IssueBrief

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National Association of Social Workers

Rethinking poverty:
An evidence-based approach to treatment

Science and data drive health care practice. At least, they usually do: Heart disease, cancers, depression—all have evidence-based standards of care. But one devastating condition affecting millions has no such standards: Poverty.

Marcella Wilson, Ph.D., founder and CEO of Transition to Success™, set out to change this, and she did. Multiple external reviews show how her model led improvements in income, mental health status, food security and several other social determinants at little or no additional cost.

Her journey has special resonance for case managers—especially those with the CCM® credential, who are ethically bound to serve as patient advocates. What Wilson learned offers insights as case managers work with clients suffering from poverty.

Taking on poverty

About 15 years ago—in the midst of the recession—Wilson left a career as a health care executive to become CEO of a charity in Detroit, then the poorest urban city in the country and with the highest infant and maternal mortality rate.

She was unfazed. "Since I had led a major corporation, how hard could a charity be?" She soon learned.

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— MARYBETH KURLAND, CAE
CHIEF EXECUTIVE OFFICER,
COMMISSION FOR CASE
MANAGER CERTIFICATION

Wilson began her tenure by doing what she always did when she took the reins of a company: She became a secret shopper. This time, she pretended to be a single parent with three children seeking assistance. She spent two days looking for services using a phone book. She had advantages over her clients: Time, unlimited hours on her phone and a very comfortable environment from which to call. She soon learned what her clients were up against.

She was unable to secure a single service—even through her own organization.

She began to learn more: She met clients, listened to their stories and witnessed poverty firsthand. "I saw the reality for the first time, pervasive hunger, homelessness and hopelessness."

Wilson also dove into the research, and it became abundantly clear to her that the best way to improve health and educational outcomes for children was to improve the health and economic self-sufficiency of their parents and caregivers.

For example, even intermittent food insecurity compromises brain development in young children, she learned. "White matter, gray matter, hippocampus and amygdala—key brain components for learning, memory and impulse control. I was devastated because every day in Detroit, in schools and across programs, we were seeing hungry children, hungry teens, hungry adults and hungry seniors.

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"Statistically speaking, children growing up in poverty complete less school, earn and work less as adults, are more likely to receive public assistance and have poorer health. This for me is at the core of the generational cycle of poverty," she says.

Poverty is also associated with increased risk for incidence of an array of diseases, as well as lower cancer survival rates. (See figure 1 below.)

"I then asked the question, 'How do you treat this condition of poverty?'"

No one could answer it. But she needed an answer because the status quo was clearly failing.

More than 40 million people in this country struggle with poverty while antipoverty initiatives proliferate. She estimates there are 92 distinct government programs and one not-for-profit for every 213 individuals suffering from poverty. (See figure 2, next page.)

She decided to find the answer, taking an evidence-driven

Health Disparities for Those Living in Poverty

Poverty status is based on Gallup's best estimate of those in poverty, according to the U.S. Census Bureau's 2011 thresholds

	Percentage with Disease in Poverty	Percentage with Disease Not in Poverty	Difference (percentage points)
Depression	30.9	15.8	15.1
Asthma	17.1	11.0	6.1
Obesity	31.8	26.0	5.8
Diabetes	14.8	10.1	4.7
High blood pressure	31.8	29.1	2.7
Heart attack	5.8	3.8	2.0
Cancer	6.3	7.1	-0.8
High cholesterol	25.0	26.0	-1.0

(Gallup—Healthways Well-Being Index, 2011)

Figure 1

approach. She ended up founding Transition to Success, a scalable, sustainable, national, evidence-based standard of care to treat the condition of poverty using existing resources. It's being implemented around the country and has been recognized as a Clinton Global Initiative.

It's an approach that resonates with the role of the case manager. Social determinants have become part of mainstream discussions of health care, observes MaryBeth Kurland, CEO of the Commission for Case Manager Certification®. "And at the same time, there is greater recognition of the case management profession's role in considering them—specifically, in ensuring conditions like poverty are addressed."

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Addressing poverty appropriately and effectively requires a change in thinking, Wilson adds.

Poverty as a medical condition

Poverty is not a character flaw, Wilson explains. It is a diagnosable, environmentally based—and *treatable*—condition.

