Welcome to August Ecosystem Enrichment!

Social Determinants of Health

WHAT IS ECOSYSTEM ENRICHMENT?

Monthly professional development opportunity for workforce professionals – career coaches, business services representatives, training instructors, and more!

Information that helps connect a complex system of services so that jobseekers can get the support they need to find, obtain, and maintain quality employment – no matter where they start!

Broadly applicable workforce development skills/knowledge with local context

Join us each month for more, invite others you think are a good fit, and reach out if you have questions about previous or upcoming sessions

Housekeeping Items

The session is being recorded, the PowerPoint and other materials will be sent out after the session.

Please mute yourselves to make sure that speakers can be heard, and we do not experience feedback. Cameras on is a great way for our speakers to see how you all are reacting to the information!

Feel free to share your own thoughts, reactions, and reflections to the topics as we go along using the chat. There is time for Q+A built in throughout the afternoon. If you have technical issues, send those to me privately!

Introductions

Type in the chat

Name, Role, Organization

What are you hoping to learn today?

Key Learning Objectives

- What are Social Determinants of Health (SDOH)?
- How are SDOH affecting health outcomes in the community?
- What screening for SDOH factors looks like and how health partners are referring to address them
- Ongoing initiatives to address health inequities in Marion County

Social Determinants (Drivers) of Health

Shannon Sleighter, MBA-HM, Manager of Life Services for CareSource (Indiana)

August 22, 2024

Our MISSION

To make a lasting difference in our members' lives by improving their health and well-being.

Medicaid | Health Insurance Marketplace | Medicare Advantage | Dual Eligibles

CARESOURCE

- A nonprofit health plan and national leader in Managed Care
- 35-year history of serving low-income populations across multiple states and insurance products
- Currently serving members in Arkansas, Georgia, Indiana, Kentucky, Michigan, North Carolina, Ohio and West Virginia
- Approximately 5,000 employees located across the U.S.

2.0M+
members


SCHOOL
BUS

What are they?

- **Social Determinants of Health (SDoH)** are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

- **SDoH** can be grouped into 5 domains:
  - ***Economic Stability***
  - ***Education Access and Quality***
  - ***Healthcare Access and Quality***
  - ***Neighborhood and Built Environment***
  - ***Social and Community Context***

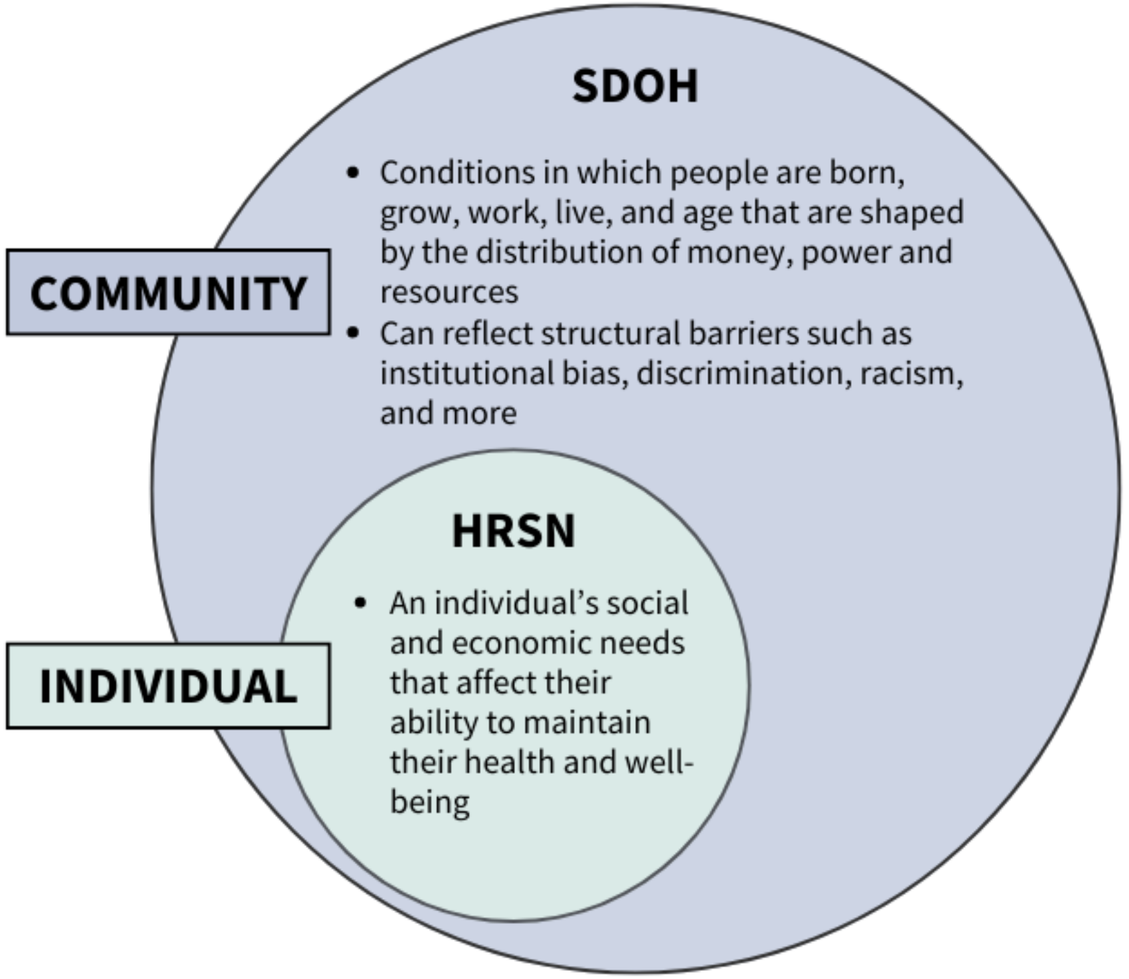
Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved August 12, 2024, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Quick clarification: SDoH vs HRSN

- **SDoH** is sometimes used interchangeably with the term “health-related social needs” (HRSN) but the concepts differ. HRSN are those individual-level needs that stem from how a certain SDoH may be impacting the person.

Example: Indianapolis has multiple neighborhoods that are considered to be *“food deserts”* (SDoH).

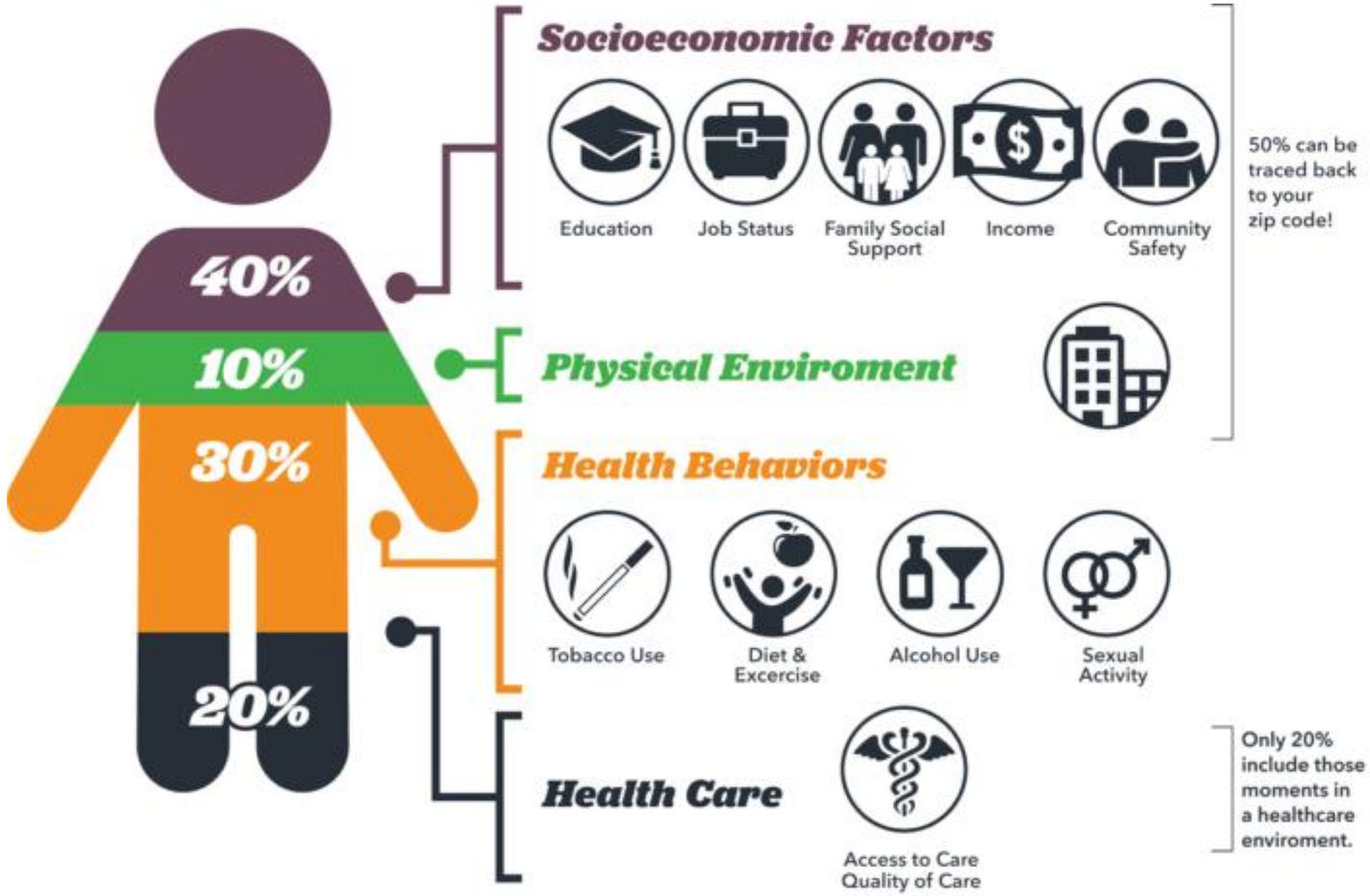
Residents with diabetes in those neighborhoods are unable to easily access the foods they need to successfully manage their condition (HRSN).



