This packet is an introduction and brief summary of information related to the strategy listed below. It is not exhaustive and is intended to be a starting point for the conversations that will take place at the Next Steps event. Your expertise and experience with this topic will help to fill in gaps and round out the conversation.

Strategy: Address social and economic barriers to health in medical settings

Group Charge: Create a plan that determines how Community Health Workers (CHW) and clinic staff meet the needs of underserved populations.

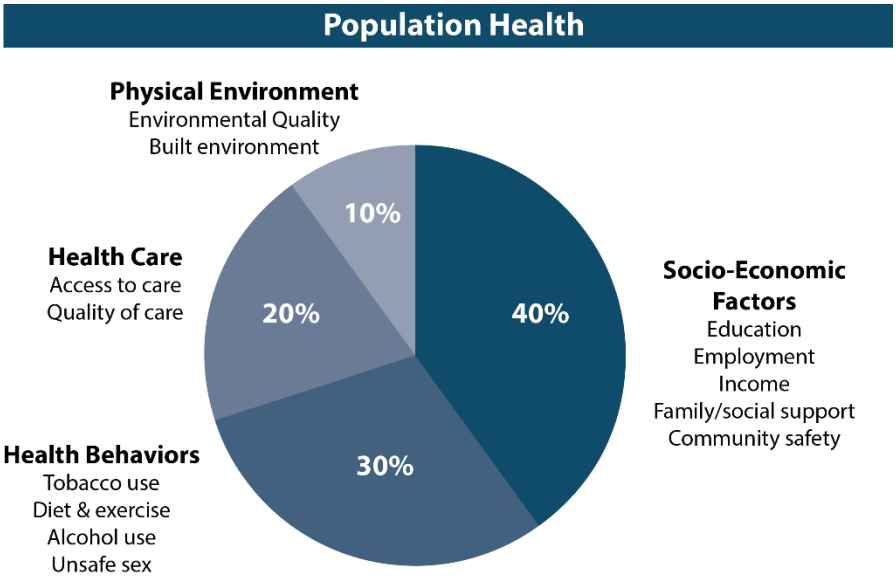
WHAT WE KNOW

Background

In general

The health of a population is largely driven by factors outside the clinical setting. According to some estimates, only 20% of health outcomes are directly influenced by clinical care; the other 80% of health outcomes are a result of social and economic determinants, health behaviors, and physical environment.[1] There is growing recognition that in order for health care reform efforts to improve population health, significant investment in understanding and addressing social determinants of health is needed.[1]

Figure 1: Social determinants of health[1]



©ICSI 2012 "Achieving Accountability for Health and Health Care" white paper available online at www.icsi.org

About this strategy

The following brief outlines key understandings and recommendations in the areas of collecting data related to the social and behavioral determinants of health and using that data to identify, refer, and connect patients to necessary care and social services. Recommendations for designing intervention models, including the Accountable Health Communities model, the Health Leads model, and community health worker model, highlight effective practices in addressing barriers to accessing care and providing holistic, culturally relevant care.

DESIGNING INTERVENTIONS TO ADDRESS SOCIAL AND ECONOMIC BARRIERS

Collect Information in the Clinical Setting

Social and environmental determinants of health, such as lifestyle behaviors and access to healthy foods, have been shown to have significant influence on the health of individuals and communities.[2] However, these factors are not often collected or used for assessment in clinical settings. In response to a call from the National Institutes for health, the Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Department of Veterans Affairs, together with various health foundations, the IOM identified 12 domains of social and behavioral information that, if collected across electronic health record (EHR) systems, could be used for diagnosis, treatment decisions, policy, and health care system design and innovation (See Table 1).[3]

Based on its work, the IOM has recommended that these domains be included in EHRs and "Meaningful Use" certification.[3] Additional recommendations include linking relevant social data to local public health departments and community health organizations.

