Care, Context & Community: Creative Ways to Address Social Determinants of Health

Social determinants of health (SDOH) are the conditions in which we live that affect our health. They can dramatically affect longevity and quality of life. They also can affect the costs of healthcare, both on an individual and an aggregate basis.

As healthcare spending in the United States climbs past $4 trillion in 2020, the need to address these determinants becomes even more critical. Further, as COVID-19 continues to transform daily life for most Americans, the pandemic highlights health disparities and confirms the link between social determinants of health and health outcomes.

The Office of Disease Prevention and Health Promotion at the U.S. Department of Health and Human Services has published Healthy People 2030, a set of 355 public health objectives for the next 10 years. The document categorizes social determinants of health as:

- Healthcare access and quality
- Neighborhood and built environment
- Social and community context
- Economic stability
- Education access and quality.*

Healthcare providers, systems and payers can find valuable partners in formulating approaches to reduce the negative effects of SDOH in local community-based organizations (CBOs), which facilitate access to local programs and services. Public–private partnerships and multi-organization collaborations are a proven way to address social determinants of health. Many successful examples are highlighted in the Healthcare Leadership Council's Redefining American Healthcare Award, which recognizes initiatives that demonstrate an increase in quality and efficiency of care through a patient-centered approach.

Thirty percent of respondents to the Change Healthcare 2020 Industry Pulse Report indicated that they are providing some level of direct support to members and patients based on SDOH; 14.4 percent are coordinating with CBOs, and that number is likely to increase.

*Education access and quality, while a critical social determinant of health, is outside the purview of this document.

30%

of healthcare providers and payers are providing direct support to members and patients to address SDOH.

Working within the Healthy People 2030 categories and associated assessment measures gives partnerships a unified starting point and a common set of goals. These collaborations can thus move more quickly to the important work at hand: taking action to address social determinants in order to improve the health of the American people and reduce the overwhelming healthcare costs that burden our economy. The objectives and measures we focus on here were selected for maximum potential impact, spread and scalability, as well as available models and examples.

In each area, where Healthy People 2030 may lay out multiple objectives, we have chosen to focus on one or two where we can provide examples of interventions that work. If we are to move beyond pilot programs and speed replication, readily available information about successes is needed. **A key recommendation herein is to develop a clearinghouse that contains data, measurement, research, and evaluation on SDOH programs nationwide and make this information accessible as best practices to stakeholders across the healthcare continuum.**

Healthcare Access and Quality

Since the passage of the Affordable Care Act, an estimated 20 million Americans have gained health insurance coverage. However, nearly one in 10 people in this country do not have health insurance. Without coverage, people are less likely to have a primary care provider and to access preventive care. It's critical that we continue to **increase the proportions of people with medical insurance** (Objective AHS-01). This will help with an associated objective, **increase the proportion of people with a usual primary care provider** (Objective AHS-07). Currently estimated at 76 percent of people, the target rate is 84 percent. Coverage and provider relationships also will help to **reduce the proportion of people who can't get medical care when they need it** (Objective AHS-04).

Once a patient encounter is underway, providers must be trained and equipped to assess SDOH needs. In response to the COVID-19 pandemic, **Kaiser Permanente** developed a simple two-question screening tool for providers as part of its COVID-19 Social Health Playbook:[1]

1. Because of COVID-19, would you like help with any of the following needs?
   - Food
   - Housing
   - Medicine or medical supplies
   - Employment
   - Transportation
   - Loneliness
   - I don't want help with any of these
2. Are any of your needs urgent?
   - Yes
   - No

When a social need is identified, the Kaiser Playbook contains a list of follow-up questions and action items for providers tailored to each need. It also contains a job aid that shows providers how to connect people to resources to meet the needs revealed in the screening, as well as a comprehensive state-by-state listing of resources for common COVID-19 related needs. **Educating providers on existing billing codes and developing additional codes for social needs care should be made available for Medicare, Medicaid, and private insurance providers. This could help to incentivize providers toward increased screening and referrals.**

Community organizations also are important gateways for access to healthcare, as Healthy People 2030 demonstrates with its objective to **increase the number of community organizations that provide prevention services** (Objective ECBP-D07).