Georgetown University, McCourt School of Public Policy, Center for Children and Families. Retrieved August 12, 2024, from https://ccf.georgetown.edu/wp-content/uploads/2024/06/Using-1115-for-HRSN-Final-PDF.pdf

Life Services® = CareSource SDoH Brand

Social Determinants/Drivers of Health focuses on ***"the person outside the patient."***



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Economic Stability

- The simple idea is those with steady and safe employment, good wages, and benefits (including PTO) are more likely to have positive health outcomes.

- These individuals will be able to purchase food and other necessities, receive health insurance, afford medications, and be able to take the time off necessary to utilize preventative physical and mental health care. The ability to afford and secure stable ***housing*** is also of particular importance.

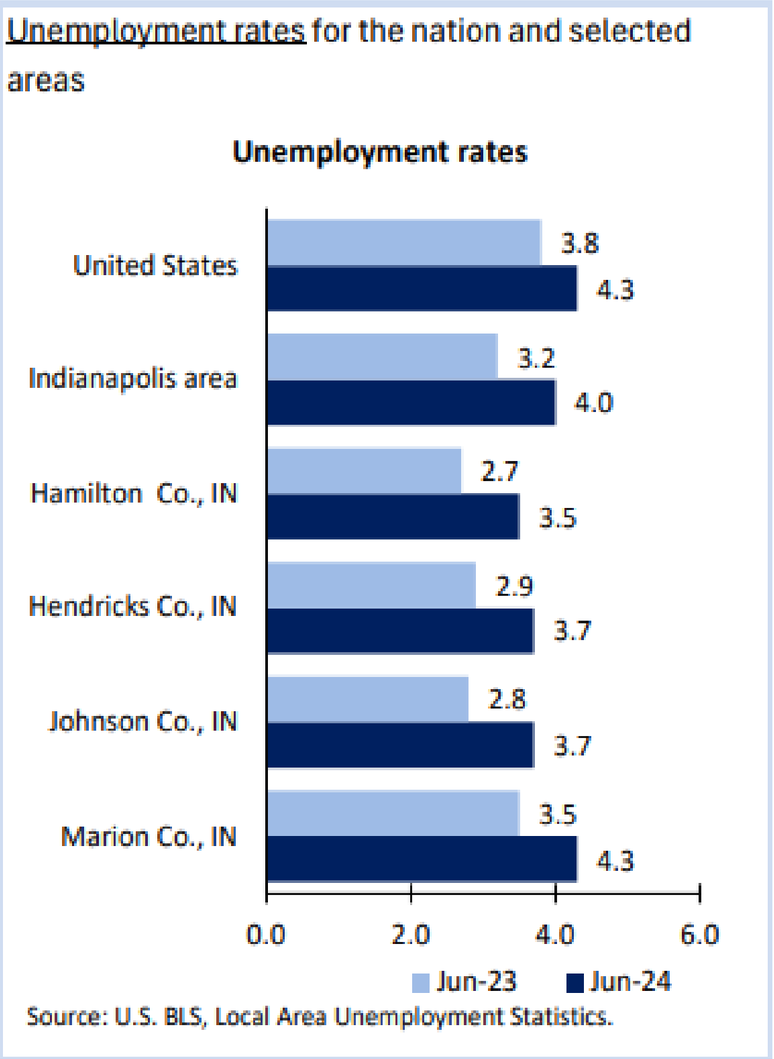
- Unfortunately, as we all know, individuals are encountering various barriers to this simple idea.

Current State of Employment

- Indiana unemployment rate stands at 3.8% which is under the National average. Marion County more closely aligns with the National average of 4.3%

- Indiana DWD reports nearly 110k job openings, but also reports a potential 160K+ amount of potential workers not currently employed.

- **Inequities:** Per the Economic Policy Institute, Black workers are twice as likely to be unemployed compared to white workers at almost every education level. Black workers are also more likely to be underemployed. (2019)



Retrieved from U.S. Bureau of Labor Statistics

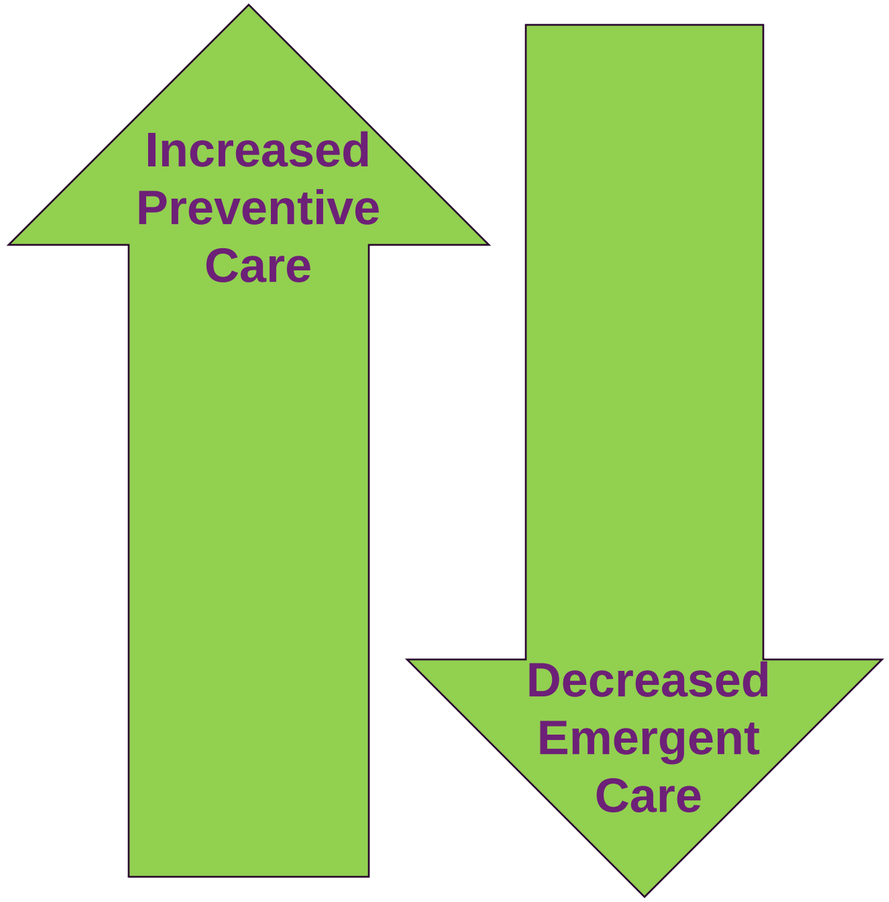
★ Discussion Break ★

Successes

- Participants of our Life Services program have been found to access preventive care more frequently than our general Medicaid population. They also utilize the emergency room less frequently. **This translates directly to our life coaches' efforts and to community partners and organizations completing this work.**

- Healthy People 2030 has noted an increase from 70.6% in 2018 to 71.3% in 2022 of the working-age population being employed. Goal is 75% by 2030.

