SOCIAL DETERMINANTS OF HEALTH 101: IMPROVING PATIENT OUTCOMES

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Partners in Care Foundation
The Social Determinants Specialists
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CE Contact Hour provided by Capital Nursing Education

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About Dianne Davis

Ms. Davis is Vice President, Health Self-Management Services at Partners in Care Foundation leading 16 professionals implementing evidence-based programs. She has 25 years' experience in healthcare administration, Managed Care and Gerontology. Ms. Davis oversees federal, state, county, city and private foundation relationships, and Partners' contracts for evidence-based programs with health systems. Ms. Davis holds a MPH from UMASS, Amherst and a post-graduate certificate in Gerontology from UMASS Boston. She speaks at numerous conferences, is a member of the Evidence-Based Leadership Collaborative, a mentor for the NCOA Network Development Learning Collaborative and taught a course at UCLA, Evidence-based Programs for Older Adults.

Objectives

1. What are social determinants of health and why are they important?
2. What is population health and risk stratification and why are these important?
3. Why is it important for clinicians and community based organizations to partner with each other?
4. What is self-management and what are some evidence-based practices that include self-management skills?

Partners in Care *(Partners)*

A Mission-Driven Organization

Our Mission

- Partners shapes the evolving health system by developing and spreading high-value models of community-based care and self-management

Our Focus on Innovation

- We shift the emphasis from illness care to preventive care, reducing costs and improving quality of life for those with chronic conditions
- NCQA accredited for Complex Care Management as defined by CMS

Our Partnership

- Partners collaborates with hospitals, physician groups, health plans, community-based organizations, and government agencies to deliver services that support adults with complex health and social services needs and their caregivers and families
- Evidence-based programs demonstrated to significantly reduce costly hospital readmissions, ED visits, and nursing home placements

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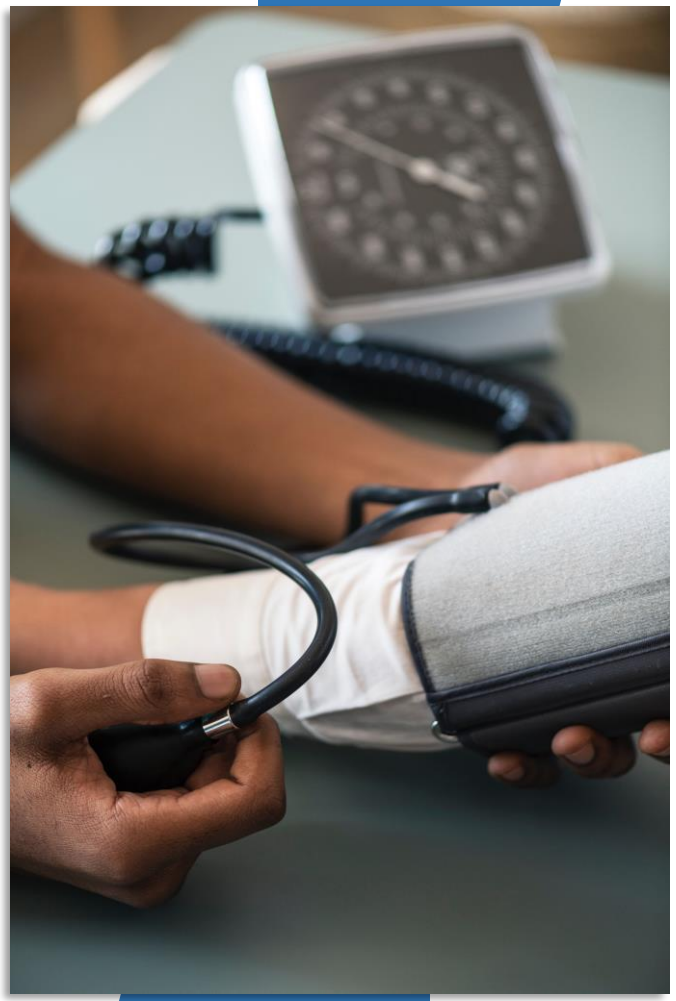

Changing the Shape of Health Care

- A think-tank and a proving ground
- Changing the shape of health care by creating high-impact, innovative ways of bringing more effective clinical and social services to people and communities
- Partners' direct services test, measure, refine and replicate innovative programs and services, and bring needed care to diverse populations

Changes We Want to See

1. Integration of medical care and social services
2. Enhanced self-management/ empowerment of consumers
3. Integration of behavioral health
4. Evidence-based interventions
5. Community Agencies forming into regional delivery systems/ networks, like IPAs

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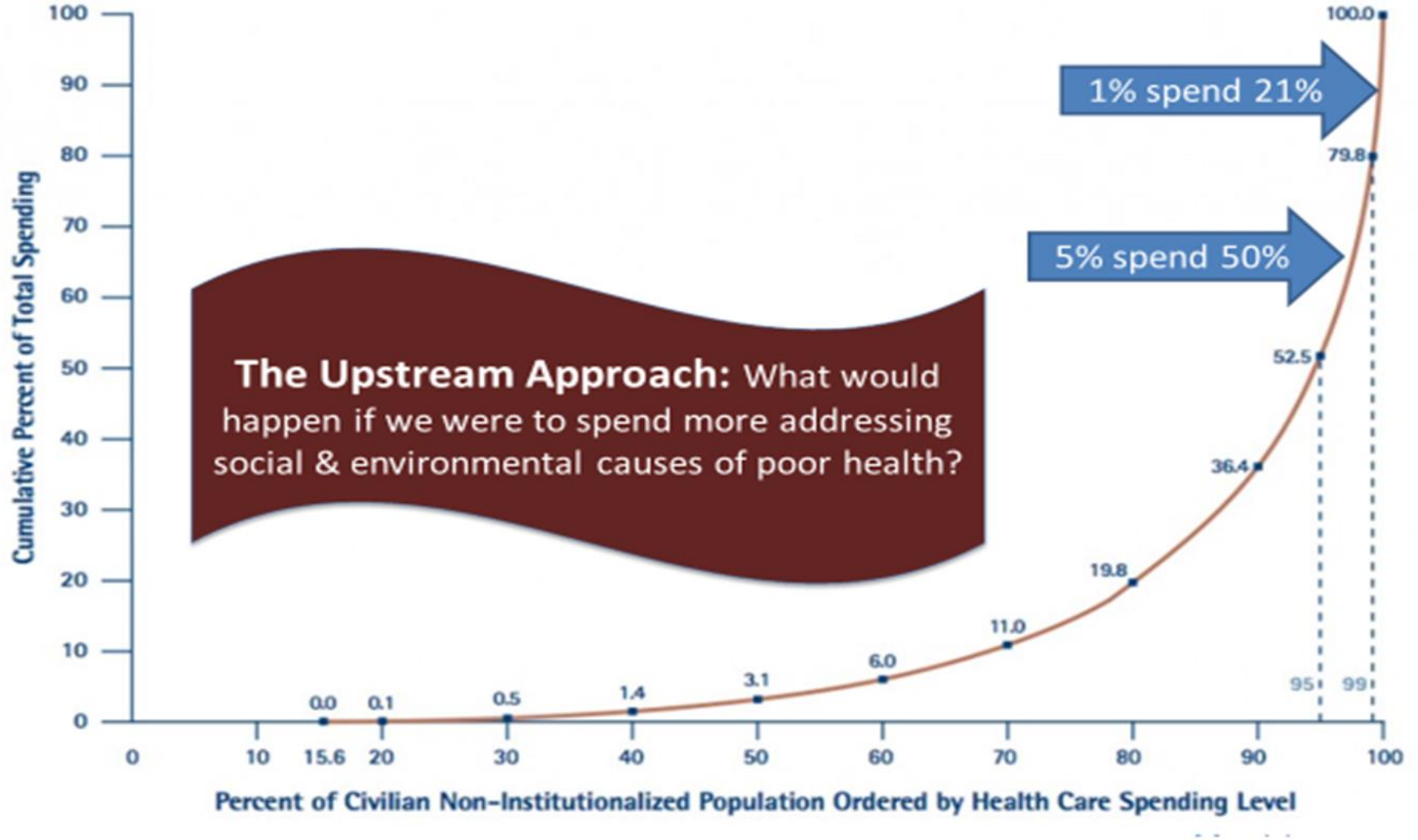
Choice: Spend Upstream on SDOH on Top 5%