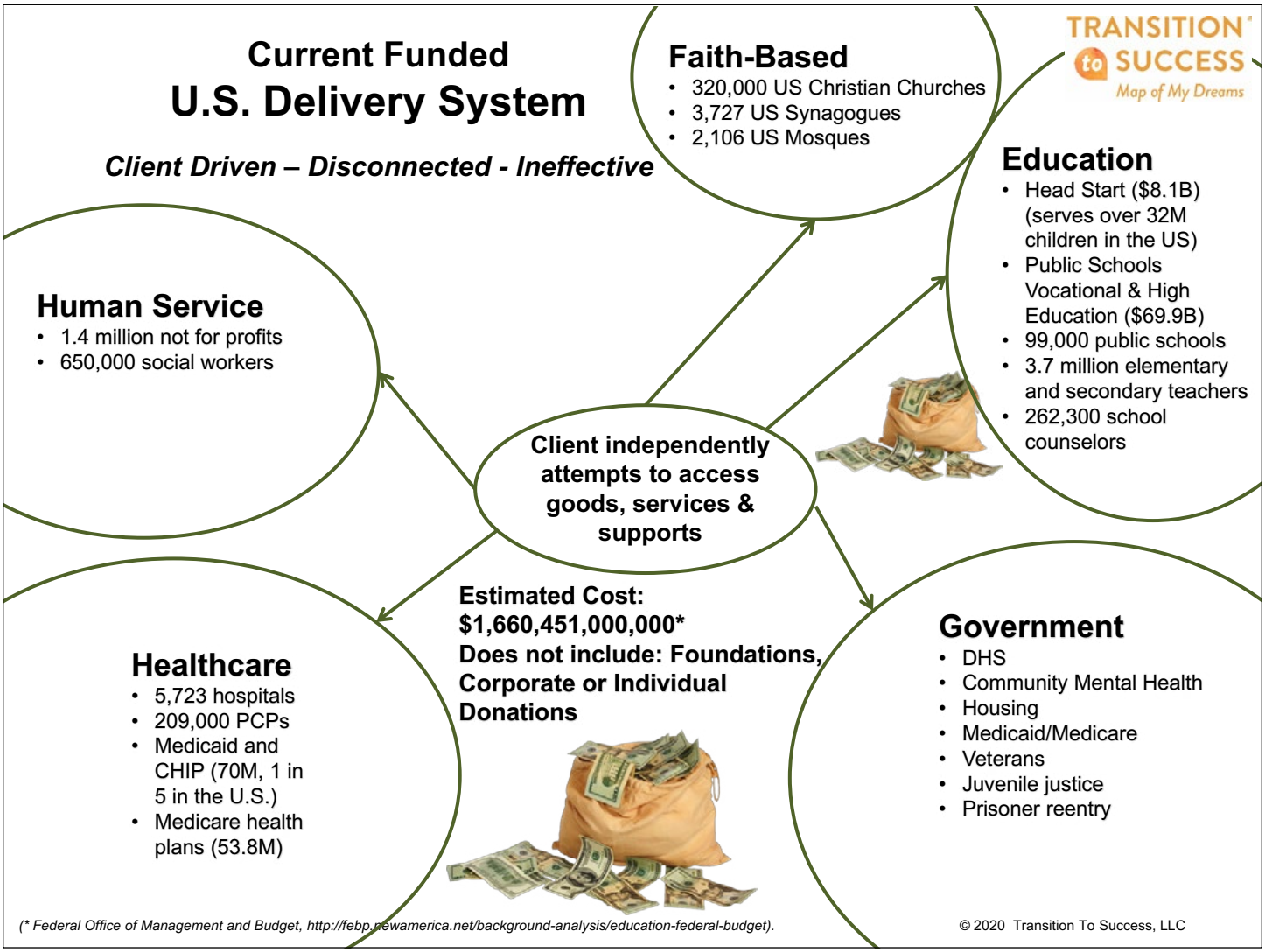

Figure 2

"The condition of poverty is caused by a person's particular social determinants of health," she says. As with any other condition—be it diabetes or cancer or lead poisoning—treatment requires intervention based on science. One doesn't "rise above" poverty any more than one rises above cancer.

That's not *just* her opinion; that's the consensus of the literature.

So how *do* you treat poverty?

