SOCIAL CONDITIONS & HEALTH REPORT

Social and Health Needs 2019 Survey Results

Social Conditions and Health

How's your day going so far? Did you sleep well? Were you able to go for a run or walk today? Is there food in your refrigerator for a healthy breakfast, lunch, and dinner?

If so, you are benefiting from ideal social conditions and should have good health. The better your everyday social conditions are the better you feel and the longer you will live.

In Tennessee, the best social conditions and health outcomes are found in Williamson County. For several years, this county has ranked number (1) in the best health outcomes.[1]

Should you happen to live 100 miles away in Clay County, chances are you are experiencing poor social conditions. In 2019, it was ranked as having the worst health outcomes in the state with little or no access to health care providers and a high rate of childhood poverty. [2]

Williamson County	**Clay County**
4% of children live in poverty	31% of children live in poverty
1 Primary Care Doctor per 670 individuals	1 Primary Care Doctor per 2, 570 individuals
1 Mental Health Provider per 580 individuals	No Mental Health Providers

Why are the social conditions and healthcare provisions so different for two counties located in the Grand Region of Middle Tennessee? What conditions contribute to Clay County residents having less access to physical and mental health providers and higher rates of childhood poverty?

It's the social conditions that our fellow Tennesseans experience daily like:

- Lack of access to food or healthy food;
- High stress levels;
- Fewer job opportunities that pay a living wage;
- A house with mold, lead, pests, or unsafe neighborhood;
- High uninsured health care rates;
- Little or no access to mental and physical health providers;
- Discrimination; and
- Limited access to exercise opportunities (the ability to safely walk outside or pay for a gym membership);

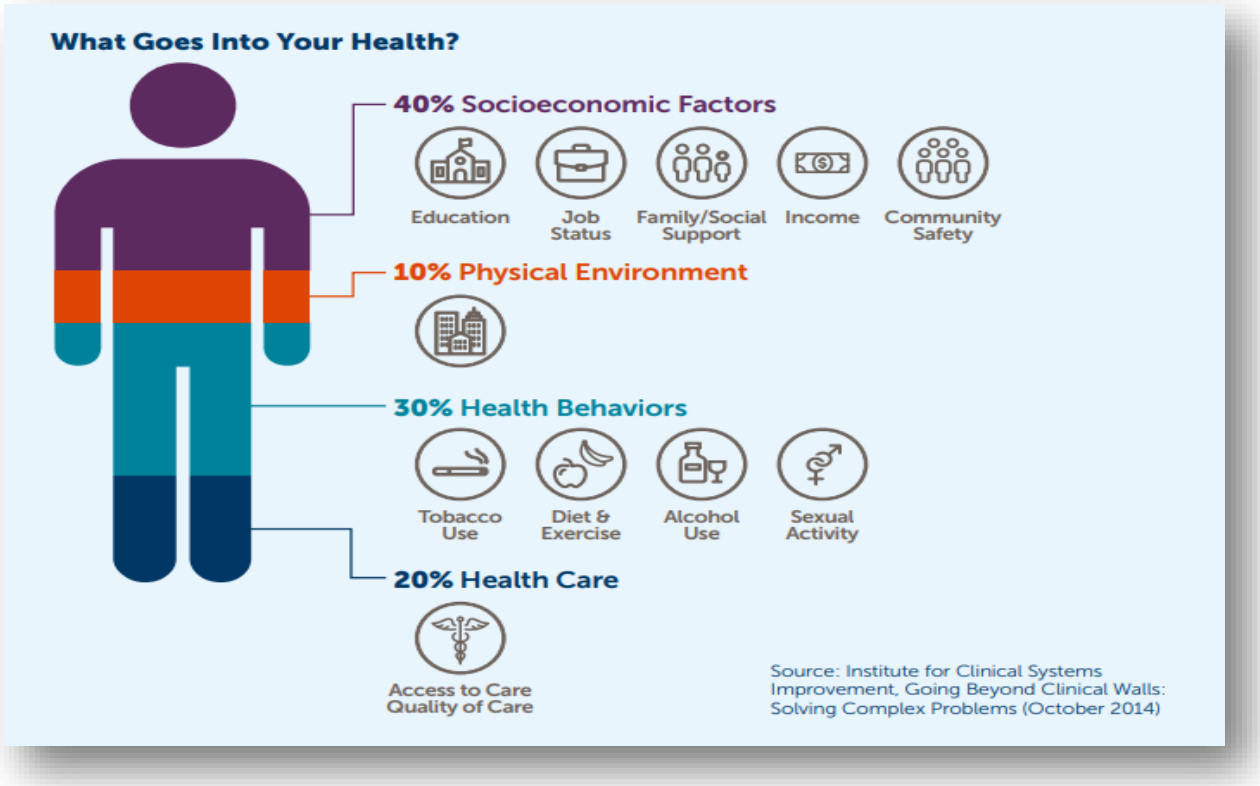
[1] 2019 County Health Rankings & Roadmap Data
https://www.countyhealthrankings.org/app/tennessee/2019/overview
[2] See 2019 Data County Health Rankings & Roadmap Data

Why is it important to improve social and health conditions?

All Americans should have the opportunity to make the choices that allow them to live a long, healthy life, regardless of their income, education or ethnic background.[3]

By working together, we can move towards improved social conditions and health outcomes. This path of collaboration is based upon building connections between our health and social systems. When these two systems interact, this coordination improves person-centered care for Tennesseans and results in better health and cost savings for the state.

