

THE SOCIAL DETERMINANTS OF HEALTH



Case Management's Next Frontier

Ellen Fink-Samnicks, MSW, ACSW, LCSW, CCM, CRP

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Ellen Fink-Samnick, MSW, ACSW, LCSW, CCM, CRP, *Author*

Heidi Samuelson, *Editor*

Adrienne Trivers, *Product Manager*

Matt Sharpe, *Senior Manager, Creative Layout*

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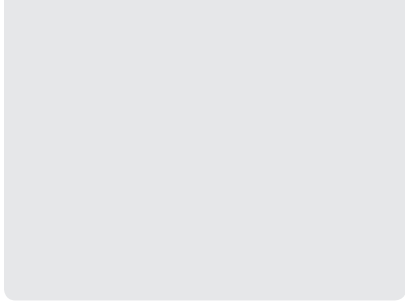
Brentwood, TN 37027

Telephone: 800-650-6787 or 781-639-1872

Fax: 800-639-8511

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Dedication

For the clients, caregivers, support systems, and colleagues I have worked with over my career:

You have inspired me in ways that continue to advance my understanding of the human condition and the value of what matters most to individuals and their communities.

To the professional case management workforce:

Do your due diligence to always be intentional, insightful, inspirational, and impactful.



Acknowledgments

To SAS: for your love, respect, patience, humor, unlimited supply of neck massages, unconditional support, public relations, and consummate editing ... YES, you were right!

To KAS: You are far away in miles, but always in my head and my heart.

To my enduring hood: You provide me unconditional support and foster my sanity, PRN-LBD, LJ, DS, GB, JW, DH, LM, SP, HT, TT, MO, II, CI, JA, JF, MF, MTF-S, SMF-S, and my mother, BF.



About the Author

Ellen Fink-Samnick, MSW, ACSW, LCSW, CCM, CRP, empowers healthcare's transdisciplinary workforce through professional speaking, mentoring, and consultation. An award-winning industry thought leader for more than 30 years, Ellen is known and respected as "The Ethical Compass of Professional Case Management." She is a popular presenter, with hundreds of offerings to her credit, and the author of well over 100 publications.

Ellen has written content for the industry's top knowledge products for professional case managers and the health and behavioral health workforce, including books, chapters, and educational modules on ethical practice, the ethical use of technology, competency-based case management practice models, and Wholistic Case Management™. Her blog, *Ellen's Ethical Lens™*, has attained global acclaim, as has her work focused on the social determinants of health, plus workplace bullying and violence. She is a contributor to *ICD10 Monitor* and *RAC Monitor* and a popular broadcaster for Talk Ten Tuesdays and Monitor Mondays. Ellen was recently named to the Council of Founders and Advisors for Reverberation 5.0 (a national collective focused on the empowerment of women over 50 in the workplace).

Ellen's passion is evident across her varied roles as professional speaker, industry consultant and subject matter expert, educator, blogger and social media moderator, continuing education content developer, accreditation specialist, clinical social work supervisor, and professional mentor to the case management community.

Her contributions to professional case management, ethics, and clinical social work span the industry's professional associations and credentialing organizations, including roles as an exam item writer and countless leadership positions. In addition, Ellen serves on the Editorial Advisory Board for the *Professional Case Management Journal* and *RAC Monitor* and is moderator of the group *Ellen's Ethical Lens™* on LinkedIn. She is a vibrant professional voice.



Continuing Education

Learning Objectives

- Define and identify the social determinants of health (SDoH)
- Discuss the evidence for the five specific domains of the SDoH
- Understand the impact of bias and case management practice in work with the SDoH
- Explore case management's principles and their relevance to the SDoH
- Explain the relationship of socioeconomic status on health and behavioral health outcomes
- Identify the unique practice implications of various specialty populations for case managers
- Understand the fiscal picture of healthcare costs in the U.S. and how those costs intersect with the SDoH
- Explain the importance of coding the SDoH and demonstrate an understanding of relevant ICD-10 codes
- Understand the Medicare Advantage program
- Demonstrate the benefit of a variety of assessment techniques for case managers
- Identify interview strategies for case managers to engage with clients
- Distinguish between the terminology associated with integrated care models
- Explain the key components of the Wholistic Case Management™ model
- Obtain information on resource programs across the SDoH domains

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Foreword

When I started in practice in 1991, I joined an established internal medicine group in a northwest suburb of Chicago. Our patient population was fairly homogeneous, with the vast majority of patients employed with good health insurance. I addressed their medical issues, ordering tests, writing prescriptions, and advising lifestyle changes to improve their health. I enjoyed my work and made lasting connections with my patients. The work was rewarding and challenging, with life expectancy getting longer. Whenever there were health threats, the ingenuity and inventiveness of the scientific community seemed to step up and offer new treatments that I could offer my patients. This was illustrated by the growing epidemic of obesity and diabetes balanced with the ever-increasing number of medications available to treat patients. The hurdles to practicing medicine and providing care to my patients were few.

Because I had trained in Los Angeles in the midst of the AIDS epidemic, I developed a reputation as a nonjudgmental physician who knew how to treat HIV. In 1997, I was asked if I would be willing to work a half day each week in a federally funded clinic for patients with HIV, and of course I agreed. I volunteered my time and even brought along my wife, a certified medical assistant, who volunteered side by side with me. The patients were as varied as could be: male, female, transgender, white, Black, Asian, Latino, employed, unemployed, single, married, in decades-long committed same-sex relationships, in abusive relationships, pregnant, desiring a family, wealthy, poor, homeless, veterans, and on and on. And there it struck me: Achieving and maintaining good health is more than eating well, exercising, not smoking, seeing your doctor, and taking your medications. In the clinic, it was easy for me to look at the test results and prescribe medications, but that was simply the prelude to the real work. Imagine having to take four pills three times a day with food and one pill every Monday, Wednesday, and Friday when you don't know where you'll be sleeping the next day or whether you will be able to afford a meal. Or perhaps you

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are employed in a workplace where revealing your HIV status would jeopardize your job, not because of risk of transmission but simply because of stigma.

The clinic's staff was amazing. Each client had a social worker who was trained to address these social determinants and help the client access the resources he or she needed, be it temporary housing, food assistance, counseling, or simply a willing listener. Despite our best efforts, patients still succumbed to their disease. As required by law, we reported the deaths to the health department. But the death certificate simply required the proximate cause of death and any contributing medical factors. There was no place to indicate that food insecurity led to an inability to adhere to the complex medical regimen, that their abusive relationship meant they frequently were too ill to take their medications, or that their undocumented status kept them from seeking medical care until it was too late for fear of deportation.

Every person in health and behavioral healthcare has seen the influence of the social determinants of health, from physicians to social workers to case managers to nurses to administrators, from obstetrics to pediatrics to geriatrics, from hospitals to outpatient clinics to shelters for the homeless or the abused. Many were not even aware that the social determinants were present or should be addressed. For far too long, patients were forced to address these determinants on their own health by themselves. But there is an important change in the air.

The book *The Social Determinants of Health: Case Management's Next Frontier* will provide the historical perspective and evolution of the study of the social determinants, which is crucial for all industry professionals to determine how to formulate solutions. The author, Ellen Fink-Samnicks, then addresses the current drivers and ever-evolving challenges faced by client populations, case managers, and their organizations. Examples of successful programs around the nation as well as resources are included. Finally, an innovative model, Wholistic Case Management® (codeveloped by Fink-Samnicks and Dr. Hussein M. Tahan), is provided to address the identification of, assessment of, and intervention with the populations impacted by the social determinants of health.

