and resource needs, which go beyond the traditional scope of acute care services. In addition to altering MMC’s resources, care coordination provides an important way for MMC to achieve value by delivering to the community as MMC looks to better align with the overall well-being of the population.

The Community Care Network (CCN) is an interdisciplinary team of dedicated clinicians who work with physicians, health care providers and other agencies to help manage chronic disease conditions, with a focus on meeting patients’ health and wellness goals. Services offered in the CCN are provided at no charge and assist the following areas: appointment adherence, multi-drug support, transportation, medication, services, nutrition, and other services. The CCN is supported by a team of nurses, social workers, and other support staff.

The four diagnoses in the program are hypertension, diabetes, hyperlipidemia, and depression. Providers also see part of the CCN program and may be referred to patients, nurses, and physician assistants.

The CCN has eight care managers consisting of registered nurses, delivered social work, delivery workers, and nurses who are assigned in the field by trained health executive. The nurses is back by medical doctors and works closely with community physicians. The CCN offers telemedicine for patients, especially for patients living in rural areas.

Increased cost associated with regulatory burden

Estimated Burden of Compliance with Regulatory Requirements for a Typical Community Hospital

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Costs</th>
<th>Impact on Access to Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Visits</td>
<td>23.2</td>
<td>$3,595</td>
</tr>
<tr>
<td>Billing &amp; Revenue</td>
<td>3.2</td>
<td>$600,000</td>
</tr>
<tr>
<td>Housing Product</td>
<td>4.6</td>
<td>$40,000</td>
</tr>
<tr>
<td>Price &amp; Quality</td>
<td>3.5</td>
<td>$40,000</td>
</tr>
<tr>
<td>Food &amp; Beverage</td>
<td>5.3</td>
<td>$800,000</td>
</tr>
<tr>
<td>Property Safety</td>
<td>5.6</td>
<td>$1,200,000</td>
</tr>
<tr>
<td>New-Medical Records</td>
<td>6.6</td>
<td>$1,500,000</td>
</tr>
</tbody>
</table>

Increasing patient visits.

*Based on a typical hospital being responsible for 1 in 5 Medicare and/or Medicaid patients. For the purposes of this analysis, the number of patient visits was calculated by averaging the number of visits among community hospitals (50,000 beds, according to 2016 AHA Annual Survey). Excludes costs related to FQHC equivalents.

Source: American Hospital Association, Regulatory Burden Survey

Value Initiative

Issue Brief 1

Reengineering the Delivery System

Hospitals and Health Systems See...

Affordability is one of the most important challenges facing health care today. A number of factors affect the affordability of our care, including patient access, transportation, education, personal choices, and the cost of health insurance, prescription drugs, and hospital services. Leaders from the American Hospital Association (AHA), hospitals, and health systems understand these challenges. New strategies are underway, and new opportunities and initiatives are emerging to help a wide range of patients and consumers have access to affordable health care.

A wide range of stakeholders contribute to health care affordability — from patients to providers to pharmaceutical companies — with no single sector or person able to solve this issue alone. Recent AHA research focused on how barriers to care contribute to the affordability conversation, focusing on specific areas to address. This research helped to advance the affordability conversation forward without compromising access or quality. In this report, the AHA develops a series of issues that will:

- Design and highlight the issue of affordability
- Analyze the issue
- Provide insight on potential tools that affect affordability
- Examine the role of various stakeholders in making care more affordable
- Share solutions and strategies that advance affordability.

One in four Americans (25%) say the cost of health care is the biggest concern facing their family.

The Value Initiative

You are invited to explore: www.aha.org/TheValueInitiative

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Advancing Health in America
AHA RESOURCES: PATHWAYS TO POPULATION HEALTH

Tools, resources and education to address social determinants as part of value, population health and health equity efforts.

P1: Physical and/or Mental Health
P2: Social and/or Spiritual Well-being
P3: Community Health Well-being
P4: Communities of Solutions

Equity

Community Well-Being Creation

Access tools and resources at: www.pathways2pophealth.org

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AHA RESOURCES: THE INSTITUTE FOR DIVERSITY AND HEALTH EQUITY

Tools, resources and education to address social determinants as part of value, population health and health equity efforts.

"There can be no quality without equity. Promoting diversity and inclusion and building community are essential strategies for delivering equitable care."

www.diversityconnection.org
MEMBERS IN ACTION: FIGHTING FOOD INSECURITY

Connecting individuals and families to health food sources and improving their health.

ProMedica

- More than 57,000 patients were screened for food insecurity
- 1,100 food insecure patients became food pharmacy clients
- Additional 4,000 Medicaid patients referred to food pharmacy
- Food pharmacy patients used ED 3% less, had 53% fewer hospital readmissions, and primary-care visits increased 4%

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MEMBERS IN ACTION: ADDRESSING TRANSPORTATION NEEDS

Creative solutions to help individuals keep needed medical appointments.

MedStar Health

Ascension Health

Denver Health
MEMBERS IN ACTION: ADDRESSING HOUSING

Providing chronically homeless individuals with stable housing and support services.

University of Illinois Hospital and Health Sciences System

BETTER HEALTH THROUGH HOUSING

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MEMBERS IN ACTION: ADDRESSING VIOLENCE

Connecting victims of violence with individual and family support to stop the cycle of violence.

Children’s Hospital of Wisconsin
MEMBERS IN ACTION: IMPROVING SOCIAL SUPPORT

Increasing physical activity and event opportunities for seniors to improve health and build community.

Northern Montana Hospital

- Activities include bus tours, picnics and fitness classes
- Built-in health screenings
- Diabetes prevention program resulted in decreased number of amputations

American Hospital Association
Advancing Health in America
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MEMBERS IN ACTION: SUPPORTING YOUTH EDUCATION

The Tipping the Scale Program provides at-risk students job training, mentoring, and summer employment.

Baptist Health

University of Florida Health

- Ninth graders begin weekly training sessions on job interviewing, resume writing, money management, and accountability
- 1,700 students each year
- 90% graduate high school
- Majority attend college, join military or get a job
MEMBERS IN ACTION: IMPROVING EMPLOYMENT AND HOUSING

SEED Program invests in a neighborhood to revitalize former vacant lots and turn around a poor retail market.

Bon Secours Richmond Community Hospital

- Initial investment - $50,000 a year with three-year commitment
- Established 14 business (still running today)
- Brought jobs to community and increased income
- Resulted in better housing opportunities

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BOARD DISCUSSION QUESTIONS

1. Which social determinants of health have the greatest impact on the communities we serve?

2. What sources of data and information (community forums, community health needs assessment results, etc.) does our hospital or health system use to understand and monitor the impact of social determinants on community health outcomes?

3. What actions is our health care organization taking to identify social determinants of health and to determine and address their impact on the patients and families we care for directly?

4. How is our hospital or health system partnering with other individuals and organizations to address social determinants of health across the communities we serve?

5. How is our organization integrating social determinants of health into its strategic and financial planning?

6. How should our governing board continue to keep apprised of the impacts social determinants of health are having on the communities we serve and how these impacts are being addressed?

7. What types of resources (issue briefs, reports, slide decks, case studies, etc.) from AHA and other sources could be most helpful to us in learning about the strategies and steps health care organizations are taking to successfully address social determinants and improve the health of the populations they serve?

Contact Priya Bathija at pbathija@aha.org with ideas for additional helpful resources.
American Hospital Association™

Advancing Health in America

Addressing Social Determinants of Health