In everyday life, this interaction can take the form of your personal doctor going over a social conditions survey with you and referring you to any needed community resources. It can also take the form of your health plan giving you a free ride to the food bank and organizations investing in affordable housing. [4]



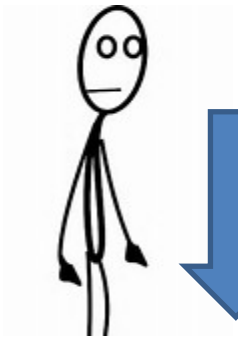
[3] A New Way to Talk About The Social Determinants of Health located at: http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf63023

[4] Below clip art from: https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2019/rwjf452222

How are Social and Health Conditions Improved?

Effects of Poor Social Conditions on Health Outcomes

Health Concerns: Asthma; Diabetes; and Depression



Assess Needs of Person

Goals: Stronger and healthier communities and lower costs for the state and its partners

Social conditions that cause poor health

Lack of jobs

Poor housing conditions;

Lack of food and healthy food

Lack of information on how to access health, work, & educational opportunities

Continued development and adjustment of initiatives based on evidence.

Re-Assess needs of person and direct towards resources

Building Connections

Create partnerships and initiatives that connect individuals to resources and spur community growth and investment.

2019 Member and Provider Social and Health Needs Surveys

On September 20, 2019, TennCare launched its fourth (4th) annual social and health needs surveys for TennCare members and providers. TennCare partnered with:

- Amerigroup Community Care of Tennessee ("Amerigroup");
- BlueCross BlueShield of Tennessee ("BlueCare"); and
- UnitedHealthcare Community Plan of Tennessee ("United")

to conduct an online and social media campaign that encouraged members and their providers to take the surveys. The member and provider survey webpages also contained a link to information about community resources.

I. TennCare Member Survey

a. Overview

In 2019, the on-line member surveys were designed to provide the survey takers with information about TennCare programs and services and how they could connect with community resources. The surveys continued to reflect the following goals of the project:

C= Connecting members with resources (like food pantries and TennCare services);

A= Acting for better health by teaching members about their care needs;

R=Reducing stigma often felt by those that are in need of help; and

E= Empowering members to take the steps needed for better health.

The CARE member surveys were conducted on-line in the English, Spanish, Arabic, Mandarin Chinese, and Vietnamese languages. The member and provider survey formats were accessible to individuals with disabilities and protected the privacy and health care data of survey responders.

The member survey captured eleven (11) social and health needs for the child and adult member populations:

1. Food needs;
2. Housing needs;
3. Utility needs;
4. Ability to pay for needed items;
5. Transportation needs;
6. Health needs;
7. Domestic violence;

8. Educational levels;
9. Access to community resources;
10. Employment needs; and
11. Social data (age, race, gender, etc..)

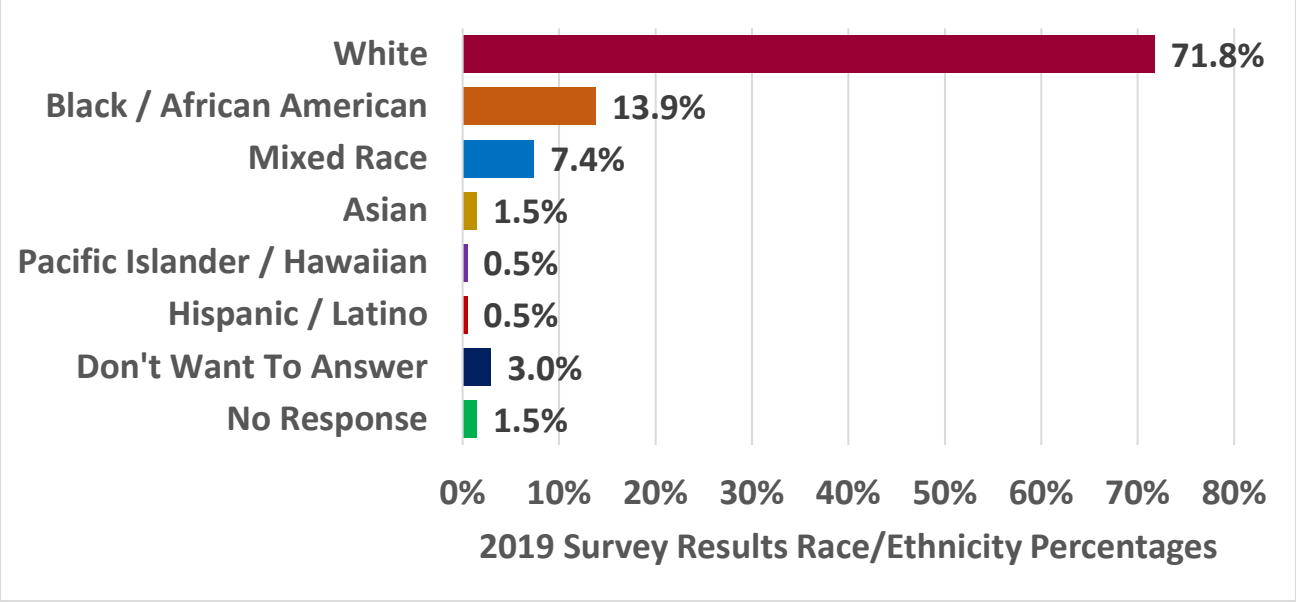
b. Who Responded to the TennCare Member Survey?

