

MOVING FORWARD ~ CHRONIC DISEASE PREVENTION

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Social determinants of health:
it takes a village



SOCIAL DETERMINANTS OF HEALTH

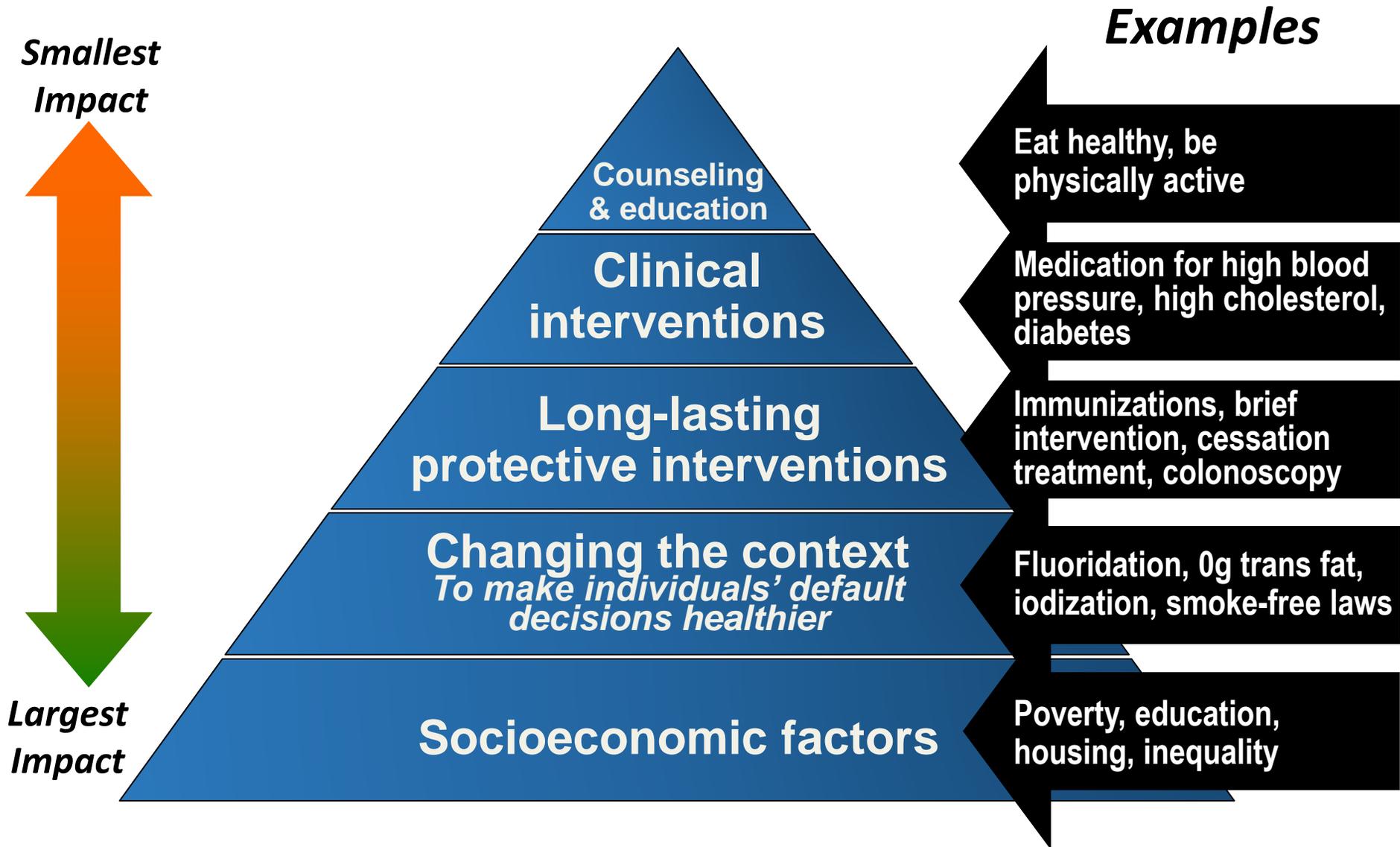
Conditions where people work, live, learn & play affect a wide range of risk and health outcomes.

These conditions are known as the Social Determinants of Health (SDOH.)

