HealthPort

The Social Determinants of Health Model of Care

HealthPort Logic Model

Dimensions of the Social Determinants of Health Model of Care	HealthPort Interventions	Goals and Outcome Measures
Housing	Residential Rehabilitation Program Psychiatric Rehabilitation Housing Stability Services Supportive Housing	At any given time, 90% of clients will be housed through the use of organizational housing services and access to subsidized housing.
Primary Care	Primary Care Screening and Intervention	The average number of abnormal values in client comprehensive metabolic panel results will decrease by 25%.
Mental Health Care	Outpatient Mental Health Treatment	The percentage of clients with low suicide risk measured by Columbia Suicide Severity Risk Scale will increase to 90%
Substance Use Care	Substance Use Treatment	Overall problematic substance use as measured by the single question screener will decrease to 20%.
Medication Adherence	Medherent Devices Multidose Strip Packaging	Medication adherence rates for clients using the Medherent Device will increase to 95%. The percentage of clients utilizing multidose strip packaging will increase to 90%.
Population Health Management	Health Promotion and Management	The percentage of clients with Healthy BMIs, Blood Pressure under 140/90, A1C under 9, and PHQ-9 scores ≤10 will increase to match Maryland rates.
Employment	Vocational Training Supported Employment	Employment rates of clients in competitive or supported employment will increase to 25%.
Financial Management	Representative Payee Services	For individuals enrolled in organizational representative payee services, 95% of all bills will be paid on time.
Transportation	Transportation Services Agency Vehicle Fleet	100% percent of clients will have access to transportation.
Community Integration	Psychiatric Rehabilitation Day Program	The percentage of clients who report they are lonely during treatment planning will decrease to under 25%.
Food Security	Food is Medicine	Each program will serve an average of 2 meals a day per client, 7 days a week.
Crisis Stabilization	Residential Crisis Services (RCS) Crisis Response System	Clients staying at RCS will not utilize the emergency department or inpatient hospitalization for psychiatric diagnosis during RCS stay and 30 days post-discharge.
Flexible Funding	Member Assistance Loans Charitable Care	100% of member assistance loans and charitable care will remove barriers related to client social determinants of health needs.

Results **Monthly Pre-Post analysis of enrolled individuals will show trending decrease of hospital utilization and cost according to health information exchange reporting tools.**

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HealthPort has developed this model of care to research the effectiveness of this model as well as develop the important factors as to what works and does not work. People who live in low-income communities experience poorer health than others due to SDOH, which studies state play a role in up to 80% of health outcomes. This is very important because the research shows that these factors which include quality of housing, crime and unemployment rates, exposure to pollution, racism and discrimination, availability of healthy food and, critically, access to healthcare must be addressed to improve health. Yet there is no integrated model developed to address these factors at the same time. Only interventions in a silo. We aim to provide this integrated model as an evidenced based practice. Addressing social determinants of health is a multifaceted endeavor, using evidence based supported employment, assertive community treatment, and case management, creating affordable, safe, attractive housing in a housing first model though our residential rehabilitation programs and supportive housing program. We believe there are 13 dimensions that when integrated into a model of care provides an impactful intervention. The following items have the dimensions listed as well as the rationale of why these dimensions were chosen and the research supporting these domains.

