ACAP
Association for Community Affiliated Plans

Positively Impacting Social Determinants of Health

How Safety Net Health Plans Lead the Way

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I. Introduction

An individual's health is shaped profoundly by life circumstances that fall outside the traditional purview of the health care system. Family support systems, housing, nutrition, income, education, and other dynamics are often collectively referred to as "social determinants of health."

Social determinants are defined by the World Health Organization as the conditions in which people are born, grow, live, work, and age.[1] In a 2008 report, the World Health Organization Commission on Social Determinants of Health cited these factors as collectively having the most significant influence on health outcomes.[2] Other studies have indicated that nearly 70 percent of health outcomes are attributed to behavior and environment.[3]

The 58 members of the Association for Community Affiliated Plans (ACAP) share a strong commitment to addressing the social determinants that may adversely affect members' health. ACAP health plans often invest substantially in innovative initiatives that, while outside the confines of the health benefits traditionally covered by Medicaid or other insurance programs, directly address social determinants that in turn have a significant (although indirect) impact on health outcomes and health care costs.

This report seeks to follow the five key areas of social determinants as outlined by Healthy People 2020, an initiative by the Department of Health and Human Services.[4] These areas include neighborhood and built environment, economic stability, education, food security, social and community context, as well as health and health care. Medicaid health plans inherently provide the health and health care aspect of social determinants in ensuring access to comprehensive primary care and other health services. This report will describe programs in which ACAP health plans are innovatively and positively impacting the other key areas of social determinants to improve health outcomes.

Despite operating within fiscal constraints – and including a need for the State to achieve net Medicaid savings through their partnership with each Medicaid health plan -- the ACAP plans have demonstrated a commitment and ability to innovate in the social determinants arena. Examples of such innovations are summarized below; the report that follows was developed by The Menges Group in partnership with ACAP and the profiled member plans.

[1] http://www.who.int/social_determinants/en/
[2] http://www.publichealthreports.org/issueopen.cfm?articleID=2476
[3] http://health.usnews.com/health-news/hospital-of-tomorrow/articles/2014/02/13/treating-hunger-as-a-health-issue
[4] http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39

II. Neighborhood and Built Environment

Neighborhood and built environment can be defined as "quality of housing, crime and violence, environmental conditions, and access to healthy food."[5] Homelessness frequently contributes to a rapid and substantial deterioration of health. Unsafe and unstable housing can also have significant adverse health consequences.

Stable housing can mitigate the impact of stress and its associated conditions. Improved housing stability also helps health plans to maintain better contact with their enrollees and assure access to needed health care services. This can be particularly challenging when an individual is discharged from a hospital and requires follow-up treatment and home health care. Quality housing also decreases exposure to allergens and toxins, which in turn improves health outcomes.[6]

Several ACAP plans have recognized the challenges in improving health outcomes without addressing the needs of the neighborhood and built environment. Selected profiles follow.

Housing Support for People who are Frequently Hospitalized (UPMC)

UPMC *for You* serves a large Medicaid population in Pennsylvania and delivers a wide array of integrated care services to beneficiaries with a high level of need. Several dynamics led UPMC to pursue a housing support initiative:

- The five percent of highest-cost UPMC *for You* enrollees averaged 5.6 inpatient hospital admissions per year.
- Repeated admissions are often more related to lack of stable housing and supports than to the presence of chronic medical conditions.
- Engaging these members with housing support would provide them with a greater, more tangible benefit than enhanced care coordination alone.

UPMC developed a "shelter plus care" program through a multi-party partnership including the targeted enrollees, Metro Family Practice (a primary care practice committed to working with persons with psychosocial challenges), the local HUD authority, and Community Human Services (CHS) -- a HUD-funded housing support agency. UPMC pays Metro Family Practice for the health care services provided, plus a care coordination fee and reimbursement for a registered nurse's salary. HUD provides a rental subsidy. UPMC also pays for case management provided by CHS. These payment amounts will increase as program capacity grows.

The housing support program initially served 22 UPMC members, all of whom met the criteria for homelessness defined by CHS and HUD. Program impacts were evaluated by comparing these enrollees' utilization patterns for the six months prior to entering the program, the first 6 months in the program, and the next six month period (7-12 months). Of the 22 members, 13 had a significant

[5] http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39
[6] http://www.nhc.org/media/files/Insights_HousingAndHealthBrief.pdf

decrease in their average medical costs under the housing support program. For this initial population, the program has yielded numerous favorable results, including:

- A 23% reduction in overall per-member-per-month (PMPM) claims costs. Before entering the program, enrollees averaged PMPM costs of roughly $4,100 versus PMPM costs of roughly $3,200 while in the program;
- PMPM cost reductions occurred in all medical service categories except prescription drugs, where a slight increase occurred; and
- The vast majority of enrollees remained stably housed.

UPMC has been pleased with the program to date; it will be expanded to serve up to 50 people. It has led to net savings; the medical cost reductions have more than offset UPMC's additional payments to Metro Family Practice. However, enrollment into the program is limited by a finite number of HUD-funded "slots" and by the number of persons for whom the involved partners can secure housing within a given HUD funding cycle.

