



Beyond the Boundaries of Health Care: Addressing Social Issues

ISSUE BRIEF

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KEY TAKEAWAYS



Beyond health care, the conditions and environment in which people are born, grow, live, work, and age impact a person's overall health.



Addressing the social determinants of health requires multifaceted, multi-stakeholder approaches, and coordinating health care and social services to best serve those in need.



Health plans address the social determinants of health by coordinating housing, employment, education, and food services and supporting other needs (e.g., child care) in addition to traditional health care services.

Introduction

During the past several decades, it has become increasingly apparent that a person's "health" is influenced by many more factors than health care alone. These other determinants are defined by the conditions and environment in which people are born, grow, live, work, and age, reaching beyond just what the delivery of acute care services can influence.¹ These "social determinants of health" result in billions of dollars of additional costs annually. By working to mitigate the negative impacts of these factors, significant benefits can be achieved that improve both access and outcomes for individuals and lower overall costs.

Addressing the social determinants of health has become a top priority for public and private institutions. State Medicaid programs and the Children's Health Insurance Program (CHIP) have introduced care models to engage patients in improving their personal well-being. Private health plans also work to address environmental factors that impact a person's health. For example, plans facilitate housing, transportation, and educational opportunities as complements to traditional health care services. Other approaches include offering early childhood support services; providing nutritional assistance for pregnant women, mothers, and children; and increasing access to case management services. While significant strides have been made to identify and address the social determinants of health, there is still much work to be done by public and private institutions to combat their influence.

Background

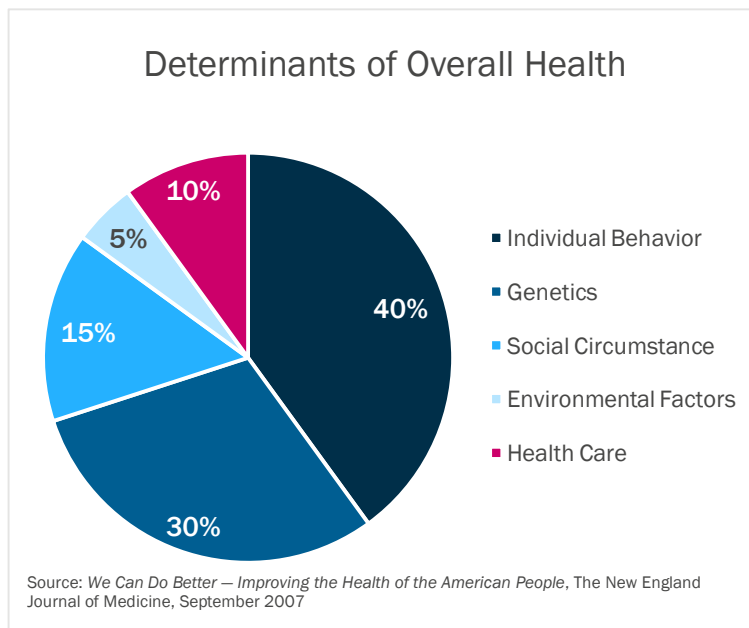
The places where people live, learn, work, play, and worship impact a person's overall health.² The financial, social, familial, and educational aspects of a person's life, as well as the physical environment in which the person lives, are termed the social determinants of health (SDOH). The Centers for Disease Control and Prevention (CDC) identifies the social determinants as conditions shaped by "money, power, and resources that people have," subject to policy choices.³

SDOH can have positive or negative manifestations, depending on an individual's circumstances. Negative social determinants include poverty, lack of access to quality education, employment status, unhealthy housing options, unfavorable working conditions, unfavorable neighborhood conditions, exposure to violence, and exposure to general disadvantage. Such adverse SDOH impose an annual social cost of billions of dollars. By working to mitigate the negative impacts of these factors, significant benefits can be achieved that improve both access and outcomes.

SDOH are correlated with "health disparities," which refer to the "rates of disease occurrence and disabilities between socioeconomic and/or geographically defined population groups."⁴ Disparities may arise as dimensions of social inequities, education, income and wealth, race/ethnicity, racism, class, immigration status, gender, sexual orientation, and disability status.⁵

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Adverse SDOH can impact individuals in a variety of ways, one of which is stress. When stress is increased in a person's life – through food insecurity, unstable housing, employment-related stress, or physical safety of a neighborhood – health outcomes begin to suffer. Stress has been associated with increased risk for coronary vascular disease, obesity, diabetes, depression, cognitive impairment, inflammatory and autoimmune disorders, and reduced physical mobility and cognitive function at older ages. People who face more stress in their lives also experience increased risk of adverse birth outcomes, and disparities have been found across childhood asthma, hypertension, substance abuse, diabetes, obesity, and depressive symptoms.⁶



Some researchers have estimated that overall health (and risk of premature death) is determined by individual behavior (40 percent), genetics (30 percent), social circumstance (15 percent), environmental factors (5 percent), and health care (10 percent).⁷

The most striking implication of these estimates is that medical care alone has a very limited effect on overall population health. The estimates also suggest that the impact of medical care could be significantly enhanced by pairing with social approaches directed toward mitigating individual behaviors (e.g., smoking) and SDOH.