Healthy People 2020 Framework



Factors That Affect Health

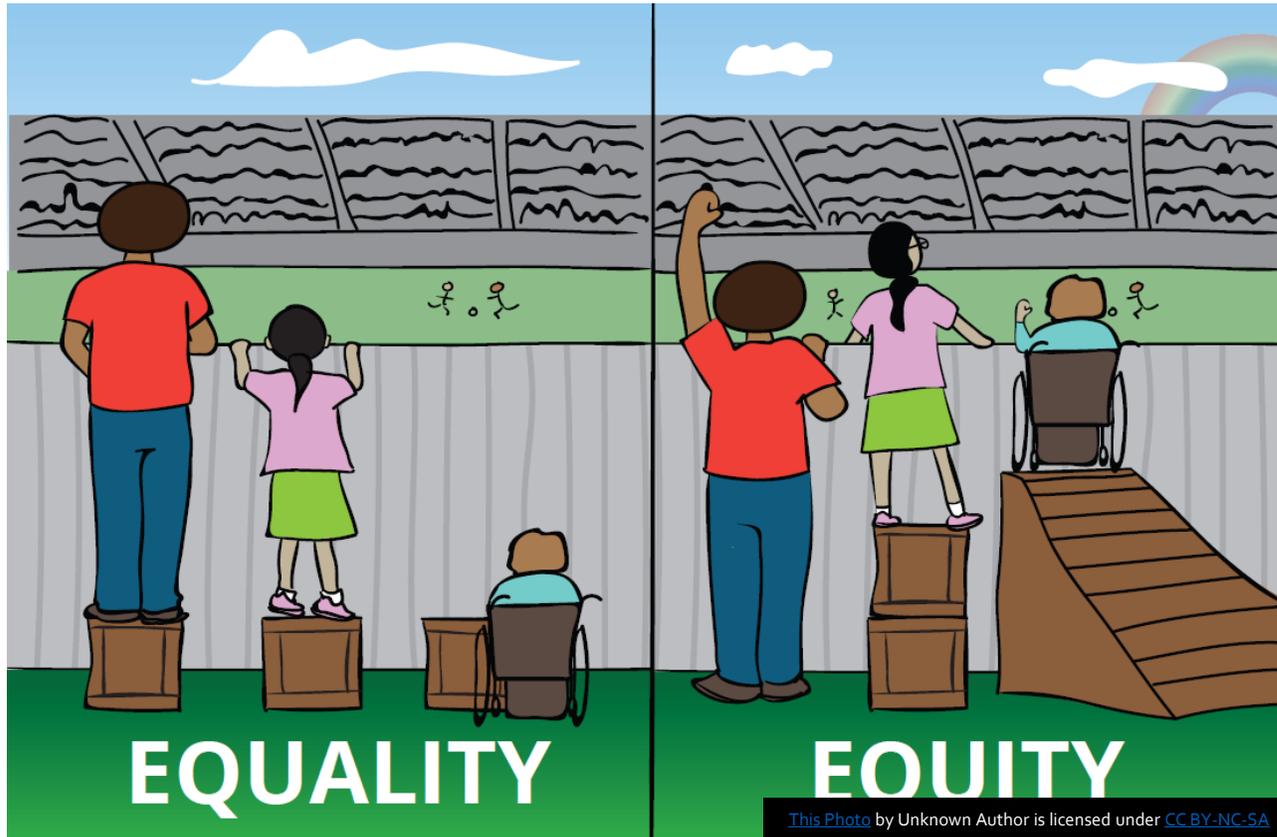


WHY ADDRESS SDOH?

“Addressing social determinants of health is a primary approach to achieving health equity”

“SDOH such as poverty, lack of education, stigma, and racism are underlying, contributing factors of health inequities”

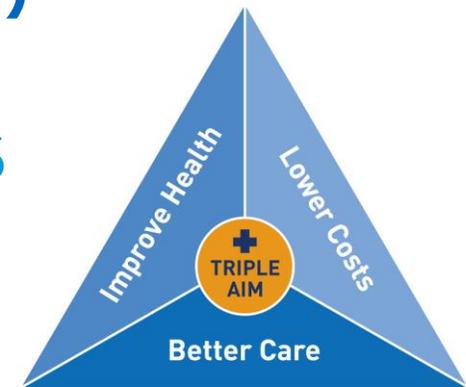
HEALTH EQUITY



“When everyone has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their socially determined circumstance”

MICHIGAN STATE INNOVATION MODEL (SIM)

- Grant from Centers for Medicaid & Medicare Services (CMS) to test delivery & payment system changes
- Focus on moving toward cost-effective use of health care \$ overall, improved patient experience & improved health outcomes (Triple AIM)
- Create a system that coordinates care within the medical system to improve disease mgmt & utilization; moves out into the community to address social determinants of health
- Strategies: PCMH, ASC, **Community Health Innovation Regions**, HIE/HIT, Collaborative Learning, Stakeholder Engagement Committee