Healthcare reform is a topic that will never cease to receive attention from politicians, health policy experts, those working in healthcare, and the public. However, until the social determinants of health are addressed with the same or even more emphasis as the medical determinants of health, a solution will never be found. *The Social Determinants of Health: Case Management's Next Frontier* is a crucial resource for case management professionals, members of the interprofessional team, administrators, and students entering the industry to gain the key knowledge they need to lead that movement.

Dr. Ronald Hirsch, MD, FACP, CHCQM
Vice President, Regulations and Education, R1 RMC Inc.



Preface

Similar to those of my esteemed colleague Dr. Ronald Hirsch, my professional experiences began on the front lines of healthcare in the 1980s. It was an interesting time to enter the industry given the introduction of diagnosis-related groups (DRG) and emerging emphasis on wrestling costs, reimbursement, and quality. Clients were allowed more choices in the type, location, and amount of care they wanted courtesy of a next generation of diagnostic and treatment innovation (e.g., MRIs, laser surgery, implantable cardiac defibrillators, computers, sophisticated portable ventilators). However, the higher price tag of care also prompted healthcare insurers to take a larger role in the monitoring, oversight, and approval of clinical processes and treatments. This reality became a double-edged sword for organizations as their population demographics also shifted to a grander payer mix of private, public, managed care, and often self-pay options.

In tandem, more complex populations appeared, all requiring intensive focus. The deinstitutionalization of the 1970s led to increased numbers of individuals challenged by housing insufficiency, mental health instability, and inconsistent access to limited treatment options. Shelters were left busting at the seams, with an overtaxing of emergency departments and clinics. Community demographic shifts yielded increased pockets of poverty amid wealth. The gap separating the haves and have-nots was now a chasm. Disparities presented at every turn, particularly for those of us working in the early iterations of safety-net hospitals and federally qualified health centers—aka the public health system.

One of my most poignant memories is from 1990, when I was coordinating manager of AIDS services at Queens Hospital Center (QHC), in Jamaica, New York. A large hospital that was part of Health + Hospitals Corporation, QHC had a unique population. The once mostly middle- and upper-middle-class community surrounding the hospital had transitioned in recent decades to one infiltrated by gangs, substance use, and poverty. The region also laid claim to one of the most concentrated and rapidly growing

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AIDS populations in the country. New York City had more than half of the nation's AIDS cases (Schilts, 1987, pg. 268), and this included the borough of Queens. That region also had a rapidly rising number of individuals diagnosed with pneumocystis carinii pneumonia in intravenous drug users (Schilts, 1987, pg. 56). A majority sought care at QHC.

My dedicated AIDS team cared for several hundred inpatients monthly, most of them just recently diagnosed. The numbers rose at an alarming rate. Every client discharged from the hospital received a follow-up appointment for the weekly AIDS clinic, which was staffed by the AIDS team. Trusting relationships developed with team members, which leveraged the care process. Despite the power of this model, there was one pressing problem: We had among the largest HIV-positive and AIDS populations in the country, but our outpatient clinic had barely a 50% show rate for appointments. I was assigned by my administrator to figure out the reason and define a strategy to resolve the problem.

Remember, this was 1990. The technology to track client data paled in comparison to what we know today, with our metrics then rudimentary at best. I can remember calculating program outcomes with a calculator. In fact, our winning submission for the initial Ryan White Grant Funding (1991) was written on a yellow legal pad, typed by a dedicated receptionist on an IBM Selectric, and hand-delivered by a courier—quite different from the grant processes of today. Staff would try to contact anyone who did not appear for their clinic appointment as scheduled, by phone and with follow-up letters. Yet, most of these communications were unsuccessful. While many clients had a telephone number listed, a larger number did not. Individuals were often evicted from their apartments or had their homes foreclosed on when they became too ill to work and unable to pay their rent or mortgage. There were no cell phones, so as clients lost their housing, they simultaneously lost their means of communicating with the world. A large number of individuals were forced to live on the street or in shelters after losing their jobs and, usually, their health insurance. Stigma became the norm when persons disclosed their HIV status to family and friends, with abandonment and isolation to follow.

The case worker for the AIDS team had a mission: to find every client on the clinic roster who did not come in for their appointment. She was from the hospital's surrounding community and knew all too well how many factors could affect why clients did not show for follow-up. Diligence was an understatement for her efforts, with visits to shelters, local bars, street corners, libraries, schools, emergency departments, clinics, and community centers. This time was also pre-HIPAA, and there was greater ability to freely share information about the whereabouts of clients. Within one month, she located close to 95% of our client population. If she was unable to find the client, she located someone who could provide answers as to why the person missed the clinic appointment.

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The reasons why clients missed their appointments had little to do with the treatment resistance and nonadherence traditionally expected of this community. Truth be told, few if any of the clients were intentionally “dissing” the hospital or failing to prioritize their care. Instead, they struggled with profound everyday realities. Many persons dealt with conflicting priorities related to coordinating their healthcare appointments with other pressing basic human needs of housing, income, food insufficiency, or employment. They juggled appointments scheduled at the same time or too close together to get from one to the other on time. Having to choose between a long-awaited appointment or phone interview with Social Security Disability and medical follow-up felt like an untenable choice. In the end, the need for income usually won out over any pressing health or behavioral health issues.

Additionally, it was the early days of treatment options for AIDS and HIV, with the diagnosis often perceived as a death sentence. The side effects of many medications were worse than the symptoms experienced from the disease states. Clients quickly deteriorated and were frequently admitted to area hospitals prior to their clinic appointment, whether to our hospital or others nearby. The last thing on a client or caregiver’s mind was to call our AIDS program office to explain why they couldn’t attend clinic or reschedule, if they were able to call at all. Food insufficiency, lack of appropriate mental healthcare, unemployment, housing, isolation, and societal stigma were recurring themes. In short, the vast majority of our clients were dealing with the socioeconomic factors that impact their health outcomes: the social determinants of health (SDoH).

Fast-forward to 2019, and the SDoH are a top priority for every healthcare organization and practice setting. A staggering \$1.7 trillion is spent on 5% of the population, with as much as 80% of an individual’s health influenced by the SDoH factors alone (Driver, 2019; Sullivan, 2017). This epidemic has come a long way from where it began, with clients living in communities having the highest incidence of downstream factors impacting health outcomes (e.g., poverty, lack of education, housing and food insufficiency, unemployment, limited access to care). The SDoH is now a global phenomenon that continues to evolve, with new populations added at a moment’s notice. Every member of the interprofessional care team faces these issues head on through their daily interventions with clients, caregivers, and their communities—especially case managers.

