



STRATEGY DEVELOPMENT AND IMPLEMENTATION TO RESOLVE SOCIAL DETERMINANTS OF HEALTH

Presentation to 2024 Louisiana Rural Health Conference

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LEARNING OBJECTIVES

01. Apply principles of social care and health equity to strategic planning and implementation of social determinants of health.

02. Engage in effective decision-making for SDOH strategy implementation.

03. Develop a funding strategy for payment of social care and other health-related social need services.





KEY TERMS



Social
Determinants/D
eterminants of Health



Health Related
Social Needs



Health Equity



Community
Health
Workers



Social Care



STRATEGY DEVELOPMENT AND IMPLEMENTATION



PLAN

Recognize an opportunity and plan for change



DO

Carry out a small-scale study of the change



CHECK


Review and analyze the results of the change



ACT

Take action based on what you learned to refine or expand





PRINCIPLES OF HEALTH EQUITY AND SOCIAL CARE



Promote WELLBEING



Seek PERSPECTIVE




Understand PLACE



Develop PARTNERSHIPS

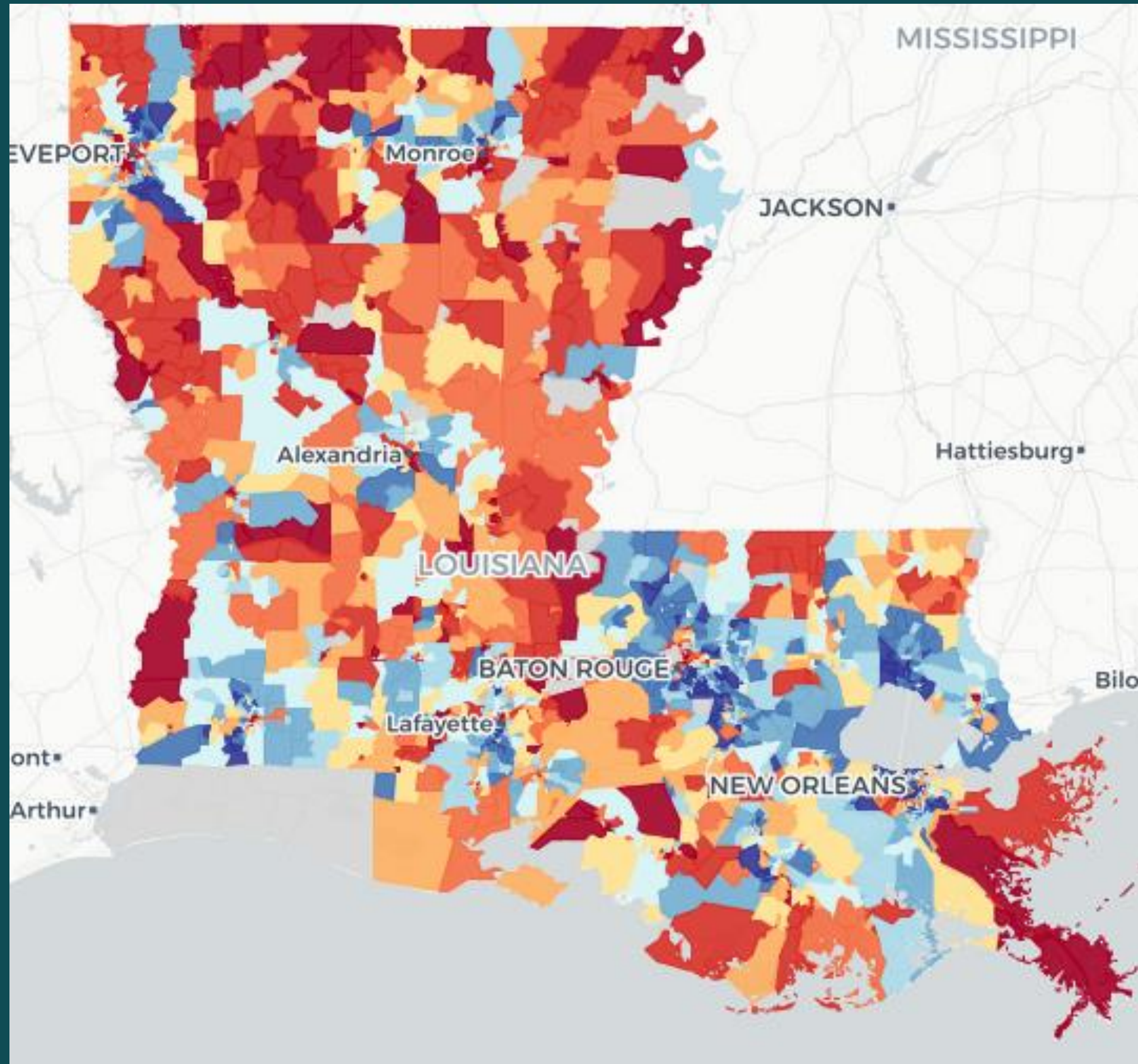


PLAN






























ASSESSMENT	Understand the current context of healthcare and Social care in your community
VISION	Articulate your realistic goals and objectives to connect patients to social care supports and services
STRATEGY	Develop a written plan of action to implement immediately and share with stakeholders including patients
PRINCIPLES	Incorporate principles of health equity and social care into all planning aspects