The broader UPMC health system operates a larger, similarly-structured housing initiative focused on persons who are experiencing homelessness and behavioral health challenges. This initiative is spearheaded by the Western Psychiatric Institute and Clinic of UPMC (WPIC). WPIC's homeless program started in the late 1990s and has provided more than 250 housing arrangements, primarily apartments, throughout Allegheny County, to families experiencing homelessness and individuals with serious and persistent mental illnesses. The program has been a model for participants remaining in the program and ending the cycle of homelessness by providing mental health treatment.

Community-Based Housing (Health Plan of San Mateo)

Health Plan of San Mateo (HPSM) is a local public health plan located just south of San Francisco that provides health care benefits to San Mateo County's underserved residents. Recently awarded a contract to participate in the Dual Eligibles Demonstration program,[7] HPSM is assuming responsibility for the entire continuum of long-term services, including Medicaid covered nursing home and personal support services and Medicare-primary services such as home health care, and will have the flexibility to pay for nonmedical supports and services (e.g., outreach services provided by non-clinically licensed staff working under the supervision of clinically licensed personnel).

The demonstration program was launched in San Mateo County in April 2014. As part of this program, HPSM strives to help *m*embers live in the least restrictive settings of their choice and build and sustain a system of community-based supports that help people safely remain in their home.

An initial area of focus for HPSM is enrollees currently living in institutions such as skilled nursing facilities who could live in the community were adequate supports available. Many of these individuals want to live in the community, but have trouble finding affordable housing. In response, HPSM identified supplemental funding, gathered information from a wide range of alternative housing

[7] CMS is in the process of partnering with states and MCOs in to integrate care and financing for dual eligibles. The demonstration program is known as the Financial Alignment Demonstration and the MCO capitation model has been approved for implementation in ten states.

providers and service organizations, and developed the concept of a "Community Care Settings" pilot program. Health plan staff engaged two entities to undertake the pilot program, Brilliant Corners and the Institute on Aging. Both organizations have worked together for years helping residents of a large San Francisco skilled nursing facility transition to less-restrictive residential settings**.**

The pilot is currently in a planning phase, with a goal to launch later in 2014 and gradually ramp the program up to serve 150 to 200 members. For the pilot to be financially sustainable, HPSM must achieve sufficient reductions in costly institutional services to procure and maintain housing and service alternatives. Therefore, at the outset, the Community Care Settings program will primarily serve individuals who have the desire and ability to live in the community. As HPSM gains experience, the health plan will identify those at high risk for institutionalization and, when appropriate, work to "intercept" their institutionalization such that they can lead healthier, more productive lives in the community.

Project Connect (Central California Alliance for Health)

Central California Alliance for Health (CCAH) has operated since 1996 and serves over 240,000 members in Santa Cruz, Monterey and Merced counties. CCAH has collaborated with local partners on several projects aimed at providing needed social services to its members.

CCAH contracts with Project Connect, a case management service operated by the Santa Cruz County's Homeless Persons Health Project, to provide outreach and assistance to medically fragile members experiencing homelessness The Alliance contracts with Project Connect to provide case management for up to 20 medically needy Alliance members.

CCAH also participates in Project Homeless Connect, a one-day annual event serving more than 700 people that addresses multiple aspects of homelessness including securing a California ID, obtaining disability benefits, and providing clothing and meals. Through partnerships with hundreds of individuals, corporations, nonprofits, and government agencies, Project Homeless Connect is able to provide services such as dental care, eyeglasses, family support, food, HIV testing, housing, hygiene products, medical care, mental health services, and job placement to its clients. Alliance staff participate and interact with clients served by the event.

CCAH also supports the efforts of the 180/180 initiative, a multi-agency effort to help 180 homeless men, women, and families move into permanent housing by July 2014 and provide the support services needed for these individuals to stay housed. The Alliance's CEO has facilitated community education and fundraising for 180/180.

In addition, CCAH is negotiating to contract with a new County-operated recuperative care center located at the Homeless Service Center in Santa Cruz. The center is a 12-bed recuperative care unit that is designed to reduce hospital visits by the chronically homeless and serve as a transitional unit until they are well.

III. Economic Stability

Economic stability includes "poverty, employment status, access to employment, and housing stability."[8] Job security and income are positively correlated to determining health outcomes.[9] Many who are eligible for Medicaid hold low-wage jobs that often lack access to health insurance benefits. Many low-wage jobs are physically labor-intensive, exacerbating the need for health services.

Parental income levels can influence their children's health outcomes. Mothers with low incomes are likelier to deliver low-birth weight and pre-term babies, frequently resulting in mental and physical delay and impairments.[10] According to the North Carolina Institute of Medicine, "Economic deprivation and hardship in childhood have been demonstrated to be significant factors for adult health, with economic hardship experienced in childhood resulting in significantly higher risk of poor health in adulthood."[11]

In recognition that helping their enrollees secure stable employment—and the resultant stable income—can be a powerful contributor to improved health outcomes, some ACAP health plans have implemented employment-related initiatives. One such program is described below.

Employment of Enrollees as Outreach Staff (Amida Care)

Amida Care is a New York City-based health plan focused on serving HIV-positive Medicaid beneficiaries. The plan is sponsored by a consortium of safety net providers and is expanding its operations to serve a larger geographical area, a broader array of clinical conditions, and a wider range of patient populations, such as patients covered through Medicare.