Dimension of the Social Determinants of Health			Scale			
Housing	**1**	**2**	**3**	**4**	**5**	**Score**
Rationale: Supportive housing provides an essential platform for the delivery of services that lead to improved health and stability. First, at the most basic level, housing provides physical safety, protection and access to basic needs. Second, supportive housing improves access to quality health care both by providing a physical space for service delivery (e.g., in-home case management, nursing, ADL supports) as well as access to support staff that link tenants to community-based social, mental health, substance abuse and primary/specialty medical care services. Third, supportive housing provides a foundation for engaging tenants in managing their own care and promoting lifestyle changes that lead to good health.	The organization has no supportive housing or housing subsidies.	The organization helps clients locate housing and assists in applying to housing opportunities.	The organization provides supervised housing connected to service provision but does not provide supportive housing.	The organization provides supervised housing and supportive housing that are connected to services and have programmatic rules in the lease agreements.	The organization has a multi-layered supervised as well as independent affordable housing program that allows clients to live in the community and receive supports inside their homes. Tenant leases comport to State law and have no additional requirements nor are connected to services by the organization.	
Primary Care	**1**	**2**	**3**	**4**	**5**	**Score**
Rationale: Approximately **67 percent** of patients with behavioral health disorders do not receive the care they need. **68 percent** of adults with mental disorders have comorbid chronic health disorders, and **29 percent** of adults with chronic health disorders have mental health disorders. Integrated Primary Care and Whole Health Approaches are the most effective intervention for vulnerable clients.	The organization has no primary care integration.	The organization provides primary screening and assessment to connect clients to primary care in the community.	The organization has an agreement with a primary care provider located at another address which is accessible for clients.	The organization has a co-located independent primary care provider on site at their clinical services location.	The organization has a fully integrated primary care practice located within behavioral health clinical services.	

Mental Health Care	**1**	**2**	**3**	**4**	**5**	**Score**
Rationale: A population's behavioral health status affects numerous essential dimensions of a healthy society. In addition to the health care system, these dimensions include academic and occupational achievement, economic productivity, social welfare expenditures, public safety, and criminal justice systems. Good behavioral health enhances human capital and social structure; poor behavioral health erodes the population's human capital and the functioning of its communities and institutions. Persons with a persistent mental illness need additional supports to succeed in their recovery.	The organization has no clinical behavioral health interventions.	The organization connects their clients to mental health providers in the community.	The organization has a co-located independent outpatient mental health provider providing services.	The organization provides outpatient mental health care through clinic services integrated with their other behavioral services.	The organization has a full continuum of care with evidenced based clinical interventions and psychosocial rehabilitation services.	
Substance Use Care	**1**	**2**	**3**	**4**	**5**	**Score**
Rationale: The profound effect that SDOH have on people struggling with addictions is borne out by the evidence. In a 2019 study from Drug and Alcohol Dependence it was found that "across 17 states in 2002-2014, opioid overdoses were concentrated in more economically disadvantaged zip codes, indicated by higher rates of poverty and unemployment as well as lower education and median household income." Integrated substance abuse treatment using harm reduction and stage wise interventions are the most effective evidence based approaches to care.	The organization has no substance abuse treatment interventions.	The organization connects their clients to substance abuse treatment providers in the community.	The organization has an agreement with a substance abuse treatment provider located at another address which is accessible for clients.	The organization has a co-located independent substance abuse treatment provider on site at their clinical services location.	The organization provides evidenced based trauma informed substance abuse treatment interventions integrated with medicated assisted treatment and stages of change / motivational interviewing interventions.	

Medication Adherence	1	2	3	4	5	Score
Rationale: According to the World Health Organization, medication adherence can have a more direct impact on patient outcomes than the specific treatment itself. Medication adherence can affect quality and length of life, health outcomes, and overall healthcare costs. Nonadherence can account for up to 50% of treatment failures, around 125,000 deaths, and up to 25% of hospitalizations each year in the United States. Most people who are vulnerable or disadvantaged need significant management to help with their medication management.	The organization has no adherence tools for medications.	The organization connects their clients to pharmacy providers in the community and helps navigate their needs.	The organization has an agreement with a pharmacy provider located at another address which clients can access.	The organization leverages technology and on site co-located independent pharmacy collaboration to assure the adherence of somatic and psychiatric medication regiments.	The organization operates its own pharmacy services and uses their internal pharmacy to manage the adherence of medications with clients and leverage technology to track this adherence.	