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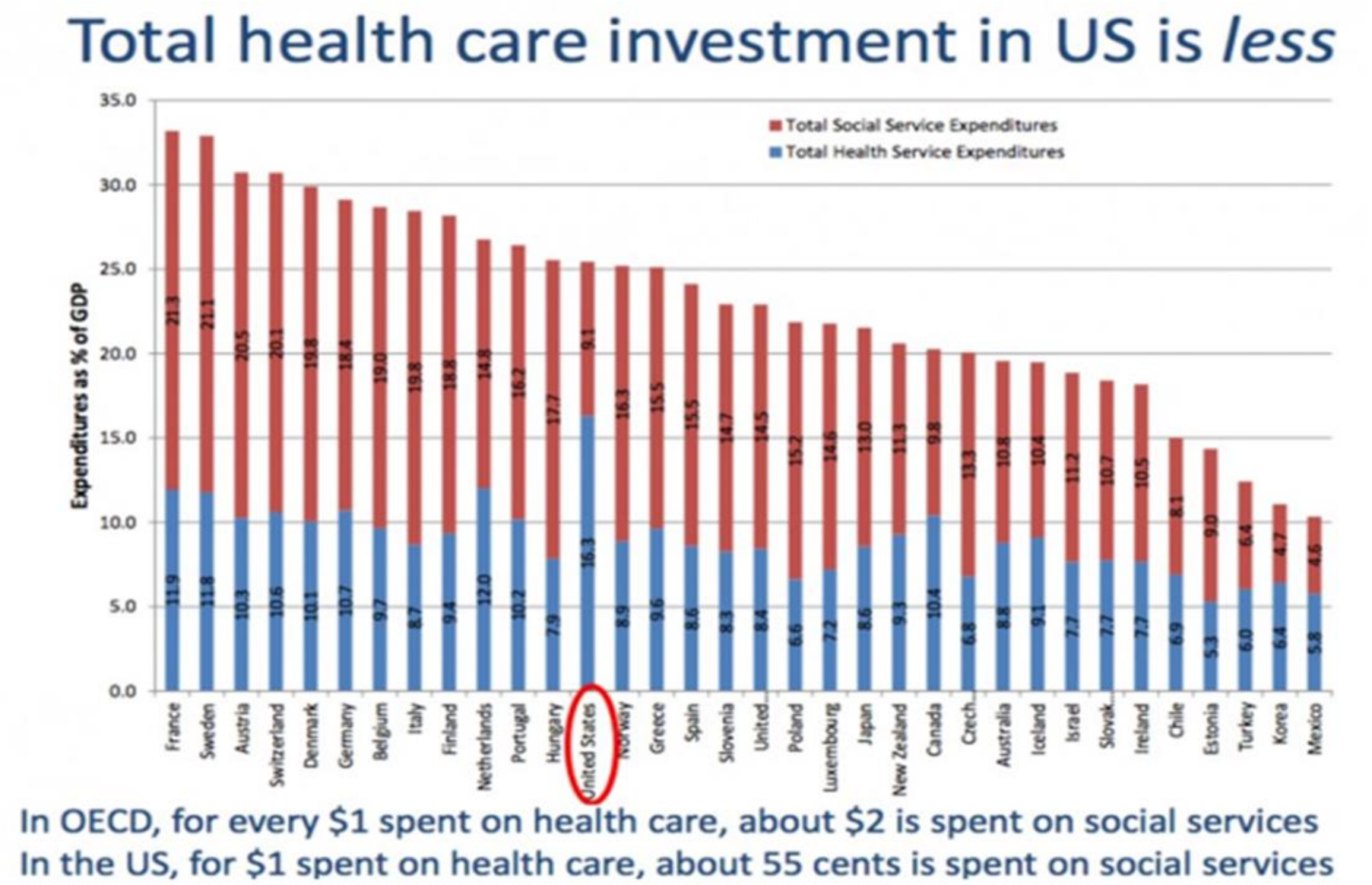
Social + Medical = Health



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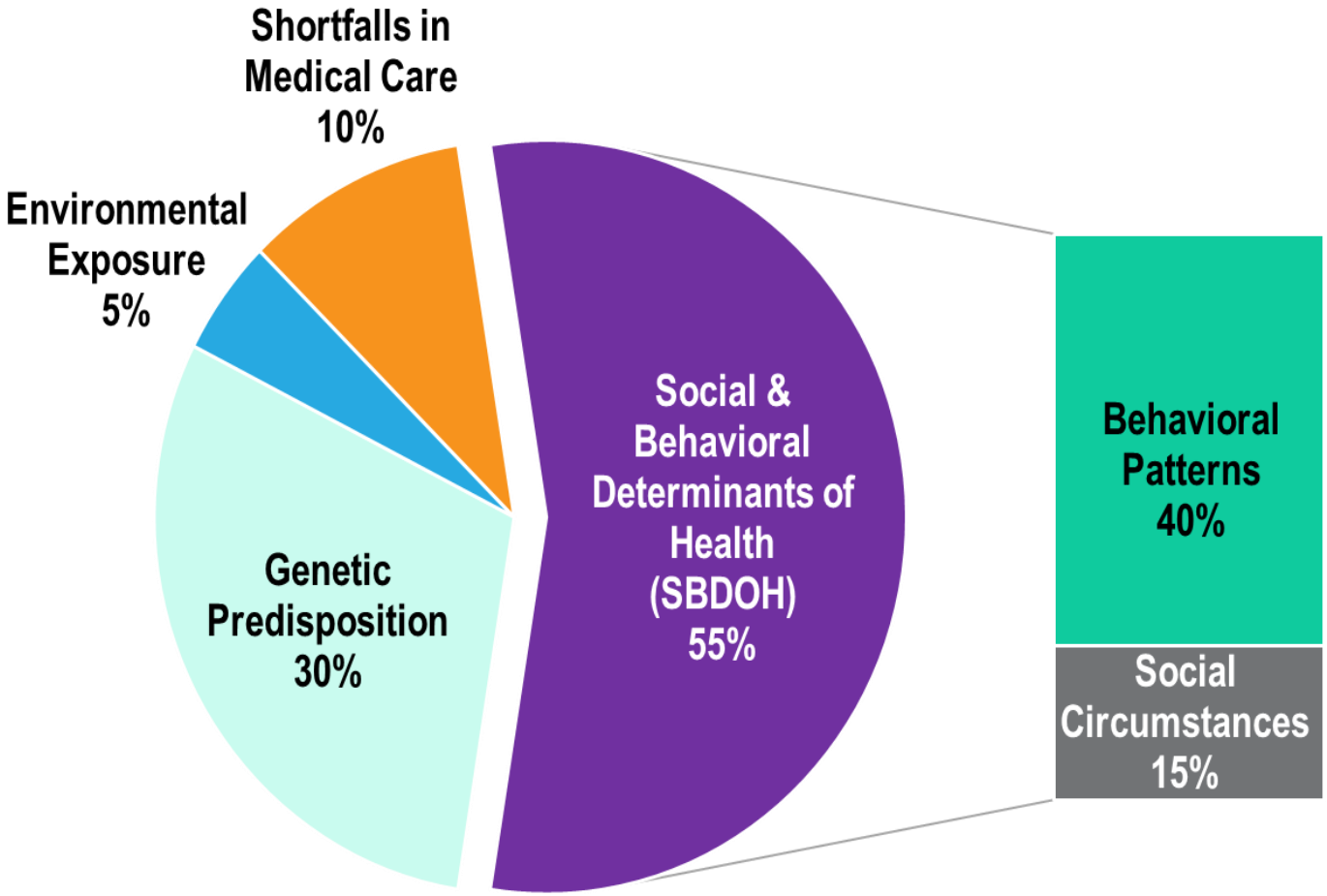
Factors in Premature Death - USA