Survey Type of Respondent	Number of Responders
All TennCare Members	202
English Survey	201
Arabic Survey	0
Chinese Mandarin Survey	0
Spanish Survey	1
Vietnamese	0

Over the past four (4) years, the majority of survey responders identify as white women between the ages of thirty-five (35) and forty-four (44). Like last year, Hamilton, Davidson, Shelby, and Knox counties continued to have the highest number of survey responders.

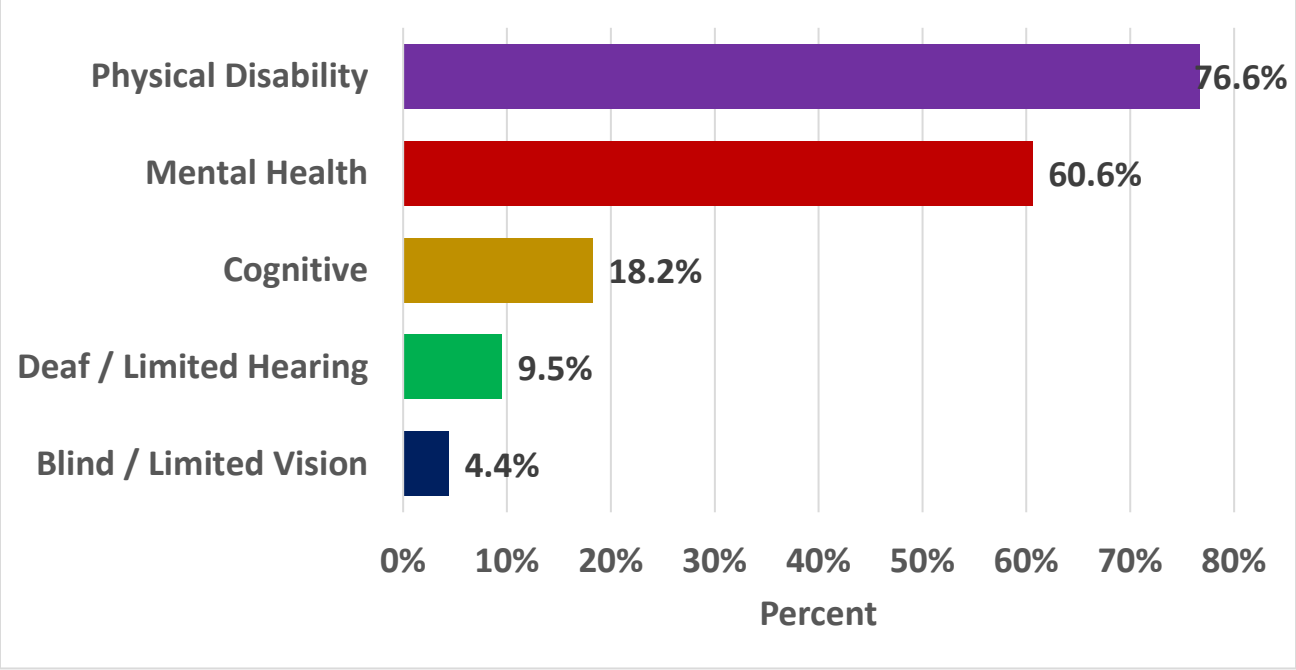
Since 2017, the response rate from individuals who identify as a race other than white has declined. In 2019, extra steps were taken to translate Spanish outreach materials in a culturally competent manner and response rates from individuals who identify as Hispanic or Latino declined by two percent (2%) as compared to the previous year's survey results.

	2019	2018	2017	2016
Female	77%	87%	80%	57%
Male	20%	10%	18%	43%
Declined to Answer	1.5%	2%	2%	
No Response	1.0%	0		



In contrast, there was a nineteen percent (19%) increase in individuals identifying as an individual with a physical disability compared to the 2018 results. However, there was a three percent (3%) decline in mental health responses with sixty-one percent (61%) of the 68% responders reporting a mental health disability compared to sixty-four percent (64%) of the 49% responders in 2018.

68% Responders reporting having disabilities in 2019



On the survey, three questions measure responder's health literacy and ability to communicate with their doctors. In 2018, eighty-nine percent (89%) of the responders reported that they do not need help speaking with their doctor and this percentage increased to ninety-five percent (95%) in 2019. However, in 2019, eleven percent (11%) of responders reported needing help

with reading documents and eighteen percent (18%) reported needing help with filling out forms.

c. TennCare Member Social Conditions and Health Needs

i. Mental Health & Substance Use Disorders

Stress is a common factor among the responders with eighty-one percent (81%) reporting that they experience stress by having more to handle than they are used to. This is an eight percent (8%) increase in stress levels from the 2018 responders. It is expected that this number will increase in the 2020 survey.

TennCare's MCOs have proactively provided stress management information to members and encouraged members to take stock of their mental health needs.[5] However, stigma continues to hinder patients from seeking treatment for mental health concerns and impacted twenty-six percent (26%) of member survey responders. Further, sixty-one percent (61%) of providers[6] reported that stigma around mental health treatment is hindering patients from obtaining care. Therefore, TennCare partners should continue with outreach and educational efforts for members on mental health awareness and reducing stigmas that impact our communities.

Compared to the substance use data from the 2018 survey, there was a five percent (5%) decrease in responders reporting drug use within the past year. In 2019, thirty- five percent (35%) of responders reported having used drugs within the past year and twenty-one percent (21%) of responders reported that they would benefit from Medication Assisted Treatment to treat opioid, alcohol, and smoking issues.