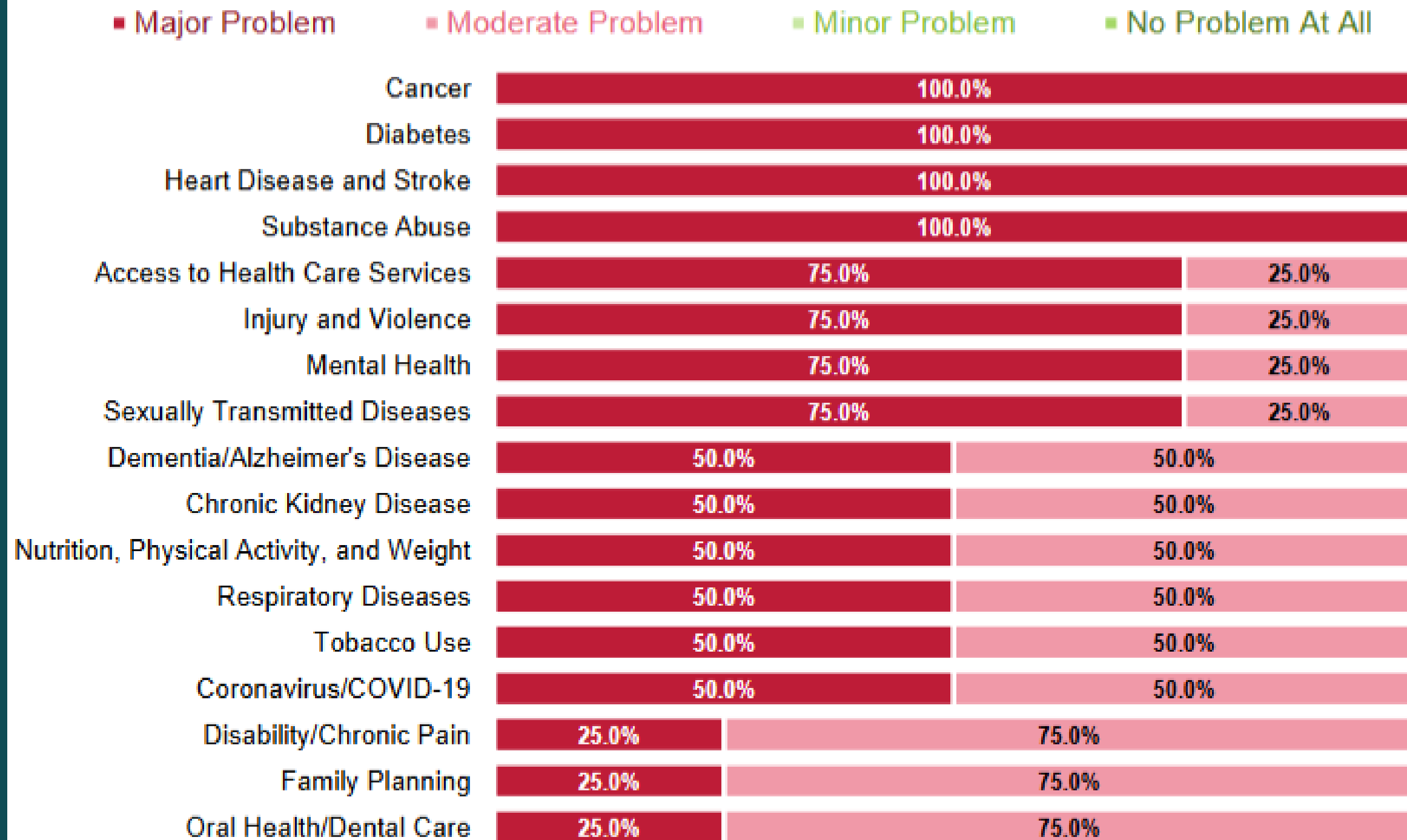






		[REDACTED] vs. BENCHMARKS				
SOCIAL DETERMINANTS	[REDACTED]	vs.	vs.	vs.	vs.	TREND
		[REDACTED]	LA	US	HP2030	
Linguistically Isolated Population (Percent)	0.6	 0.7	 1.7	 4.3		
Population in Poverty (Percent)	24.4	 21.0	 19.2	 13.4	 8.0	
Population Below 200% FPL (Percent)	48.7	 43.0	 39.0	 30.9		
Children Below 200% Poverty (Percent)	58.4	 50.8	 48.6	 40.1	 8.0	
Unemployment Rate, Percent (Jan 2022)	4.1	 3.5	 4.3	 4.4		 7.9
No High School Diploma (Age 25+, Percent)	23.2	 16.6	 14.8	 12.0		
% "Fair/Poor" Condition of Neighborhood Homes	25.8	 27.1				 18.7
% "Fair/Poor" Availability of Affordable Housing	62.5	 53.4				 43.4
% Displaced From Housing in Past 2 Years	12.5	 16.0				 13.7

Key Informants: Relative Position of Health Topics as Problems in the Community





COMMUNITY RESOURCES FOR HEALTHCARE AND SOCIAL CARE



Churches
Community Foundation
Council on Aging
Counseling Center
Farmers Market
FQHC
Grocery Stores
Parks and Recreation Dept
Psychiatric Hospital
Public Health Unit
Rotary Clubs
Rural Health Clinic
School Board
Substance Use Treatment Facility