GUIDING THOUGHTS:

For the purposes of this book, here are several guiding thoughts for readers:

1. My intent is for this text to serve as your primary SDoH resource to leverage practice by:
 - Sharing key knowledge and theories associated with the SDoH
 - Describing the scope of populations, both traditional and emerging

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- Ensuring access to dedicated assessment tools for implementation
 - Providing validation of the ethical issues associated with managing the population
 - Helping you gain mastery of dedicated case management models
 - Exploring current and evolving resources across the industry
 - Describing the socio-political drivers of SDoH advancement
 - Gleaning regulatory guidance on legislation, reimbursement, and compliance
 - Investigating career implications and opportunities
 - Studying successful programs and initiatives
 - Serving as a teaching tool for new students or orientating staff
 - Guiding how to approach the SDoH at your practice setting or organization
 - Developing innovative means to address the cost, quality, and care balancing act
2. The term “client(s)” will be used throughout the book as a generic term for all users of the healthcare system. Exceptions may occur for any direct quote or reference using another specific term (e.g., patient, member, consumer, customer).
 3. Because case management is interprofessional in scope, my lens is attentive to care rendered by any and all disciplines actively engaged in the treatment process. Although the book is targeted to those individuals primarily in case management roles, the content will speak to members of the interprofessional care team. This encompasses individuals engaged in direct client intervention, those in leadership roles, as well as community resource strategic partners of healthcare organizations. The industry is faced with some of the most complex populations to date, with more and more coping with the SDoH. The collective expertise of every member of the workforce is necessary to ensure quality-driven, cost-effective, and ethical care for every person and community.
 4. The book is divided into three sections:
 - Section 1: Understanding the Social Determinants of Health
 - Section 2: Leveraging Assessment
 - Section 3: Programs and Application

Each chapter begins with a main page that details the objectives and essential terms discussed. You will be provided with practical and relevant knowledge that is thorough yet comprehensive. The concepts presented in earlier chapters will leverage information presented in subsequent sections. There is original content to implement, from the Wholistic Case Management™ Model and Comprehensive Case Management Path®, along with assessment tools and an array of tables, templates, and figures. You will want to keep each one of these resources at your fingertips!

Preface

My goal is for this book to be applicable to your daily work experience. The content has been considered to encourage active reflection of the information presented. Innovative case scenarios have become my hallmark, and appear throughout the book. There are many opportunities to engage your critical thinking and directly apply the material to your practice setting. Finally, each chapter ends with contemplation questions to continue your learning, whether in the classroom, with colleagues, or for solo deliberation.

Because nothing in our industry remains constant, the SDoH will continue to evolve. Let this book set your core foundation and be among your most reliable companions. Time to begin your journey to the next frontier!

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Driver, T. (2019, January 11). How social determinants of health data can provide actionable insights. HealthDataManagement. Retrieved from <https://www.healthdatamanagement.com/opinion/how-social-determinants-data-can-provide-actionable-insights>

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Section 1

Understanding the Social Determinants of Health

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Chapter 1

Foundation and History

*Great thoughts speak only to the thoughtful mind,
but great actions speak to all mankind.*

—Theodore Roosevelt

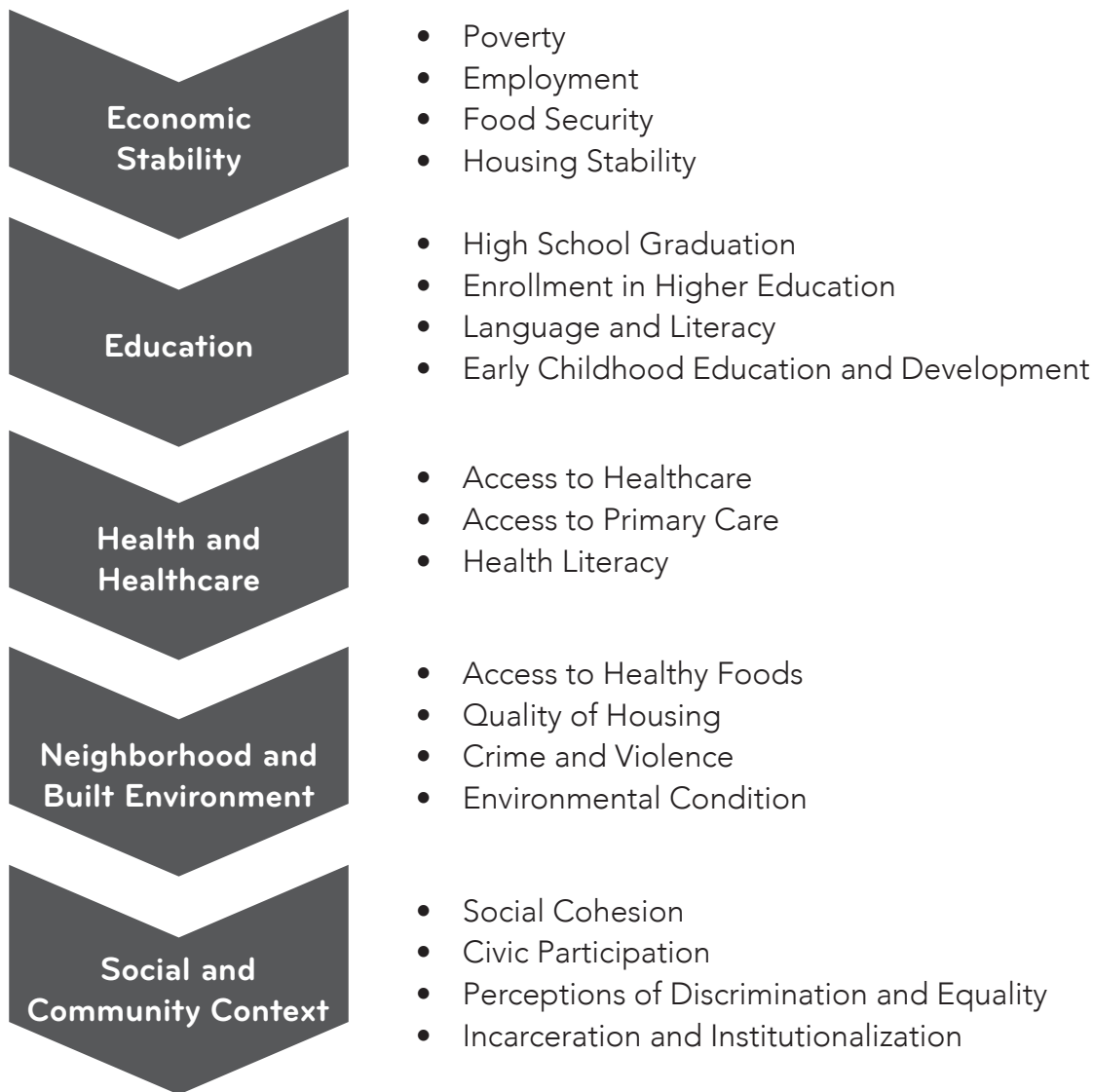
Learning Objectives

1. Define the social determinants of health (SDoH) and related terminology
2. Provide relevant historical context
3. Identify key foundational theories, definitions, and concepts
4. Understand the relationship between structural and intermediary determinants
5. Understand the impact of power and oppression on the evolution of the SDoH
6. Discuss the traditional and emerging populations impacted by the SDoH

Essential Terms

- Epidemiology
- Food insecurity
- Intermediary determinants
- Life course
- Macro
- Mezzo
- Micro
- Power
- Oppression
- Social determinants of health
- Social causation
- Social selection
- Socioeconomic status
- Structural determinants

Figure 1.1: Social Determinants of Health Expanded



Source: Adapted from HealthyPeople.gov. (2019). Approach to the social determinants. Retrieved from <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>. Figure by the author.