Table 1: IOM's 12 social and behavioral domains

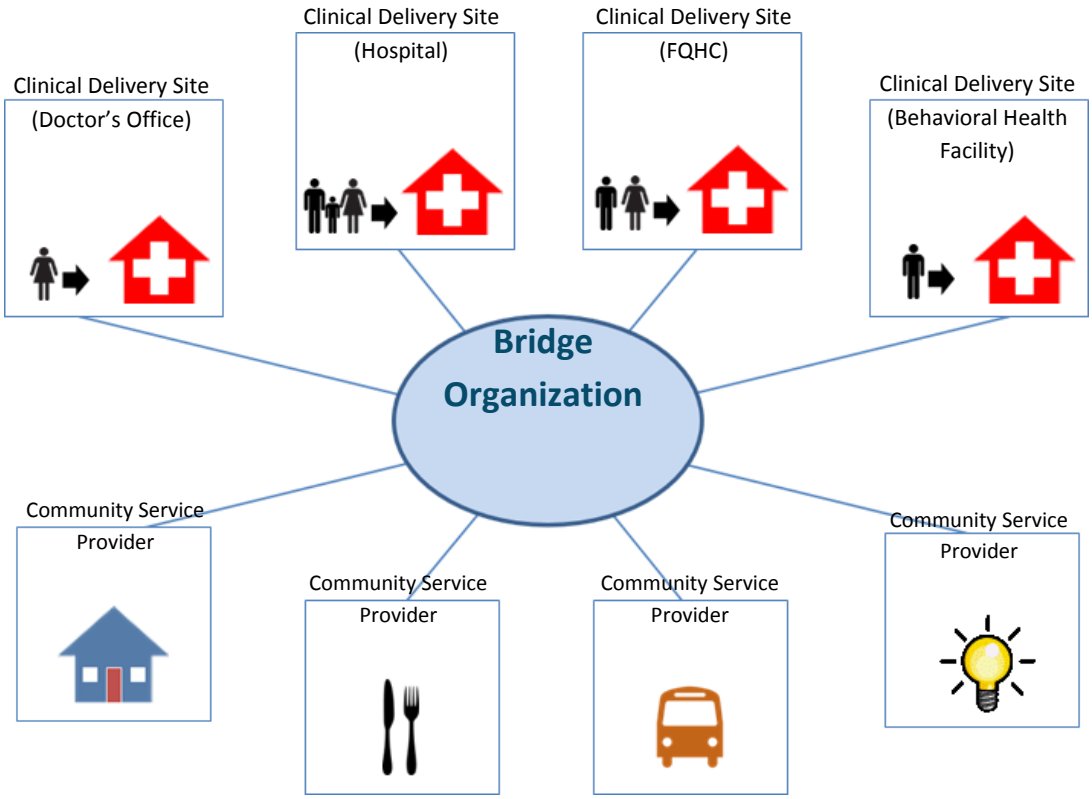
Identified Domain	Suggested Frequency of Assessment
Alcohol use	Screen and follow up
Race and ethnicity	At entry
Residential address	Verify every visit
Tobacco use & exposure	Screen and follow up
Census tract-median income	Update on change
Depression	Screen and follow up
Education	At entry
Financial resource strain	Screen and follow up
Intimate partner violence	Screen and follow up
Physical activity	Screen and follow up
Social connection & isolation	Screen and follow up
Stress	Screen and follow up

Intervene at Multiple Points

Accountable Health Communities

The *Accountable Health Communities Model* (AHC) is an approach to health care delivery that seeks to bridge current gaps between clinical and community services to better meet the health-related social needs of a population. The model promotes shared responsibility and community-level engagement, emphasizing the need for enhanced health and social service networks.[4] The model specifies four elements of comprehensive intervention—screening, referral, navigation, and care delivery—and highlights the need to connect these points of intervention across the continuum of care. A diagram of how these points of care coordination intersect can be seen in Figure 2. For more information on the AHC model, see **Appendix A: Excerpt from the FOA**.