Adapted from McGinnis JM, Williams-Russo P, Knichman JR. The case for more active policy attention to health promotion. Health Affairs (Millwood) 2002;21(2):78-93

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Addressing the Social Determinants

Across Settings And Populations

PARTNER

With hospitals, physicians & heath plans

FOCUS

The home

PAYERS

- Medi-Cal
- Medicare
- Private health plans

NEW DIRECTIONS

Transforming Medicare and Medi-Cal

Focused on the Social Determinants of Health (SDOH)

Home and Community-Based Services

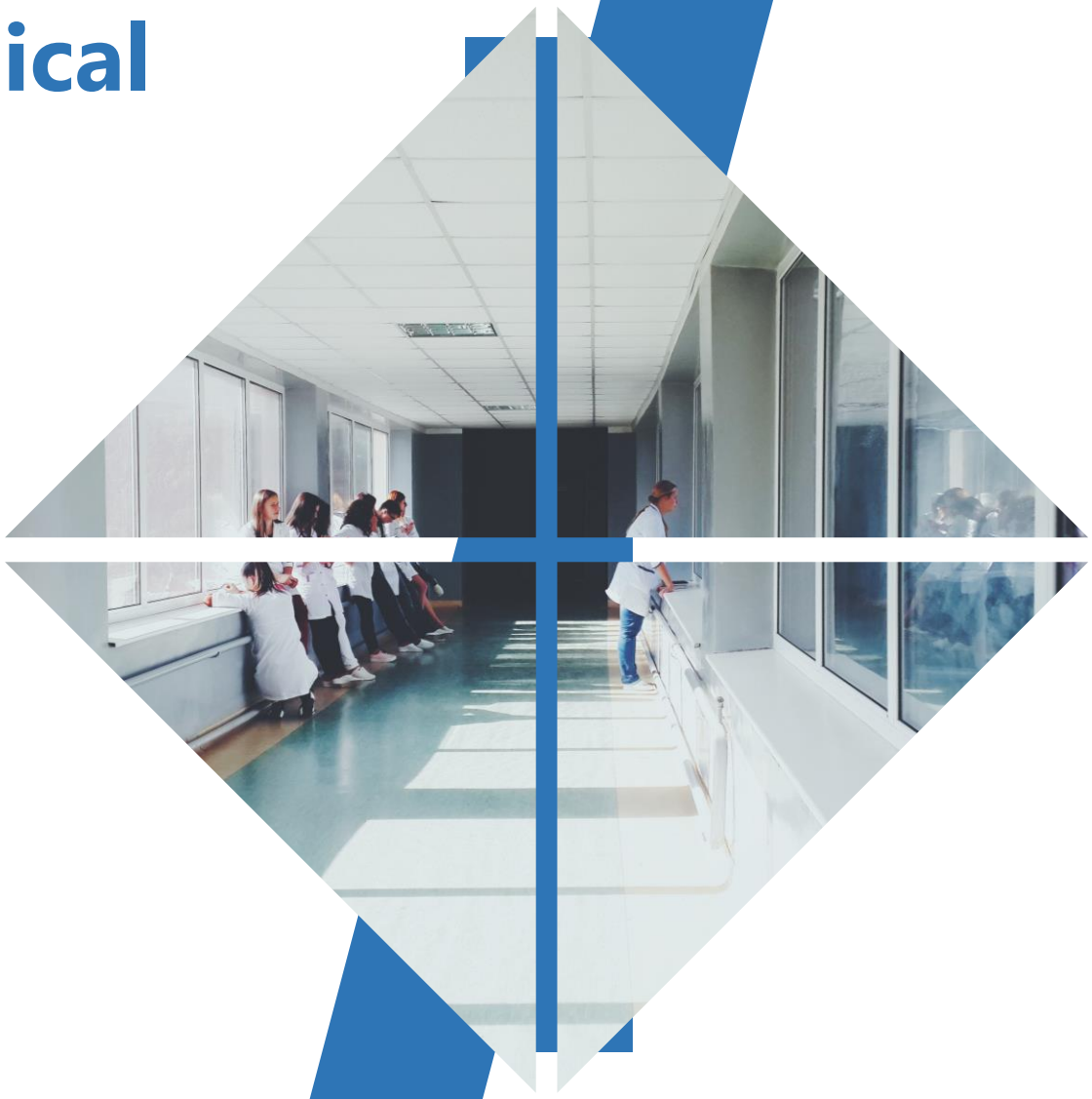
Healthcare's Blindside

The Robert Wood Johnson Foundation survey of 1,000 PCPs

- 80% not confident in their capacity to address their patients' social needs
- 86% said unmet social needs are leading directly to worse health
- 76% wish the healthcare system would cover cost of connecting patients to services to meet health-related social needs
- 1 of 7 prescriptions would be for social supports, e.g., fitness programs, nutritious food, and transportation assistance

New Roles for the Medical System

- Risk ***Stratification*** -
  Active screening and targeting
- Continual ***Monitoring*** for "trigger events" that could change a risk category
- ***Build*** comprehensive partnerships with community providers as part of the delivery system for population health



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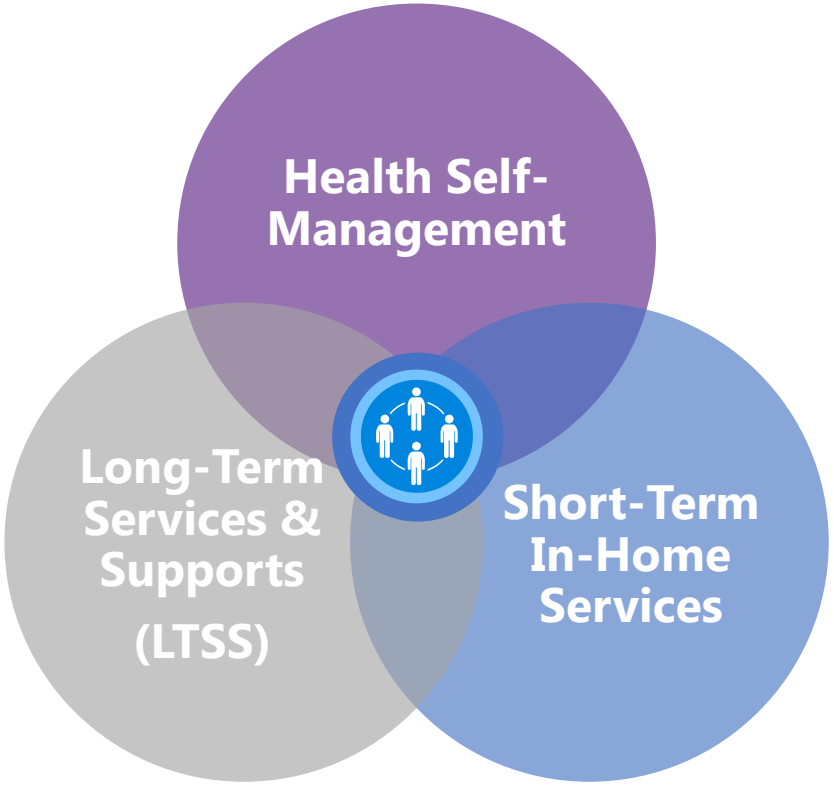
CBOs: Bridge to the Home

- CBOs have worked to improve health and functioning at home for decades
- Local trust, history and community support
- Know the lay of the land — quality of services — Not a call-center approach — local employees
- Mobility and flexibility — responsive, nearby
- Health coaches, navigators, social workers, community health workers — an alternative and affordable workforce
- Culturally and linguistically matched

A Full Range of Evidence-Based Programs & Services

Complementing the Clinical Model



Health Self-Management
Multi-session workshops such as Chronic Disease Self-Management (or pain or diabetes versions), Arthritis Walk with Ease, A Matter of Balance, Tai Chi