Structural Determinants and Intermediary Determinants

Two key concepts provide an understanding of the influences that bear on the incidence and prevalence of SDoH. The *structural determinants* are the socio-political contexts that impact and reinforce social stratification in society. These determinants affect an individual's access to multiple resources within a society's distinct hierarchy of power (e.g., income, education, occupation, social class, gender, race/ethnicity, etc.). Structural determinants are *macro-scale*, or larger-scale, levels of society, such as governance and economics, social and public policies, and any unique cultural values and social mores. These factors also encourage the division of society into levels according to social strata.

Chapter 1

policies, programs, and resources in place. These in turn would empower all persons to achieve the highest levels of functionality in all aspects of their lives:

“Societies that enable all citizens to play a full and useful role in the social, economic, and cultural life of their society will be healthier than those where people face insecurity, exclusion, and deprivation” (Wilkinson & Marmot, 2003, pg. 12).

Wilkinson and Marmot’s next phase of work was the identification of ten “solid facts” to understand the SDoH, shown in Box 1.1. The authors painted an enduring picture of why social policies should be addressed across all societal sectors and levels of operation (e.g., government, public and private institutions, workplaces, and the community). However, they identified that a wider responsibility for addressing the SDoH was necessary to create the healthiest societies. Aligning seminal data with each of their domains, Wilkinson and Marmot highlighted the main problems for society and detailed further key policy areas for attention.

Box 1.1: The Solid Facts Perspective

- Social gradient
- Stress
- Early life
- Addiction
- Food
- Social exclusion
- Work
- Social support
- Unemployment

Source: Wilkinson, R. G. & Marmot, M. (2003). *Social determinants of health: the solid facts* (2nd ed.). Denmark: World Health Organization.

Theories and Foundational Frameworks

Research on the SDoH continued, with a foundation of knowledge that grew to encompass the cause, scope, and impact of challenges throughout the world. Three theoretical perspectives developed that affirmed how social, economic, and political factors contributed individually and collectively to the evolution of disease across populations:

1. Psychosocial approaches
2. Social production of disease and political economy
3. Ecosocial theory

Table 1.1 provides a brief explanation of each theoretical area.

Foundation and History

Poverty and food insecurity often go hand in hand. Close to 18 million households are food-insecure, with more than 49 million persons struggling to put adequate food on the table. Table 1.3 explains the various levels of food insecurity, and Box 1.5 displays those states with a food insecurity rate higher than the U.S. national average. Food insecurity is not a problem of the U.S. alone. More than 821 million people worldwide are chronically undernourished. The countries with the highest rates of undernourishment or food insecurity appear in Box 1.6 (Food and Agriculture Organization of the United Nations, 2019; U.S. Department of Agriculture Economic Research Service, 2019).

Table 1.3: Ranges of Food Security and Insecurity

High food security	<ul style="list-style-type: none">• No reported indications of food-access problems or limitations
Marginal food security	<ul style="list-style-type: none">• One or two reported indications, typically anxiety over food sufficiency or shortage of food in the house• Little or no indication of changes in diet or food intake
Low food security	<ul style="list-style-type: none">• Reports of reduced quality, variety, or desirability of diet• Little or no indication of reduced food intake
Very low food security	<ul style="list-style-type: none">• Reports of multiple indications of disrupted eating patterns and reduced food intake

Source: Adapted from United States Department of Agriculture Economic Research Service. (2019). Food insecurity in the United States, Retrieved from <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics.aspx>. Table by the author.

Box 1.5: 15 States With Highest Food Insecurity Rates

Percentages represent members of the state's population who have experienced limited or uncertain access to adequate healthy food at some point during the year.

- | | | | |
|------------------|-------|---------------|-------|
| • Mississippi | 20.1% | • Texas | 15.4% |
| • Arkansas | 17.2% | • Georgia | 15.1% |
| • Louisiana | 16.7% | • Ohio | 15.1% |
| • Alabama | 16.5% | • Missouri | 14.7% |
| • Oklahoma | 16.2% | • W. Virginia | 14.6% |
| • New Mexico | 15.7% | • Tennessee | 14.5% |
| • Kentucky | 15.5% | • Michigan | 14.2% |
| • North Carolina | 15.4% | | |

Source: Data from The State of Obesity. (2018). Overall food insecurity rate. Retrieved from <https://stateofobesity.org/state-policy/policies/foodinsecurityrate/>



Contemplation Questions: Chapter 1

Reflect on your volunteer, educational training, or professional experiences to answer the following questions.

1. Discuss your experiences in working with populations impacted by the SDoH.
 - a. What specific challenges have you faced?
 - b. Which SDoH have been the toughest to reconcile, and why?
 - c. Which have been the easiest, and why?
 - d. What lessons did you learn from those experiences?
 - e. What surprised you about the situations you faced?
2. When working with clients impacted by the SDoH, what feelings did you experience about:
 - a. The client(s)?
 - b. The response(s) of your colleagues?
 - c. The response(s) of the resource community?
3. What structural determinants you have encountered?
4. Which intermediary determinants have you needed to address?
5. How have the themes of power and oppression impacted your life experiences:
 - a. Personally?
 - b. Professionally?
6. Discuss how the contemporary theories in Table 1.1 support your experiences from working with clients affected by the SDoH.
7. Discuss how the conceptual frameworks in Table 1.2 support your experiences in working with clients impacted by the SDoH.
8. What other populations would you add to Box 1.7, The New Faces of SDoH?
9. In considering the case scenarios in Box 1.3, Traditional Faces of the SDoH:
 - a. Which SDoH are at issue?
 - b. What recommendations would you make to address the issues at hand?
 - c. What challenges might you anticipate?
 - d. Which client would be easier for you to address?
 - e. Why?
10. What about the SDoH interests you the most?