Amida Care believes that employment can play a major role in strengthening the physical and behavioral health status of its enrollee population. To this end, Amida Care has to date hired, trained and employed more than 250 of its enrollees to serve in a variety of community-support roles. In most instances, the employment is limited in hours and payment so that the initiative does not jeopardize the individual's Medicaid eligibility. This does not preclude the individual from seeking/obtaining full-time employment and private health coverage, but rather affords experience that can lead to attainment of full-time employment.

These positions include the following roles and timeframes:

- **Peer Specialists:** Amida Care enlists people to provide peer coaching that includes sharing personal experiences to help motivate enrollees who are facing similar challenges. The engagement is for a six-month cycle and participants are paid a modest stipend.

- **Community Health Outreach Workers (CHOWs):** Amida Care employs CHOWs to canvass the community and help the health plan re-engage with enrollees who have dropped out of care.

[8] http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39
[9] http://www.nciom.org/wp-content/uploads/NCIOM/projects/prevention/finalreport/Prevention-Chpt11.pdf
[10] http://www.nciom.org/wp-content/uploads/NCIOM/projects/prevention/finalreport/Prevention-Chpt11.pdf
[11] http://www.nciom.org/wp-content/uploads/NCIOM/projects/prevention/finalreport/Prevention-Chpt11.pdf

- **Health Navigators:** Amida Care employs full-time health navigators to conduct peer coaching, escort enrollees to/from care, and provide other navigation support. Health navigators typically work 35 hours per week.

- **Member Advisory Council (MAC):** MAC participants attend 6-8 meetings per year, serving as advisors to health plan management on consumer feedback and ways to improve health care delivery and increase satisfaction.

Amida Care is also currently exploring options to contract with up to three community-based organizations to provide education, GED completion and job training programs to its enrollees.

IV. Education

A recent report by Virginia Commonwealth University sponsored by the Robert Wood Johnson Foundation found that Americans with less education have lower life expectancies than those with more education. As of 2008, the life expectancy gap between the most- and least-educated individuals was 14 years for males and 10 years for females.[12] Clear disparities exist between individuals with a high school diploma or a GED and college graduates. People who do not obtain a college degree are more than twice as likely to be diagnosed with diabetes and nearly three times as likely to smoke compared with those who had graduated from college.[13]

Education provides opportunities to improve one's health status, break the poverty cycle, and reside in safer areas. Higher education leads to jobs with a stronger likelihood of having health benefits and higher income, which in turn leads to a healthier lifestyle.[9] Several ACAP health plans have developed programs to promote education for their members; four of these programs are described below.

Internship Program (Community Health Choice)

Community Health Choice (Community) serves the Metro Houston area and nine surrounding counties. The health plan covers over 240,000 Medicaid and CHIP enrollees.

Among Community's efforts to disrupt the cycle of poverty in its community, Community provides career counseling and workforce training to underprivileged high school students and young adults. Community hires interns from local schools and educates them about health care and provides them work experience within the day-to-day operations of the health plan.

Community has developed strong partnerships with two organizations to address workforce training and place underprivileged young adults in meaningful internship programs. Both programs expose participants to the work environment in their preferred field, providing internships with local companies.

[12] http://societyhealth.vcu.edu/DownFile.ashx?fileid=1739
[13] http://societyhealth.vcu.edu/DownFile.ashx?fileid=1739

Genesys Works, based in several states, is a placement program and matches students to employers throughout the Houston area. For interns placed at Community by Genesys Works, the students work four hours a day, Monday through Friday year-round. Community has hired eight interns through Genesys Works over the past four years, one of whom has since become a permanent employee.

Community Health Choice has also hired six interns to date from Cristo Rey high school. Cristo Rey is a college preparatory high school for under-represented urban youth, operating in several states. The health plan pays $7,000 to hire one Cristo Rey intern for an entire school year, all of which goes directly toward the intern's tuition at Cristo Rey.

"I hope to become a doctor one day, so working at Community Health Choice has been a great way for me to learn more about the industry," said one Cristo Rey intern. "I feel lucky because a lot of people won't get this experience until they are in college, but I am a sophomore in High School and have already learned so much!"

Book Club (Family Health Network)

Limited literacy has been proven to be strongly associated with inadequate knowledge of health care services and outcomes. It is also associated with increased likelihood of hospitalization and increased prevalence of chronic diseases. In an effort to favorably impact the literacy challenges that are prevalent among impoverished children, Family Health Network (FHN), the Chicago area's only not-for-profit Medicaid health plan, began a book club for its members 5 to 16 years of age. The Book Club Program seeks to reward children for completing academic work and improving their reading skills, with FHN providing books to its Book Club members on an ongoing basis.[14]

Children may select any books to read for the program. The children are asked to send the book reports in the format they use for school submissions. While there is no required length for the reports, FHN has found most reports to be appropriate and complete for the age of the child. FHN does not prohibit members from using school required book reports for the Book Club submissions.

