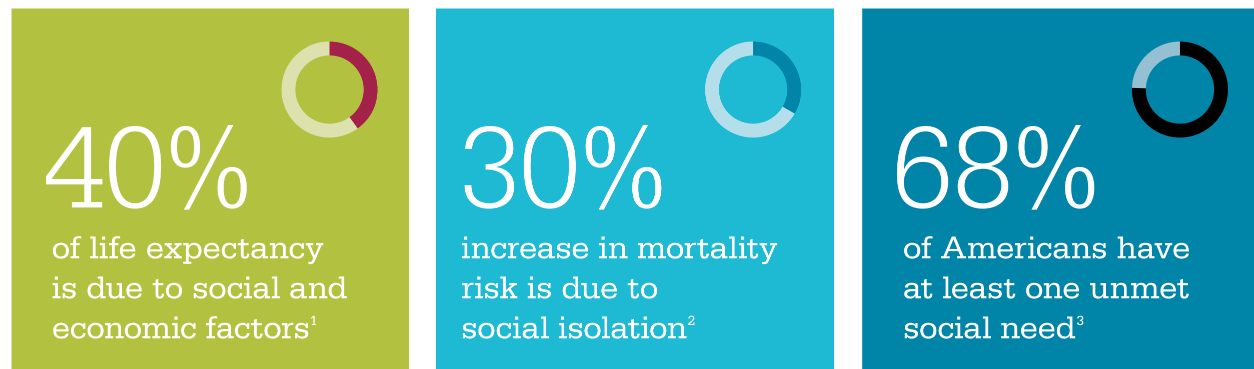
Determined to Reduce Disparities: **Solutions to Address Social Determinants of Health**



SOCIAL AND ECONOMIC FACTORS have a profound impact on our health, longevity, and quality of life. They are the main drivers of health disparities in our society.

They include:

- Housing
- Health literacy
- Food insecurity
- Social support
- Crime & violence
- Economic wellbeing
- Transportation

Awareness of the critical role social determinants play is increasing, and organizations nationwide are working to find solutions to these difficult problems.

The need is clear.

Aggregate healthcare spending in this country is approaching 18 percent of gross domestic product, yet we lag other developed nations in health outcomes on such measures as obesity, chronic conditions, infant mortality, and life expectancy.[4] Investment in social services is a stronger predictor of health outcomes than healthcare spending,[5] so it's easy to see that addressing social determinants to improve population health can help slow the cost growth curve.

For example, states that provide higher levels of social services successfully reduced rates of obesity, asthma, mental health problems, cancer, myocardial infarction, and type 2 diabetes, representing significant avoided healthcare costs.[6]

There are many other positive indicators that awareness of the impact of social determinants is increasing, as stakeholders across the continuum are working to address their negative effects on health. Medicare Advantage, an option within Medicare that allows seniors to enroll in private plans offering wrap-around health coverage and benefits, now covers transportation services and nutrition counseling. And many states are receiving federal waivers to expand Medicaid programs to support initiatives in housing, employment, food access, and transportation.

Solutions: Keys to Success

Collaborations and partnerships are key to addressing social determinants of health. Public-private partnerships and multi-organization collaborations bring together the strengths of multiple players and maximize the contributions of all. We must work together to coordinate healthcare and social services outreach; bridge incentives across health services; integrate the voices of patients; and improve data strategies.

Coordinating Healthcare and Social Services Outreach

Providers and health systems must work more closely with community social service organizations that identify social needs and provide assistive services. These organizations have established local networks and credibility. When healthcare providers and organizations better understand specific community health needs, they can leverage community assets to meet those needs. These linkages and referrals can help surmount critical barriers to addressing social determinants, including vulnerability and distrust.

For example, social service organizations in Appalachia tailor outreach initiatives to link pregnant women struggling with opioid abuse with the appropriate health resources. Meals on Wheels programs provide beneficiaries with social engagement and human contact, building the trust necessary for other social determinants interventions. Some colleges are opening their campuses and resources to senior citizens in their local communities for social engagement and stimulation. However, providers may be unaware of the rich assortment of programs available in their area.

42%

of Americans say they would turn to their medical services provider when looking for information on community resources to help with social needs[7]

Healthcare entities and social services providers have built-in incentives to seek collaboration. Social service organizations that work with other institutions can broaden their reach and breadth of assistance. Healthcare payers and providers can, by working with community and social services organizations, keep individuals healthier through attention to social determinants and curb long-term health cost growth.

>> TO DO Collect and categorize community resources so healthcare providers can provide vital connections for patients with social needs.