- Sayre & Conroy recently completed an analysis of over 130 articles in academic journals and did find a common thread, that employment and higher wages equal better health and well-being. (2023)



Neighborhood and Built Environment

- Skipping ahead to Neighborhood and Built Environment so we can discuss housing. Housing spans both of these SDoH domains as it can be dependent upon employment and availability of safe and affordable housing in the community.

- Where people live has a tremendous impact on their health and well-being. Whether it be the water they drink, the air they breathe, or how safe (i.e. crime rates) they are while walking or visiting a local park, if one exists.

- In addition to other things; access to technology such as broadband is unfortunately getting worse especially as funding to the Affordable Connectivity Program (ACP) has ceased. Internet Essentials or Internet Essentials Plus through Xfinity still active.

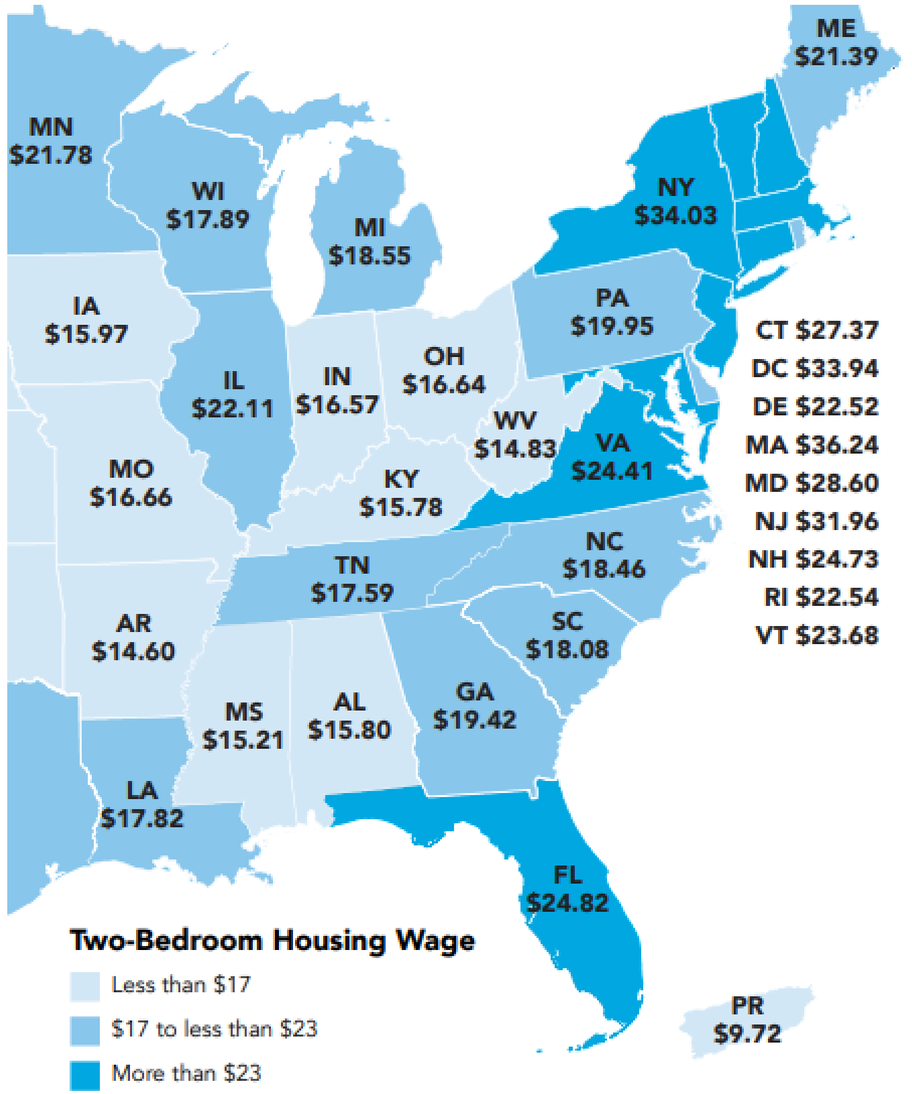
State of Housing in U.S.

- There is nowhere in the U.S. that someone working full-time and paid minimum wage can afford* the Fair Market Rent (FMR) for a Two-Bedroom unit. *(National Low Income Housing Coalition (NLIHC))*

- Home ownership rates continue to climb, but mortgage payments on the median-priced home were up by 20 percent in March of 2023. *(Joint Center for Housing Studies (JCHS))*

- Number of cost-burdened homeowners sharply rising, and number of cost-burdened renters reached all time high in 2021. *(JCHS)*

*Based on 30% of the Area Median Income (AMI)



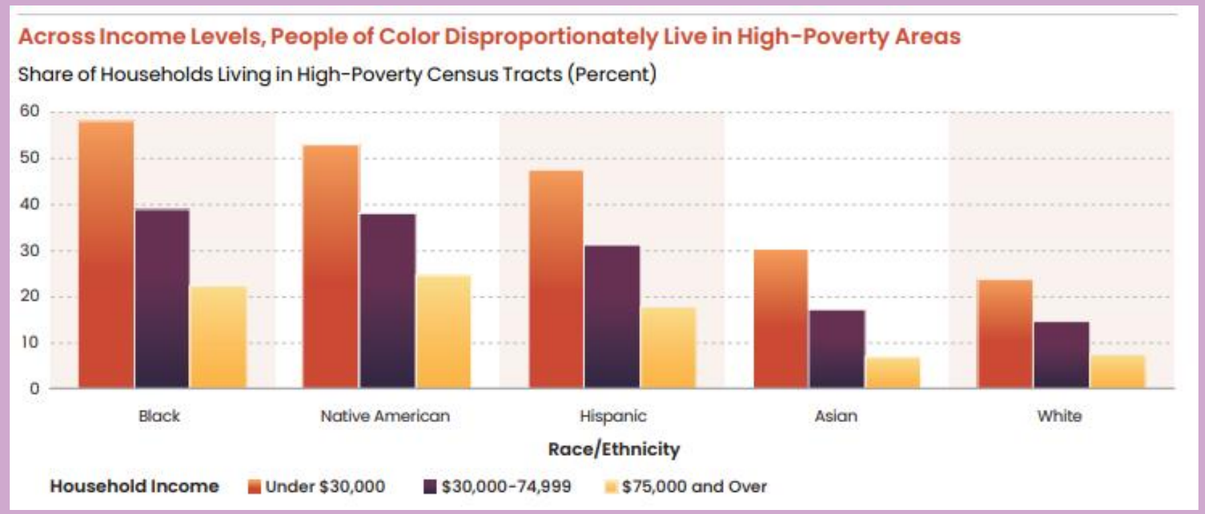
Retrieved from NLIHC's Out of Reach 2021 Report

Disparities in Housing

- While homeownership has been rising, that is not the case for Black households as Census data shows just 44.1% own a home, which is down from the decade prior. Hispanic homeownership did grow to an all-time high.

- The increase in rent amounts also disproportionately affects minority households as 58% of Black households and 54% of Latino were renters in 2019, compared to just 28% for white. *(Census, 2020)*

- "People of color are overrepresented in neighborhoods with high poverty rates, where essential resources like quality schools, full-service grocery stores, safe and healthy parks, and reliable transportation are often lacking." *(Turner & Greene, Urban Institute)*



Retrieved from JCHS's The State of the Nation's Housing 2023 Report

★ Discussion Break ★

Impact on Health Outcomes

Homelessness or Housing Instability

- People experiencing chronic homelessness typically have long-term health conditions, such as mental illness, substance use disorders (53%), physical disabilities, or other medical conditions. *(National Alliance to End Homelessness)*

- Call-out for pregnant women suffering from housing instability:

  A study found that these women were 1.73 times more likely to have low birth weight and/or preterm birth, NICU stays, and extended hospitalization. *(Leifheit, 2020)*

