It's complicated, or is it?

- Health is mostly determined by things other than medical care.

- Social determinants of health are mostly driven by political decisions.

What are social determinants of health?

- *Economic and social conditions that influence the health of people and communities. These conditions are shaped by the amount of money, power, and resources that people have, all of which are influenced by policy choices. Social determinants of health affect factors that are related to health outcomes.*

  http://www.cdc.gov/nchhstp/socialdeterminants/faq.html

Social Determinant of Health Categories

It is widely understood that SDHs play a much larger role in peoples' health than does medical care, but our medical care system has, for the most part, not engaged in addressing SDH.
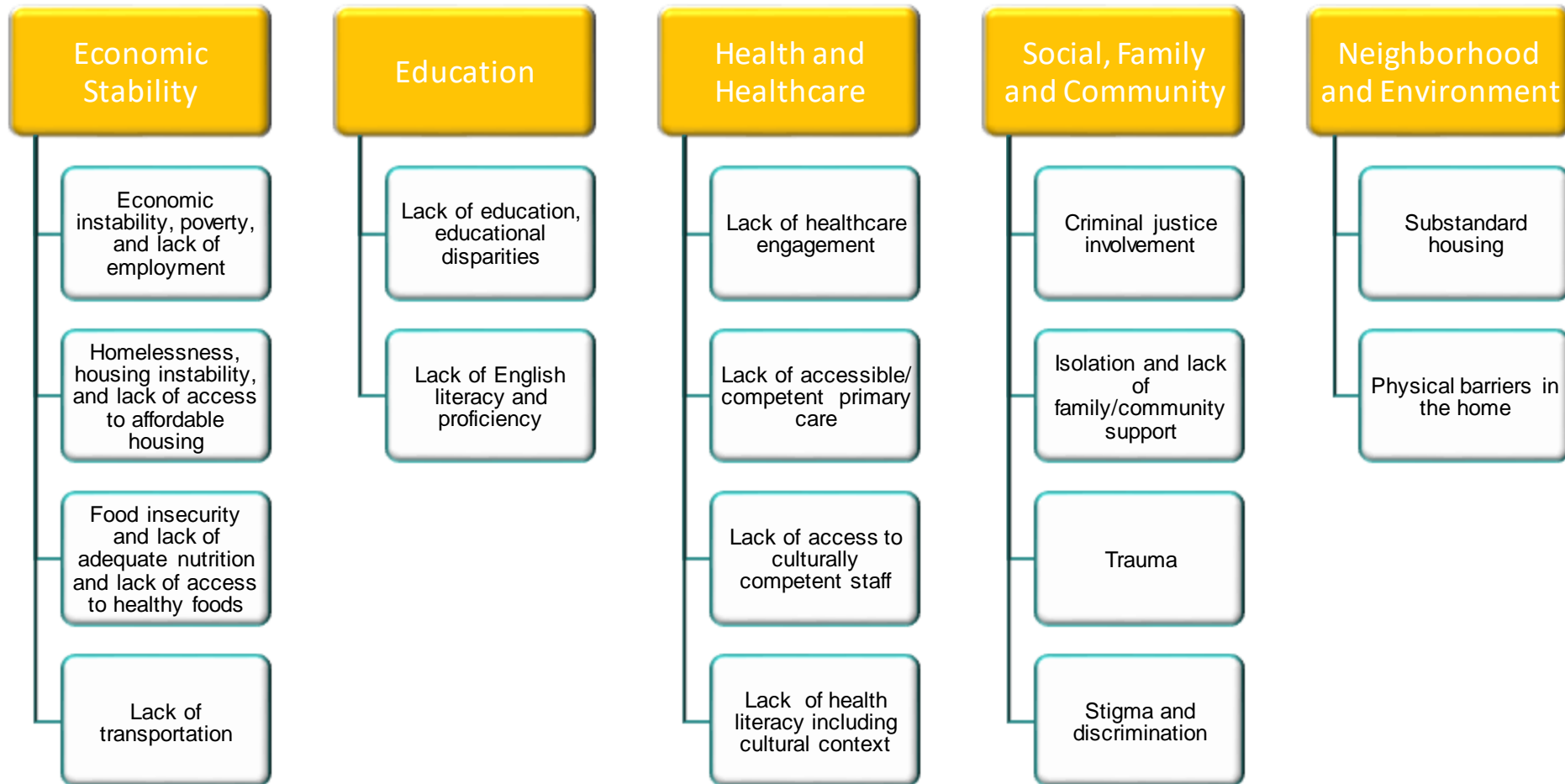
Examples of social determinants of health