Since 2014, Fort Worth, Texas, has undergone a neighborhood-by-neighborhood transformation through an innovative partnership with **Blue Zones**

Project by Sharecare, a community-led well-being improvement initiative designed to make healthy choices easier through permanent changes to a city's environment, policies, and social networks. Participating communities have experienced reductions in health inequities, improvements in life expectancy, double-digit drops in obesity and tobacco use, and have saved millions of dollars in healthcare costs. Fort Worth's overall Community Well-Being Index (CWBI) score rose 3.7 points in four years, with smoking rates dropping by more than 30 percent, exercise rates increasing nearly 17 percent, and 14 percent more residents reporting as "thriving" in their life evaluation. Neighborhoods and sectors of the city whose residents had the most well-being disparities in 2014 have experienced the greatest gains in well-being.

While community organizations provide a valuable service in prevention, helping to address SDOH upstream, we envision a greatly expanded role for CBOs in addressing social determinants of health. CBOs have many advantages in serving as a linchpin connecting payers, providers, and nontraditional partners to provide services to people who need them. But CBOs must be equipped and empowered to act as strong lead organizations and true business partners. The ability to enter into and manage contractual arrangements, develop infrastructure for data analysis and robust reporting, engage non-traditional partners, craft models tailored to location and community, and improve handoffs with the health system are essential characteristics of CBOs that make them attractive partners for payers and providers, who can leverage these insights and pathways into community needs and resources.

10%

of Americans do not have medical insurance, and 4 percent can't get medical care when they need it.

This model has been proven to work by **Aetna Better Health of Ohio**, which partnered with local Area Agencies on Aging (AAAs) to provide integrated care management services to members who receive home- and community-based waiver services, called **MyCare Ohio**. Aetna supplies the technology and analytics, as well as medical and behavioral health expertise, to allow the AAAs to manage the member's complete health picture. In the first 18 months of the program, the number of beneficiaries who received home- and community-based services increased by 9 percent; their use of institutional services declined commensurately.

Neighborhood and Built Environment

44%

of Americans do not have broadband access to the Internet.

It's been said that a person's zip code is as strong a health determinant as their genetic code.[2] Where people live drives access to beneficial inputs such as healthy food and clean air and water; or harmful ones, such as poor air quality or violence. According to West Side United, life expectancy varies by as much as 16 years between Chicago's West Side and the affluent downtown Loop area.

The COVID-19 pandemic rapidly accelerated the widespread adoption of telehealth and demonstrated its effectiveness in treating a range of health problems. Providers were able to connect with greater numbers of patients with efficiency and speed, regardless of location. But one segment of the population is consistently left behind in health technology developments: those without broadband Internet access, which is referred to as a "super-determinant" of health by the Center for Public Health Law.[3] To ensure equitable access to telehealth as well as Internet-based health information, **we must increase the proportion of persons with broadband access to the Internet** (Objective HC/HIT 6). In 2017, nearly 56 percent of Americans age 17 and older reported having this access; the target is 60.8 percent.

Lack of broadband access affects providers as well as consumers, and the issue is especially acute in rural areas: The Pew Charitable Trusts estimates that 60 percent of healthcare facilities outside metropolitan areas lack broadband access.[4] **The LAUNCH Initiative** (Linking and Amplifying User-Centered Networks through Connected Health) has been at work in rural Kentucky since 2017. LAUNCH features a unique partnership between the Federal Communications Commission, the National Cancer Institute, the Markey Cancer Center (Lexington, Kentucky), and a user-centered design team at the University of California, San Diego. Its objective is to use participatory design to co-create culturally sensitive solutions with consumers.[5]

Social and Community Context

The objectives in this area focus on relationships and helping people increase and improve their interactions with others. Health literacy plays a vital role in people's ability to find and manage health information and communicate with their healthcare providers.[6] **We must improve the health literacy of the population** (Objective HIT 1) to improve the overall health of the nation. **Texas Health Resources** created HELP (Healthy Education Lifestyle Program) to assist uninsured people with chronic diseases in making lifestyle changes. Participants attended an education session to increase their health literacy and were assigned an ongoing support group that helps them continue to build agency and understanding.