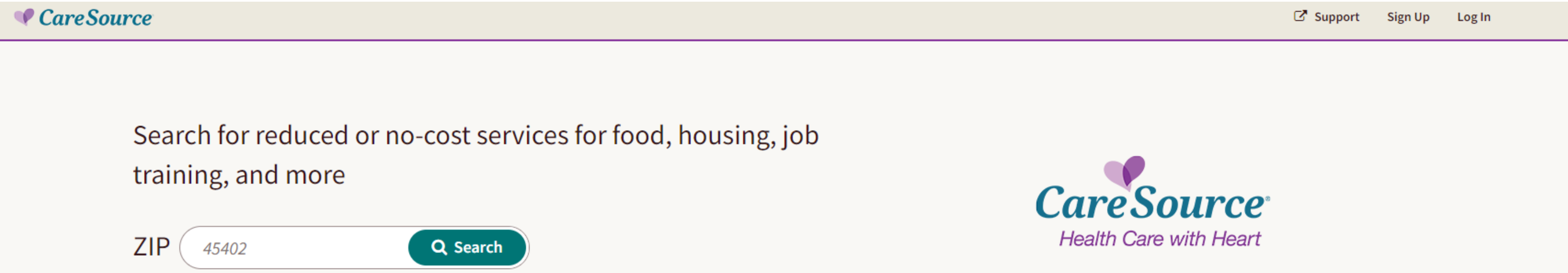
Housing Quality and Conditions

Large focus for Healthy People 2030

Resources

- **Indiana 211** by phone or online is always a great starting point regardless of need; shelter, food, financial assistance for housing, utilities and so much more.
- For long-term housing needs; access points are Adult & Child, Damien Center, Homeless Initiative Program (HIP), and Horizon House. Visit Need Help - Homelessness Assistance - CHIP Indy for details.

  *Young adults (18-24), Veterans, and domestic violence victims will have specific resources available on that page as well.
- Findhelp also has community resources listed. We have our own version of findhelp if anyone is interested in claiming their program for direct referrals from our Life Services team. Visit CareSource.findhelp.com



★ Discussion Break ★

Education Access and Quality

- Again, the simple idea here is that people with higher levels of education are more likely to be healthier and live longer so increasing high quality education and opportunities is the goal.

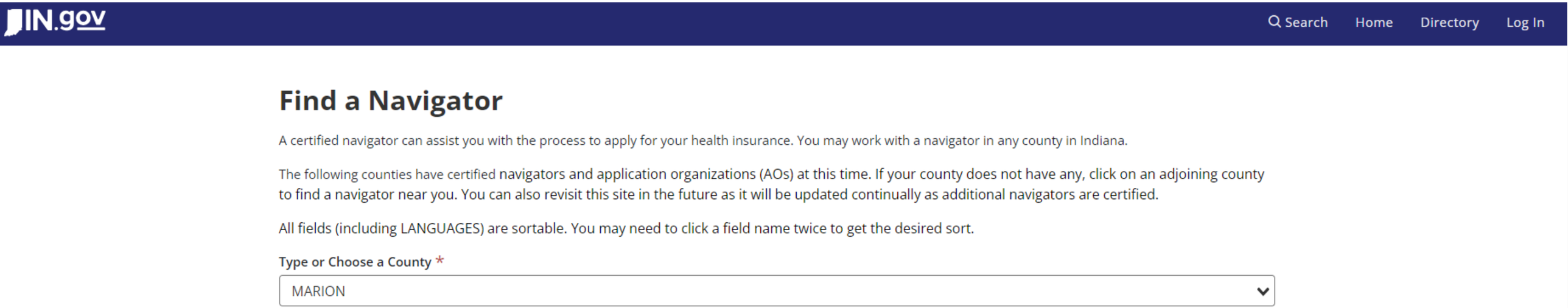
- Per our internal SDoH risk dashboards, Marion County is ranked mid-to-high risk with about 46% of our membership having a high-risk score. This prompted us to send out information for adult education opportunities to all our members (19+).

- **Success:** Healthy People 2030 has noted an increase from 84.1% in 2016 to 86.6% in 2022 of high school students who graduate in 4 years. Goal is 90.7% by 2030.

★ Discussion Break ★

Health Care Access and Quality

- About 1 in 10 people in the United States don't have health insurance or those that do have insurance are not utilizing their benefits and receiving the preventive care they need.
- **IMPORTANT:** If you are working with someone that is uninsured direct them to someone that can help. There are certified navigators and application organizations available to assist.



Visit: Find a Navigator: IDOI Public (accessgov.com)

★ Discussion Break ★

Social and Community Context

- We know that connection to others is vital for both physical health and especially mental well-being. Not everyone has a strong connection with family or friends so other connections with co-workers and community members becomes increasingly important.

- We recently conducted a survey with over 100 Medicaid members and found something interesting. While “Social Support” was ranked as the lowest SDoH need, “Connection to Support Groups” was selected as the second highest thing that could improve respondents' quality of life.

- Healthy People 2030 has a goal to reduce the number of children who experience a parent/guardian serving jail time which is improving. Equally important is providing services to those returning from incarceration.

“Shout-out” to Community Partners

- **Economic Stability:**
  - EmployIndy/WorkOne,
  - Centers for Working Families,
  - Community Development Corporations,
  - Community Action Agencies &
  - so many more…
- **Education Access and Quality:**
  - Adult Education & Learning (various),
  - Goodwill/The Excel Center &
  - Indy Achieves
- **Healthcare Access and Quality**
  - Covering Kids and Families
- **Neighborhood and Built Environment:**
  - Keep Indianapolis Beautiful,
  - Home Repairs for Good (NeighborLink),
  - INHP, Gleaners & so many more…
- **Social and Community Context**
  - Recovery Café/We Bloom,
  - Trusted Mentors,
  - NAMI & other support groups
- **Multiple SDoH Organizations**
  - Eskenazi, other federally qualified health centers, community mental health centers &
  - so many “community centers”

CareSource Life Services® as a Partner

There is **no wrong door** for members to access our team for SDoH barrier-busting assistance.

Requirements:

- Must be a CareSource member (of legal working)
- The parent/guardian of a CareSource member

Members and/or partners can contact Life Services directly at 844-607-2832 or email us at LifeServicesIndiana@CareSource.com.

Secure webforms are also available:

Member: CareSource™ - CareSource Life Services® Request Info

Partner/Provider: CareSource™ - CareSource Life Services® Request Info

Individuals with health and/or chronic condition related concerns can access our Nurse Case Managers and care management team who are available to help coordinate CareSource member's care.

Members can contact CareSource directly at 844-607-2829 for any need or inquiry. Member Services is available Monday – Friday, 8:00am – 8:00pm EST.

Q & A

Presented by:

Shannon Sleighter

Manager of Life Services for CareSource (Indiana)

August 22nd, 2024

CARESOURCE.COM

Health Equity

Helping people live longer and better lives.

Eskenazi Health Center Grassy Creek staff launch the Health Equity Zone on the Far Eastside of Indianapolis

Eskenazi Health 2024

- A major asset for our City
  - Serving record number of primary care patients
  - Serving record number of mental health care patients
  - Serving record number of hospitalized patients
  - The cornerstone of our city's response to COVID, violence, the opioid epidemic, and care for vulnerable populations

Lisa Harris, MD
CEO, Eskenazi Health

Virginia A. Caine, M.D.
Director, MCPHD

Dawn Haut, MD
CEO, Eskenazi Health Centers

Ashley Overley, MD
CEO, Sandra Eskenazi CMHC

- Institutional leadership
- Mission-driven staff
- Safety net health system
  - Embedded CMHC
  - Embedded FQHC
- Expertise in innovation
- Excellent IT and business organization and support
- Community partners
- Community trust

Building on our tradition of Social Care

- Medical Legal Partnership
- Sandra Eskenazi Mental Health
- Food as Medicine
- Housing as Medicine
- Lifestyle Medicine
- Transportation as Medicine
- Prescription for Hope
- Other Partnerships

Eskenazi Health Screening for SDOH

Social Determinants of Health

Tobacco Use
NOV 10 2020 — Medium Risk

Alcohol Use
NOV 10 2020 — Heavy Drinker

Financial Resource Strain
NOV 10 2020 — High Risk

Food Insecurity
NOV 10 2020 — Food Insecurity Present

Transportation Needs
NOV 10 2020 — Unmet Transportation Needs

Physical Activity
NOV 10 2020 — Insufficiently Active

Stress
NOV 10 2020 — Stress Concern Present

Social Connections
NOV 10 2020 — Moderately Isolated

Intimate Partner Violence
NOV 10 2020 — Not At Risk

Depression
NOV 10 2020 — Not at risk

Housing Stability
NOV 10 2020 — Low Risk

Resources Needed
NOV 10 2020 — NO

SDOH Food Insecurity Screening-

Food Insecurity Screening- “Hunger Vital Signs”

Food Insecurity

Within the past 12 months, you worried that your food would run out before you got the money to buy more.