As with any other condition, research and evaluation define evidence-based best practice, she explains, and there is a robust collection of evidence on how to treat poverty. What was lacking was a comprehensive, cross-industry, interdisciplinary, uniform analysis to support condition-specific continuous quality improvement.

So instead of a standard of care for poverty, she found three "dead end" approaches:

- **Client self-navigation:** We don't tell a patient with cancer to "go figure it out," but that's precisely what we do to patients suffering from poverty, she says. "We expect those most at risk to navigate health, human services, government, education and faith-based services independently."

- **Practitioner preference:** Health care providers follow standards of care when treating patients with various conditions. But not when poverty is the condition. "The treatment is really led by the individual's understanding, beliefs, good intentions and motivations. There's no standardization."

- **Organizational preference:** Without a standard of care for poverty, each organization determines for itself how it will respond to the condition. The response, she says, is often based on their own review of the literature, good intentions and funding methodologies.

In short, science and data were not driving practice. Changing that in a comprehensive way requires a new way of viewing poverty. That's why treating poverty as a mental condition is so crucial.

"We need to move the understanding of poverty as a nation, as a society, out of that primitive lens of character flaw—shame—into the science-based reality," she explains. "We know what causes poverty, and it has nothing to do with choice because no one chooses to be poor."

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EXECUTIVE OFFICER
TRANSITION TO SUCCESS™

A paradigm shifts

It's what Transition to Success has been doing for years. It's not just lip service or simply calling poverty a condition. It's much deeper than that.

Think about it this way, she says: If an individual, regardless of age or race or culture or religion is exposed to lead, they will have corresponding symptomology that includes long-term neurological damage. There is an agreed-upon diagnosis: lead poisoning. It is driven specifically and entirely by environmental exposures.

"We have standards of care to treat and respond to lead ingestion and we have unique standards of care for responding to lead ingestion for children," she says. What's more, these services are billable. (See Figure 3, next page.)

Understanding and treating poverty the same way requires a paradigm shift, she argues. "We need to move the understanding of poverty as a nation, as a society, out of that primitive lens of character flaw—shame—into the science-based reality," she explains. "We know what causes poverty, and it has nothing to do with choice because no one chooses to be poor."

She points out that 70 years ago, there was no medical model for addiction. Addiction, especially alcoholism, was considered a character flaw. The stigma persists, but the paradigm has shifted. "Today, we have science, we have treatment pathways, we have medications, we have data and

we have a medical model that recognizes the science-based condition of addiction."

That's what must happen with poverty, she argues. And by using a medical model, organizations can be reimbursed for treating poverty.

Payment pathways

The scaffolding is already in place: Social determinants and the condition of poverty were recognized then in the ICD-9 and now in the ICD-10.

Transition to Success has developed a social determinant of health (SDOH) screening tool that can be aligned with billable behavioral health and substance abuse screening tools to create a billable pathway for Medicaid and Medicare.

> ***"We identify their priorities based upon their social determinant exposure priorities, and we coordinate all of the services hand-in-hand through basic needs, unskilled employment, literacy/GED, skilled-employment training and living-wage employment. "***
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Organizations can link the social determinant screening with behavioral health and addiction screening as a value-add to create a billable pathway, she explains. TTS has already developed pathways for Johns Hopkins University that will lead to the billable pathways for each state in the country positioned to screen and respond to SDOH as billable services.

Once SDOH issues are identified, case managers can coordinate

Treating Environmentally Based, Industry-Accepted Medical Conditions *

Environmental Exposures	Symptoms	Diagnosis	Standard of Care	Billable
Lead ingestion	Irritability, high blood pressure, long-term neurological damage	Lead poisoning	Required	✓
Asbestos	Trouble breathing, nausea, vomiting	Cancer/ Mesothelioma	Required	✓
Mosquito bites	Fever, rash, joint pain, conjunctivitis, muscle pain, headache	Zika, West Nile, yellow fever, and malaria viruses	Required	✓
Limited access to fresh fruits, vegetables, and exercise	Increased thirst, blurred vision	Type II diabetes Obesity	Required	✓
Cigarette smoking and second-hand exposure	Wheezing, increased risk of cancer, asthma, COPD	Nicotine addiction	Required	✓
Accidents	Broken bones, closed head injuries	Trauma	Required	✓
Pollution	Difficulty breathing, decrease in lung function, wheezing	Asthma/COPD	Required	✓
Social Determinants of Health Food insecurity, high crime rates, inadequate/unaffordable housing, lack of access to basic needs/resources, limited access to quality healthcare, poorly performing schools, racism, and unemployment, transportation	Increased rates of diabetes and blood pressure, infant and maternal mortality, increased depression and mental health disorders, asthma, compromised immune system and brain development, higher death rates	Extreme Poverty (ICD 10 Z59.5) Homelessness (ICD 10 Z59.0) Lack of adequate food or safe dinking water (ICD 10 Z59.4) Low Income (ICD 10 Z59.6)	**TTS Screening Assessment Referrals:** Behavioral Health, Substance Abuse and Social Determinants	Social Determinant Solutions Billable CPT Codes for Medicaid, Medicare and Third Party