The Realities

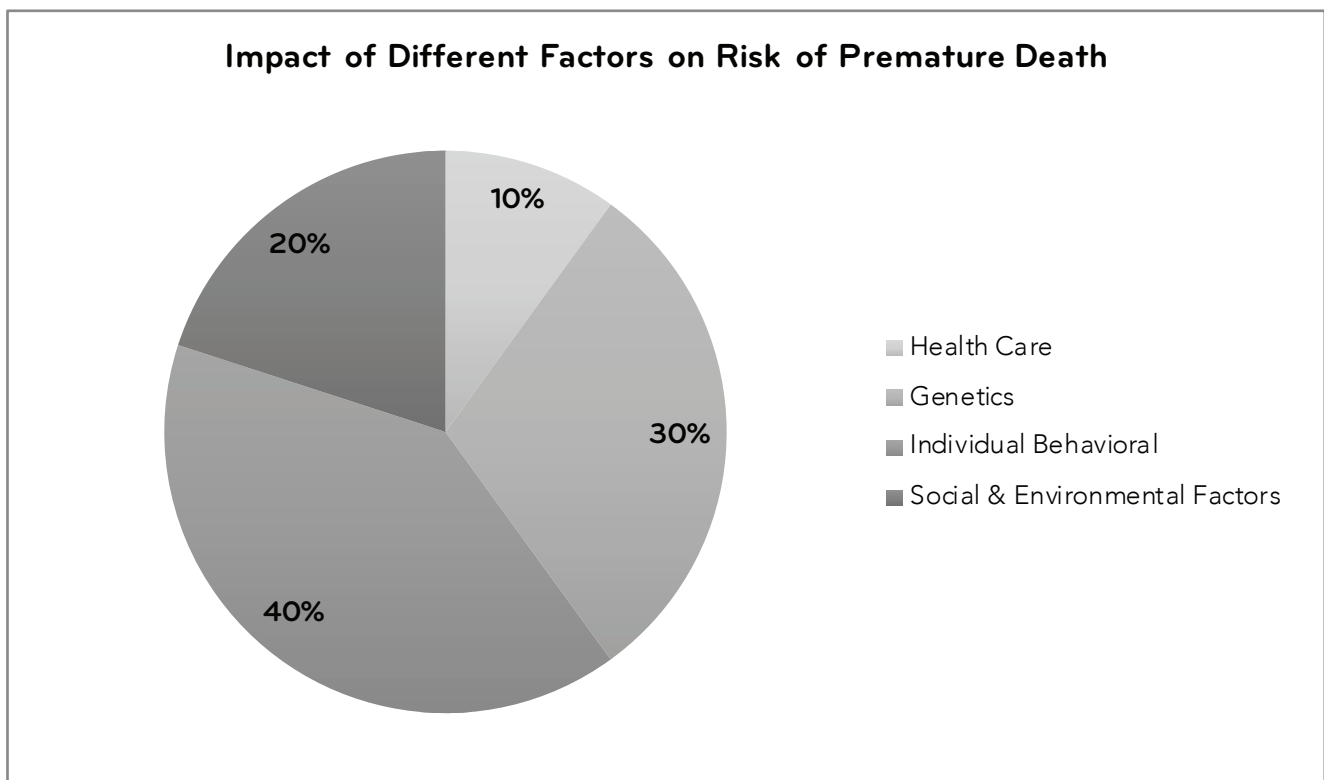
- 60% of a person's risk of premature death result from behavioral patterns, social circumstances, and environmental exposure
- 86% of current healthcare spending is related to chronic conditions, with the SDoH having an impact on 60% of outcomes

Organizations are hemorrhaging dollars to address challenges. The literature provides significant evidence-based validation of the impact of SDoH across society and the providers and practice settings rendering care to each population.

The Landscape Across the Social Determinants

The past several years have witnessed data of epic proportions to validate the connection between the SDoH across diagnoses, race, ethnicity, and a host of other contexts. The seminal work of Schroeder's study more than a decade ago, as shown in Figure 2.1, triggered the industry to take note that clinical factors played a relatively small role in the premature death of adults, with individual behavioral and social and environmental factors yielding 60% of the punch. A stream of studies have followed to validate the conclusive connection between the SDoH and health outcomes.

Figure 2.1: Impact of Different Factors on Risk of Premature Death



Source: Adapted from Schroeder, S.A. (2007). *We Can Do Better-Improving the Health of the American People*, New England Journal of Medicine, 357, pg. 1221–1228. Figure by the author.

Chapter 3

Population-Focused Challenges

We cannot despair of humanity, since we ourselves are human beings.

—Albert Einstein

Learning Objectives

1. Discuss the evidence for specific at-risk populations and the social determinants of health (SDoH)
2. Explore the unique practice implications of each population for case managers
3. Discuss the intersection of gender, ethnicity, race, and health outcomes
4. Understand how the SDoH appear across the developmental life span
5. Validate how the life-course conceptual framework accounts for the SDoH
6. Understand how trauma affects health and behavioral health outcomes
7. Define the principles of a trauma-informed approach to care
8. Understand the scope of the McKinney-Vento Homeless Assistance Act
9. Identify how loneliness and socialization impact health outcomes
10. Review the elements of the UCLA Loneliness Index Summary
11. Be familiar with types of exploitation scams targeting older and disabled adults
12. Understand the scope of Long-Term Supports and Services (LTSS)
13. Identify the demographics for uninsured adults
14. Discuss the SDoH across the LGBTQ community

Population-Focused Challenges

Despite shifts in federal and state legislation, LGBTQ persons and same-sex couples must deal with problems regarding access to and receipt of appropriate healthcare. Reports of treatment being minimized, delayed, or refused present across the industry. The ACA prohibits healthcare providers and insurance companies from engaging in discriminatory practices, yet lawsuits continue against providers who have rendered unacceptable care. Eight percent of LGBTQ individuals, almost 27% of transgender and *gender-nonconforming* individuals, and 20% of HIV-positive individuals report being denied needed healthcare outright (National Women's Law Center, 2014). The term, *gender non-conforming* has gained popularity, especially among the student community, and refers to a person whose behavior or appearance does not conform to prevailing cultural and social expectations about the gender they were assigned at birth.

Incidents of healthcare professionals using harsh language toward LGBTQ clients, along with refusals to touch or examine the person, have been reported. Other issues cited involve practitioners using excessive and unwarranted precautions (e.g., full isolation garb, masks) or blaming the individual for his or her own health status. More than 20% of transgender or gender-nonconforming persons reported being subjected to harsh or abusive language by a healthcare professional or blamed for their presenting health problem. LGBTQ persons who reside in rural communities face considerable discrimination, with some individuals having to travel as much as 500 miles to find a physician who would agree to render care (National Women's Law Center, 2014).

The Aging With Pride Study

The Aging With Pride Study was the first federally funded longitudinal national project designed to enhance understanding of the aging, health, and well-being of LGBTQ midlife and older adults and their families. A summary of the data appears in Box 3.10. Of relevance to this section are the services most identified as needs by older LGBTQ adults, including appropriate housing (66%), transportation (62%), and legal services (53%). A strong need for social connection has also been identified, with 55% of those surveyed seeking support groups. Although persons who identify as caregivers are more likely to be partnered or married and have greater social support, they experience a higher incidence of behavioral health symptoms, disability, victimization, discrimination, and violence than do noncaregivers (Fredriksen-Goldsen et al., 2011).

Box 3.10: Caring and Aging With Pride Inaugural Study Summary

N=2,560

Summary: Conducted across 11 U.S. agencies to better understand the physical and mental health of lesbian, gay, bisexual, and transgender (LGBT) older adults

Average age: 67

Race and ethnicity: 87% Non-Hispanic White

Incomes below the poverty level: 30%

- Bisexual older women and men are more likely to be at or below 200% of the Federal Poverty Level than older lesbians and gay men

Health and behavioral health:

- Close to one-fourth (22%) of participants reported poor general health
 - 45% had a disability
 - 29% experienced depression

Source: Data adapted from Fredriksen-Goldsen, K. I., Kim, H.-J., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C. P., ... Petry, H. (2011). *The Aging and Health Report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults*. Seattle: Institute for Multigenerational Health; Fredriksen-Goldsen, K. I., Emlet, C. A., Kim, H. J., Muraco, A., Erosheva, E. A., Goldsen, J., & Hoy-Ellis, C. P. (2012). *The physical and mental health of lesbian, gay male, and bisexual (LGB) older adults: the role of key health indicators and risk and protective factors*. *The Gerontologist*, 53(4), 664–675.

Since the inaugural Caring and Aging Study was completed in 2010, the project has expanded to a range of activities that encompass ongoing research, education, and resource developments for aging persons in the LGBTQ community. The URL to the site is available through the resource listing at the end of the chapter.