DO



PEOPLE

The target population for the small-scale study

PARTNERS

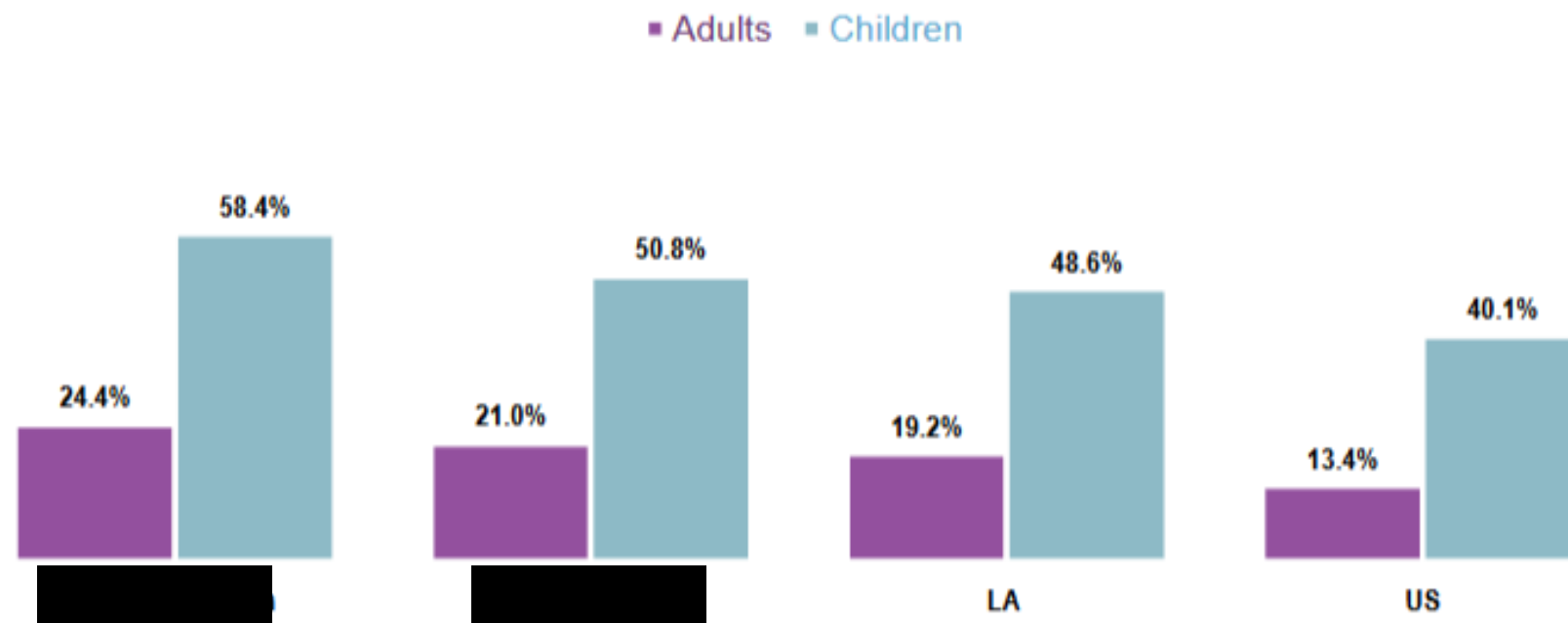
Internal and external stakeholders and collaborators essential for success

LOGISTICS

Specific details such as timeframe, required documentation, and responsible parties



Population in Poverty (Populations Living Below 100% of the Poverty Level; 2015-2019) Healthy People 2030 = 8.0% or Lower



Total Population by Race Alone (2015-2019)