Sometimes true taken yesterday

Never true	Sometimes true	Often true	Patient refused

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

Sometimes true taken yesterday

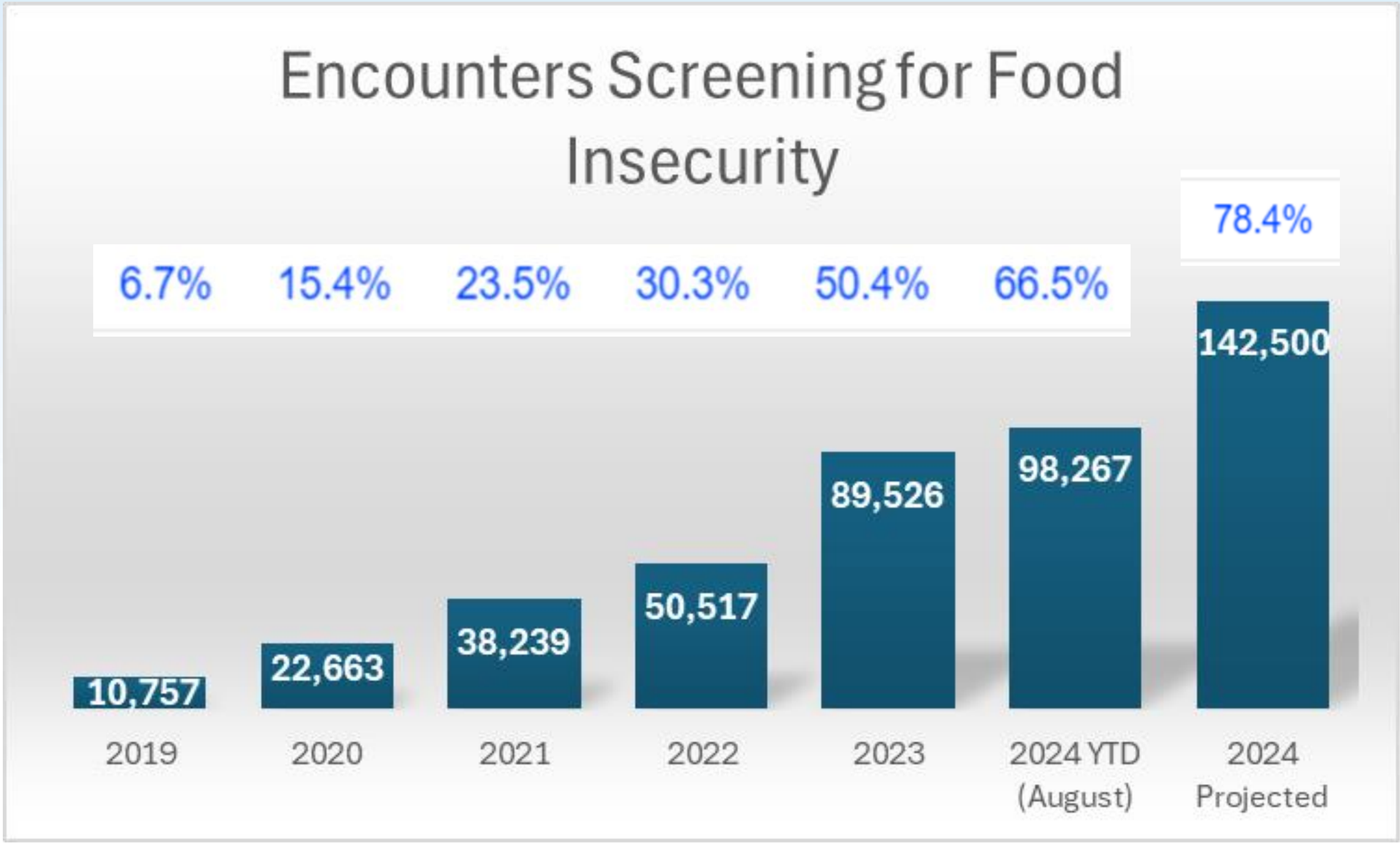
Never true	Sometimes true	Often true	Patient refused

Do you or someone in your family receive SNAP (Supplemental Nutrition Assistance Program)?

Yes, I or a family member receive SNAP	No, do not need or qualify at this time	No, I would like additional information and assistance
Decline		

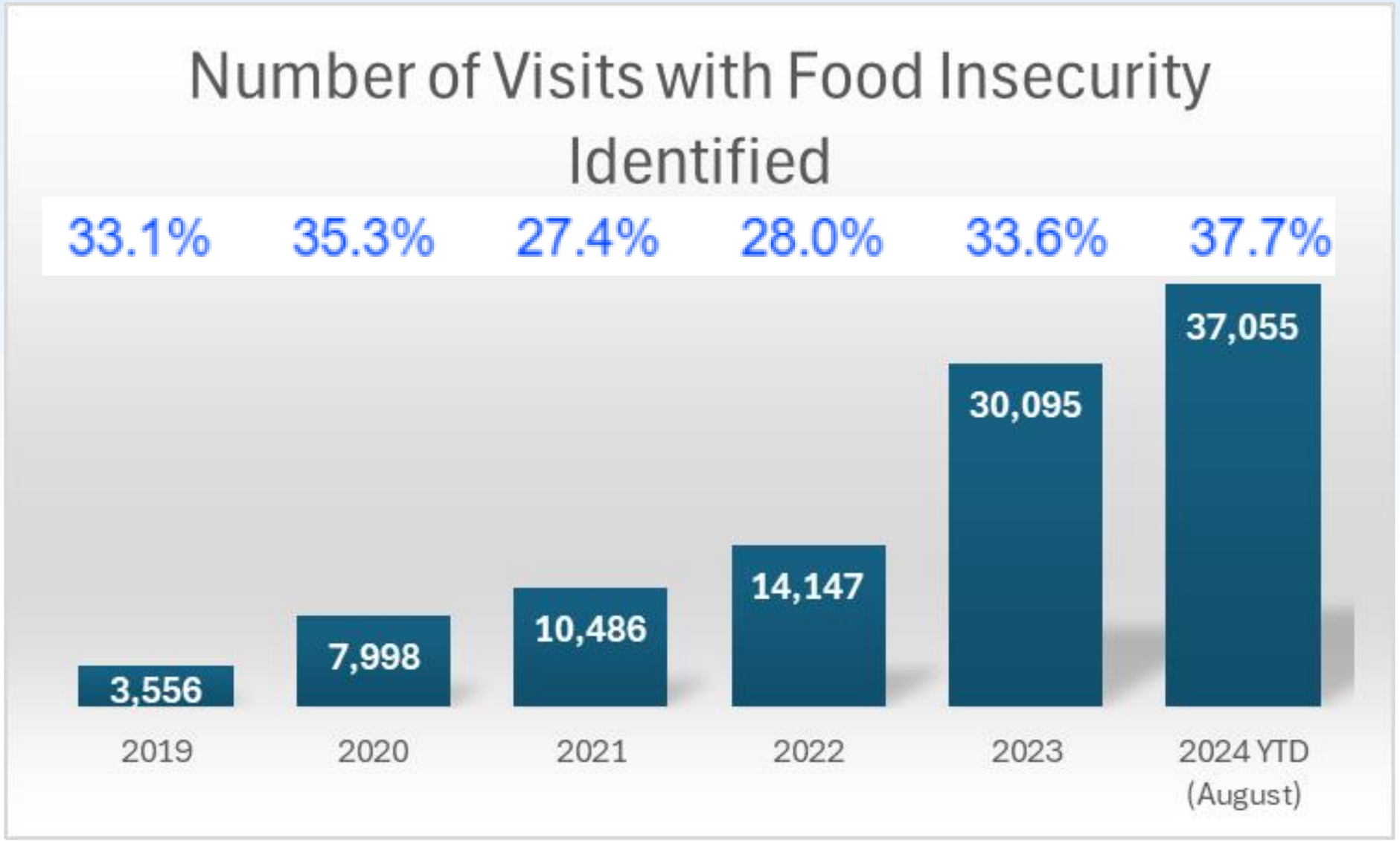
Eskenazi Health Fresh for You Market on Wheels