A member can initially enroll in the Children's Book Club by submitting three book reports accompanied by a registration form. In return they receive a club book bag, a new book, reading certificate and a $10 Target gift card. After the first submission, members continue to receive the reading certificate, new book and gift card for every quarter they continue to participate by submitting three book reports.

The program was recently expanded to give toddlers access to high-quality books, exposing them to educational basics such as colors, shapes, alphabet and numbers. Members whose children are in the Toddler Book Club send their form quarterly to receive a new book. For very young FHN Book Club members who are not yet writing, FHN asks that they draw a picture about the book.

As of 2013, approximately 1,700 children have participated at a level that earned rewards through this education initiative, with FHN supplying more than 15,000 books in total.

[14] http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0033257/

Members of FHP's Consumer Advisory Group give the Children's Book Club very high ratings; some mothers use the club awards as an extra incentive to encourage summer reading activities.

Scholarship Program (AlohaCare)

AlohaCare has served Hawaii's Medicaid population since 1994. Founded by Hawaii's community health centers, AlohaCare has demonstrated a longstanding commitment to health education and community service through numerous initiatives that extend beyond delivering integrated health coverage.

The AlohaCare Believes in Me Scholarship was created in 2003 in partnership with the University of Hawaii Foundation. Since its inception, AlohaCare has helped more than 300 students across all 10 University of Hawaii campuses reach their higher education goals.

The program was initially designed to help AlohaCare's QUEST (Medicaid) members. Over the years, the scholarship initiative has expanded to include helping students majoring in health care or a health-related field. First preference is given to students hailing from or attending school on a Neighbor Island. The amount each student receives is based on individual monetary need.

AlohaCare's total annual scholarship donations have ranged from $20,000 to $40,000.

Individualized Family Service Plan Involvement (HSCSN)

Health Services for Children with Special Needs, Inc. (HSCSN) is a health plan located in the District of Columbia dedicated to serving Medicaid-eligible children with special needs and disabilities up to the age of 26 years. With its specialized population, HSCSN developed a unique care coordination model that addresses many of the social determinants facing the plan's members and their caregivers. Each enrollee is linked with an HSCSN care manager; these care managers provide the link between the plan and the member and play a key role in ensuring that members are accessing needed services.

Many of HSCSN members experience developmental delays in their first four years of life, requiring them to annually receive an Early Intervention and Individualized Family Service Plan (IFSP) from a speech therapist, physical therapist, occupational therapist, or combination of the three. When IFSP meetings occur, the family, member, provider, and a representative from Office of the State Superintendent of Education (OSSE) are in attendance. When invited by the child's primary caregiver, the HSCSN Care Manager also attends these meetings, bringing an interdisciplinary team model to these meetings.

HSCSN Care Managers attend approximately 250 IFSP meetings annually. The Care Manager benefits from being at these meetings by getting a firsthand understanding of the child's needs, the caregiver's needs and perspectives, the perspectives of the involved providers and of the OSSE representative. Through attending the IFSP meetings, the Care Manager also develops and strengthens interpersonal relationships with all the involved individuals. In the other direction, the Care Manager *contributes to* the IFSP conversations, both in providing ideas as to how the child's needs can best be

met and helping to ensure that identified needs are addressed in a relatively cost-effective manner when alternatives of equal clinical quality exist.

The Care Manager can then ensure the IFSP is incorporated into the member's care plan. By addressing development delays early and getting directly involved in the child's educational needs determination, HSCSN is attempting to positively impact its members' health outcomes. Recognizing HSCSN's expertise with children with a high level of need, the District's TANF health plans occasionally seek to involve HSCSN Care Managers in their own enrollees' IFSP meetings and transition these children into HSCSN.

V. Food Security

Access to healthy food is imperative in maintaining health and preventing chronic conditions. But a 2013 U.S. Department of Agriculture (USDA) study found that 1 in 7 American households live with food insecurity, indicating insufficient food for all members of a household to live healthy and active lifestyles.[15]

A disproportionate number of people with low incomes live in areas that qualify as "food deserts," defined by USDA as "urban neighborhoods and rural towns without access to fresh, healthy, and affordable food."[16] These areas often have cheaper, yet unhealthier, alternatives in lieu of healthy food options. The poorer diets resulting from such food options frequently contribute to chronic disease such as heart conditions or diabetes.

Food insecurity has significant implications for health outcomes. In one report, it was found that nearly 16% of families with incomes below $25,000 reduced their child's meal size because they were unable to pay for food.[17] Food security has also been directly linked to postponing medical care and increased emergency department usage.[18] Select initiatives ACAP health plans have introduced to address food insecurity are described below.

Improving Access to Healthy Foods (Health Plan of San Joaquin)

Health Plan of San Joaquin (HPSJ) serves residents with low incomes in the Central Valley of California, with a current enrollment of approximately 240,000. Recognizing that food insecurity was a prominent issue with many of its members and the community, HPSJ sought to alleviate the challenges these families face through sponsorships, grants and partnerships with local community organizations. The goals of HPSJ's funding efforts are to work with community organizations and families to not just deliver food to people with low-income, but to ensure that the food is of high nutritional value -- and comes with educational support to help people learn how to choose affordable healthy foods and cook more nutritious meals. HPSJ's initiatives are summarized below.