LTSS
MSSP: Services to keep people at home (nursing home diversion)
CA Community Care Transitions: Returns people home from nursing home ("repatriation")

Short-term In-Home Services

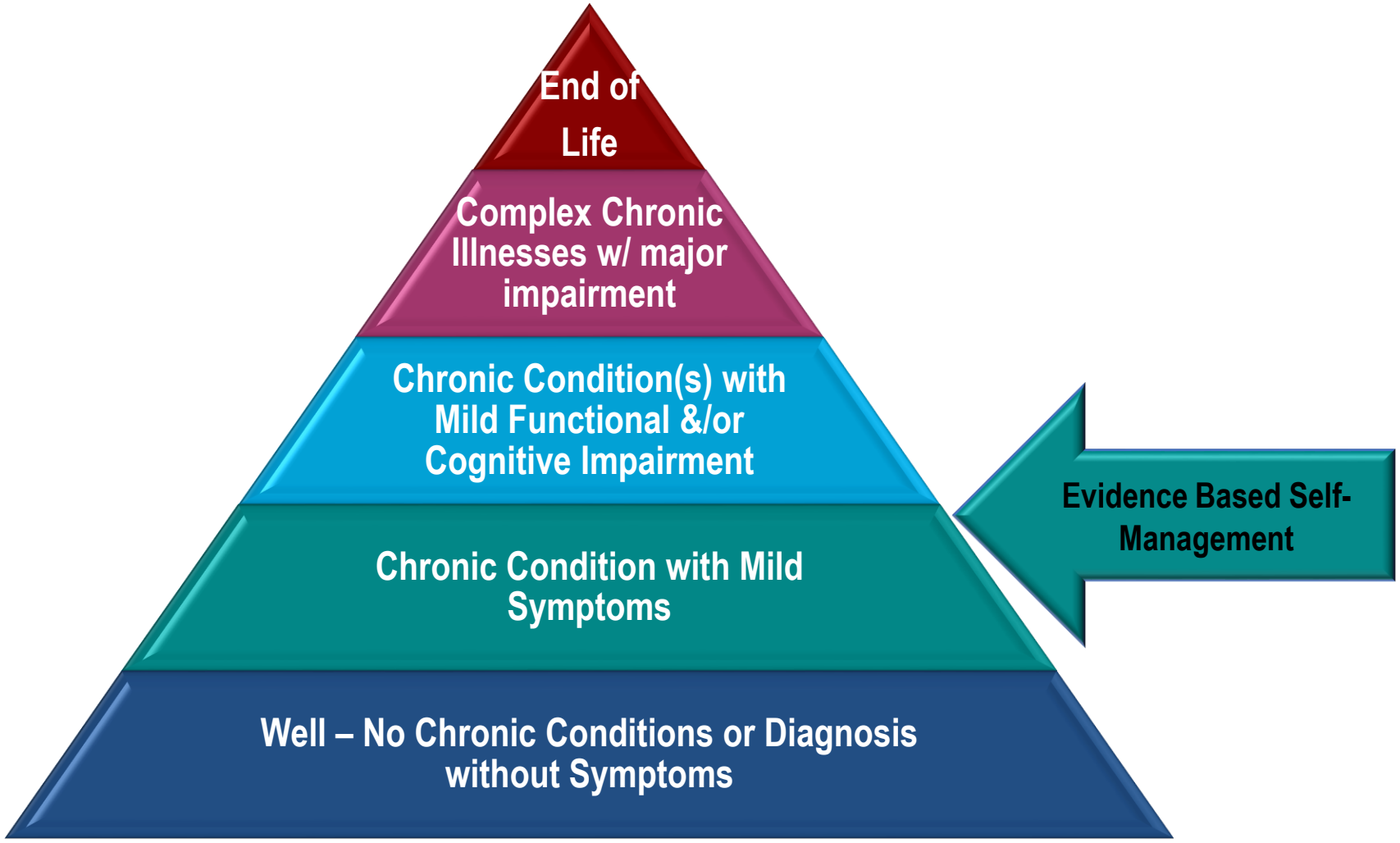
Care Transition Choices: Coaching or telephonic social work support after discharge from hospital

HomeMedsPlus: Medication inventory, psychosocial, functional, cognitive & home safety assessment & service coordination

TCM/CCM: Medicare fee-for-service physician billing codes for transitional care management & chronic care management.

Targeted Patient Population Management

Services for Progressing Disease/Disability



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Evidence-Based Health Promotion Programs

Promising Practice → Best Practice

- Supported by extensive research (RCT)
- Measurable, proven outcomes to achieve specific goals
- Clear, structured, detailed program
- Peer-reviewed, published & endorsed by a federal agency
- Replicable in many settings

Health Self-Management Services

Evidence-Based Group Programs

- Exercise Programs
- Chronic Disease Self-Management Programs
- Fall Prevention Programs

Operations

- 250 Workshops per year
- 172 Partner sites
- 17 Full time staff
- 19 Volunteers

Funding Sources

- City and County IIID
- Community Development Block Grant
- ACL PPHF grants
- BSC contract
- Promise Health Plan contract
- LA Care Contract
- AARP Foundation w/Cedars Sinai
- Private Foundation Grants

Programs for Self-Management

Falls Prevention and Exercise

Population

- 1+ chronic diseases and their family, friends or caregivers
- Normal to mild cognitive impairment

SMRC
Self-Management
Resource Center

Self-Management Programs

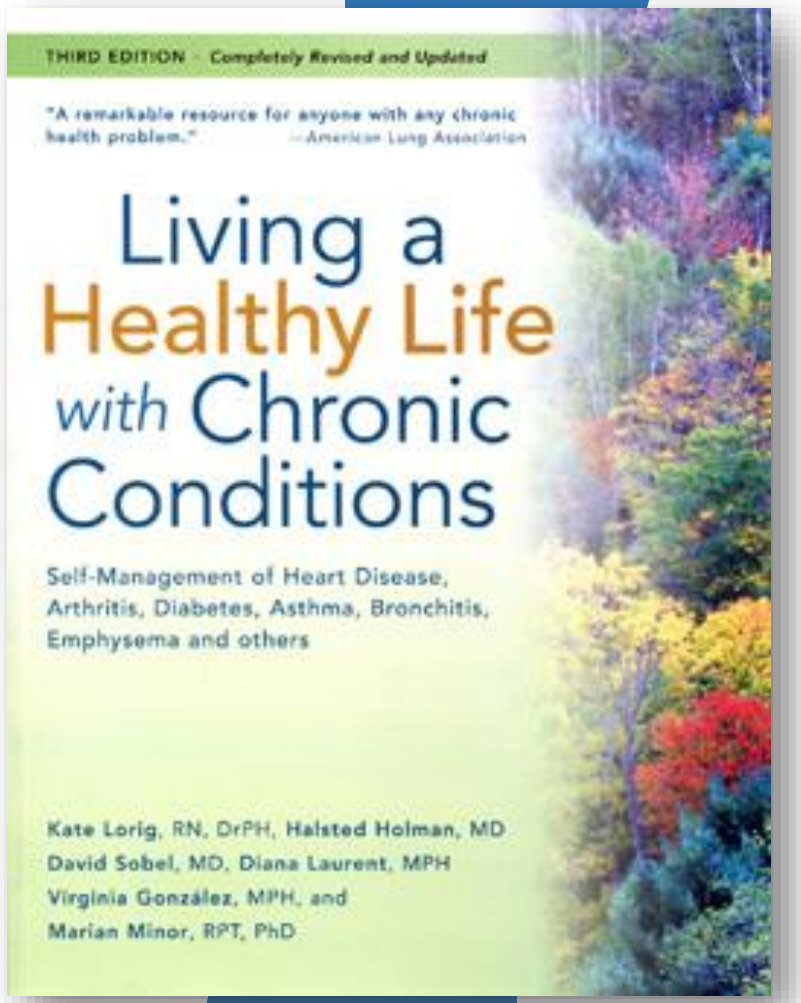
- Suite of Self-Management Programs developed at Stanford University
  - Chronic Disease Self-Management* / *Manejo Personal de la Diabetes*
    - online, in-person and toolkit
  - Diabetes / *Manejo Personal de la Diabetes*
  - Pain Self-Management