A deeper analysis of the 2019 mental health data revealed correlations with drug use in the past year, having a disability, and inability to afford: clothing, phone, and medicine.

Mental Health	**ϕ Score**
Drug Use in Past Year	0.259
Disability	0.301
Unable to afford:	
Clothing	0.266
Phone	0.273
Medicine	0.330

ii. Food Insecurity

Compared to last year's results, there was an eleven percent (11%) increase in the number of responders who reported that they are food insecure. Forty-seven percent (47%) of responders reported having to eat less and skip meals. Notably, participants in a focus group held by Amerigroup reported that while individuals were food insecure, stigma and finding it hard to accept help kept people from contacting food banks. One participant reported that

[5] https://www.healthwise.net/bluecaretennessee/Content/StdDocument.aspx?DOCHWID=rlxsk
[6] Based on 2019 Provider Social and Health Needs Survey Results

having a personal interaction with the resource provider helped them accept the needed food items.

For the responders that reported being food insecure, there was a strong correlation with them also experiencing multiple issues listed below, including stigma and domestic violence:

Issue Related Food Insecurity	**ϕ Score**
Stigma	0.258
Domestic Violence	0.259
Finding Community Resources Y/N	0.354
Having Main Doctor Connect to Resources Y/N	0.336
Knowing MCO Can Connect to Resources	0.258
Using Downers	0.464
Having Sufficient Money	0.506
Afford Listed Items:	
Clothing	0.502
Phone	0.425
Medicine	0.428
Health Care	0.261
Utilities	0.265

iii. Other Results

Sixty-seven percent (67%) of responders reported that in the past year they were not tested for HIV/AIDS and thirty-eight percent (38%) of providers reported they did not screen patients for HIV or AIDS. According to HIV.gov, this is another area where stigma impacts decisions concerning testing and preventive measures. The Southeast Region of the United States, which includes Tennessee, has some of the highest rates of HIV and AIDs. And HIV and AIDS diagnoses disproportionally impact women, people of color, LGBTQIA+, and college students.[7] To help end stigma around testing and treatment, HIV.gov created the Positive Spin resource for care: https://positivespin.hiv.gov/. The AID Education & Training Center Program offers education and training resources for providers including a Cultural Humility & Reducing Stigma and Discrimination Provider Handbook: https://www.seaetc.com/.

Eleven percent (11%) of responders reported experiencing domestic violence in the past year, which is an increase of five percent (5%) from last year. This supports a continuation of efforts to ensure information and resources are provided to our member population, as many of our members are women, children, minorities, and aging populations who are often the victims of domestic violence.

Like last year's results, there is a discrepancy between members reporting that their doctors do not help them connect to community resources and providers reporting that they do help

[7] https://www.seaetc.com/

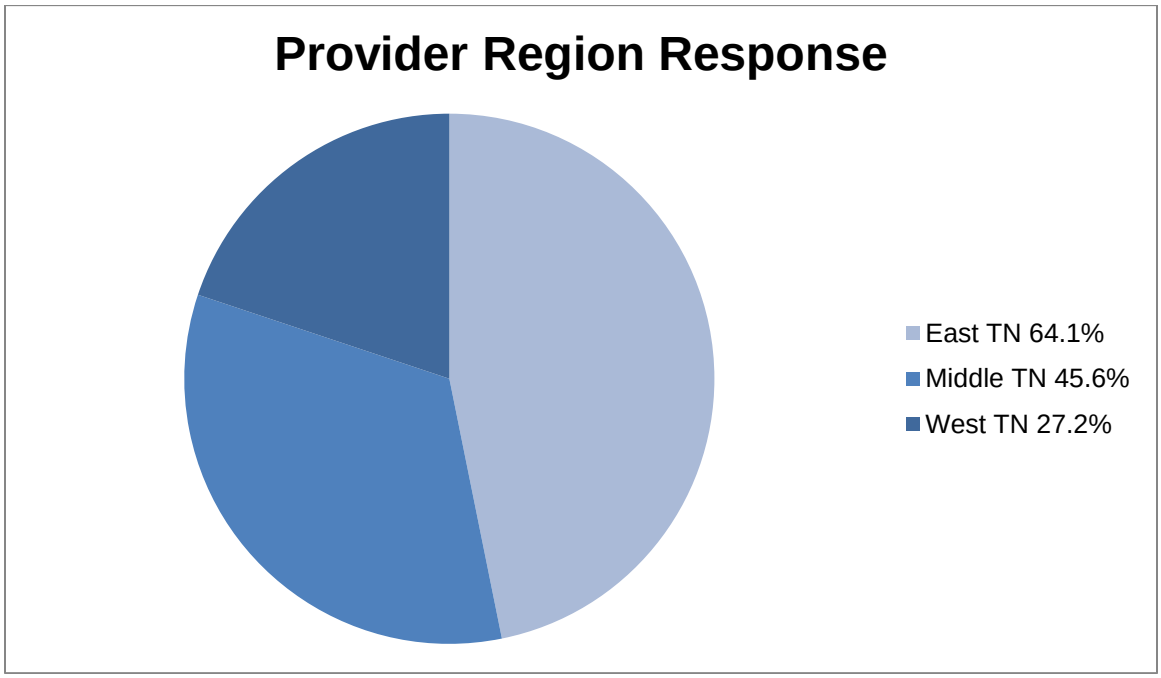
patients connect to resources. When asked if their personal doctor helps connect them to community resources, sixty-three percent (63%) reported that their doctor does not help them. However, this data conflicts with the provider survey results (located below), in which eighty-five percent (85%) of the provider survey responders reported helping patients connect to community resources.