EH Food Insecurity Screening



July 2024- 37,440 screened encounters for FI

Food Insecurity Identified



Largest Food Pantries in Marion County

1. Gleaner's Food Bank Pantry ~26,900/month
2. St. Vincent de Paul Food Pantry ~14,800/month
3. Old Bethel & Partners Food Pantry ~4,500/month
4. Crooked Creek Food Pantry ~ 4,000/month
5. Eskenazi Health Fresh For You Market ~2000/month
6. Mid-North Food Pantry ~1500/month

FFYM New Lunch Menu Offerings

ESKENAZI HEALTH
Fresh for You Market

Lunch is Available Daily
11 A.M. – 1:30 P.M

COLD WRAPS & SALADS

Spicy Chicken Caesar Wrap - $6.99
Spicy Breaded Chicken Breast, Parmesan Cheese, Romaine Lettuce, Caesar Dressing

Chef Salad - $6.99
Ham, Turkey, Shredded Cheddar Cheese, Diced Egg, Diced Tomato, Spring Mix

HOT SANDWICHES

Philly Cheesesteak - $7.99
6" Hoagie, Seasoned Philly Beef, Peppers, Onions, Provolone Cheese

Vegetarian Panini - $6.99
Sourdough, Zucchini, Peppers, Onions, Italian Dressing, Mozzarella

Pesto Grilled Cheese - $6.99
Sourdough, Cheddar Cheese, Mozzarella Cheese, Provolone, Tomato, Basil Pesto

CHEF'S SPECIAL

Jumbo Walking Taco - $9.99
Choice of Doritos or Fritos, Seasoned Ground Beef, Cheddar Cheese, Shredded Lettuce, Diced Tomato, Salsa, Sour Cream

Chips - $1.99

16oz Aquafina Bottled Water - $1.00

20oz Bottled Soda - $1.99

Partnership Referrals

Find Help!

When patients screen at risk in one or more of the SDOH domains, staff members have multiple avenues to provide resources/assistance:

- Internal referrals (social work, dietician)
- External referrals (WIC, food pantry, health department programming)
- Find Help! (can search for programs using zip codes or key words)

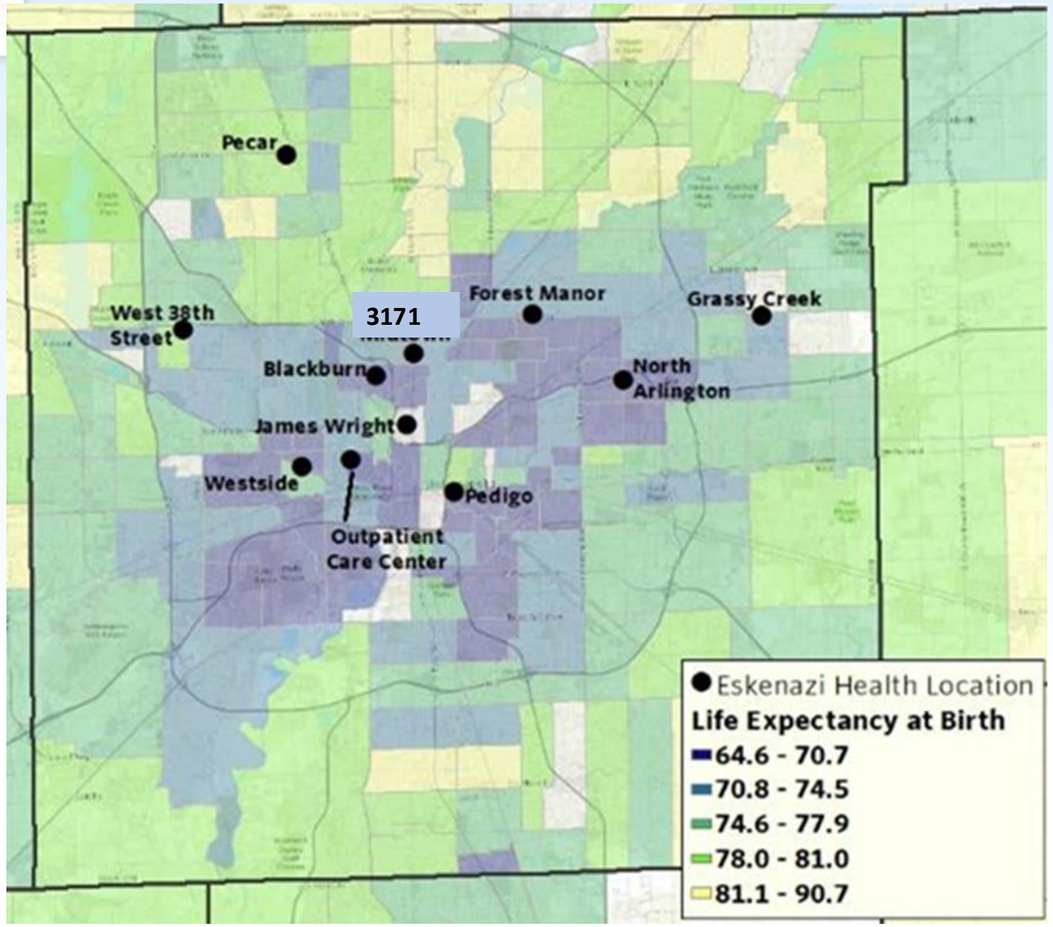
SDOH Resources from SDOHFOLLOWUP SmartPhrase (since 11/18/2019)

	Value	Time
Food Insecurity	Internal Referral	11/17/2020 12:42 PM
	Fresh for You Market	11/17/2020 12:42 PM

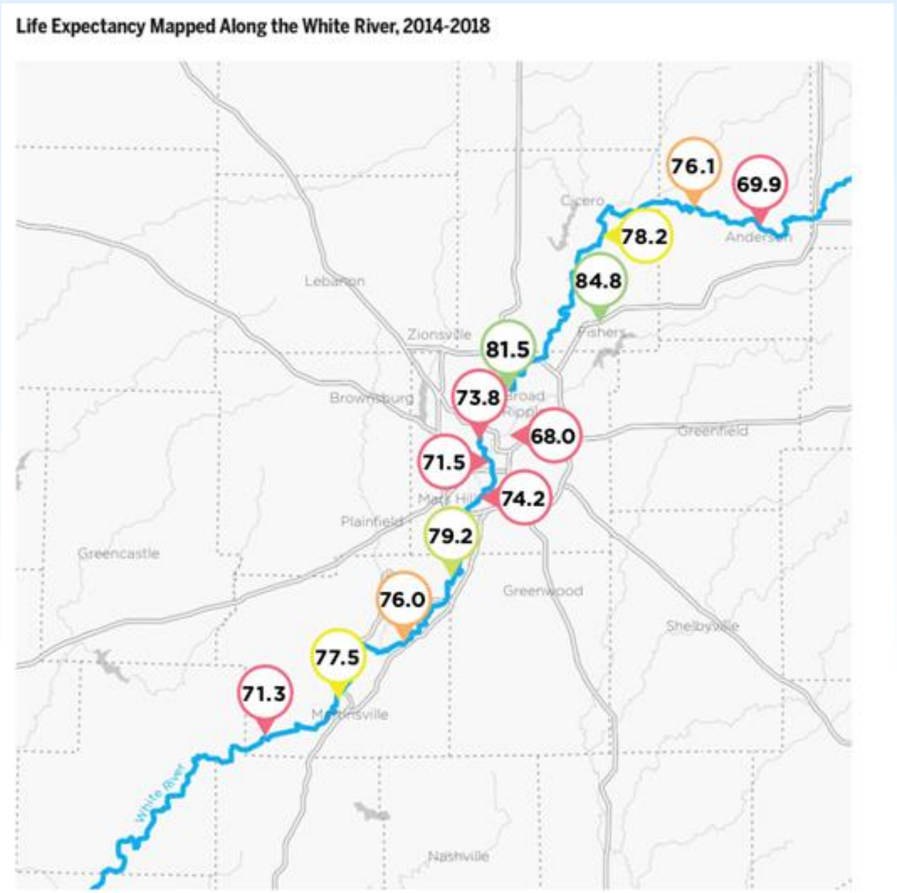
Any follow up is documented using a Smartphrase, and all follow up actions are then captured in an SDOH Resources section of the LPOC report in the chart

Find Help! Search Utilization

LIFE EXPECTANCY GAP IN NEIGHBORHOODS OF INDIANAPOLIS



Source: Life Expectancy at Birth in Years (2015)/US Small-Area Life Expectancy Project

