The Social Determinants of Health: Our Doorway to Collaborating with Health Care Professionals

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Goals

- Identify at least 5 social determinants of health.
- Explore how social determinants of the over 65 are different than other age cohorts.
- Design plans of care to reduce readmissions using the social determinants.
- Gain approaches that will open the ears of those in medical practices to understand the value and the role a Care Manager/Aging Life Care Professional™ can be in their patients' lives.

What are Social Determinants of Health (SDH)

Group
- Economic Stability
- Educational Attainment
- Employment Status
- Food
- Housing/Environment (zip code)
- Community & Social Context
- Healthcare System
Research

- Philips Wellcentive White Paper – included with your slides.

"Ongoing analysis shows that the majority of treatments & services patients pay for play a small role in determining overall health."

"Our care delivery system currently does not provide adequate care coordination."

David Nash, MD, MBA
Jefferson College of Population Health

Determinants of Overall Health

- 37% Behavioral
- 25% Genetic
- 20% Socioeconomic
- 12% Healthcare
- 6% Environment

What Do You See as the Major Health Care Determinants?

- Group Discussion - Break out into small groups and discuss with your group what you are seeing as the major determinants to health.
What Did We All Come Up With?

<table>
<thead>
<tr>
<th>Social Isolation</th>
<th>Dementia or Mental Health Issues</th>
<th>Safety – Home &amp; Community</th>
<th>Family – Elder Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of over the counter medications</td>
<td>Transportation</td>
<td>Finances - Ability to use resources is limited by $ or knowledge</td>
<td>Poor Diet (Weight issues (Due to lack of education, $ or awareness))</td>
</tr>
<tr>
<td>Bladder or Bowel issues not being addressed naturally</td>
<td>Alcohol or Drugs</td>
<td>Toxic Environment</td>
<td>Elder Abuse, Others...</td>
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</tbody>
</table>

Research on Over 65 Social

The most common type of needs identified by “Health Coaches” were:
- Caregiver Needed 17.7%
- Food Boxes 15.2%
- Medical Transit 10.4%
- Med Equipment 7.3%
- Home Repair 6.2%
- Financial Support 3.1%

* "Approximately 20% of Medicare patients with complex chronic care needs account for some 80% of costs. If we can find & better manage these 20% of patients, we have a fighting chance of reducing healthcare costs”

Client Centric vs. Client Centered Care?

- What do you think the difference is from these two terms?
- How might you explain how we work to a medical provider who says they are doing “client centered” care?
Medical Providers Want “Best Practices Proof”

Do they want data and numbers to support your interventions?

How can you explain this to those in your community medical practices & hospitals?

What Do Medical Providers Want to Hear?

Leading Research
Identifying at risk population based on social determinants of health and then tailoring healthcare to them via care management and preventive care will reduce costs.

20% of Medicare recipients with complex care account for 80% of costs.

Philips Wellcentive - White Paper on Community Vitals & the importance of social determinants in population health

What Medical Teams Do You Approach?

- Hospitals?
- Medicare Advantage Insurance providers?
- Skilled Nursing?
- Medical Clinics or Physician Practices?
Designing Care Plans Interventions to Reduce Re-Hospitalization – Addressing the SDH

There are 7 conditions that result in hospitals being penalized if a patient is re-hospitalized within 30 days.

- Acute Myocardial Infarction (AMI)
- Chronic Obstructive Pulmonary Disease (COPD)
- Heart Failure (HF)
- Pneumonia
- Coronary Artery Bypass Graft (CABG) Surgery
- Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA/TKA)

We can design specific plans of care for each of those conditions.

Let’s look at a draft of one I designed for care managers on (COPD).

Designing Care Plans

What interventions have you added to address the “Social Determinants” that are often overlooked by medical providers?

What Went Wrong on Discharge?

- How has a client of yours been put in jeopardy because of a poor discharge plan?
- How did you follow up with the PCP?
- What should you do when this happens?
  - Approach is collaborative not punitive
  - Advocate as if you want them to refer clients to you…because you assist with “compliance” and positive outcomes. Showcase your abilities to address those “Behavioral issues with a spin on quality of life”
Working With the High Risk Client

- If you could help the client prepare for a hospitalization – you can reduce negative outcomes
  - Pre-conditioning
  - Prepare for transition to home – moving furniture, etc.
  - Education on what to expect reduces stress & worry
  - Communicate to hospital staff sensory or cognitive issues that could affect treatments or in-hospital compliance

Planning with Families

- Pre-Hospital – "Readiness"
- ER-Admissions
- Expectations – During and post hospitalization
- Care Plan Adjustments
- Training home-care on "red flags"
- Educate families on the social determinants of health

Our “Doorway”

- The Approach
- The Goal
- Feedback
- Solicit Ideas
- Compliance
Questions & Comments

Presenter’s Information

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Eldercare Services – Since 1989 – 29+ years
Past President (2010)- Aging Life Care Association previously The
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Eldercare Services provides advocacy, counseling, Professional Care Management, home
(from 2 hours to 24 hours), support groups and family education. We have experts who
become your “navigator” and let you be the “Captain” of your long life.

Research for Workshop

- Phillips Wellcentive White Paper on “Community Vitals”
- CHCS Screening for Social Determinants of Health in Populations with
  complex needs: Implementation Considerations by Caitlin Thomas-Henkel
  and Meryl Schulman, Center for Health Strategies, Brief
  October 2017
- CMAJ-JAMC Taking action on the social determinants of health in clinical practice: a framework for health professionals, Anne
  Andermann, MD, CMAJ 2016 Dec 6
- American Society on Aging – Aging & Disability Business Institute. The
  Social Determinants of Health: Key Factors in Creating Value Through
  CBO-Health Care Partnerships
- CDC Center for Disease Control and Prevention, CDC Research on
  SDOH
- Linda Fodrini-Johnson, MA, MFC, CMC – 34 years as a Professional
  Care Manager, Educator and Coach