- How a person develops during the first few years of life (early childhood development);
- The education a persons obtains;
- Discrimination and social support
- Being able to get and keep a job;
- What kind of work a person does;
- Having healthy food;
- Housing status;
- How much money a person earns

http://www.cdc.gov/nchhstp/socialdeterminants/faq.html

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Identifying Effective Interventions – SDH Categories Expanded

Economic Stability

- Economic instability, poverty, and lack of employment
- Homelessness, housing instability, and lack of access to affordable housing
- Food insecurity and lack of adequate nutrition and lack of access to healthy foods
- Lack of transportation

Education

- Lack of education, educational disparities
- Lack of English literacy and proficiency

Health and Healthcare

- Lack of healthcare engagement
- Lack of accessible/ competent primary care
- Lack of access to culturally competent staff
- Lack of health literacy including cultural context

Social, Family and Community

- Criminal justice involvement
- Isolation and lack of family/community support
- Trauma
- Stigma and discrimination

Neighborhood and Environment

- Substandard housing
- Physical barriers in the home
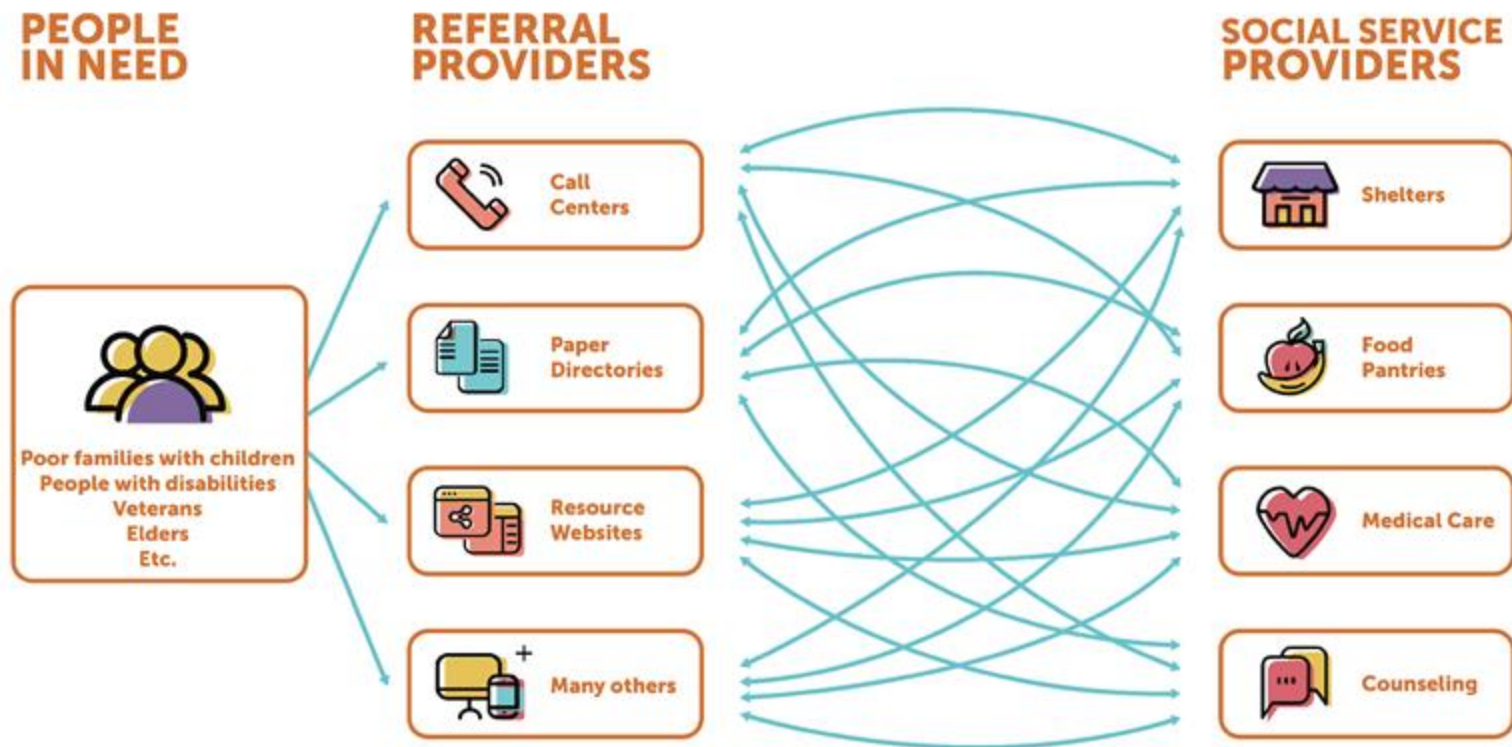
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Challenges

- What interventions to implement: what is needed, what is available, what is most effective

- Metrics to track the success of SDH interventions.