*Leader manual available in Arabic, Bengali, Chinese, Dutch, French, German, Greek, Hindi, Italian, Japanese, Korean, Khmer, Norwegian, Punjabi, Russian, Somali, Swedish, Tagalog, Tamil, Turkish, Vietnamese

CDSME Program Design

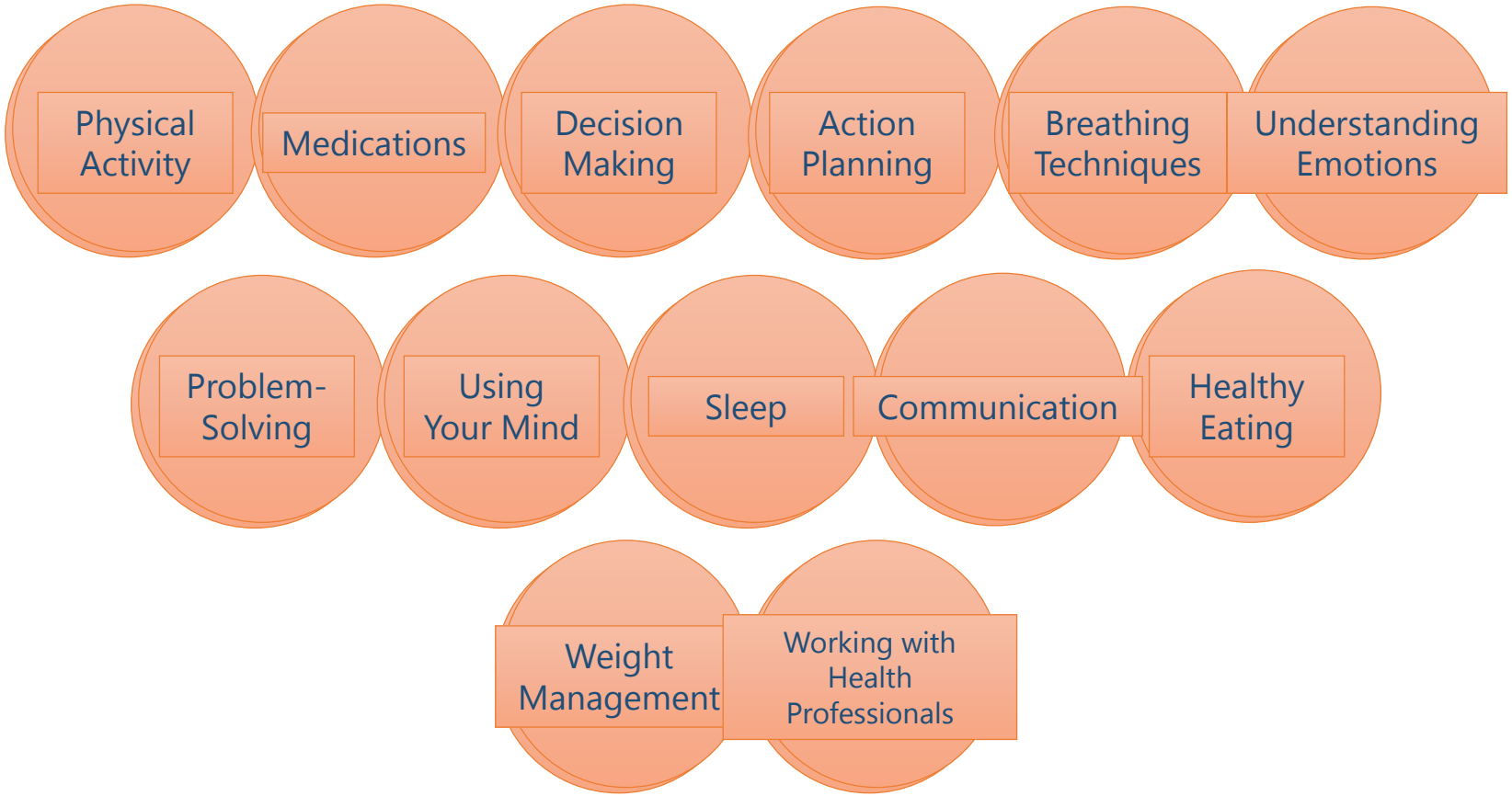
Chronic Disease, Diabetes and Pain Self Management Programs

- 12 -16 participants
- Two Trained Leaders
- People with different conditions
  - *Six-week Program*
  - *2 ½ hours, one day a week*
  - *Includes:*
    - *Group discussions*
    - *Activities*
    - *Short lectures*
  - *Book: Living a Healthy Life with Chronic Conditions*



Learning Skills to Manage Chronic Illness

Emphasis Changes by Program



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What A Class Looks Like . . .

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Chronic Disease Self-Management Program (CDSMP)

Clinical Outcomes

- **Population:** 571 union members w/chronic conditions in MCO
- **Intervention**: CDSMP + monthly meetings + incentives (discounted medication co-pays)
- **Outcomes**:
  - **Compared to baseline, after 12 months**
    - **Self-rated health** good or excellent: 60% vs. 32% at baseline
    - **BMI** ↓ 1 point
    - **A1C** ↓ 1 point
    - **Systolic BP** ↓ 11 points
    - **Depression** score ↓ from 5.8 at baseline to 3.2
    - **Pain** ↓ from 3.2/10 to 2.0/10
  - **Compared to baseline, after 12 months**
    - ↑ **aerobic exercise** from 51 to 75 minutes per week
    - ↑ **stretching/strength** exercise from 21 to 35 minutes per week

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Diabetes and Chronic Pain Outcomes

Diabetes Study[1]

- Statistically significant improvement in participants
  - Completing suggested laboratory tests for diabetes
  - With HbA1c >=9 decreased their HbA1c by approximately the same amount as one would expect by taking metformin
  - Additionally, 75% of sample improved by an effect of 0.4 or more for at least one of the following:
    - Depression,
    - Hypoglycemia,
    - Adherence to medications, and
    - Minutes of exercise

Pain Study[2]

- Participants showed improved confidence in keeping certain symptoms from interfering with the things they want to do:
  - Fatigue
  - Physical discomfort
  - Emotional stress
- The workshop helped participants be more confident they can do things outside of seeing their doctor or taking medication to reduce the effect pain has on their everyday lives

[1] Lorig K, Ritter PL, Turner RM, English K, Laurent DD, Greenberg J "Benefits of Diabetes Self-Management for Health Plan" Members: A 6-Month Translation Study, J Med Internet Res 2016;18(6):e164

[2] Gordon, D. et al., "Impact of the Harborview Chronic Pain Self-Management Program on participants' quality of life, confidence and pain experience",The Journal of Pain , Volume 18 , Issue 4 , S68

A Matter of Balance

Falls Prevention Programs

- Acknowledges the risk of falling but emphasizes practical coping strategies to reduce this fear, including:
  - Promoting a view of falls & fear of falling as controllable
  - Setting realistic goals for increasing activity
  - Changing the environment to reduce fall risk factors
  - Promoting exercise to increase strength and balance
- Meets once a week, 2 hours for 8 weeks

Tai Chi for Arthritis

- Led by a Certified Instructor, the program includes:
  - Warm up and cool down exercises
  - Progressive learning of movements leading to 6 basic core movements and six advanced movements
  - Breathing techniques
  - Tai Chi principles to improve physical and mental balance
- Meets twice a week for 1 hour for a minimum of 8 weeks

Arthritis Foundation Exercise Program

Exercise Programs

- Trained instructors cover:
  - Range-of-motion exercises
  - Endurance-building activities
  - Relaxation techniques
  - Health education topics

- All exercises can be modified to meet participant needs
- Classes meets twice a week for 1 hour, for 12 weeks

Arthritis Foundation Walk With Ease

- Community-based walking program
- Meets 3 times per week for 6 weeks
- Pre-walk discussion covering a specified topic related to exercise and arthritis
- Followed by a 10-40 minute walk

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Celebration Is Important!