II. TennCare Provider Survey

We value the role and experiences that our TennCare providers and organizations engage in on a daily basis to deliver care to our member populations. The provider survey responses lend deeper insight to the social conditions and health needs that impact health outcomes of our communities and informs us about learning opportunities that would benefit provider practice teams. To accomplish these goals, the provider survey collects information in four (4) areas:

1. Provider Demographics
2. Patient Interactions
3. Patient Screening; and
4. Learning Opportunities

In 2019, 104 providers responded to the survey questions. The results of the survey were reported at the East, Middle, and West Tennessee regional levels.



a. Social Conditions and Health Needs

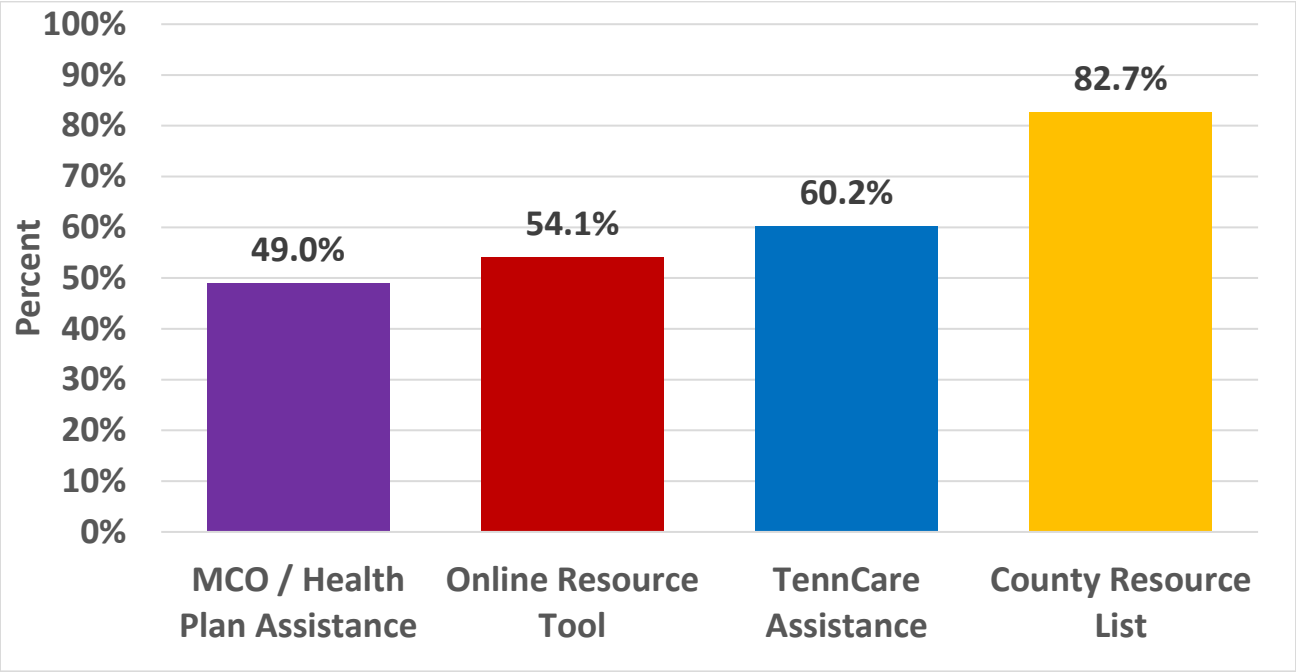
Interestingly, fifty percent (50%) of the providers reported that there was a lack of resources to address the social conditions and health needs within the community where their practice operates. Providers reported the following as the top three (3) needs in their community:

1. Behavior health/mental health treatment;
2. Housing; and

3. Transportation.

When asked what tools would help their practice teams connect patients to community resources eighty-three percent (83%) reported that a community resource list would be beneficial.

What tools would help your practice team connect patients to community resources (check all that apply)?



Eighty-five percent (85%) of the provider responders reported that they helped connect patients to community resources. Of the fifteen percent (15%) that reported they did not connect patients to resources, they selected the following as the top three reasons:

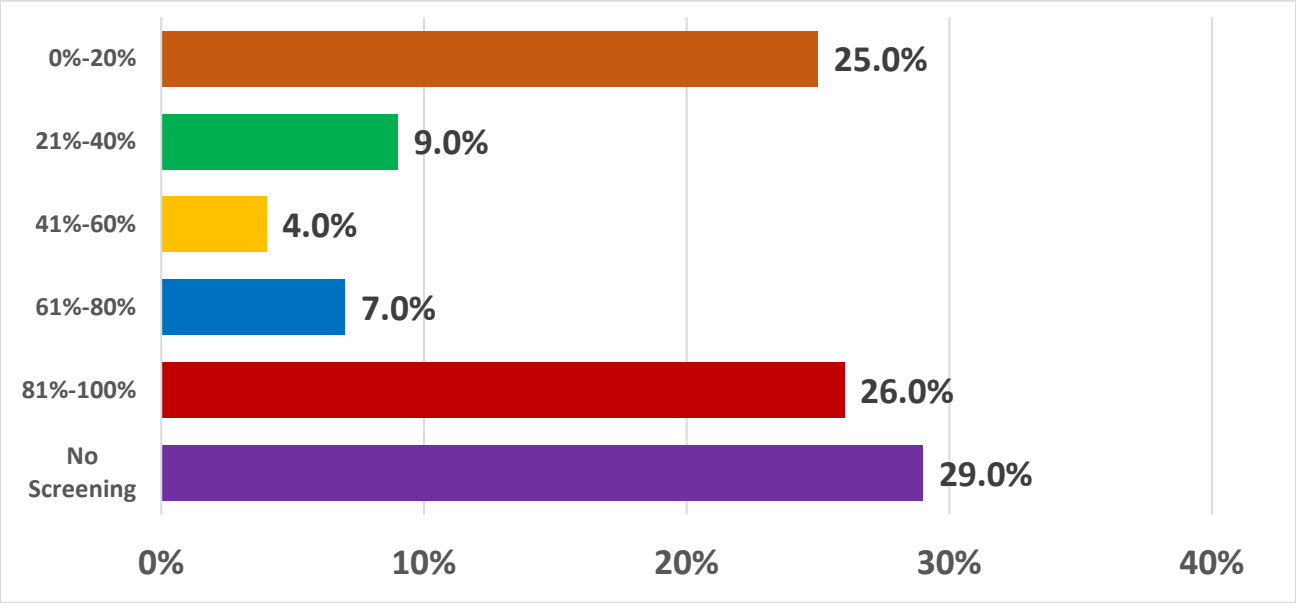
1. Fifty-two percent (52%) - Lack of knowledge about community resources;
2. Forty-eight percent (48%) – Lack of Time; and
3. Thirty-three percent (33%) – Lack of Compensation.

Based on the above results, TennCare and its partners should create and make available to the provider community a resource list. Providers should also consider using the 2-1-1 Helpline system[8] and community referral platforms that may be available from their contracted managed care organization.

When it came to screening patients for social needs, seventy-one percent (71%) reported some level of screening. Forty-two percent (42%) of providers reported tracking patient social needs outcomes.

[8] The United Way's 2-1-1 Helpline is a 24/7, 365 day information and referral help line that provides resources to cover basic needs in a time of crisis.

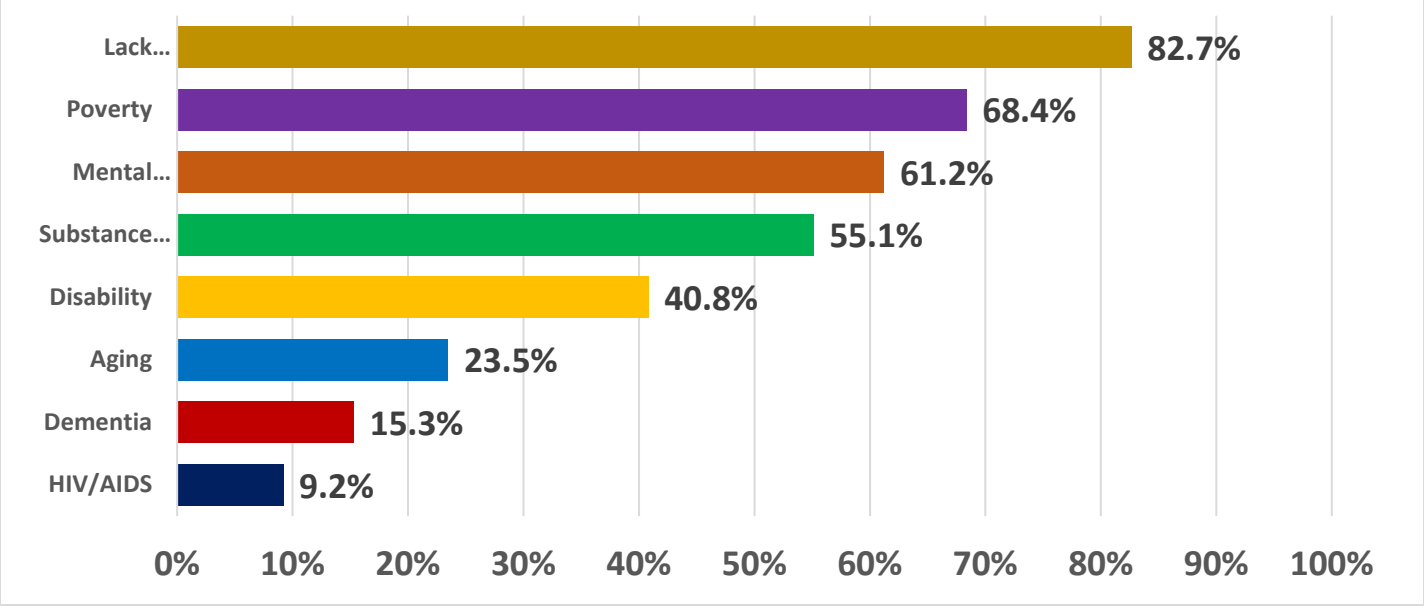
In the last 12 months, estimate the percentage of patients that your practice team screened for social needs like food, housing, transportation



b. Stigma

As discussed throughout this report, stigma is preventing patients from obtaining care. Sixty-nine percent (69%) of the providers reported that they do discuss stigma with their patients. For the second consecutive year, providers reported the following three (3) stigmas as the most predominant barriers that keep people from obtaining care:

1. Lack of understanding about healthcare;
2. Poverty; and
3. Mental health concerns.

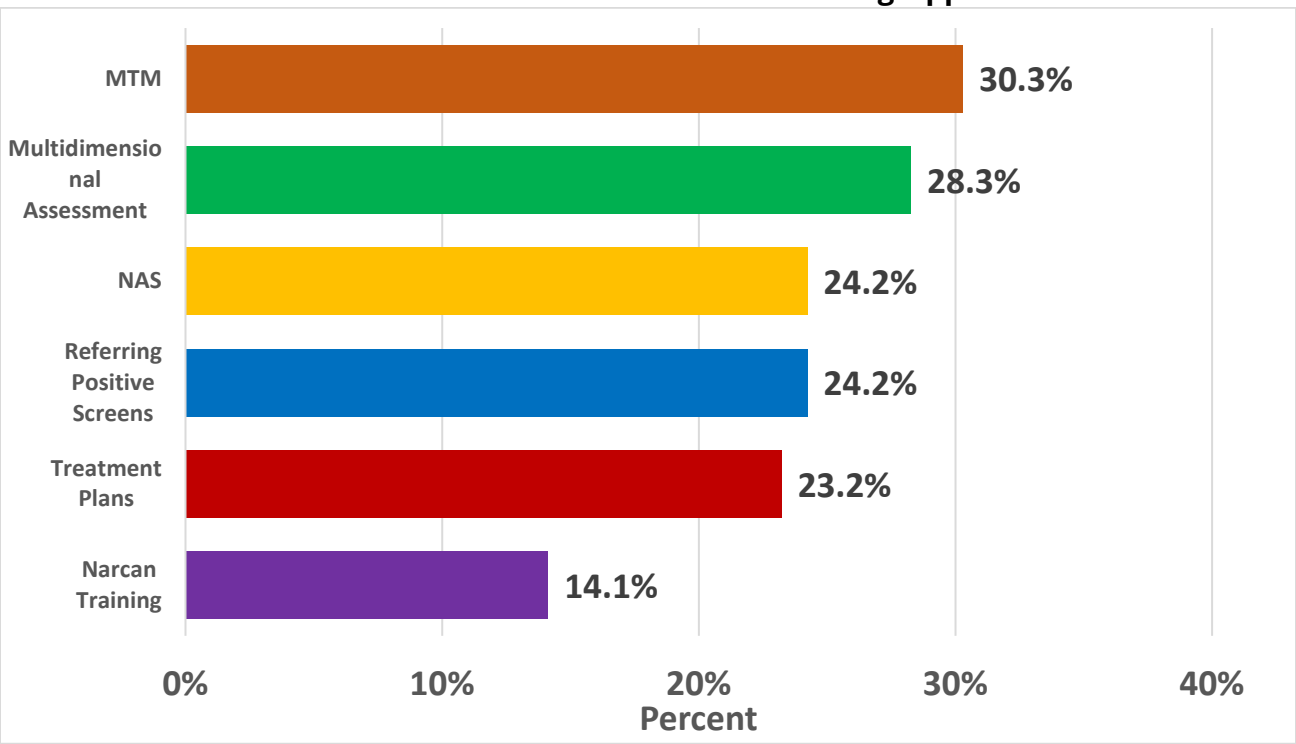


C. Learning Opportunities

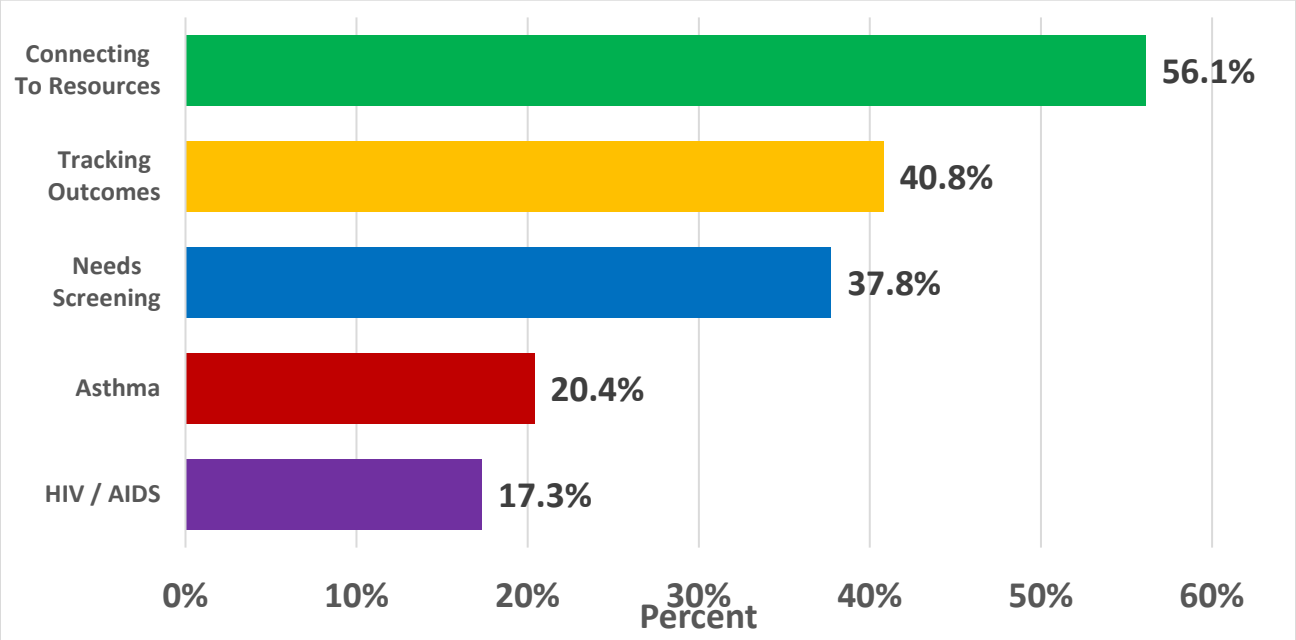
The annual survey gives providers the ability to tell us about the learning opportunities that would be useful to their practice teams. The providers reported that their practices would benefit from learning more about the following topics:

- Substance use disorders; and
- Social conditions and health outcomes.