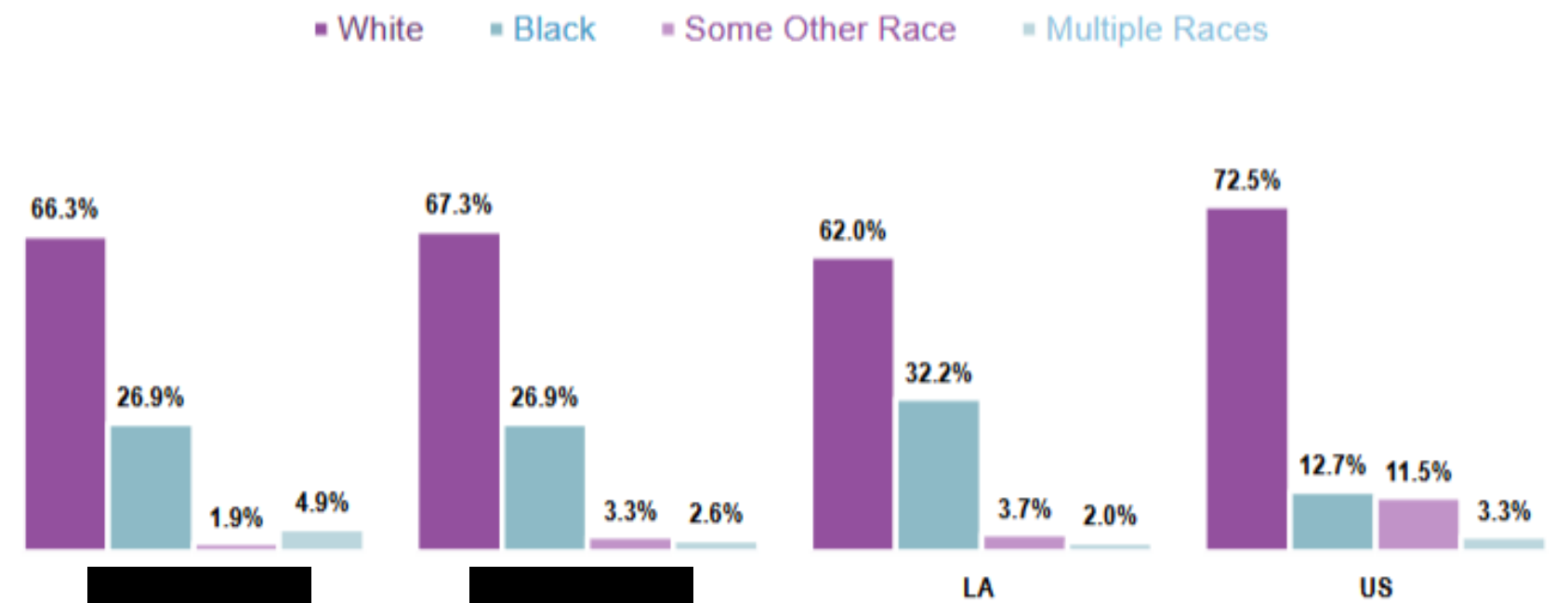