***Note:** Recognized disease* without *genetic predisposition*

Figure 3

needed resources, maximizing all the programs and services for which patients are eligible.

It's about putting the client first.

What does the client want?

The first question clients are asked is, "Would you like help identifying all of the resources that you're eligible for?" If the client agrees, the team puts together that care plan by identifying all the available resources.

The next question is "What's your dream?" The answer helps in building the care plan. Clients can define a path based on their needs, challenges and circumstances—ultimately moving them closer to that dream.

"We identify their priorities based upon their social determinant exposure priorities, and we coordinate all of the services hand-in-hand through basic needs,

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unskilled employment, literacy/GED, skilled-employment training and living-wage employment," she explains. (This is just one of the pathways—there are others for children, teens, the elderly and those with disabilities.)

The approach is built on four primary therapeutic interventions identified in the research:

- **Comprehensive CARE management:** CARE, in this case, stands for coordinating all resources effectively. "We know care management is key to whole-person care. We know it's key to improving health, education and economic outcomes. We know it reduces costs and improves quality," Wilson says.
- **Financial literacy:** Improving financial literacy is a powerful antidote to poverty. TTS puts a particular focus on predatory lending.
- **Peer mentoring:** Identifying somebody in your own community who's relatable to you, that you can connect with and reach. This relationship begins to provide a supportive, helpful relationship.
- **Volunteerism:** "The research is clear," she says. "People who volunteer do better socially, psychologically, educationally, physically, mentally and economically." Volunteerism transforms the needy to the needed.

TTS-trained providers incorporate comprehensive care management with direct care professionals

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across health, faith-based, education, government and human services agencies to coordinate existing, already-funded services into logical, step by step processes creating a CARE plan. Clients then, with assistance, create a "Map of My Dreams" that includes volunteerism and financial literacy. Peer mentors and human services professionals then support clients as they begin to follow their maps.

Using a "train the trainer" model, TTS began to expand, providing curricula and tools to train others and measure results. It now has six successful pilots in seven states.

Advocacy, dignity and the role of the case manager

This approach aligns with what case managers do every day. "The role of the case manager in the patient's journey cannot be overemphasized," Kurland says. Moreover, advocacy is at the heart of a case manager's role; it's addressed in the first principle under the Code of Professional

Conduct for Case Managers: *CCMs will place the public interest above their own at all times.*

The responsibility to respect the inherent dignity of even the poorest clients is articulated in the second principle: *CCMs will respect the rights and inherent dignity in all of their clients.*

Case managers have the knowledge, training and expertise to help treat poverty and guide clients on the path forward, Kurland says.

Wilson agrees, suggesting case managers can have an impact far beyond the client journey. "I see your role changing a nation's understanding in response to poverty as profound." ■

Case example: Medicaid behavioral health clinic

WHAT: A 12-month independent evaluation of Transition to Success by the Kellogg Foundation.

WHERE: Family Service of Detroit and Wayne County, an outpatient, behavioral health, Medicaid clinic in Detroit.

COST: Other than research and evaluation there was no additional funding for staffing or training.