[15] http://www.ers.usda.gov/publications/err-economic-research-report/err155.aspx#.U1-mCfldXjU
[16] http://apps.ams.usda.gov/fooddeserts/foodDeserts.aspx
[17] http://www.nciom.org/wp-content/uploads/NCIOM/projects/prevention/finalreport/Prevention-Chpt11.pdf
[18] http://www.nciom.org/wp-content/uploads/NCIOM/projects/prevention/finalreport/Prevention-Chpt11.pdf

- Initially, HPSJ became a sponsor of the downtown Stockton Farmer's Market. HPSJ then provided multiple grants for community-sponsored projects. For example, HPSJ issued a grant of more than $35,000 for a county-wide mobile farmer's market to bring fresh produce, nutritional education classes, and meal preparation instructions (including cooking demonstrations) to low-income communities.

- HPSJ also provided a grant of more than $30,000 to support an urban community farm in a low-income, food desert area. This program helps local residents grow organic produce and eggs, along with setting up a farmer's market that generates revenue that will go to creating more urban community farms in San Joaquin County. During the course of the 2011-2012 HPSJ grant, 31 low-income families (five at the San Joaquin County Fair and 26 at Boggs Tract Community Farm) directly benefitted from Health Plan funding. These families retained the produce grown from their own garden plots and also received free eggs and other produce.

- HPSJ also issued a grant for a project providing nutrition education and supplementing nutritional offerings at a shelter for homeless women and children.

- Additionally, HPSJ provided financial support for the purchase of a refrigerated truck shared by a coalition of shelters and organizations to distribute food to those in need. The refrigerated truck allows these organizations to be able to provide perishable items including meat, seafood, and dairy products.

From 2011 to 2012, approximately 2,000 community members indirectly benefitted from the program by volunteering on the Farm, attending educational workshops, and/or receiving affordable organic produce from the farm. While the programs are available to individuals throughout the community, HPSJ staff indicate that at least 80 percent of program participants receive Medi-Cal (Medicaid). Surveys of the persons receiving food and educational support through the Mobile Farmers Market yielded encouraging findings:

- 91% of respondents indicated that they *buy* more fruits and vegetables;
- 96% of respondents indicated that they *eat* more fruits and vegetables; and
- 77% of respondents had used at least one of the recipes they received through the program

Diabetic Food Pack Program (CareSource)

CareSource, Ohio's largest Medicaid MCO, launched a statewide case management strategy in late 2012 that included deploying more than sixty Patient Navigators to the homes of more than 8,000 high-risk members. More than 1 in 4 of these members live with diabetes. Many were found to lack the healthy food options they need to keep their blood sugar appropriately controlled, while others did not understand how their diet could influence the course of their diabetic condition.

Prompted by feedback from their Patient Navigators, CareSource partnered with The Foodbank, a Dayton area community organization, to create a portable, diabetic-friendly food pack. The Foodbank put together non-perishable food boxes packed with more than 17 pounds of such healthier food options as peanut butter, brown rice, whole wheat spaghetti noodles, canned low-sodium vegetables, pinto beans, low-sugar whole grain cereals, chunk chicken, unsweetened applesauce and mandarin oranges. The Diabetic Food Packs cost less than $15 apiece.

At quarterly visits with high-risk members with diabetes, the Diabetic Food Pack serves as a jumping-off point for CareSource's care management team to expand the member's understanding of diabetes basics, discuss diabetes self-management, support health goals, and connect members to relevant social services.

The primary Case Manager and Diabetes Disease Management Nurses, supported by Patient Navigators, strive to engage members in candid conversations about the implications of a diabetes diagnosis and the central role a healthy diet plays in managing diabetes. To reinforce this message, CareSource includes educational materials from the American Diabetes Association in its Diabetic Food Packs.

The Diabetic Food Pack initiative has been funded as a two-year pilot program through a grant of $140,000 to The Foodbank from the CareSource Foundation. While the program is relatively new – about 1,350 Diabetic Food Packs have been delivered to date – CareSource is still gathering survey data; however, an initial survey of more than 80 participants has shown a high level of satisfaction with the program:

Subject	Extremely Satisfied	Satisfied	No Comment	Not Satisfied
Overall satisfaction with Diabetic Food Pack	38%	50%	11%	1%
Views about education given in conjunction with Diabetic Food Pack delivery	17%	48%	33%	1%
Satisfaction with variety of food provided	19%	53%	29%	0%
Satisfaction with quality of food provided	15%	49%	35%	1%

CareSource recently announced that it is expanding this initiative beyond Diabetic Food Packs. CareSource will donate $100,000 to five Ohio food banks to help them distribute backpacks of food to the under-privileged, many of them school children. This funding is intended to provide food backpacks to 25,000 low-income Ohioans.

Food Rx Program (CareOregon)

CareOregon has served Oregon's Medicaid beneficiaries since 1994 and currently provides coordinated care services to approximately 160,000 persons. The organization is committed to promoting health for all, regardless of income or social circumstances.

CareOregon has recently teamed with three of its network clinics to provide $15 food vouchers, which the physicians deliver to enrollees during patient visits similar to handing out prescriptions. The program is thus titled "Food Rx." CareOregon is piloting Food Rx to approximately 100 enrollees across a six-week timeframe.