Youth

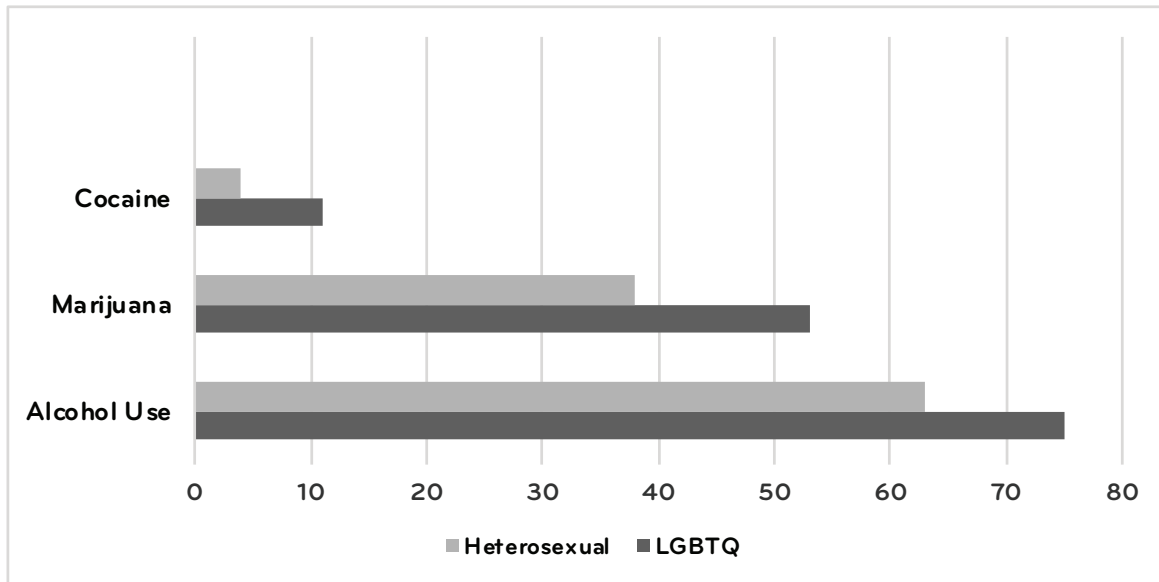
Behavioral Health and Suicide

Approximately 1.3 million high school students (roughly 8% of all) self-identify as LGBTQ or gender-nonconforming. LGBTQ students are more likely to be homeless and live in poverty than non-LGBTQ youth, with rejection from family as a primary driver. Their exposure to risky behaviors and victimization by peers can have damaging implications. Some 18% of LGBTQ students report having been raped at some point in their lives—more than three times the rate of students who identify as straight and cisgender. They are twice as likely to be bullied (online and on school property)

Population-Focused Challenges

and more than twice as likely to stay home from school to avoid anticipated violence. Substance use, primarily alcohol, is a large issue for these students, as shown in Figure 3.2 (Shlanger, 2017; Institute of Medicine, 2011).

Figure 3.2: Substance Use Among LGBTQ Youth Compared to That of Heterosexual and Cisgender Counterparts



Source: Data from Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding*. Washington, D.C. Figure by the author.

Increased attention by schools to the challenges faced by LGBTQ youth has led to campaigns focused on bullying and violence, especially involving social media. Dating violence rates are higher for this population, along with injury from fights and bullying behaviors. The increasing visibility of LGBTQ youth has led to higher levels of awareness, wider acceptance, and increased tolerance among peers and school communities. However, extensive and consistent ongoing education is needed. Vigilance is still needed to address the escalating rates of depression, suicidal ideation and action, homelessness, and substance use among the population. Teens in this population face alarmingly high rates of suicidal ideation and intent. Close to half of high school students who identify within the community have seriously considered suicide. The results of a large national study comparing LGBTQ and heterosexual teens across the country appear in Box 3.11.



Contemplation Questions: Chapter 3

1. Discuss your experiences in working with clients represented by the content in this chapter.
 - a. Share what challenges you faced during the care process.
 - b. What was the outcome of the client situation?
 - c. Discuss what you learned from your work with the client and situation.
2. Consider what populations you would add to this chapter and why.
3. Discuss your experiences with trauma-informed care.
 - a. How would a trauma-informed approach benefit your client populations?
 - b. How could you implement a trauma-informed approach at your organization (whether it is a practicum or employer)?
4. Discuss your perspectives on the social determinants of mental health (SDoMH).
 - a. How would incorporating the SDoMH support your work with clients?
5. What surprised you about the evidence in this chapter?

Use the case scenario below to answer questions 6–7.

Emma is the case manager for a family clinic at Soho Hospital, a large safety-net hospital in an inner-city community. She is working with Amina, a 30-year-old woman of Rwandan descent. Amina resides with her spouse, 4-year-old daughter, and father in an apartment. The family emigrated to the U.S. over 25 years ago to flee the violence in their home country. Amina witnessed the murder of her oldest sister and several friends.

Amina and her family own a food truck that supports several households—Amina’s as well as those of both brothers. Everyone works hard, with little time left for anything else, beyond rest and church on Sundays. Last year, Amina’s mother became ill, was hospitalized, and was diagnosed with invasive breast cancer that metastasized and spread to her lungs. Amina’s mother died within a week of hospitalization. When the physician asked Amina about a family history of cancer, she evaded the question. Amina had no knowledge of her mother’s medical history or that of anyone else in her family. Health was never a priority for Amina’s family, not with so many other more important things. Amina remembers going to the clinic with her brothers at the start of each school year and occasionally being given a shot. During her pregnancy, Amina received prenatal care at the clinic but has had no time for follow-up since her daughter’s birth. Besides, everything has been fine, and, as her mother would say, “Why tempt fate?”

The physician recommends that Amina obtain a mammogram and have genetic testing to address her predisposition to cancer. It has also been recommended that Amina bring her

Socio-Political Drivers

from the airport. I can recall my own share of experiences, having worked at hospitals in the proximity of the nation's largest airports. These are very complicated and labor-intensive situations that feel like a full-time effort. If there is a need to contact the embassy or legal channels to facilitate a return trip, it becomes even more difficult.

When the immigrant client arrives healthy, other priorities of housing, employment, and education for children may supersede attending to healthcare. Small symptoms are ignored, so that by the time care is obtained, a costly hospital stay or invasive treatments may be required. Clients are playing catch-up with efforts to attain health and wellness. The stressors of ensuring income for the basic necessities of food, clothing, and shelter may lead to an exacerbation of substance use. Case managers must address a diverse range of issues for clients and their families, maneuvering a migration maze across every SDoH domain, as shown in Figure 4.3.