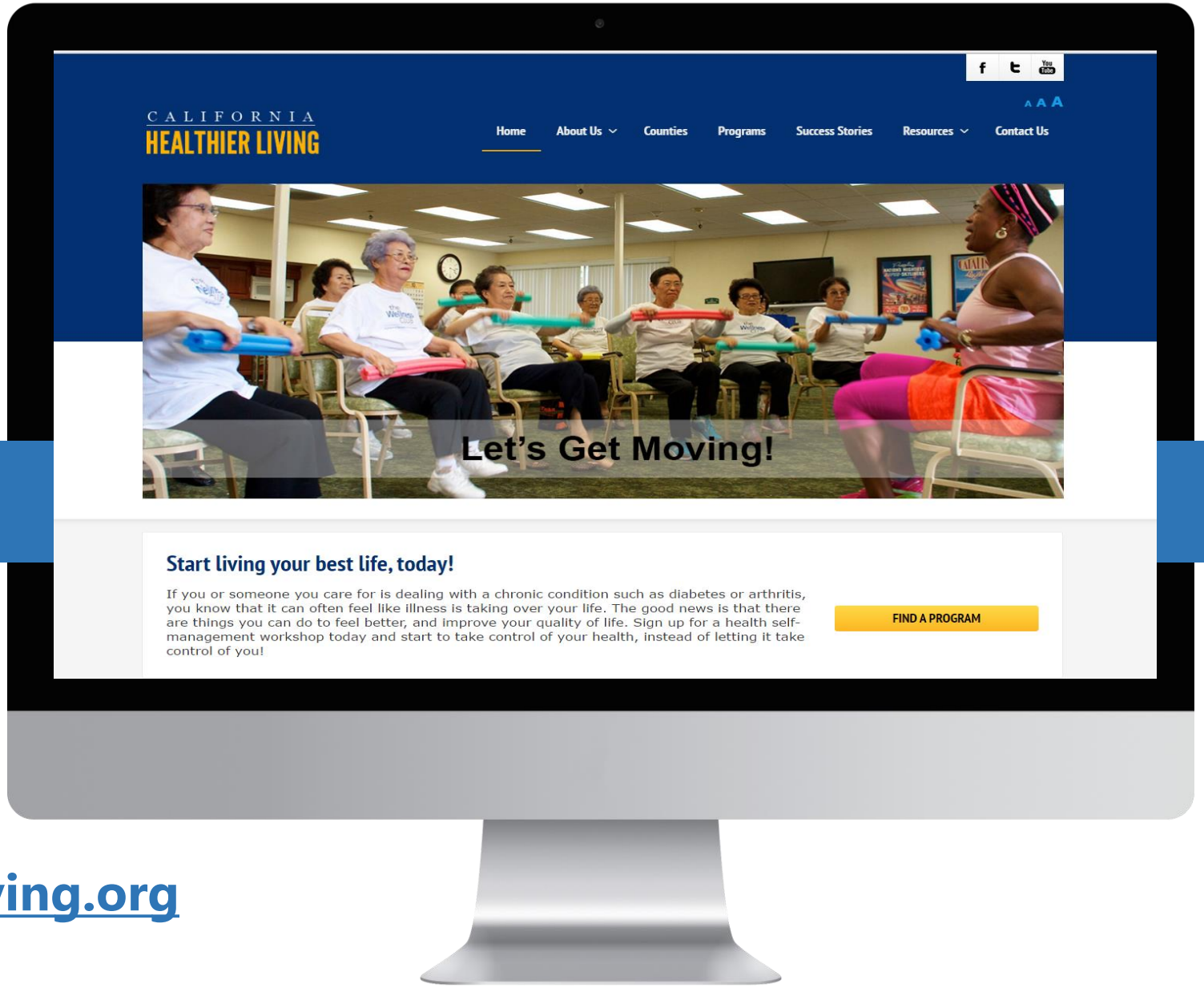
Participant Testimonials

- *"The workshop **put me back in charge of my life**, and I feel great. I only wish I had done this sooner."*

- *"I found the interaction with the other students in the class to be most enlightening. I realized that although I have a chronic illness **I am not alone**. Thank you for all the lessons in helping me to deal with this."*

- *"It **helped me be more conscious of my emotions – I'm meditating now**. The workshop led me to that and brought me to the point where I'm not on my anti-depressants any more. It was the catalyst for so many different things for me."*

- *"Because I have been afflicted with Parkinson's for over 20 years, I have suffered a great deal of depression. **The skills you've taught me in maintaining positive thinking and combating depression have really helped** to improve my condition."*



http://www.cahealthierliving.org

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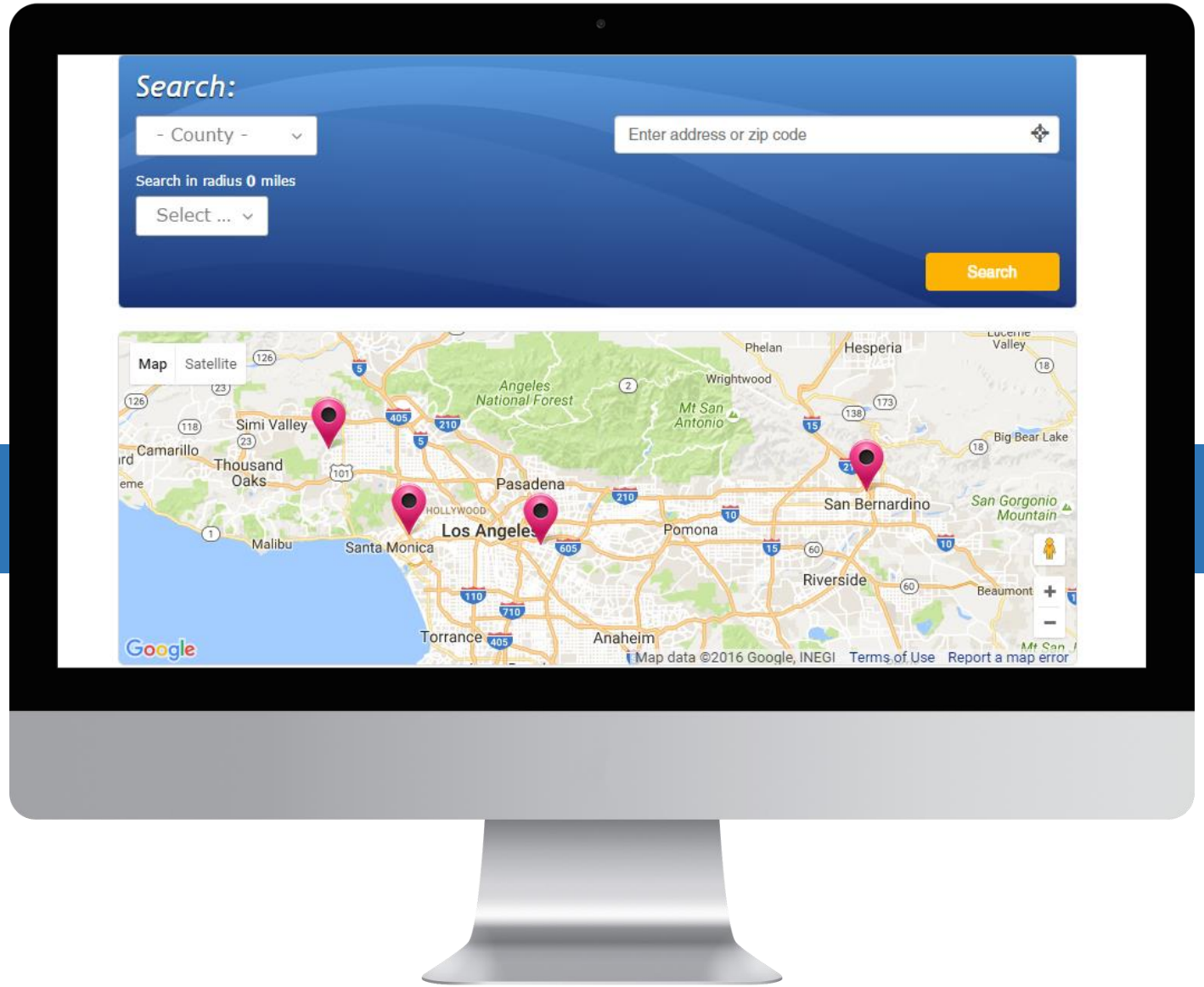
How to make a referral