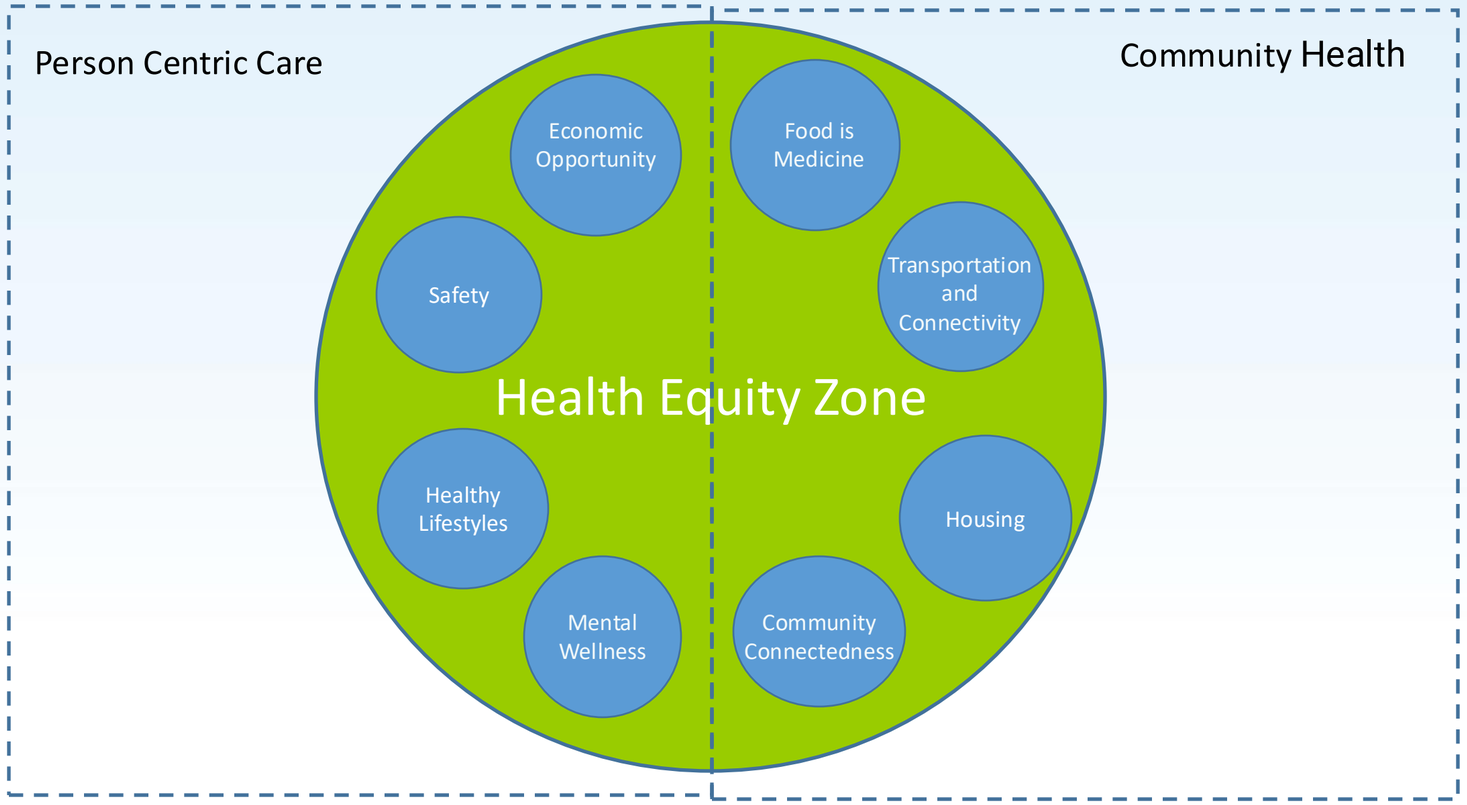


Life Expectancy Gap from Fishers to Downtown Indianapolis is 16.8 years (84.8 to 68.0)

WHAT IS A HEALTH EQUITY ZONE?

A defined geographic place where Eskenazi Health deploys its own unique health capacity and partners with community organizations, creating a healthy neighborhood through a shared vision and joint implementation of health goals that address long-term social determinants of health including racial equity and economic mobility, resulting in increased life expectancy for neighborhood residents.

SOCIAL DETERMINANTS OF HEALTH IN HEALTH EQUITY ZONE



Food as Medicine—Eating healthy and nutritious food

Transportation and Connectivity— Connecting to health, education, and employment

Housing—Supporting quality affordable and safe housing

Community Connectedness—Building social capital and connection

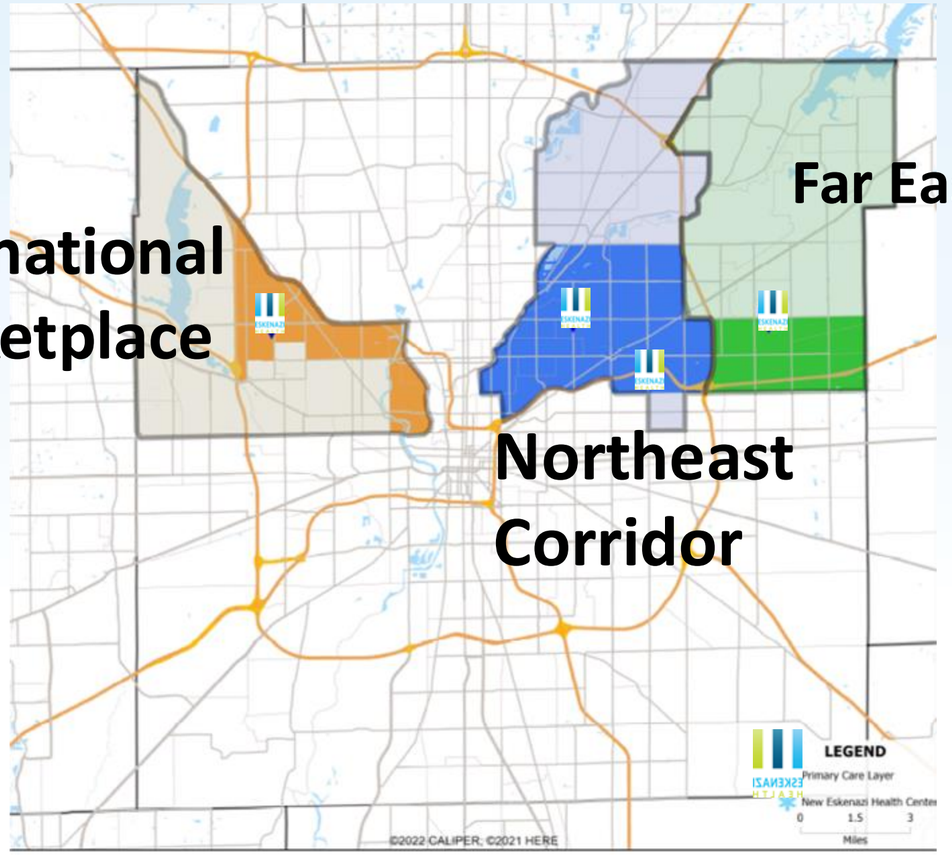
Mental Wellness—Fostering resilience and healthy mindset