The program targets persons who are food insecure and/or who have chronic health issues related to diet. Each $15 "prescription" comes with two refills, for a total of $45 that can be spent on organic food at an area grocer (which operates trolleys parked outside the participating clinics). A recent article about the program in the Portland Business Journal reported that "Among the items available Friday were fresh melons, asparagus, avocados, tomatoes and other fruits and vegetables. There were also canned goods, flour, bread, pita chips, meats, eggs ... the list goes on."[19]

One goal of the program involves enlisting physicians to directly educate patients on how to shop for and prepare nutritious food. Another is to determine whether the impact a trolley vendor serving a "food desert" has on purchasing and eating habits.

Enrollees and providers will be surveyed at the end of the six weeks to measure the program's impact. CareOregon will expand the program if it is deemed successful in favorably influencing improved dietary habits.

VI. Social and Community Context

Social and community context can be defined as "family structure, social cohesion, perceptions of discrimination and equity, civic participation, and incarceration."[20] Health outcomes can be directly impacted by the level of social support an individual is receiving, whether through family dynamics or broader social constructs. In 2000, 162,000 deaths were attributed to weak social support systems.[21] Residents of urban and rural communities with low incomes frequently lack access to health care and social support systems, which contributes to health disparities. Many ACAP health plans have implemented programs addressing these social support needs.

[19] "Prescription Veggies? CareOregon pilot program helps patients eat healthier food." Portland Business Journal, May 30, 2014, written by Elizabeth Hayes.
[20] http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39
[21] Bachrach, Deborah, Helen Pfister, Kier Wallis, and Mindy Lipson. *Addressing Patients Social Needs.*

Health Equity Initiatives (Neighborhood Health Plan)

Neighborhood Health Plan (NHP) is a Massachusetts managed care organization (MCO) that has served Medicaid subgroups for more than 25 years. Through its consistent performance at a high level on quality scores reported through the Healthcare Effectiveness Data and Information Set (HEDIS®)[22], NHP has been named repeatedly as one of the top ten Medicaid health plans in the country by the National Committee for Quality Assurance (NCQA).

Over the past several years, NHP has performed a close analysis of its HEDIS scores in an effort to identify adverse racial and ethnic health disparities, and targeted its operations in a concerted initiative to confront and reduce select disparities. NHP's recent efforts have targeted mammography screening and diabetes and blood pressure management – all of which addressed highly prevalent conditions that can be favorably impacted through early detection and effective management.

Mammography Screening: NHP's HEDIS analysis identified lower rates of breast cancer screening among African-American women ages 40 and over compared with other ethnic groups. In response, NHP designed a suite of interventions in an effort to raise mammography rates. Initial efforts included a birthday card reminder and a separate mammogram reminder postcard. A subsequent campaign included advertisements and culturally sensitive educational messages placed in newspapers (e.g., a poster of three African American middle-aged women with the caption "One of these women has never had a mammogram. Have you?", with more detailed information on the cancer danger and information on how to access the exam), public transportation, and community locations. Comcast commercials aired in the targeted communities. A Breast Health Phone-A-Thon was conducted with the YWCA of Boston and Dana Farber, and collateral materials listing breast cancer and screening resources were developed.

At the outset of these targeted efforts in 2009, NHP's breast cancer screening rate among African American enrollees was one percent below the rate for white enrollees. However, the postcards, advertisements and targeted educational messages had a positive impact. By 2012, NHP's screening rate was almost five percentage points higher for African American women (74.3 percent) than for white women (69.4 percent).

Diabetes and Blood Pressure Management: In 2010, NHP identified another key disparity: among its enrollees age 40 and above, African Americans with diabetes were less likely to keep their blood pressure controlled to recommended levels. The gap compared with white enrollees was 8.9 percentage points. Having high blood pressure increases the chance of developing heart disease, stroke, kidney and eye disease, and other complications.

NHP engaged in a multipronged effort to close the gap in health outcomes. Interventions included educational and reminder mailings, a diabetes self-management toolkit, and distribution of food choice and blood pressure control booklets. In 2011, NHP implemented an integrated health and wellness education campaign and a reminder campaign that were modeled on the mammogram initiative. And the concerted effort helped narrow the disparity in blood pressure control; by 2012, the gap had been

[22] HEDIS is a standardized set of quality measures on which most managed care organizations publicly report results; 'HEDIS' is a registered trademark of NCQA.

lowered from 8.9 to 4.6 percentage points. NHP continued its efforts in 2013 through a targeted advertising campaign on cable television.

Ongoing Efforts: NHP continues to seek out opportunities to reduce health disparities by implementing a reduction initiative each year; a current initiative focuses on depression management. NHP reviews HEDIS results annually with a drill-down based on race and ethnicity to evaluate the performance of its current Health Equity Initiatives and identify any new areas for future improvement.

Male Caregivers Support Group (HSCSN)

Health Services for Children with Special Needs, Inc. (HSCSN) is a health plan located in the District of Columbia dedicated to serving Medicaid-eligible children with special needs and disabilities up to the age of 26.

HSCSN noticed that at an ongoing support group for parents and caregivers, few males were in attendance. The plan recognized the need for an outlet and support group specifically tailored to male caregivers so they could discuss the needs of their children with others in similar situations.

