Community Health Navigators Address Social Determinants of Health to Impact High Hospital Utilization

It is well known that access to proper health care alone is not enough to ensure improved health outcomes.[1] While deficiencies in the health care system contribute to about 10 percent of total mortality rates, health-risk behaviors and social determinants of health (SDOH) like education, racial segregation, lack of social supports, and poverty account for **more than half of premature deaths** in the United States every year.[1] These SDOH yield a high-utilizer population who receive lower-quality care and suffer from poorer health outcomes than their counterparts who have fewer psychosocial barriers.

SOCIAL DETERMINANTS OF HEALTH

THE CONDITIONS IN WHICH PEOPLE ARE BORN, GROW, WORK, LIVE, AND AGE, AND THE WIDER SET OF FORCES AND SYSTEMS SHAPING THE CONDITIONS OF DAILY LIFE… [INCLUDING] ECONOMIC POLICIES AND SYSTEMS, DEVELOPMENT AGENDAS, SOCIAL NORMS, SOCIAL POLICIES, AND POLITICAL SYSTEMS.[2]

HEALTH CARE INEQUITIES

18%

differential between low- and high-income earners reporting financial barriers hindering them from accessing necessary health care services.[3]

HEALTH CARE COSTS

5%

of the U.S. population account for 50% of total health care expenditures.[4]

HEALTH CARE REPUTATION

11TH

place U.S. ranking in health care system performance among other high-income countries.[3]

AmeriHealth Caritas leverages its community care management teams led by a medical director and consisting of community health navigators, community care managers, and a program manager to engage high- and emerging-risk members to increase their access to care and improve their overall health care experience through care management services delivered in member homes, with an emphasis in screening for and addressing SDOH. This person-centered, trauma-informed strategy to screen for and address SDOH for members has been adopted by our Medicaid managed care organizations serving six states and the District of Columbia.

Our SDOH survey data[5] demonstrated our success in identifying and addressing specific SDOH vulnerabilities at both the population and member levels. High-risk members engaged with community-based services had more SDOH vulnerabilities, like health literacy, transportation to medical facilities, and food insecurity than those not engaged with these services.

34% of high-risk engaged members (n=677) had vulnerability in health literacy versus only 7% of all other members (n=102,924).[§]

23% of high-risk engaged members (n=677) had vulnerability in transportation to medical facilities versus only 7% of all other members (n=102,924).[§]

23% of high-risk engaged members (n=677) had food insecurity versus only 8% of all other members (n=102,924).[§]

The provision of community-based services resulted in marked reductions in acute utilization from baseline in the engaged population.

- ⬇ 26.3% inpatient (IP) admissions.*
- ⬇ 27.2% IP days.*
- ⬇ 9.7% emergency room (ER) visits.*
- ⬇ 22.0% potentially preventable IP admissions.*
- ⬇ 12.0% potentially preventable ER visits.*

SOURCES:

1. Anna Spencer, Bianca Freda, Tricia McGinnis, and Laura Gottlieb, M.D. “Measuring Social Determinants of Health Among Medicaid Beneficiaries: Early State Lessons.” Center for Health Care Strategies, Inc., December 2016. https://www.chcs.org/media/CHCS-SDOH-Measures-Brief_120716_FINAL.pdf.
2. “About Social Determinants of Health.” World Health Organization. Accessed September 18, 2018. http://www.who.int/social_determinants/sdh_definition/en.
3. Eric C. Schneider, Dana O. Sarnak, David Squires, Arnav Shah, and Michelle M. Doty. “Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care.” The Commonwealth Fund, July 2017. https://interactives.commonwealthfund.org/2017/july/mirror-mirror.
4. Steven B. Cohen, Ph.D., and William Yu, M.A. “The Concentration and Persistence in the Level of Health Expenditures Over Time: Estimates for the U.S. Population, 2008 – 2009.” Agency for Healthcare Research and Quality, January 2012. https://meps.ahrq.gov/data_files/publications/st354/stat354.pdf.
5. Standardized SDOH screening is conducted via an enterprise-wide member survey (n=120,000) adapted from the validated PRAPARE tool (National Association of Community Health Centers; Bethesda, MD). The survey assesses the member’s unmet SDOH needs across five domains: education; health literacy; transportation (medical and non-medical); housing; and material security (i.e., food, utilities, child care, clothing, phone, and household needs). For every plan, the member’s survey response to each SDOH status query was risk-stratified as “declined,” “stable,” “vulnerable,” and “crisis” (housing only) for every domain and subdomain.

* Calculated from weighted pre-post means per six lines of business.

§ Other SDOH fields with greater member vulnerability include challenges in transportation to non-medical facilities, education level, food, housing, utilities, phone bill, clothing, and everyday expenses.

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