Population Health Management	1	2	3	4	5	Score
Rationale: Many elements come into play during the movement between healthcare practitioners and settings. This is care transitions: constant change reflecting the evolution of the patient milieu where excellent coordination and communication are essential. Embedded within care transitions is consideration of the elements that affect outcomes for a specific group of individuals. Known as population health management (PHM), this goes beyond traditional disease management to gain an understanding of both the clinical and nonclinical characteristics of a population, and the associated risks. The merger of care transitions and PHM is the cornerstone of value-driven accountable care, resulting in achievement of better quality care, lower cost, and improved patient experience.	The organization does not have any population health systems or interventions.	The organization has chosen common health conditions to focus on and connect clients to specialists to address these chronic health conditions.	The organization connects to other health care providers in the community that provide population health management services.	The organization utilizes independent health professionals to track, analyze and coordinate health care interventions to prevent and address chronic health conditions.	The organization utilizes its own health professionals to track, analyze and coordinate health care interventions to prevent and address chronic health conditions. PHM efforts improve chronic diseases identified for the population.	

Employment	1	2	3	4	5	Score
Rationale: Those who are unemployed report feelings of depression, anxiety, low self-esteem, demoralization, worry, and physical pain. Unemployed individuals tend to suffer more from stress-related illnesses such as high blood pressure, stroke, heart attack, heart disease, and arthritis. In addition, experiences such as perceived job insecurity, downsizing or workplace closure, and underemployment also have implications for physical and mental health. Persons with persistent mental health and substance abuse issues need additional supports to succeed in their recovery.	The organization has no program to help people get a job.	The organization encourages clients to pursue employment opportunities on their own.	The organization helps clients apply for employment opportunities as they are asked or made aware of these opportunities.	The organization has a collaborative agreement to refer clients for evidenced based employment services to another organization to provide these services.	The organziation provides evidence based supported employment services to any client expressing a desire to work.	
Financial Management	**1**	**2**	**3**	**4**	**5**	**Score**
Rationale: Exposure to prolonged economic hardship has detrimental impacts on individual health and well-being. Despite the widespread acceptance of economic hardship as a social determinant of health, the way it has been measured is restricted to income in relation to the federal poverty line (FPL) or to issues related to housing insecurity, food insecurity, healthcare tradeoffs, and other measures related to tangible basic needs. Comprehensive solutions, such as efforts to improve financial capability (known as a combination of self-efficacy, skill, attitude, and knowledge needed to make financial decisions), build assets to protect from financial shocks, and reduce income volatility are missing from public health research.	The organization has no formal program to assist clients with their financial management.	The organization assists with financial management with basic assistance not grounded in psychosocial rehabilitation services. The organization does not provide Representative Payee Services.	The organization has access to independent Representative Payee providers to refer their clients. The organization provides case management and psychosocial rehabilitation services to assist clients with budgeting.	The organization has a collaborative agreement to refer clients for evidence based representative payee services and financial management education to another organization to provide these services.	The organization provides Representative Payee services to assist clients with budget management utilizing evidenced based psychosocial rehabilitation principles.	

Transportation	1	2	3	4	5	Score
Rationale: Each year, 3.6 million people in the United States do not obtain medical care due to transportation issues. Transportation issues include lack of vehicle access, inadequate infrastructure, long distances and lengthy times to reach needed services, transportation costs and adverse policies that affect travel. Transportation challenges affect rural and urban communities. Because transportation touches many aspects of a person's life, adequate and reliable transportation services are fundamental to healthy communities. Transportation issues can affect a person's access to health care services. These issues may result in missed or delayed health care appointments, increased health expenditures and overall poorer health outcomes.	The organization does not provide any assistance or subsidy to help clients with transportation.	The organization provides public transportation training and education and assists clients with access to transportation vouchers.	The organization assists clients to get to their medical appointments and a limited type of transportation to help them in their recovery.	The organization partners with a local transportation provider and subsidizes the cost of transportation for their clients.	The organization provides all community staff access to a vehicle or provides mileage reimbursement to transport clients to any and all services and activities connected to their health care and recovery.	
Community Integration	**1**	**2**	**3**	**4**	**5**	**Score**
Rationale: Social isolation, defined as an "objective deficit in the number of relationships with and frequency of contact with family, friends, and the community," is associated with increased rates of loneliness and suicide, hypertension, and other physical health effects that may be mediated by neurohormonal-immunological pathways. Demonstrated to be as dangerous to health as smoking 15 cigarettes per day, social isolation has been identified as worthy of being a public health priority.	The organization has no services or structure in place to have clients get together.	The organization plans social activities for clients to gather a couple of times per month to support each other.	The organization provides a daily location 2-3 times a week for clients to gather and provide support to each other to promote social connection.	The organization provides a daily location Monday through Friday for clients to gather and provide support to each other to promote social connection.	The organization provides a daily location for clients to gather and provide support to each other as well as provide weekend social activities to reduce loneliness 7 days a week.	