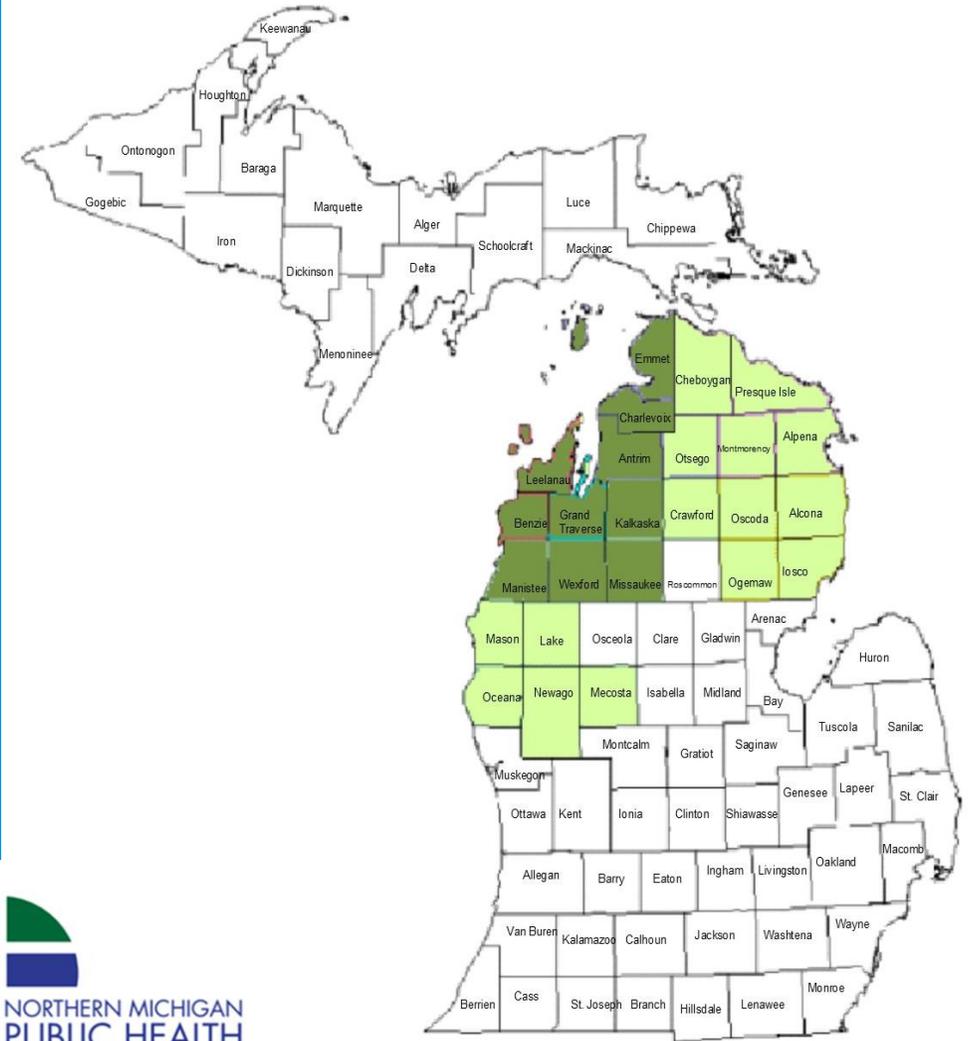
NMCHIR



Michigan's SIM includes the addition of 5 Community Health Innovation Regions

Northern Michigan Community Health Innovation Region (NMCHIR)

- * Only Rural CHIR
- * Only CHIR with a Public Health foundational approach





COMMUNITY CONNECTIONS

In partnership...



COMMUNITY BASED ACCESS POINT

District Health Department #10 HUB

Kalkaska, Manistee, Missaukee, Wexford Counties

Grand Traverse Regional HUB

Benzie, Grand Traverse, Leelanau Counties

Northwest HUB

Antrim, Charlevoix, Emmet, Otsego Counties

Screening

Screening of SOD at PCMH and/or patient referral from ED, community agency, self-referred, etc.

Intake

Intake completed by Call Center/Intake Worker & transferred to HUB Coordinator

HUB TEAM

Individual assessed for level of need and assigned to HUB Team Member

HUB TEAM



Intake Worker



HUB Coordinator



Community Health Worker



Social Worker



Registered Nurse

COMMON *REFERRALS*

Inappropriate
ED Use

Immunizations
update

Frequent no
shows/ At risk of
dismissal

Behind on well-
child/adult
exams

Oral health
service
navigation

Behavioral
health

Substance
Abuse

New patient
engagement
with PCMH

Transportation
assistance

Any SDOH
needs identified

Pregnancy

Appointment
reminders

PATHWAYS

Evidenced based model,
researched and tested

Metric that provides steps
to measure successful
resolution

Based on Social
Determinates of Health

PATHWAYS			
Adult Education	Behavior Health	Developmental Referral	Developmental Screening
Education	Employment	Family Planning	Health Insurance
Housing	Immunization Referral	Immunization Screening	Lead
Medical Home	Medical Referral	Medication Assessment	Medication Management
Postpartum	Pregnancy	Smoking Cessation	Social Service Referral

BEYOND THE INDIVIDUAL...

Resources may not exist to address all of the needs that are identified, for example low income housing or behavioral health providers.

Pathways provide data that can be shared with community groups and/or legislators to advocate for the “gaps” in our communities.

The primary purpose of the CC HUB is *finding those most at risk in the community and ensuring that risk is reduced*, leading to better health outcomes and lower costs.

The Public Health Code mandates local health departments to address "*prevention and control of health problems of particularly vulnerable population groups.*"

HOW DOES CC ALIGN WITH PUBLIC HEALTH?