Males with low incomes face a unique set of challenges as parents; for example, they frequently live outside their children's' household, with the mother serving as the primary caregiver. The National Fatherhood Initiative notes, "Children in father-absent homes are almost four times more likely to be poor. In 2011, 12 percent of children in married-couple families were living in poverty, compared to 44 percent of children in mother-only families."[23]

The challenges common to fathers with low incomes are magnified when their child has special needs. Accordingly, HSCSN created a weekly support group focused on adult male caregivers' perspectives and needs, in an effort to engage these males more constructively in the lives of their children, working to counter the stereotype of the "absentee father." "You can be in the home and still be an absent father," notes one group attendee. "If you are outside the home you can still be a father who supplies the kid's needs."

Meetings are held at the plan's community outreach offices, close to where many members reside. HSCSN provides transportation for those who need it. Attendees participate with the goal of supporting one another in their efforts to become better attuned to meeting the needs of their special needs child or children.

After a dinner is served, the meeting opens with a "check in" segment where each person shares any pressing issues (with the child or himself) that would be useful for the group to discuss. This is followed by a guest speaker who leads a facilitated discussion. A recent meeting featured a representative from the District of Columbia Public Schools, who provided communication tips for more effective parenting.

[23] Source: U.S. Census Bureau, Children's Living Arrangements and Characteristics: March 2011, Table C8. Washington D.C.: 2011.

The meetings are loosely structured and aimed at facilitating discussion among male caregivers facing similar challenges. Most of the meeting is devoted to having attendees share their concerns, offer their perspectives, and describe resources they have found to be particularly helpful. "Men can be unknown subjects inside our family -- this group has helped me find my voice," added a recent meeting participant.

A survey of support group attendees indicates extremely high satisfaction with the program among long-time and new attendees alike. "Somebody here has already been through whatever it is I'm going through," noted one meeting participant.

Over the 10-year life of the male caregivers support program, several hundred male caregivers support group meetings have occurred—helping one father at a time.

Health Education for Teenagers (Passport Health Plan)

Passport Health Plan is a non-profit, provider-sponsored Medicaid health plan in Kentucky whose business model is predicated upon community sponsorship and engagement. Under the umbrella of its Passport Teens program, Passport focused many of its educational efforts on teenagers in an effort to decrease the incidence of risky behaviors and preventable disease in adulthood. Initiatives undertaken by Passport Teens staff during 2013 include:

- Sponsoring an anti-bullying radio campaign
- Participating in HealthWise, a four-week summer program for middle and high school students interested in health careers
- Sponsoring ten YMCA locations across Kentucky to promote health education through nutrition education, teen leadership training, and community service projects
- Sponsoring a team of six teens from Henry County and their school nurse at the Kentucky Teen Institute, a four-day camp which prepares teens to advocate for a pressing health issue in their community. The teens from Henry County chose underage drinking. The course was taught by Passport's Public Health Educator (a position title which depicts Passport's commitment to strengthening education in its community).
- Passport's communications staff also taught teens basic career skills such as video, social media, writing press releases, and outreach strategies to assist in their campaign for Youth Advocacy Day
- Mentoring students as part of the Urban League, a civil rights organization that advocates against racial discrimination
- Hosting discussions with teens and parents during Family Night at CLASP, an after-school program run by Jefferson County Public Schools
- Participating in community events such as the Men of Quality Conference in Lexington, the Men Building Men Conference, the Kentucky Teen Institute, Urban League Conference, Urban League all-day health fair, and Hope Starts Here Conference

In 2013, Passport sponsored or participated in more than 800 community events throughout Kentucky. In 2013, Passport dedicated $300,000 in grants, donations and sponsorships to community events and Passport staff volunteered more than 4,000 hours. Passport staff feel that these investments contribute to Passport's quality score achievements.

Family Resource Center Project (L.A. Care Health Plan)

L.A. Care Health Plan provides health coverage to more than 1.3 million residents of Los Angeles County through Medi-Cal, California's Medicaid program. This is the largest enrollment of any single-state Medicaid health plan in the country; in fact, L.A. Care covers more persons than the entire Medicaid population of all but 12 states.

A regional analysis of community health indicators, including demographics, access to care, health outcomes, health status, and concentration of individuals receiving public assistance, revealed significant health disparities in several areas of Los Angeles County. In an effort to extend its services to the low-income residents of its community beyond the traditional confines of health care, L.A. Care opened Family Resource Centers in select underserved areas of Los Angeles County. The first two Centers opened 2007 in Lynwood -- a predominantly Latino/Hispanic neighborhood – and in 2009 in Inglewood -- a predominantly African American community.[24]

The Centers are a resource for L.A. Care members, health care providers, and the broader community. For members, the Family Resource Centers help enrollees better understand their health benefits and identify local providers available to them. The Centers also provide free classes on topics such as parenting, asthma and diabetes disease management, healthy living, and weight management. The Family Resource Centers also offer an array of workshops, lectures, self-management health programs, and health screenings. For the broader community, the Centers help individuals obtain health coverage, provide free health classes, and connect with community support organizations and services.