CDC has identified addressing SDOH as “the primary approach to achieving health equity,” and the goal of public and private efforts.⁸ CDC has encouraged programs that work across sectors to improve housing, education, and transportation, in partnership with community activities.⁹

CDC has also included SDOH in its Healthy People 2020 initiative. This initiative consists of 1,200 objectives across 42 topic areas that have been targeted for their importance to public health. The stated goal of the SDOH topic area is to “create social and physical environments that promote good health for all,” which can be achieved through advances in health care, education, child care, housing, business, law, media, community planning, transportation, and agriculture. To work towards these goals, the Healthy People 2020 initiative seeks to explore how programs, practices, and policies affect the health of individuals, families, and communities; establish common goals, roles, and ongoing relationships between the health sector and the targeted areas for advancement; and maximize opportunities for collaboration across federal, state, and local partners.¹⁰

Challenges in Addressing SDOH

Given their complex nature, addressing SDOH requires multifaceted interventions that target multiple mechanisms simultaneously.¹¹ In addition, there are challenges involving the populations themselves. To achieve community-wide improvements, stakeholders implementing such changes must understand the population being addressed to ensure that the right programs are targeted to the right people in the right way.¹² Those designing and implementing programs also need to gain community buy-in to achieve the best results.¹³ Language barriers, educational gaps, and misunderstanding of cultural practices may undermine the success of already-difficult initiatives. Designing a program to work on multiple levels with multiple populations concurrently, using evidence-based practices from a comparable sample, has proven very challenging.¹⁴

Policy challenges exist as well, including on states' abilities to spend Medicaid funds on non-medical interventions, such as housing or employment programs. Restrictions on the way funds may be spent must be re-examined and rationalized to best support cost-effective services to reduce the impact of SDOH.¹⁵

Government Stakeholder Activities

Federal, state, and local government stakeholders have begun to recognize the impacts of SDOH in recent years and have developed strategies to address them.

As Medicaid and Medicare continue to transition to value-based payment models, there is a more compelling economic case for public

programs to deliver the most cost-effective care and services with a whole-person approach, even beyond traditional clinical services. Interventions have been introduced on patient and population levels, with targeted approaches intended to have an impact in the near-term as well as long-term effects on the health of future generations.

The Centers for Medicare and Medicaid Services (CMS) launched the Accountable Health Communities (AHC) model in 2016 to create community partnerships among providers and nonmedical social support groups to improve overall health and health care delivery. This model promotes clinical-community collaborations, including screenings to identify unmet health-related social needs, referrals to community services, navigation services to help high-risk beneficiaries access community services, and alignment of clinical and community services.¹⁶

CMS is testing the AHC model over a five-year period in 44 award sites, where 12 "Awareness" projects were awarded \$1.17 million each, 12 "Assistance" projects were awarded \$2.57 million each, and 20 "Alignment" projects were awarded \$4.5 million each. Award recipients will partner with state Medicaid agencies, clinical partners, and community services providers to improve linkages between clinical care and community services and to address SDOH.

Since CMS funds cannot be used to pay for community services, recipients will use AHC monies to fund interventions designed to connect people to available community services in the areas of housing instability and quality, food insecurity, utility needs, interpersonal violence, and transportation.

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New York, Washington, Colorado, California, and Connecticut, among other states, have used State Innovation Model (SIM) grants to focus attention on addressing SDOH. The SIM demonstrations provide links across different types and settings of care, and incorporate concepts relevant to addressing SDOH, including housing, employment, and food security.¹⁷

The National Institute on Minority Health and Health Disparities has partnered with several other National Institutes of Health centers and the Agency for Healthcare Research and Quality (AHRQ) to conduct research on addressing disparities in certain health care areas.¹⁸

- CDC highlights successful programs to address community-wide disparities in its Morbidity and Mortality Report, including:
- Promoting health and traditional food practices among American Indian and Alaska Native communities
- Community-based initiatives to reduce asthma complications among African American and Hispanic children
- Evidence-based interventions to increase colorectal cancer screenings among minorities in Alaska and Washington
- Community-based approaches to promote condom use and STD testing among Latino men

Health Plan Efforts to Address SDOH

Health plans are proactively addressing SDOH and health disparities in a variety of ways. For example, health plans assist low-income individuals and families with housing support, providing nutritional assistance and education,

promoting case management services, and integrating health care for at-risk individuals and families.