Figure 4.3: The Migration Maze for Case Management

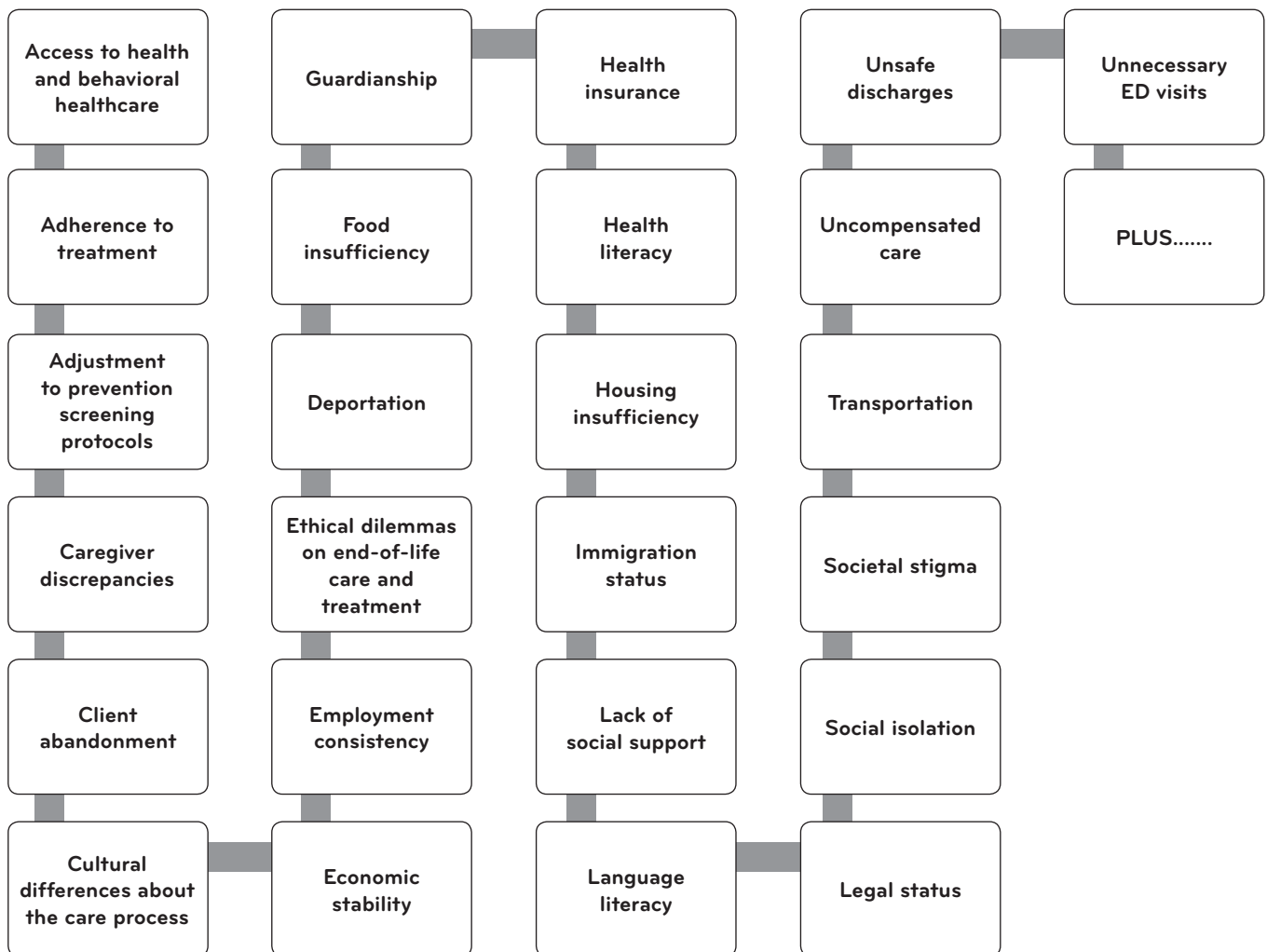
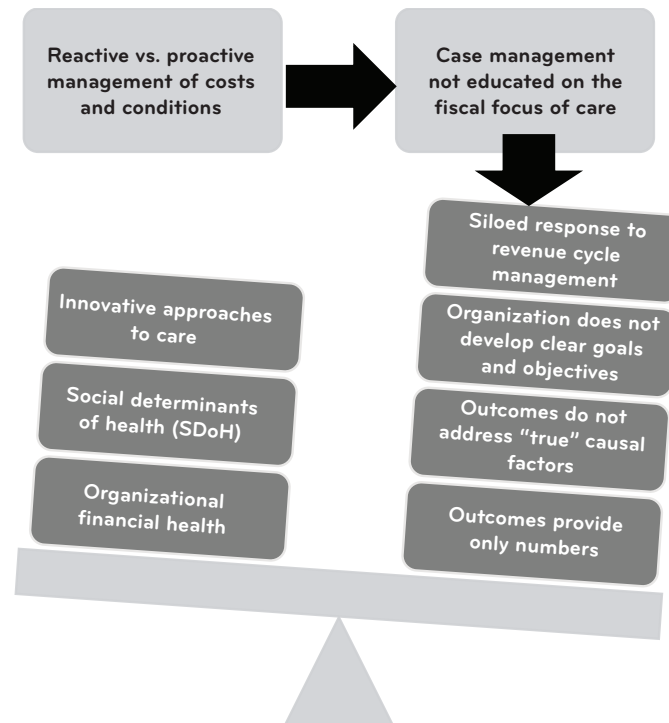


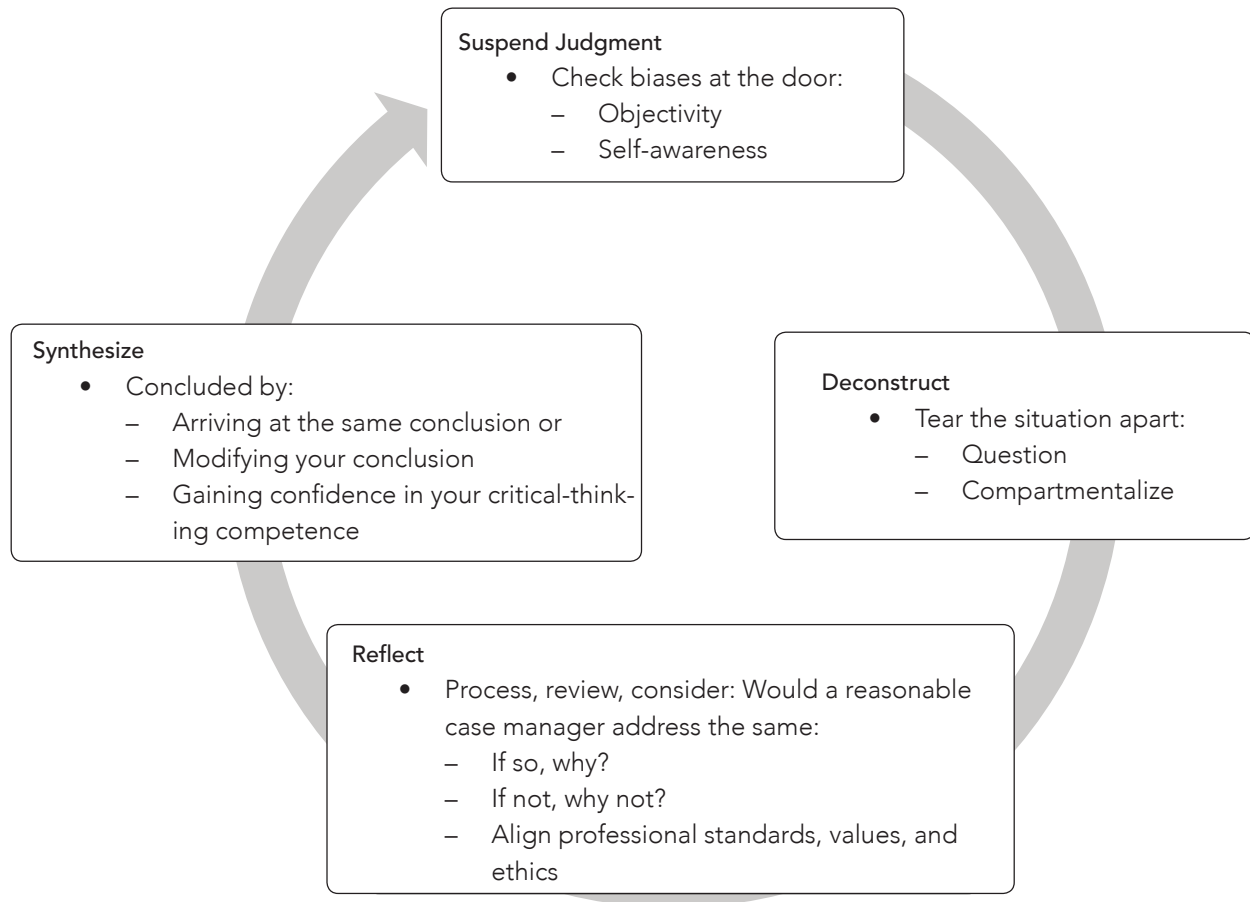
Figure 5.3: Factors Toppling Organizational Financial Sustainability