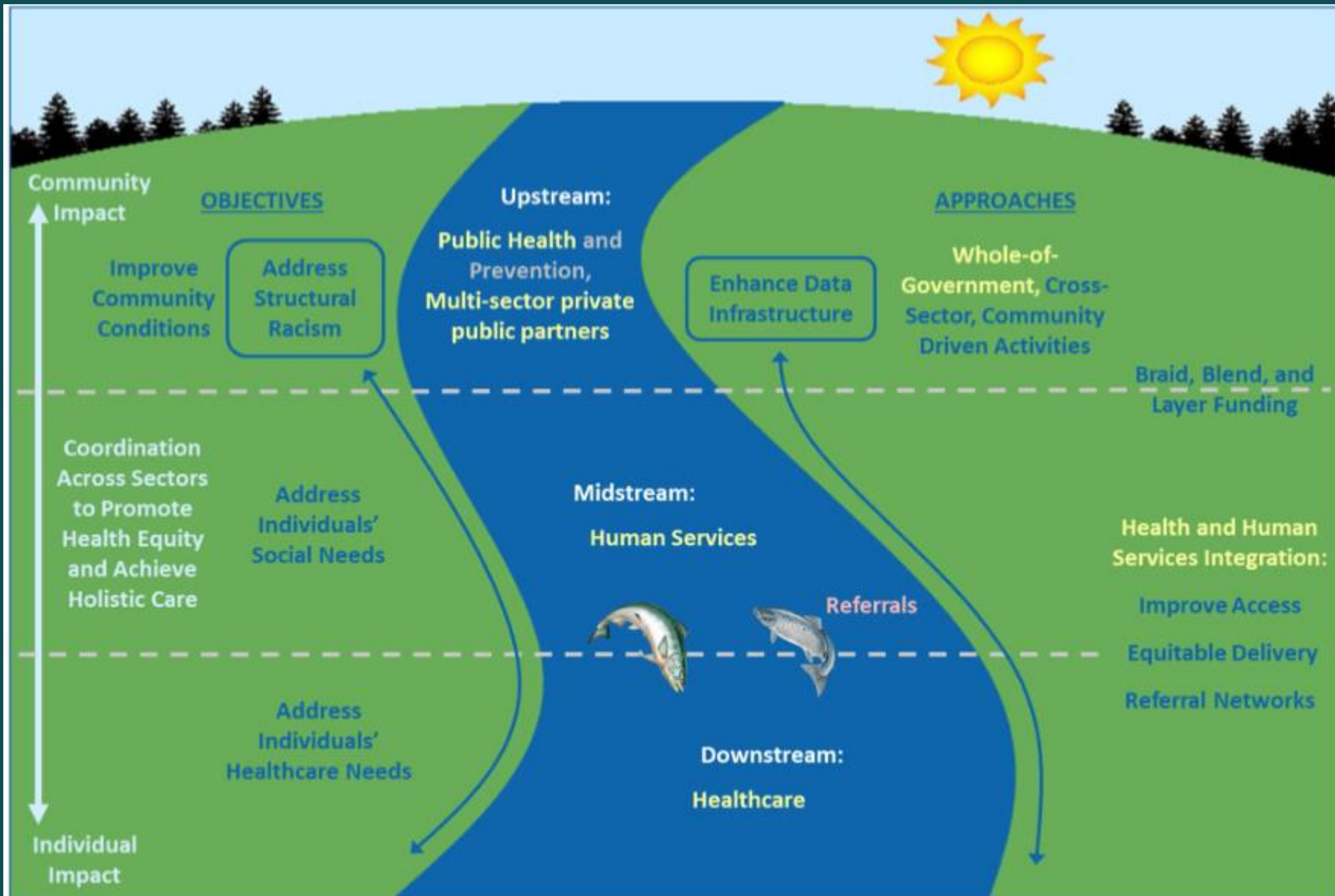