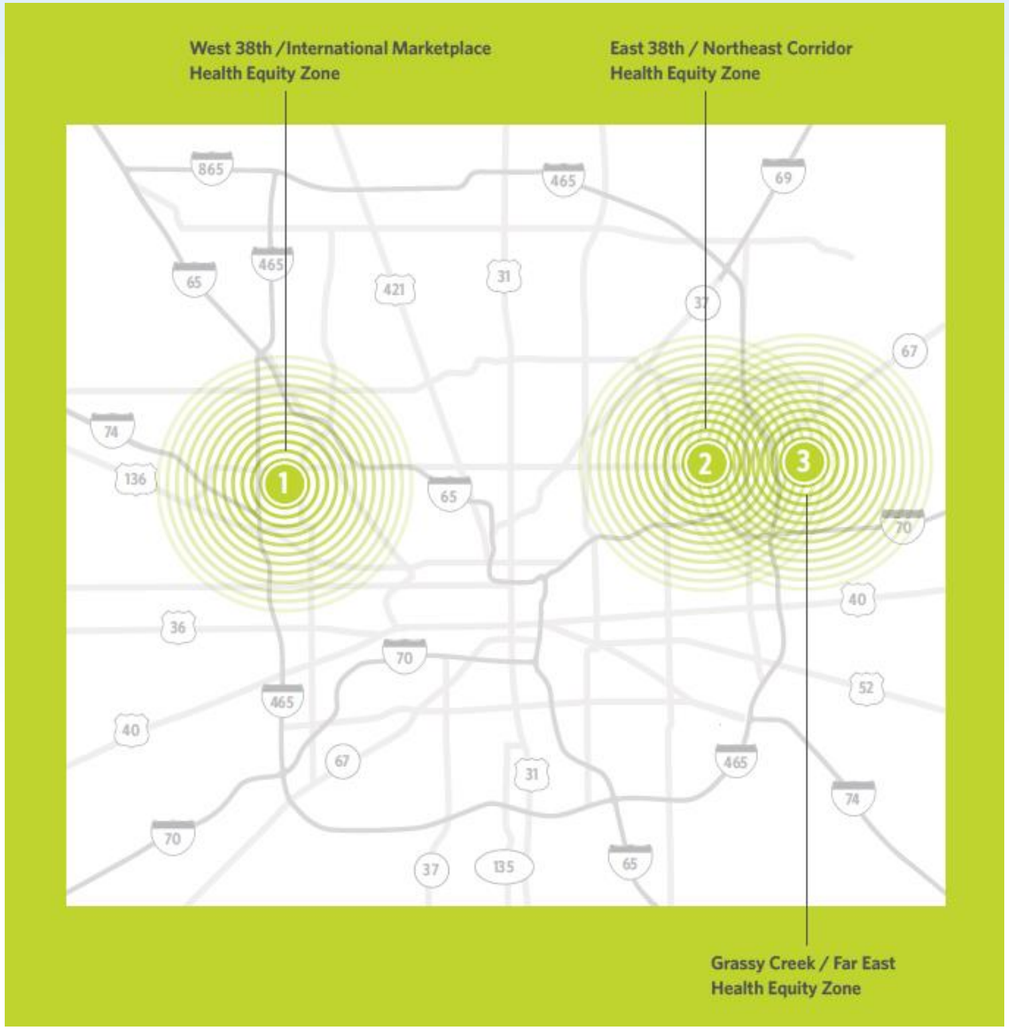
Healthy Lifestyles—Creating the conditions for healthy living

Safety—Living free of violence, including intimate partner violence and child abuse.

Economic Opportunity—Creating pathways to economic self-sufficiency

Initial Three Health Equity Zones





Partnering for Community Health

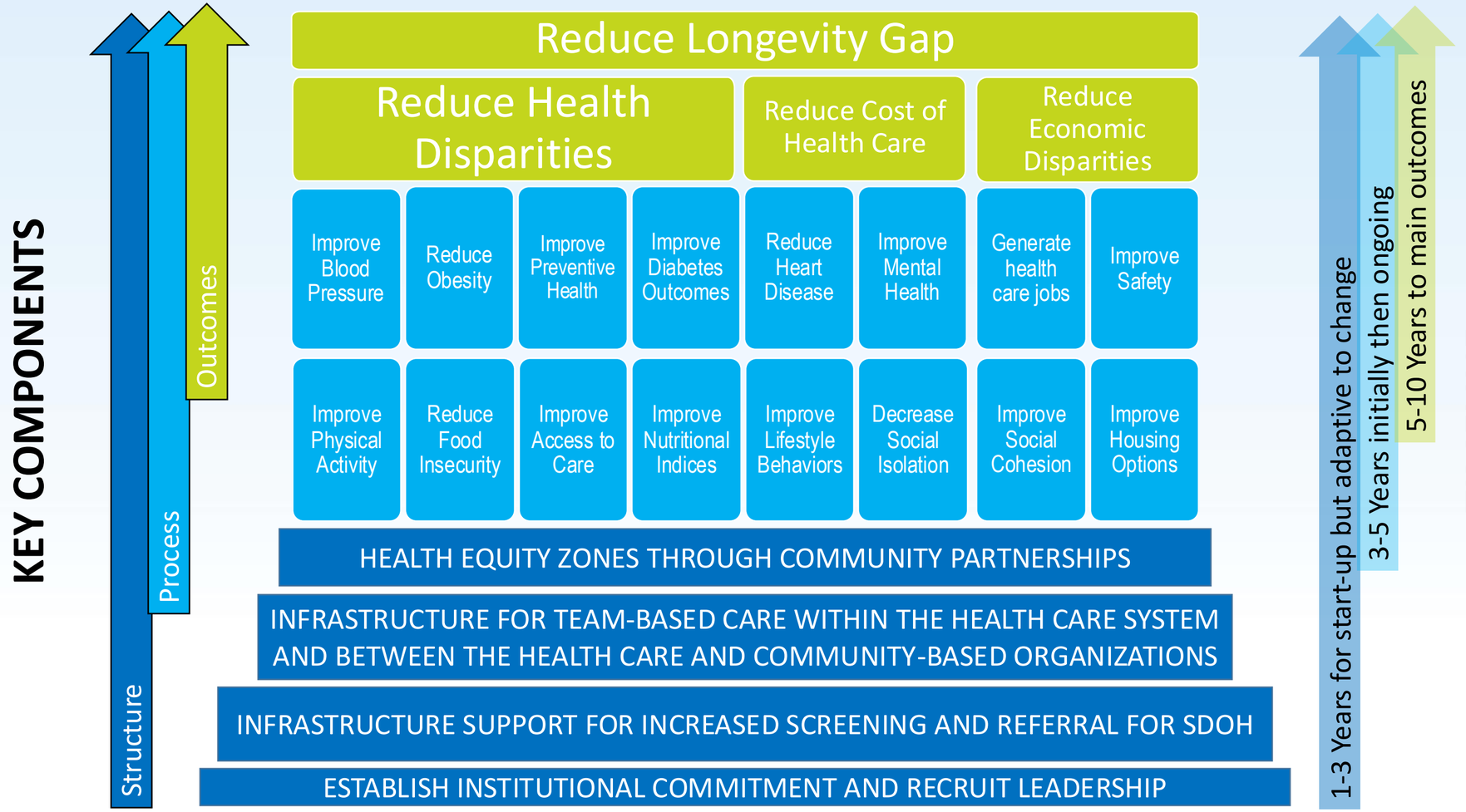
Health Equity Zone Partnership Structure Elements

Each neighborhood has unique assets, with many organizations working on various aspects of Social Determinants of Health.

Connecting to and complementing these efforts will require reciprocal communication, collaboration and, at times, additional capacity.

Long-term relationships with a strong network of neighborhood organizations is the key to addressing upstream health challenges.

Measure success?



Overview of Eskenazi Health SDOH Evaluation Plan 2021-2022

Growing our capacity

- Community Health Workers
- Community Weavers
- Doulas
- SNAP Outreach Coordinators

Tripling our neighborhood facing staff

How Eskenazi is Addressing SDOH

- Community Weaver

Acts as a point of contact for the Health Center he or she serves. The Community Weaver will form relationships with organizations in the surrounding neighborhood of the clinic; Provide outreach events at organizations where the Community Weaver will provide community resources to the people who live in the neighborhood, which will improve social determinants of health.

- Community Health Worker
- Acts as a liaison for the patient. The CHW encourages the patients to advocate for themselves. The CHW provides the patient with community resources. The CHW assist with goal setting and completion. The CHW is there to serve the patient as a partner in their journey. The CHW empowers the patients.

Thank You!

https://www.eskenazihealth.edu/programs/social-determinants-of-health#

Tedd Grain
Director, Social Determinants of Health

Phyllis Morgan
Community Health Worker Supervisor (not pictured)

Kimberly McElroy-Jones, PhD, DMin
Director, Community Partnerships for Community Health

Deanna Reinoso, M.D.
Pediatrician and Medical Director, Social Determinants of Health

Chris Callahan, M.D.
Chief Research and Development Officer

Seth Grant
Director, Food & Nutrition and System Food Strategy
Food Services Administration

Hannah Carty
Area Operations Director, Social Determinants of Health

Sabine Augustin
Enterprise Project Manager, Social Determinants of Health

Tierra Pinkins
Enterprise Project Manager, Social Determinants of Health

Dan Clark, PhD
Medical Sociologist, Evaluation (not pictured)

Rate the Session

Wrap-Up

Next Session: September 26nd

Register Here

Are you a new career coach, navigator, or case manager looking for resources?

Are you a seasoned professional with resources to share?

Check out the Resource Library where you can access & request materials to help as you serve jobseekers

Program Year 2024 Topic Calendar