Step 1: Search for a program to refer into

- What you need to know
  - What type of program is the individual interested in?
  - What county and zip code do they live in?
  - How far are they willing/able to travel? (5, 10, 15, or 20 miles)



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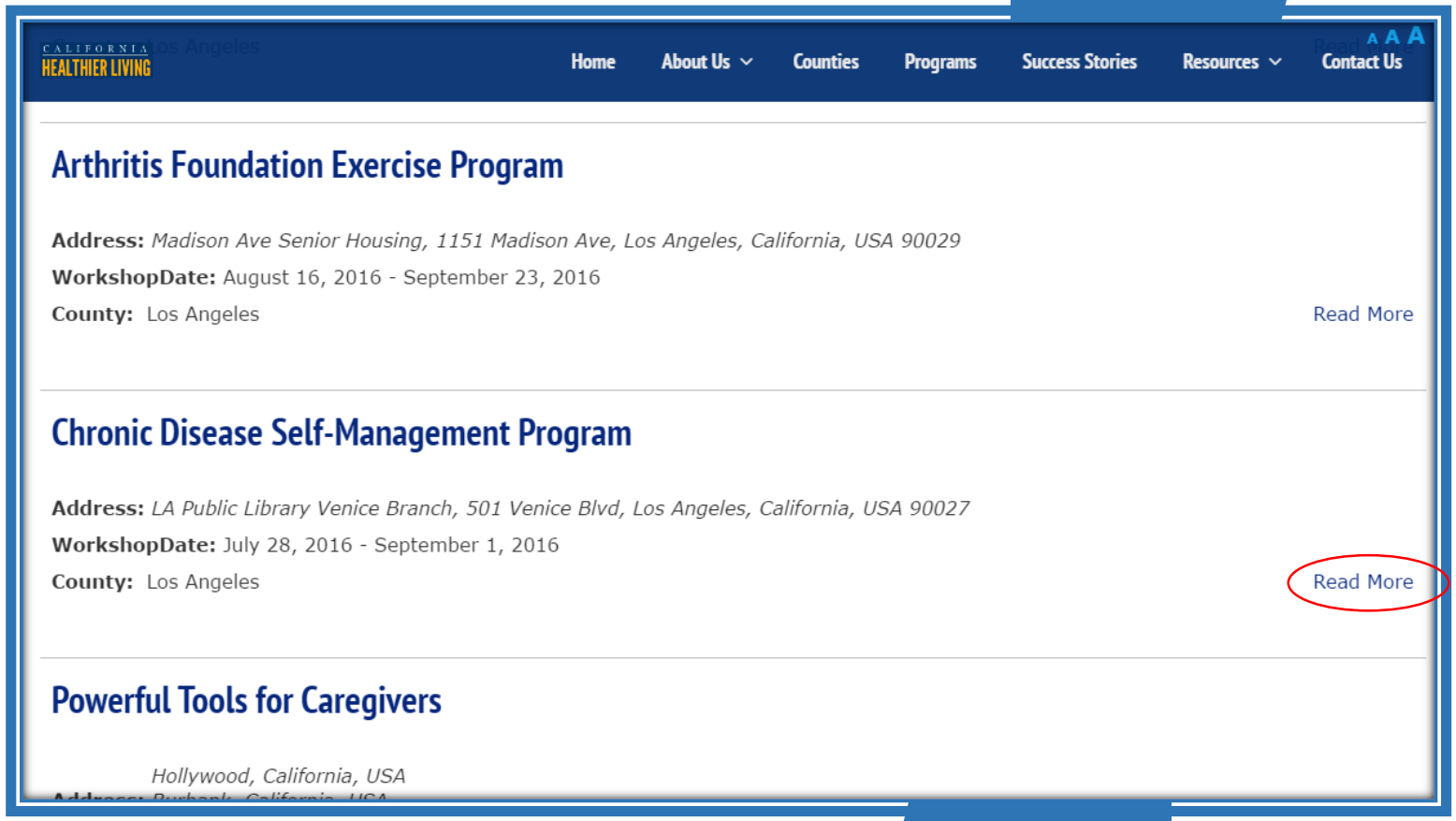
How to make a referral

Step 2: Decide on a workshop

- Things to consider
  - Workshop type
  - Distance from home
  - Start date (some are wait listed)



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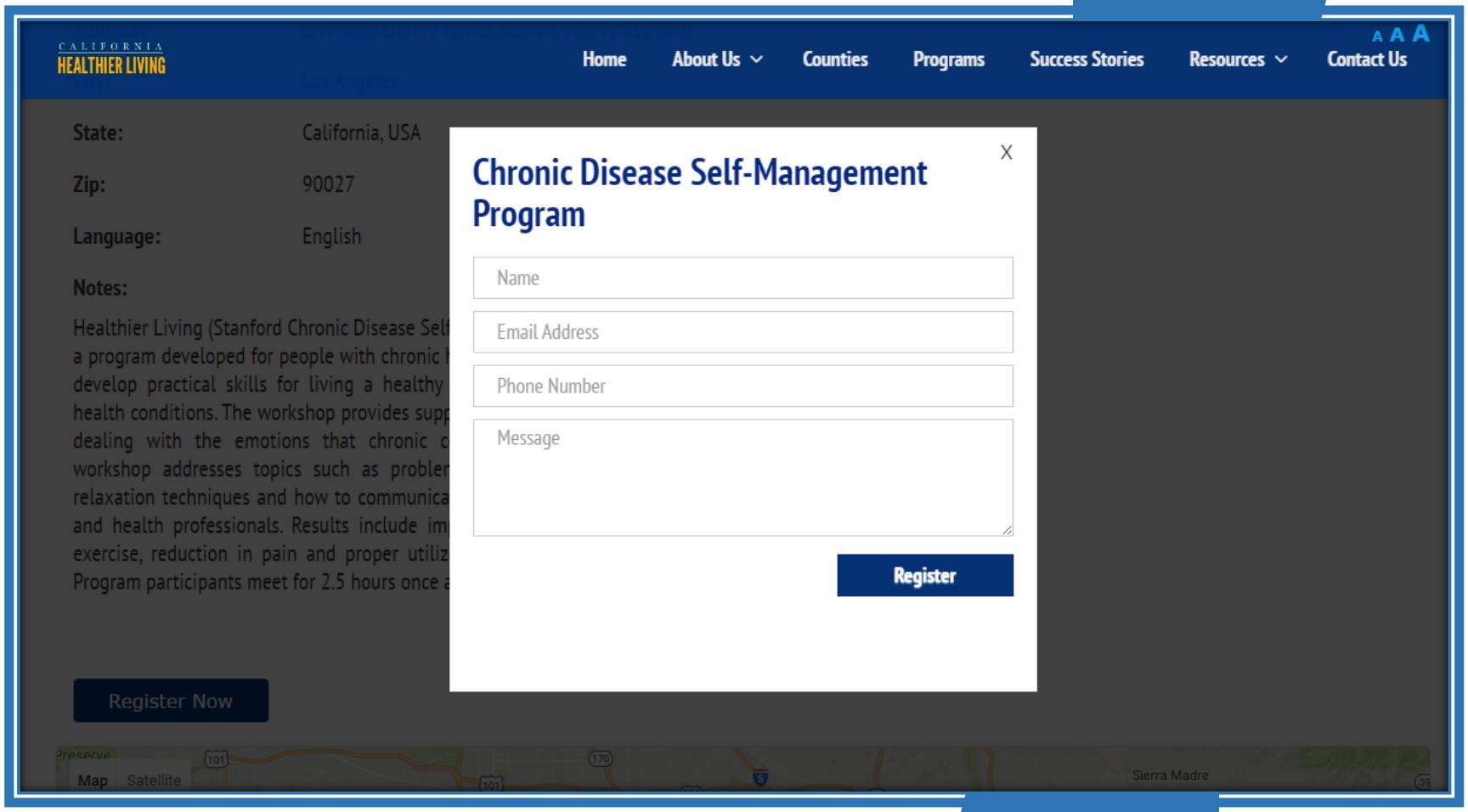
How to make a referral