Food Security	1	2	3	4	5	Score
Rationale: One of the most visible and actionable SDOH for healthcare providers is food insecurity. Food insecurity is a direct contributor to poor health outcomes and excess healthcare costs, primarily due to a higher prevalence and exacerbation of chronic disease among the affected population. Nutrition programs, such as the Supplemental Nutrition Assistance Program (SNAP) and home-delivered and medically appropriate meals, can significantly reduce 30-day readmissions, inpatient days and overall healthcare costs. The Food Is Medicine approach which recognizes the need to eat whole food with no additives, chemical, and preservatives is an essential intervention in health care.	The organization has not formal program to help clients obtain food.	The organization partners with the Food Bank and other emergency food programs to obtain food for the clients they serve.	The organization provides access to food resources as well as provide grocery shopping services to promote healthy food choices.	The organization has a commercial kitchen which provides food to clients at least 4 days a week as well as food subsidies, grocery shopping services, and nutritional education.	The organization provides healthy and nutritious food to their clients Significant food subsidies, grocery shopping services, and nutritional education are embedded within its food intervention.	
Crisis Stabilization	**1**	**2**	**3**	**4**	**5**	**Score**
Rationale: There is a strong relationship between social determinants of health and Emergency Department utilization. Studies have shown that utilizing the Emergency Department for mental health crises is not sufficient to address the continuum of needs related to mental health crises. Evidence suggests that a comprehensive response to substance use and mental health crises, including a contiuum of best practices across prevention, response, and postcrisis risk reduction, by existing treatment providers leads to better outcomes for the person in crisis.	The organization has no program in place to help clients in crisis.	The organization uses an independent provider to accept and screen calls for crises. There is no on site response capability.	The organization uses its own staff to field crisis calls 24/7 to assist clients and provides onsite response when needed.	The organization uses its own staff to field crisis calls 24/7 to assist clients and provides onsite response when needed. The organization has a partnership with a residential crisis bed program to place clients during a crisis.	The organization provides a residential location to support clients during a crisis or support clients coming out of the hospital. The organization also provides onsite and telehealth support to clients 24/7.	

Flexible Funding	1	2	3	4	5	Score
Rationale: Experiencing somewhat of a financial hardship was linked to 3-7 times higher odds of anxiety and depressive symptoms and a likely eviction, and 11 times higher odds of food insufficiency. Experiencing considerable financial hardship predicted 5-7 fold higher odds of anxiety and depressive symptoms, 34 timeshigher odds of a likely housing eviction, and 37 times higher odds of food insufficiency. Clients with adverse socioeconomic exposure need significant supports to be successful in the community. Removing debts to obtain housing and care is an essential intervention to successful recovery.	The organization has no formal program in place to help remove financial barriers for clients.	The organization provides referrals to emergency assistance programs to assist clients with financial issues and has a resource list available to obtain other needed items.	The organization has a coordinated case management program to assist clients to obtain access to emergency funding as well as obtain needs and items in the community for their lives.	The organization provides client assistance to allow clients to borrow funds to remove barriers and pay the organization back over a period of time interest free.	The organization provides client assistance, borrowing, and donated goods to assist clients to remove financial barriers to recovery and community integration.	
					Fidelity Score Total	
					Fidelity Score	