Figure 2: AHC model structure[4]



Health Leads

The *Health Leads Model* (HLM) is a holistic approach to medicine in which physicians also screen their patients for unmet social needs and prescribe necessary medications or basic resources their patients need to be healthy, such as food or heat.[5] These prescriptions can be filled at a Health Leads Desk by advocates who work with the patients to obtain community resources and public benefits. Figure 3 displays the process of the HLM. The model effectively addresses the social determinants of health by using an innovative method of integrated partnerships, a well-trained, lay workforce, sustainable funding from earned revenue as well as local and national philanthropy, and generous volunteerism from college students and health care professionals.[6,7]

Those who practice using the HLM began by researching and inventing innovative care delivery methods. They engage patients by having trained advocates follow up with them shortly after their appointments. To

reach out to their resources seamlessly, the HLM utilizes technology to map out the details and locations of the resources and exchange data with those resource centers. Health care providers who become clinical partners with Health Leads USA gain access to workshops, consultation services, a peer collaborative, direct staff support, and a software platform. As of 2014, there were 23 Health Leads clinics in 6 geographic areas.[8]

Figure 3: Health Leads Model[5]

Community Health Worker

Community Health Worker (CHW) Programs have been growing after the implementation of the Affordable Care Act. CHWs are able to spend ample time with patients, assist them in making behavioral changes, and help to address barriers by providing outreach, education, counseling, social support, and advocacy in a culturally competent manner.[9] Research has found that CHWs help to reduce health disparities, expand access to coverage and care, and improve quality outcomes, such as increased immunization rates, breastfeeding success, and pulmonary tuberculosis cure rates.[10]

To create a strong CHW program, organizations should conduct research and evaluate a broad spectrum of CHW programs currently in use to see which approach is best for the organization.[9,10] They should then create a task force to identify key stakeholders from both the public and private sectors. These stakeholders are needed to develop CHW program goals, pass any necessary legislation, and form partnerships within the community. See Table 2 for a detailed description of the legislation needed to start a CHW program. CHWs will be more successful if they have a network or association to provide support and ensure they are a part of

the conversation regarding CHW policies. Educating health care providers on how they can utilize CHWs is important for creating an environment that supports CHWs.[9]

Table 2: Key policy components which need to be addressed when creating a CHW program in your state[10]

Key Comprehensive Policies	Policy Components
Financing mechanisms for sustainable employment	CHW services are: • Reimbursable by public payers (e.g. Medicaid, Medicare, SCHIP) and private payers, including fee-for-service and managed care models • Reimbursable in specific domains (e.g. FQHCs, community health centers) • Reimbursable to public health and to community-based organizations • Reimbursable on levels that have commensurate with a living wage
Workforce development	CHW training: • Allocates specific resources for the CHW workforce • Focuses on core skills and competency-based education • Includes core training and disease-specific training needed by CHW for the jobs for which they are hired • Includes continuing education to increase knowledge and improve skills and practices • Includes programs for supervisors of CHW as well as the CHWs themselves
Occupational regulation	The parameters of the CHW workforce: • Develop competency-based standards for CHWs that are compatible with a set of "core competency skills" recognized statewide • Include state-level standards for certification that are determined by practitioners (CHWs) and employers • Include a defined "scope of practice" • Recognize the CHW Standard Occupational Classification
Standards/guidelines for publicly funded research and program evaluation on CHWs	CHW Research: • Incorporate common metrics to improve its comparability and generalizability • Incorporates program evaluation and community involvement • Contributes to the evidence base

Best practices

Research has found four CHW program components that can contribute to positive health outcomes:[9]

- CHW completes a minimum of 40 hours of training
- CHW visits a patient's home or environment
- The in-person interaction between a patient and CHW lasts for at least 1 hour
- The CHW and patient share a community, ethnicity, or health condition

Implementation guide

The St. Johnsbury Community Health Team model was originally implemented in Vermont and evaluated by the Centers for Disease Control and Prevention (CDC).[11] The model includes an administrative core, extended community health team, community connections team, and advanced primary care practices. See **Appendix B** for detailed information on how to implement this model.

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