Customer satisfaction surveys have determined that most visitors are highly satisfied with the services they received at the Family Resource Center. Moreover, the majority of area physicians surveyed are also very satisfied with the services provided, and some have indicated that the classes provided have had a direct impact on their patient's health status.

Poverty Simulation Employee Training Module (CareSource)

CareSource invests heavily in employee training and education. As an example, an entire floor of CareSource's central offices in Dayton, Ohio is configured as "CareSource University" to support staff development. Five years ago CareSource added an experiential poverty simulation module to its employee training process.

The Poverty Simulation is a 3 hour session in which each participant "becomes" a Medicaid beneficiary. They are given a hypothetical but representative family structure, the health status of each family member, and a monthly income. Participants are shown the different needs and desires the family members have which require financial outlays, time prioritization and coordination among family members. They are asked to balance and prioritize these needs and desires during the training session. Approximately 700 staff have participated in the Poverty Simulation training.

[24] Information about the Family Resource Centers, including two videos, is available at the following website: http://www.lacare.org/aboutlacare/milyresourcecenters

CareSource's employee participants report that the Simulation experience has helped them relate to and engage more effectively with the health plan's enrollees. In addition, the cross-functional teams gained insight as to how they work together to best meet member needs. Surveys of the employee participants indicated that 97% of participants agreed the program increased their awareness of poverty, promoted open dialogue around poverty, and would positively impact member interactions.

VII. Conclusion and Policy Implications

This paper describes sixteen specific examples of initiatives that ACAP member plans have implemented that far exceed the provision of traditional health insurance coverage, which are designed to favorably impact social determinants of health.

These initiatives span across many different areas (housing, education, food security, etc.) and vary from enterprise-level investments to pilot programs that have been introduced on a smaller scale. These pilot initiatives are nonetheless extremely valuable -- they allow the organization to "self-learn" how to best structure a program before making a large, but potentially sub-optimal, investment. While measuring impacts in the social determinants arena is inherently difficult, the ACAP plans are making strong efforts to measure these impacts and the report has shared statistical outcomes where available.

Regardless of the degree to which statistical outcomes are available, all the investments described in this paper are laudable – striving to take Medicaid to a higher level of societal benefit. Creating better housing, access to healthier food and increased dietary knowledge, new employment opportunities, social support groups, teenage drinking education, etc. for the low-income population can only be beneficial to the target population's health. These initiatives will help ACAP plans discern where to cost-effectively invest in the social determinants arena.

It is important to emphasize that the initiatives cited in this report reflect a subset of the programs the 58 ACAP health plans have introduced to impact social determinants rather than a comprehensive survey. With regard to the broader national need to better impact social determinants, ACAP plans would welcome other organizations – both in their states and elsewhere – expanding upon the initiatives they have initiated. This will help to strengthen our collective ability to favorably address social determinants and improve health outcomes and cost-effectiveness in Medicaid on a national scale.

Policy Implications

ACAP member plans are playing a pioneer role in demonstrating how and where to invest in social determinants. Notwithstanding these important and highly commendable efforts, far more work in this area needs to occur. There is much to learn regarding which kinds of investments will prove cost-effective, for which persons, and in which situations. An initial policy observation is that State and Federal policies need to encourage – or at least not discourage – this process of innovation and learning.

As an example, if a health plan finds that its homeless enrollees collectively incurred inpatient costs of $500,000 during the most recent winter, and that paying for housing for these individuals would cost $50,000 and likely lower these persons' inpatient expenditures by more than half, the state/MCO partnership needs to allow this to occur without requiring the MCO to provide a winter housing benefit to all enrollees. In this example, it is important that a health plan successfully making that type of housing investment be rewarded rather than penalized (e.g., for exceeding an arbitrary loss ratio threshold) for doing so.

Capitation rates to Medicaid MCOs are based on medical costs for Medicaid covered services and do not typically compensate for interventions that address social determinants – even though these interventions may ultimately result in lower overall net costs. The ACAP health plans operate in an environment where their enrollees' needs – particularly in regards to social determinants – far surpass what the health plans can fully address within the confines of the revenue they receive via their Medicaid capitation payments.

State rate-setting policies can be structured to encourage experimentation and innovation in the social determinants arena. For example, states can also allocate a certain PMPM amount (e.g., $0.50) for new innovations in social determinants. MCOs could be required to annually propose what investments they will make -- and how they will evaluate the initiative's effectiveness. States would then approve the approach in order for a given MCO to earn the add-on payment each year. States can also encourage investments in social determinant areas by awarding points in competitive procurements for demonstrated prior efforts and/or commitments for upcoming contract periods.

These types of policy initiatives and supports can hasten the learning process the ACAP health plans have fostered and expand the nation's collective knowledge base.

About ACAP

The Association for Community Affiliated Plans (ACAP) is an organization dedicated to representing and strengthening not-for-profit Safety Net Health Plans as they work with providers and caregivers in their communities to improve the health and well-being of vulnerable populations in a cost-effective manner. ACAP provides policy support to and fosters shared learnings among 58 member health plans, which operate in 24 states. ACAP plans are not-for-profit entities focused largely—often exclusively—on Medicaid and other vulnerable populations.

For more, visit www.communityplans.net.