For More Information Please Contact

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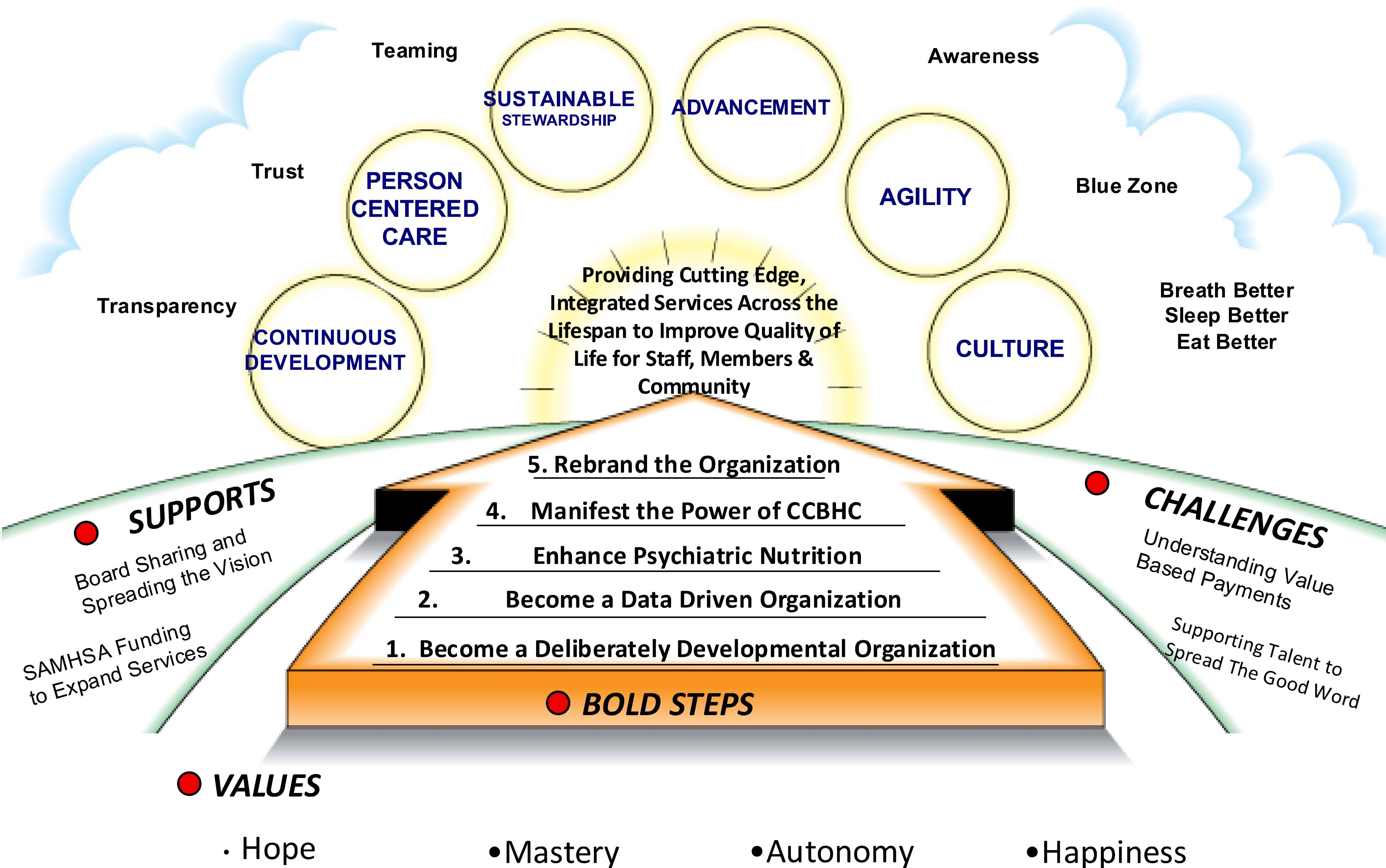
Healthport

www.healthport.org

Lower Shore Clinic Strategic Priorities 2023 - 2026



VALUES

- Hope
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