Once people have broadband Internet access and improved health literacy, we can **increase the proportion of adults who use IT to track healthcare data or communicate with their provider** (Objective HC/HHIT-07). Currently estimated at 80 percent of adults, people who deploy technology to manage healthcare information and talk with providers are likely to have better health.

20%

of adults do not use technology to manage healthcare information.

Economic Stability

Economic stability is paramount to improving health. In 2019, more than 10 percent of the American population—34 million people, including 10 million children—was living in poverty.[7] Low incomes are strong drivers of chronic illness and death. Poor adults are five times as likely to report being in poor or fair health[8] and tend to live seven to eight years less.[9] Poverty also correlates directly with food insecurity—lack of access to sufficient food for a healthy life.[10] Negative health outcomes stemming from poverty and hunger are well documented and cost the country as much as $160 billion per year, according to estimates.[11]

Providers, payers, community-based organizations and other partners can collaborate to **reduce household food insecurity and in doing so reduce hunger** (Objective NWS-01). In 2018, 11 percent of households were food-insecure. The target is 6 percent. In one successful collaboration, **Tivity Health** established a partnership

11%

of households were food insecure in 2018.

with the National Association of Area Agencies on Aging and the National Association of Nutrition and Aging Services Programs to provide meals to homebound seniors during the COVID-19 crisis. To date, more than 400,000 meals have been delivered; the number and need continues to grow.

It's also critical to **reduce the proportion of households that spend more than 30 percent of their income on housing** (Objective SDOH 4.1.1). That figure is currently at more than 34 percent; the target is 25 percent. Naturally, homelessness is a real risk for low-income people whose housing costs become untenable. **SCAN Health Plan**, which serves 220,000 Medicare beneficiaries in California, launched a Housing and Homelessness Care Management Initiative in July 2019. SCAN collaborates with providers and CBOs to provide long-term complex case management to homeless or at-risk members. This project was informed by SCAN's meetings with more than 20 local organizations to understand the housing system, stakeholders, how organizations and programs were operating and cooperating, and the needs of low-income seniors and the barriers to healthcare they faced.

Other examples:

- In 2019, **CVS Health** invested $67 million in affordable housing, helping to construct 2,200 housing units in 24 cities across six states. The company's 2020 affordable housing commitments total $100 million.
- The **American Medical Association** is part of West Side United, a Chicago-area collaboration of six leading area hospitals investing capital in local businesses and organizations. Focusing on affordable housing and community redevelopment, the partnership is investing $6 million in the area in 2020.

Keys to Replicability and Scale

Since July 2019**, Lutheran Services in America** (LSA) has been piloting a person-centered service coordination model in Toledo, Ohio that is comprehensive and robust. Serving low-income older adults with chronic health illness, the program includes a comprehensive screening of SDOH and connects older adults to services and supports in their community. LSA has both local partners such as the Area Agency on Aging, meal delivery and home health services; and national partners such as the LTSS Center @UMass Boston (evaluation partner) and Simply Connect (technology partner). The program, which has been highlighted by the Commonwealth Fund, identified 787 gaps in care among 890 affordable housing residents.

This document contains a number of recommendations to address social determinants of health, as well as successful examples like the one above. These recommendations rest on a three-part foundation we believe will help collaborations across the country move beyond pilot programs to implement robust interventions and achieve significant results. The three-

The Three-Part Foundation

1. A standard set of SDOH definitions in the Healthy People 2030 framework, giving all partners and stakeholders a common starting point and frame of reference
2. Community-based organizations that are positioned and equipped to act as true business partners
3. A national clearinghouse of program information and best practices

part foundation comprises: 1) a standard set of SDOH definitions in the Healthy People 2030 framework, giving all partners and stakeholders a common starting point and frame of reference; 2) community-based organizations that are positioned and equipped to act as true business partners; and 3) a national clearinghouse of program information and best practices.