- Follow through and closing the loop

- Who develops, maintains, ensures accuracy of a catalogue of community resources.

- Sustainability/who pays

Challenges

PEOPLE IN NEED

Poor families with children
People with disabilities
Veterans
Elders
Etc.

REFERRAL PROVIDERS

Call Centers

Paper Directories

Resource Websites

Many others

SOCIAL SERVICE PROVIDERS

Shelters

Food Pantries

Medical Care

Counseling

Slide Credit: Open Referral

Focus on available, sustainable social needs interventions

- Community-based organizations (CBOs) are well-positioned to help address SDH.
- BUT which agencies, what services, where are they located, what languages, who is eligible, when and how are services accessed….???
  - CBO services are not evenly available
  - No organized system exists to connect people with identified SDH needs to available resources in their own communities.
- Private firms have tried to fill some gaps – NowPow, UniteUs, Healthify, Open Referral
- In some communities 211 and/or United Way assist with connections.
- In NYC, Health Information Tool for Empowerment (HITE) online directory with information on 6,000+ health/social services in NYC, LI, Westchester.
- Monroe County Integration Project. Multi-sector, person-centered system of service delivery with goal to establish connections between 300 local health, human service, and education providers. Aims to transform the way the community works together to help individuals and families seeking support.

Screening Tools

- Screening for social needs without the capacity to offer/connect with assistance can cause trauma and mistrust.

- Screening tools for SDH are limited, especially for children

- 25 states require Medicaid plans to screen for/provide referrals for social needs.

- There is not one tool, but many, so consistency of information/data is challenge.

- NYS DOH list of commonly used tools

NYS Medicaid increasing attention to SDH

- Bureau of Social Determinants of Health
  - Spring 2018, Office of Health Insurance Programs (OHIP) formed new Bureau of SDH
  - Primary goal is to help health care providers, managed care organizations address SDH needs of the members they serve
- In Value Based Payment (VBP) Arrangements
  - VBP contractors in level 2 or 3 agreements are *required* to implement at least one social determinant of health intervention
  - Starting January 2018, all Level 2 and 3 VBP arrangements must include a minimum of one Community Based Organization (CBO)

NY eHealth Collaborative and the SHIN-NY

- Statewide Health Information Network (SHIN-NY) designed to allow electronic exchange of clinical information and connect health care professionals statewide.

- Regional hubs (QEs) currently connect data from clinicians, clinics, hospitals, nursing homes, labs.

- Currently exploring intersection of CBO services and SDH with health information exchange and health information technology, and associated challenges and opportunities in to improve health outcomes. Issues include privacy, security,

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Maternal Infant Care Initiative: Connecting HV, SDH, data

- Screen for SDH, provide assistance to families in navigating community or clinical services

- Link families to appropriate community-based mental health and well-being, or educational resources

- Provide up to 3 "light touch" home visits as needed to identified high-risk mother/newborn/family to assess for additional home visiting level of need

Maternal Infant Care Initiative Goals

- Improve access for high-risk populations to available resources. Coordinated health care and other services can reduce/ameliorate impact of adverse circumstances. Peer navigators connecting individuals with needs to appropriate health and supportive services and maintaining the individual's/family's engagement with services.

- Expanding universal light touch home visitation (offered to caregivers at any stage during pre/post natal period). MICI "Universal Light-Touch" home visitation model is a modification of the Family Connects nurse-driven, postnatal home visitation program.

- Improving communication between community-based organizations and primary care providers. Timely referral and better integrated services might help children reach their full potential and return them to healthy developmental trajectories.

Political determinants of health

- Drivers of health inequities in our society are political; every social determinant of health is preceded by a political action or lack of action.

- COVID laid bare that it is not a coincidence that certain groups of people in the US experience higher premature death rates or poorer health outcomes.

- Research shows air pollution; climate change; toxic waste sites; unclean water; lack of fresh fruits/vegetables; unsafe, unsecure, and unstable housing; poor-quality education; inaccessible transportation; lack of parks/recreational areas; other factors play an outsized role in determining our overall health and well-being. They increase stress, expose us to harmful elements, and limit opportunities to thrive.

- Systemic racism can affect physical and mental health. Systemic, racial inequities embedded within interconnected social, political, and economic systems have deep historical roots

- Residential segregation is associated with significant differences in neighborhood quality, living conditions, and access to opportunities. Drives SDH.

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Going upstream: addressing the political determinants of health

- Political education, community organizing, issue advocacy, civic engagement, and policy change

Comments, questions?

Talk amongst yourselves.