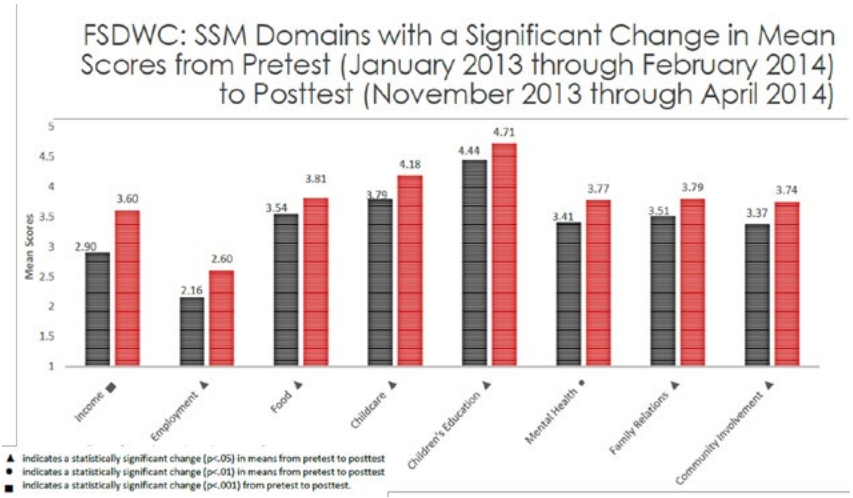
OUTCOMES: Statistically significant improvement in eight of 18 social determinant domains, most notably in income.

TTS Independent Evaluation Results

TTS Independent Evaluation Family Service of Detroit and Wayne County (FSDWC)

This 12-month independent evaluation of Transition To Success was completed at FSDWC, an outpatient, behavioral health, Medicaid Clinic in Detroit. Other than research and evaluation there was no additional funding for staffing and TTS training was accomplished within the existing training budget. In this study Master level, State of Michigan licensed therapists were trained in TTS, integrating social determinant screening and care management into the therapeutic response.

With an average length of stay of 6 outpatient visits clients reported statistically significant improvement in 8 of 18 domains, including but not limited to income, employment, food and mental health. All services provided were reimbursed by Medicaid at a cost of less than $600.00 to the insurer.



Transition To Success® Final Evaluation Report – 8/29/2015 W.K. Kellogg Foundation Grant: P3018954

* FSDWC: Family Service of Detroit and Wayne County

Licensed masters-level therapists were trained in TTS methodology, integrating social determinant screening and care management into the therapeutic response. On average, clients had six outpatient visits. Wilson attributes the improvement in mental health directly to care coordination. "It isn't rocket science, when clients reported improved access to food, improved financial supports and access to entry level employment, we also saw a statistically significant improvement in mental health." ■

About the Experts

Marcella Wilson, Ph.D.
Founder and Chief Executive Officer
Transition to Success™

Marcella Wilson, Ph.D., is CEO and founder of Transition to Success. She has over 30 years of extensive experience in health care administration, not-for-profit management, behavioral health, criminal justice and public sector programming.

She is a University of Michigan alum and holds a master's degree in Social Work and a Ph.D. in Health and Higher Education. Dr. Wilson is an Emmy Award winner for the "What Are You Fighting For" documentary promoting youth volunteerism. In her role as president and founder of Transition to Success, Wilson is leading a national social change movement with a standard of care to treat poverty as an environmentally based medical condition and not a character flaw. Dr. Wilson's book, "Diagnosis: Poverty" defines a scalable, sustainable, measurable, multi-generational response to poverty—an approach being implemented around the country and recognized as a Clinton Global Initiative.

Today, with statistically significant outcomes in 5 independent evaluations, Transition to Success, defines uniform protocols and analytics to treat poverty across human services, health care, education, government and faith-based programs.

MaryBeth Kurland, CAE
Chief Executive Officer
Commission for Case Manager Certification

MaryBeth Kurland leads and sets the Commission's strategic mission and vision. She manages relationships with likeminded organizations and oversees business development as well as the Commission's programs, products and services. She works directly with the Board of Commissioners, building its corps of volunteer and subject-matter experts who directly support and evaluate certification and related services.

Prior to becoming CEO, Kurland served as the Commission's chief operations officer and was staff lead for the development and launch of the Commission's signature conference, the CCMC New World Symposium®. Kurland brings extensive experience to her role, having served as executive director of organizations including the Association of Medical Media, Office Business Center Association International and the League of Professional System Administrators.

She holds a bachelor's degree from the University of Delaware and is a member of the Institute for Credentialing Excellence, the American Society of Association Executives and the Mid-Atlantic Society of Association Executives. In 2011, Kurland was recognized as Association TRENDS Young & Aspiring Association Professional.

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