This national clearinghouse will leverage the Healthcare Leadership Council's established Redefining American Healthcare framework. It will include a dashboard, a set of recommended measurements, descriptions of successful pilot programs, tools and methods for research and evaluation, and a compendium of best practices.

In October 2020, the Healthcare Leadership Council, an alliance of innovative healthcare companies from all health sectors, and two of its members, Aetna and Tivity Health, convened a virtual roundtable involving more than 100 organizations from the healthcare, public policy, academia, non-profit, patient advocacy, and private industry spheres. The objective was to focus on identifying actionable recommendations to reduce health disparities by addressing social determinants of health. The solutions laid out in this document were generated by the roundtable participants and will be used to create strategic and advocacy recommendations for the 2021 Administration and Congress. Previous publications in this series include a primer on social determinants of health and a report from a July 2019 roundtable.

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1 Kaiser Permanente COVID-19 Social Health Playbook, October 2020. Available for download at https://about.kaiserpermanente.org/content/dam/internet/kp/comms/import/uploads/2020/10/KP_COVID-19_Social_Health_Playbook_FINAL.pdf

2 Seavey, John W., How's your health? What's your zip code? Poverty and health. 2008: The University Dialogue, 42. Available for download at https://scholars.unh.edu/discovery_ud/42/?utm_source=scholars.unh.edu%2Fdiscovery_ud%2F42&utm_medium=PDF&utm_campaign=PDFCoverPages

3 Broadband Access as a "Super-Determinant" of Health. Blog post, July 12, 2018: The Network for Public Health Law. https://www.networkforphl.org/news-insights/broadband-access-as-a-super-determinant-of-health/

4 How States Are Expanding Broadband Access. Report, February 2020: The Pew Charitable Trusts. Available for download at https://www.pewtrusts.org/-/media/assets/2020/03/broadband_report0320_final.pdf

5 FCC-NCI Broadband Cancer Collaboration Project Homepage. https://www.fcc.gov/health/cancer

6 Benjamin, Regina M. Improving Health by Improving Health Literacy. *Public Health Rep.* 2010 Nov-Dec; 125(6): 784-785. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2966655/

7 Semega, Jessica, Melissa Kollar, Emily A. Shrider, and John F. Creamer. U.S. Census Bureau, Current Population Reports, P60-270, Income and Poverty in the United States: 2019, U.S. Government Publishing Office, Washington, DC, 2020. Accessed at https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-270.pdf

8 Khullar, Dhruv, Chokshi, Dave A. Health, Income, & Poverty: Where We Are & What Could Help. Health Policy Brief, October 4, 2018: *Health Affairs.* https://www.healthaffairs.org/do/10.1377/hpb20180817.901935/full/

9 Conway, Claire. Poor Health: When Poverty Becomes Disease. Blog post, January 6, 2016: University of California San Francisco. https://www.ucsf.edu/news/2016/01/401251/poor-health-when-poverty-becomes-disease

10 Coleman-Jensen, Alisha, Matthew P. Rabbitt, Christian A. Gregory, and Anita Singh. 2020. Household Food Security in the United States in 2019, ERR-275, U.S. Department of Agriculture, Economic Research Service. https://www.ers.usda.gov/webdocs/publications/99282/err-275.pdf?v=6293.6

11 Cook, John T., Poblacion, Ana Paula. Estimating the Health-Related Costs of Food Insecurity and Hunger. Appendix to the 2016 Hunger Report: Bread for the World Institute. Accessed at https://childrenshealthwatch.org/wp-content/uploads/JohnCook_cost_of_hunger_study.pdf

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