Practice Team Would Benefit from SUD Learning Opportunities



Practice Team Would Benefit from these Learning Opportunities



Social Conditions and Health Outcomes Pilot Program

TennCare will work in partnership with each currently contracted TennCare managed care organization ("MCO") to implement a social conditions and health outcomes[9] pilot program ("Pilot"). This program is currently scheduled to run from the second quarter of 2021 to the second quarter of 2022 and will focus on identifying opportunities to test and improve the value returned from addressing social conditions impacting the health outcomes of TennCare members.

I. Goals of the Pilot:

TennCare recognizes that each MCO is actively leading innovative and important work addressing social conditions impacting their membership. The goals of the Pilot are to identify potential gaps and opportunities by rapidly testing solutions for poor social conditions that drive a greater return for improving and investing in healthier communities. The Pilot should not replace or reduce any ongoing MCO-led social conditions and health screening or referral efforts. Rather, it builds upon existing MCO initiatives or accelerates new pilot models to gather evidence-based research. By supporting multiple pilot models with different provider types, TennCare hopes to partner with and learn from the MCO's efforts in maximizing the value and return from addressing social conditions that produce poor health outcomes for our member population. Examples of pilot theories to be tested:

- Identifying methods for and barriers to administering social conditions screening questions
- Collecting data and learning best practices in data collection of social conditions screening, referrals, and closed loop utilization (ability to track referral outcomes)

[9] Also, known as Social Determinants of Health (SDOH).

- Testing member engagement strategies that maximize member comfort with and understanding of social conditions screening questions, member experience of accessing resources, and member reported outlook after receiving community resources
- Testing and innovating provider engagement strategies that drive effective referral to services and community resources
- Finding barriers and potential interventions that maximize partnerships with community-based resources that improve members' use of services
- Comparing and evaluating the impact of MCOs providing more direct member social supports (e.g., transportation vouchers for member travel to a community-based resource)
- Identifying data collection methods and testing the effectiveness of various health outcome measures for improving social conditions in the short-term and medium term

II. Pilot Design – Initial guidelines:

TennCare will support each MCO with their individual pilot design over the next three (3) to four (4) months. The goal of the Pilot is to support multiple provider types and testing specific interventions to evaluate impact on maximizing social conditions and health screenings, use of community resources and needed health services, and health outcomes tracking. The initial parameters are detailed below as a starting point but may evolve during the planning and design phase.

III. MCO Responsibilities:

Provider Selection – Each MCO will select four (4) to eight (8) providers at a Tax Identification Number ("TIN") level, with at least (1) representative from all of the following provider populations: Tennessee Health Link ("THL"), Long-Term Services & Supports ("LTSS") (e.g. agency providers offering attendant care, personal care, or supportive homecare services), Patient-Centered Medical Homes ("PCMH"), and Hospitals.

Funding – Each MCO will receive up to $1-1.5 million to cover Pilot operation costs such as incentives for providers, social conditions and health training and supports and other MCO resource needs. Each MCO will incentivize Pilot providers to conduct social conditions and health screenings, referrals, and closing of the loop.

Data Collection & Sharing – Each MCO will collect and share with TennCare population level data including: results of the social conditions and health screening tool, referral and referral outcome tracking data, and any health outcome measures selected by TennCare (e.g. emergency room use) using a TennCare provided data reporting template. TennCare will work with the MCOs on the data templates and any customizations by provider type, such as how to incorporate the Person-Centered Support Plan (PCSP) for the LTSS providers. Each MCO will design a process for collecting qualitative member and provider data, including member comfort with the understanding of social conditions and health screening tool questions, member experience of accessing services, and member accounts of health outlook post-receipt of community resources (ad hoc member stories or survey data), and provider experience during the Pilot. The qualitative data collection process may be conducted by random sampling at MCO-selected intervals. Any data showing that there are no community

resources available to address specific social conditions or health needs in specific geographic areas will be reported to TennCare.

Outreach & Training – MCOs will ensure that all Pilot providers are trained on the use of the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences ("PRAPARE") screening tool and sensitive social conditions data collection techniques that build relationships with patients, such as empathic inquiry, which facilitates collaboration and emotional support for both members and health care staff throughout the social conditions and health screening process. Each MCO will work with its Pilot providers to develop appropriate social conditions and health screening workflows based on their staffing models and an approach to responding to the unique social conditions of their members that accounts for the availability of resources in each provider's community.

Tentative Dates	Milestone
June 1, 2020	Designate MCO Social Conditions and Health Pilot lead
June – September 2020	Periodic meetings with TennCare and MCO for Pilot development
October 1, 2020	MCOs submit a Pilot plan to TennCare
November 1, 2020	MCOs have formal Agreements with Pilot providers in place
April 1, 2021	Pilot providers are incentivized for screenings, referrals and closing the loop (ability to track referral outcomes)
July 1, 2021	MCOs begin quarterly reporting of social conditions and health screenings, referrals, and closed loop data to TennCare
March 31, 2022	MCO-collected qualitative data is reported to TennCare