Table 1: Selected Evidence-Based Interventions Used In HHS Agencies: Illustrative Examples*

AGENCY	CMS	HRSA	CDC	ACL	ACF	SAMHSA
Housing Related Services	X	X		X	X	X
Home Modifications and Improvements	X	X	X	X		
Food Access	X		X	X	X	
Non-Emergency Medical Transportation	X	X		X		
Public Transportation			X	X		
Case Management & Social Service Connection	X			X	X	X
Community Health Workers	X	X	X	X		
Social and Economic Mobility			X		X	

Note: This table is not an exhaustive list of HHS activities in these areas and also does not necessarily reflect specific funding or designated programs in each area.



CHECK



FORMATIVE

Was the strategy implemented as designed and to the expected extent?

SUMMATIVE

Did the strategy have the intended outcomes for the patient participants?

DETERMINATION

Was the intervention successful, and is it replicable and/or expandable?

REFINEMENT

What changes need to made to the strategy to move forward?



ACT



PEOPLE

With expansion, continue to consider populations to be served and their perspectives.

PARTNERS

With expansion, continue to invest in developing and deepening partnerships with community-based organizations.

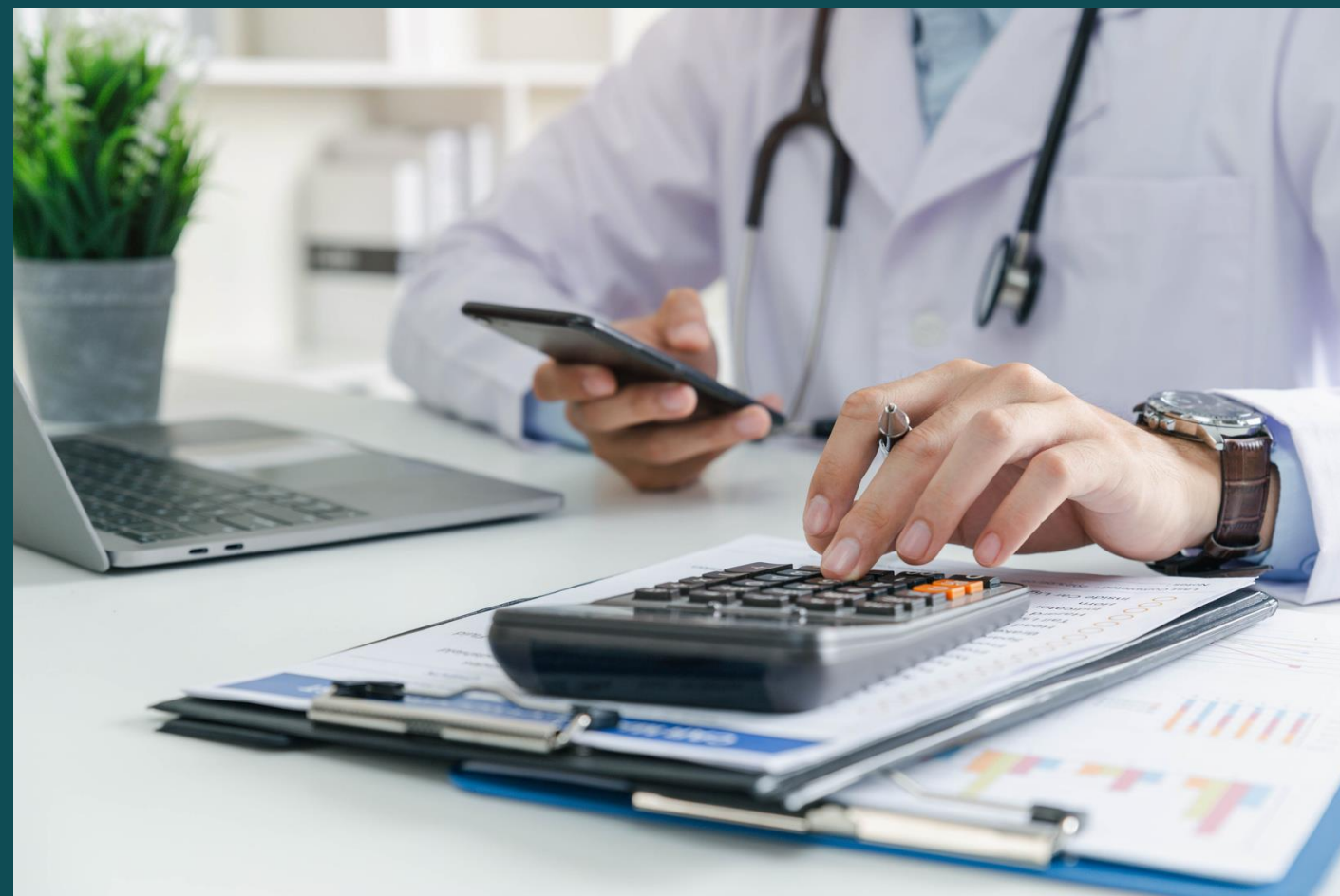
FUNDING

Determine ongoing funding streams to ensure sustainability of the strategy.