Plans have moved beyond traditional medical care to provide coordinated social services and educational opportunities to plan members while connecting them with community-based organizations. Examples of health plan programs are described below.

Anthem, Inc. has partnered with the National Urban League, City of Hope, and Pfizer to create *Take Action for Health*, a free program designed to reduce breast cancer and heart disease and promote emotional well-being in African American communities nationwide. The goal is to increase mammograms, blood pressure screenings, and screenings for depression and anxiety.¹⁹

CareSource Life Services *JobConnect*, a pilot program in Ohio and statewide in Indiana and Georgia (July 2017), is designed to help members get and keep jobs that can improve their lives. The program identifies and addresses gaps in members' educational needs, interview skills, employment assistance, and job training. CareSource then links members with employer partners to improve long-term financial stability through employment. The program provides work-necessary supports like stress management, dependable transportation, childcare, and budgeting and personal finance literacy by partnering members with Life Coaches. These Life Coaches help build a "personal plan for success" and members utilize community resources to support unmet needs on their pathway out of poverty and up their career ladder.

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Harvard Pilgrim Health Care (HPHC) launched an initiative to reduce racial/ethnic disparities in colorectal screening, and expanded the program to health literacy. The initiative reduced the screening gap between groups with low health literacy and the general population from 11 percent to 4.1 percent in four years. HPHC also works to increase the number of members who self-report race, ethnicity, and preferred language (REaL) information. Through this self-reported REaL demographic data, HPHC is better able to partner with the provider community and continuously improve health equity efforts.²⁰ The HPHC Strategic Plan includes a focus on addressing SDOH, including providing access to fresh and healthy food, important to preventing obesity and related chronic diseases.²¹ This further supports the HPHC's Foundation partnerships with nonprofit organizations throughout the plan's service areas that make fresh – and often local – food easier to find and buy.

Health Net, Inc.'s efforts to reduce disparities and advance health equity include several multipronged interventions in California. Its use of geospatial mapping helps target disparity-reduction efforts, access to care issues, and secure 95 percent of members' race and ethnicity data. Health Net established a Health Equity Advisory workgroup and implemented a disparity-reduction model utilizing a multidimensional approach to improving quality and delivery of care that involves the community, provider, member, and system-level touch points. Health Net's innovative Postpartum Project for African-American women in the Antelope Valley aims to improve postpartum visit rates by addressing the barriers around timely access to care and providing transportation – with no prior

authorization requirement – to appointments for mothers and their children. This initiative showed a 40 percent gap reduction and increased compliance from 17 percent to 33 percent. In another effort to address SDOH that impede postpartum care rates, Health Net implemented a clinical home visitation program to support targeted measures.

Humana has created the Bold Goal initiative, which seeks to build community trust, encourage participation in clinical programs, establish behavior change, and ultimately lower costs and improve health. The Bold Goal is to improve health in the communities they serve by 20 percent by 2020 by making it easier to achieve best health. The goal is tracked through Healthy and Unhealthy Days, a measure of population health designed to better evaluate overall well-being and mental health, including perception of purpose, sense of security, and feeling of belonging. Humana's Bold Goal program strives to increase the number of Healthy Days by incorporating clinical health care (primary care visits, specialists, pharmacy, and hospitals) with prevention efforts, community partnerships, wellness and behavioral health, and home care. These efforts are underway in seven communities: San Antonio, Tampa Bay, Louisville, Knoxville, New Orleans, Baton Rouge, and Broward County, FL.²²

Kaiser Permanente is advancing a "Total Health" framework focused on aligning and activating all of its resources – including sourcing and procurement, workforce pipeline development, training, investment capital, education programs, research, community health initiatives, environmental stewardship, and clinical prevention – to maximize physical, mental, and social well-

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being for its members and the communities it serves. As part of this strategy, Kaiser Permanente supports place-based initiatives to address the social determinants of health in neighborhood and school settings that focus on health-promoting policy, system, and environmental changes. To address the social and non-medical needs of its members, it is also creating the capability to screen patients for unmet social needs and refer them to relevant resources in their communities. In Southern California, this work has been undertaken in partnership with the non-profit group Health Leads, targeting predicted high utilizers. Data shows that 78 percent of those screened have one or more unmet social need.²³ Similar initiatives have been undertaken as part of Kaiser Permanente's complex needs in its other regions.