Step 3: Input the individual's information

- You will need:
  - Name
  - Email address
  - Phone number



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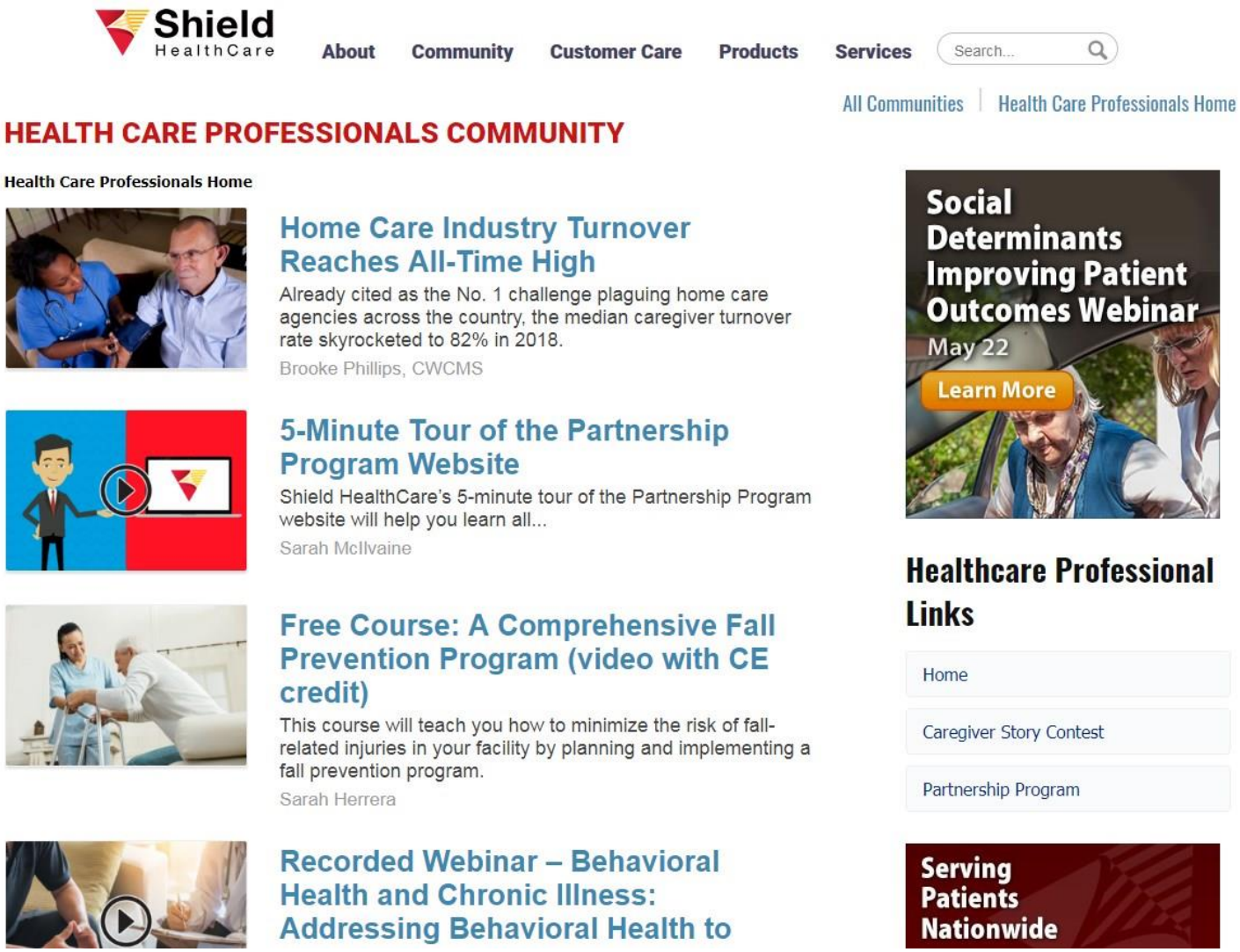

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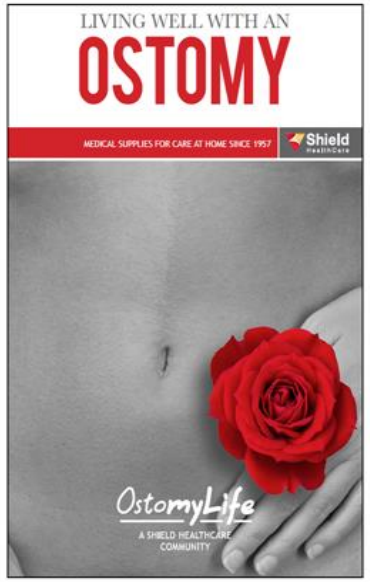
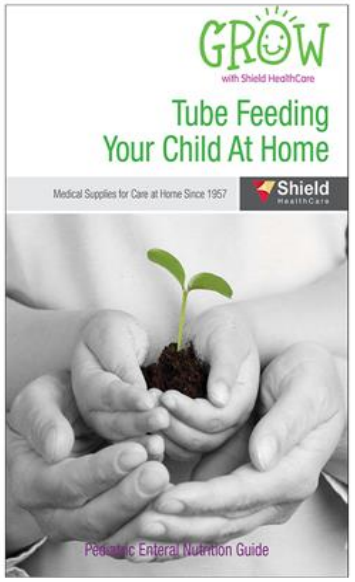
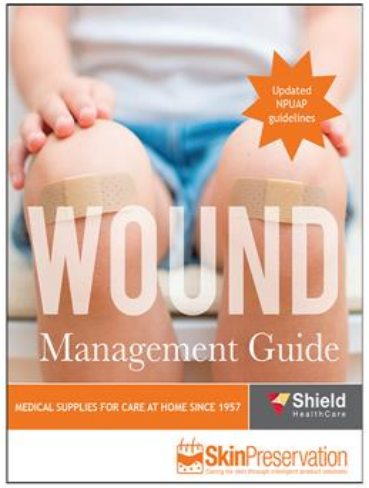
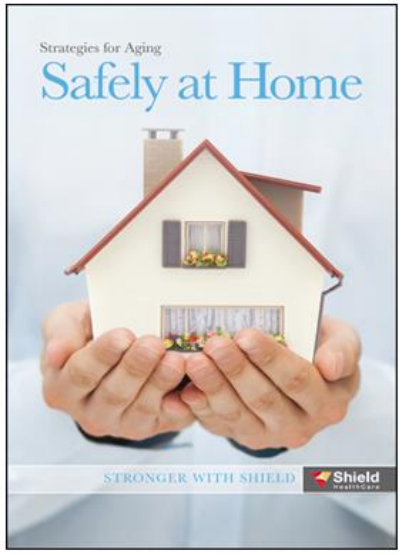
FREE EDUCATIONAL BOOKLET GUIDES

Patients, Family & Healthcare Professionals Can Request Guides Online:









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PLEASE CONTACT US!

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FOR MORE INFORMATION, OR TO ASK QUESTIONS ABOUT THE PRESENTATION, CONTACT:

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QUESTIONS?

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