DOCUMENT

Continue to document results and outcomes as well as aggregated results and findings.





FUNDING THE STRATEGY



POTENTIAL FUNDINGS SOURCES



Cost
Avoidance



Grants and
Community
Funding



Social Care
Billing
Codes



Value-
Based
Care



Decision Support Table

Decision Matrix	SDOH Risk Assessment	CHI	PIN	PIN-PS
HCPCS Code(s)	G0136	G0019 – 60 min; G0022 – add 30 min.	G0023 – 60 min; G0024 – add 30 min.	G0140 – 60 min; G0146 – add 30 min.
Rate (Non-Facility)	\$18.64	60min: \$79.24. Add 30 min: \$49.44	60min: \$79.24. Add 30 min: \$49.44	60min: \$79.24. Add 30 min: \$49.44
Eligible Provider	Physician or Non-Physician Provider (PA, NP)	Physician or Non-Physician Provider (PA, NP)	Physician or Non-Physician Provider (PA, NP)	Physician, Non-Physician Provider, Psychologist
General Supervision Rules apply	No	Yes	Yes	Yes
Auxillary staff	Not Applicable	Yes	Yes	Yes
Billing Frequency	Once every six (6) months	G0019 first 60 minutes; G0022 each additional 30 min (no limit per month)	G0023 first 60 minutes; G0024 each additional 30 min (no limit per month)	G0140 first 60 minutes; G0146 each additional 30 min (no limit per month)



QUESTIONS AND COMMENTS

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