L.A. Care Health Plan committed \$20 million over five years to fund an initiative aimed at securing permanent supportive housing for homeless individuals in Los Angeles County as part of the Whole Person Care pilot, a component of the 1115 Medi-Cal Waiver. This grant will support L.A. County's Housing for Health program, which offers permanent supportive housing, housing navigation and tenancy supports, connections to primary care, intensive care management services, and other resources for people experiencing homelessness who have complex physical and behavioral health conditions. Additionally, funding from the Blue Shield of California Foundation enabled L.A. Care to lead a planning grant and conduct two consumer listening sessions with formerly homeless individuals to improve outreach and engagement efforts, care coordination, and patient experience. L.A. Care has shared these findings with key partners and continues to serve as a

leader in facilitating discussions with the L.A. County Health Agency, community-based organizations, hospitals, clinics, sheriff, probation, and other entities serving vulnerable populations such as those reentering their communities from jail or struggling with homelessness.

Molina Healthcare opened a resource center for homeless members designed to avoid emergency department use for nonmedical needs (such as food, showers, and transportation) with plans to expand the center to computers, laundry, social services, and workshops.²⁴ Molina also recently purchased two behavioral health subsidiaries of Providence Service Corporation to "focus on social determinants of health," and initiated the WellRx pilot in New Mexico, a clinical setting to screen patients for nonmedical social needs.^{25, 26}

UPMC Health Plan partners with Pittsburgh-based Community Human Services, a local nonprofit agency, to fund "Cultivating Health for Success." The housing funding is made available through the US Department of Housing and Urban Development. The program integrates permanent supported housing, an assigned medical home, and case management/care coordination to help provide stability for UPMC for You Medicaid or Special Needs Plan members. Since 2010, medical costs and unplanned care have declined among homeless individuals who gained stable housing through the initiative. Initiative participants who gained housing saw an average annual health savings of \$6,384.

Conclusion

Increasingly, there is an understanding that the health of individuals is influenced by determinants beyond genetics and health care, including socioeconomic status, education, employment status, availability of social support networks, their personal behaviors and lifestyle, and physical environment.

Many stakeholders, from state Medicaid agencies and policy makers to providers and health plans as well as community-based services, recognize the importance of broadening medically-focused care programs to include elements that address SDOH and individual behaviors. Addressing social and behavioral factors has the potential to increase the effectiveness of health care and associated health care dollars, thereby improving outcomes and overall health. Given the importance of SDOH, efforts are underway to account for socio-economic factors in quality measurement. The Department of Health and Human Services Secretary for Planning and Evaluation (ASPE) and the National Quality Forum are making recommendations in this regard.

Despite the growing awareness, state Medicaid programs continue to be constrained by policies that limit spending of Medicaid funds to direct care services. Governments, Medicaid agencies, and managed care plans try to work within those policy constraints by referring enrollees to external agencies and programs, and coordinating services with unrelated organizations.

There are several policy options that increase the ability and effectiveness of stakeholders to address negative impacts of SDOH and individual behaviors:

- *Permit greater latitude in use of “in lieu of services” (ILOS).* Medicaid managed care plans are permitted to provide some services that are not normally covered by the Medicaid state plan if those services are appropriate to the individual’s needs and substitute for a covered service at a lower cost. ILOS might be appropriate in addressing certain SDOH to mitigate a given issue so it does not present a barrier to effective medical care.
- *Increase flexibility in Medicaid waivers.* Similar to ILOS but at the level of the waiver application, it would be helpful to modernize existing Medicaid policies to permit states to broaden the scope of covered services to include specific non-medical services and interventions intended to address specific SDOH.
- *Create a pathway for interdisciplinary/interagency waivers.* State Medicaid agencies should be allowed to partner with other state agencies (such as Housing or Employment) to request interdisciplinary waivers and associated funding from multiple federal agencies under a combination of federal titles and funding sources. For example, a state’s Medicaid and Housing agencies could apply to CMS and the U.S. Department of House and Urban Development for a joint waiver to provide integrated health homes for homeless individuals with severe mental illness, pairing comprehensive medical and behavioral health care with limited-term direct housing assistance.

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In addition to these policy changes, there are other opportunities for further innovation. While improvements are being made, there is more work to be done to continue to improve the quality and access to affordable care across the country, including addressing SDOH.

Related Topic



Endnotes

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