Revenue Cycle Management

The increased emphasis on the importance of coding and reimbursement in organizations has meant new roles and opportunities under the case management umbrella. Many organizations have hired *revenue cycle managers or specialists*—individuals who track the financial life of the client’s care episode, from start to finish. The role traditionally encompasses everything from registration and appointment scheduling to the final payment of an account balance. With this position still evolving, everyone I know has incorporated the function somewhat differently. Some hospitals have a distinct revenue cycle management department with full-time specialists to oversee the process. Other organizations may opt to bring the role into an existing case management department, an especially common trend in hospital systems. In settings where case managers play a key role in utilization review activities, collaboration with revenue cycle management yields opportunities to optimize reimbursement. In addition, adding clinical documentation integrity (CDI) specialists to the team further amplifies opportunities to coordinate and leverage reimbursement

Figure 6.4: Critical Thinking for Professional Case Management



Source: Adapted from Treiger, T. & Fink-Samnick, E. (2016). *COLLABORATE for professional case management: A universal competency based paradigm*, 1st ed. Philadelphia, PA: Wolters Kluwer Health. Figure by the author.

Critical thinking has long been considered the switch to trigger the mental calisthenics required to engage the *Case Management Process* (Treiger & Fink-Samnick, 2016, pg. 106). The seven steps of this research-informed process serve as the benchmark of case management intervention. Each step seeks to define the essential functions of case managers across practice settings and appears in Figure 6.5. Consider how you move through each step for your clients. An important question beckons case managers in their work with the multifaceted clients and communities dealing with the SDoH: Is either of the two processes sufficient to case manage the most complex populations to date? We know the answer to that closed-ended question as well!

Chapter 7

Wholistic Case Management™

Co-authored with Hussein M. Tahan, PhD, RN, FAAN

"We must care for the person with an illness, not the illness of the person."

—Hussein M. Tahan

Learning Objectives

1. Distinguish between the terminology associated with integrated care models
2. Explore the historical evolution of case management practice
3. Distinguish between wholistic and holistic care
4. Define Wholistic Case Management™
5. Present the benefits of Wholistic Case Management™
6. Identify five industry tenets supporting use of Wholistic Case Management™
7. Discuss the key Wholistic Case Management™ model influencers
8. Present the three health domains considered in Wholistic Case Management™
9. Identify the essential aspects of Comprehensive Case Management Assessment
10. Discuss the relationship between the social determinants of health (SDoH) and Wholistic Case Management™
11. Explain the key components of the Wholistic Case Management™ model
12. Discuss the five core principles and interventions of Wholistic Case Management™
13. List the 15 core competencies of Wholistic Case Management™

Table 7.4: Application Wholistic Case Management™

Core Principles	Application	Standards of Practice Application
Person-centered and team-based care	Sally contacts her clinic medical director, Dr. Kane, to review Steve's situation. They schedule an impromptu transdisciplinary care team conference about Steve to review his current treatment needs, recommendations, and plans. There is agreement about Steve's commitment to wellness and the current obstacles (e.g., insurance coverage, the transplant, manifestation of depression secondary to life stress and ongoing adjustment).	<p>ACMA: Accountability; Collaboration; Care Coordination; Advocacy</p> <p>CMSA: Client Assessment; Ethics; Facilitation; Coordination; Collaboration</p> <p>CCMC: Principle 3: Maintain objectivity; Principle 4: Maintain integrity and fidelity</p> <p>Standards: The Client Advocate; Case Manager/Client Relationships; Professional Responsibility; Professional Relationships</p>
Population-based care	<p>Sally contacts the dialysis program case manager, Michelle, to schedule a virtual interagency meeting to discuss Steve's treatment recommendations. Steve provides permission to meet but is unable to attend due to his work schedule. Sally agrees to contact him after the meeting.</p> <p>In attendance are the two case managers and their respective medical directors. Michelle is surprised to hear Steve was rejected for his transplant. She digs deeper and discovers several contributing factors:</p> <ul style="list-style-type: none"> • A traveling nurse was assigned to Steve the week he missed treatment. She met him once during his prior session. On the day of the missed visit, she documented, "Client is 'noncompliant' for missing dialysis. This miss is a concerning pattern." • She also wrote, "I'm concerned the client is using again." The nurse did not discuss the concerns with Steve, the medical director (Dr. Nepro), the program social worker, or Michelle. 	<p>ACMA: Collaboration; Care Coordination; Advocacy</p> <p>CMSA: Client Selection Process for Professional Case Management; Care Needs and Opportunities; Planning; Monitoring; Cultural Competence</p> <p>CCMC: Principle 2: Respect rights and inherent dignity</p> <p>Standards: The Client Advocate; Case Manager/Client Relationships</p>



Epilogue

All the world is my school and all humanity is my teacher.

—George Whitman

It was a little challenging to determine the best way to end a book on a topic as serious and fluid as the social determinants of health (SDoH). Recognizing this fluid nature of change in healthcare was one possible starting point. I've always wished I could see into the future to know how events will unfold (yes, I'm one of those folks who often reads the last chapter of a book to know how it ends!). I've joked for years that my crystal ball and magic wand remain at the shop, with the replacement parts on back order. Although humorous, the comment reflects a common frustration of the workforce: We want to know how situations will turn out and that we will have the needed resources to manage them.

I then thought of providing readers with a list of various clichés about change. Clichés help us ground by rationalizing reality. It can appear that clichés—or at least their authors—acknowledge how tough the times can get. When clichés are adopted by popular culture, they become validation of our exasperation—as if someone has finally acknowledged our frustration on a grand scale and gets it! Clichés can also bring a smile, and comic relief is always welcome from my lens.

THE SOCIAL DETERMINANTS OF HEALTH



Case Management's Next Frontier

Ellen Fink-Samnicks, MSW, ACSW, LCSW, CCM, CRP

As insurers and health organizations move toward value-based care models that incorporate population and community health, social determinants of health (SDoH) are becoming a point of focus in clinical practice. While the application of SDoHs is fairly new, the external social and economic conditions that affect a wide range of health risks and outcomes—such as where people are born, grow, work, and live—are not.

The Social Determinants of Health: Case Management's Next Frontier is designed to help case managers develop strategies to manage and intervene with the populations predisposed to the risks associated with SDoHs. Not only does this new resource provide practical understanding and theory-based teaching around SDoHs, it also offers coding, assessment, and reimbursement tools for professionals in a clinical setting.

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