Bridging Incentives Across Health Services

Addressing the social determinants of health presents significant financial challenges to patients and providers. Patients may be reluctant to seek care out of fear, distrust, or an inability to pay. Social safety nets are insufficient to link underserved populations with available services, and financial incentives may clash with family autonomy.[9]

Providers have concerns too. Not only are payment structures and effective metrics for non-medical solutions lacking, but healthcare leaders see slow patient adoption of solutions as a significant barrier as well. But there are many bright spots in innovation and payment reform. For example, the Social Determinants Accelerator Act, a bipartisan proposal for a federal grant program, would fund local programs developing silo-breaking interventions under Medicaid. Medical providers are working with local ride-share businesses to address the four million missed medical appointments each year, and states are reforming ride-share reimbursement laws to advance this cooperative effort.

49%

of healthcare leaders cite lack of payment structures for non-medical activities as a barrier to addressing social determinants of health[8]

Creative payment policy solutions for addressing social determinants of health will be central to the current transition of healthcare to value-based models. New accountable and value-based care models, which integrate medical resources and global budgets, should align incentives for healthcare entities with those for social services and vulnerable patient segments. Integrated interventions can be pursued at all levels: federal, state, and local.

To realize the potential of those value-based models, we also must modernize the nation's healthcare fraud and abuse laws. Crafted to prevent improprieties in a fee-for-service environment, they are poorly suited for value-based care that emphasizes collaboration and the more robust care coordination needed to address social determinants of health.

>> TO DO Design new care delivery models to align incentives and integrate interventions to address the adverse effects of social determinants of health.

Integrating the Voices of Patients

Effective social determinants solutions give patients a voice, especially when the solutions are a co-creation between the patient and the community. Collaboration, information gathering, and information sharing can help beneficiaries feel invested and can help to build trust. Sharing their stories elevates their experience, gives it value, and helps forge connections with others in need. Viewing patients as critical stakeholders can help to overcome the vulnerability many feel when they come into contact with the healthcare system and can help alleviate distrust.

97%

of Americans feel that their medical provider should ask about social needs[10]

Barriers and Bright Spots

Common barriers can stand between people with social needs and the resources that can reduce disparities and improve their health:

- Vulnerability: economic insecurity, difficulty getting or keeping a job, food insecurity, unreliable or unaffordable transportation, broken familial relationships, insurance coverage gaps
- Distrust: a lack of trust in public safety and police, institutions, organizations; reluctance to share information, engage with the healthcare system, accept assistance
- Social isolation: loneliness, feelings of helplessness, crippling fear

Fortunately, there are bright spots: initiatives that have proven to break down (or leap over) those barriers and connect people to the resources they need.

For example, Tivity Health's SilverSneakers program uses group physical fitness activities to help participants maintain good physical health and age with vitality. The SilverSneakers program addresses multiple barriers. Its success underscores the importance of creating vehicles that enable greater social connectedness, the ability to create new friendships, and the sense of being part of a larger community. These initiatives enhance participants' physical, social, and mental health and well-being.

Similarly, Aetna works to build "healthy homes," from repairing rickety stairs and unsafe porches to installing equipment to help those with mobility challenges. The project has demonstrated how important it is to remove those physical causes of isolation. Safer housing enables people to interact more frequently with neighbors and community, and to be reached with nutritious meals and other essential services.

In addition to sharing their stories, patients should also share in the savings that result from their proactive participation in health programs. This, too, acknowledges their role as critical stakeholders.

>> TO DO Share patient stories and give them a voice in how a portion of shared savings will be spent.

Improving Data Strategies

While we may understand intuitively the value of addressing social determinants, we need data and evidence to engage and enlist the support of policymakers and stakeholders. By aggregating and refining data, we can develop analytical strategies that illuminate the effects of social determinants and make the case for proposed solutions. Data analysis is critical to bringing about systemic improvements in how social determinants are addressed at individual and population levels.

The relevant data resides in multiple repositories including private organizations as well as such public sources as Medicare and Medicaid. Although community service organizations collect data during patient interventions, they often lack the capacity and infrastructure to analyze it. Data integration is critical for informing healthcare delivery systems and governmental decision-making bodies and for assessing the effectiveness of possible solutions.

More systematic data collection and analysis on social determinants and aggregating it from a variety of public and private sources will improve care and service delivery to individuals and inform programmatic refinements through evidence-based population health strategies. Marrying granular information with population-level data will enable its translation into new and improved solutions.

Inconsistent data collection, both in quality and frequency of collection, slows the broad application of social determinants solutions, while a shortage of methodologies to evaluate them frustrates potential adopters. To expand the resource flow into these solutions, we must find ways to demonstrate on a systemic level that these programs are generating positive return on investment in terms of greater access, better health, and improved outcomes.

43%

of healthcare leaders say limitations on data sharing present a significant barrier to addressing social determinants of health[11]

>> TO DO Enlist key players in various health sectors to determine a strategy for incorporating methods for better data collection and integration and sharing of what works.

Determined

The sheer breadth of the social challenges that people face in their homes, stages of life, and communities can be daunting and make it difficult to get our arms around the idea of addressing social determinants of health. Whereas one person may live in an area plagued by crime, another may live in an isolated rural area that makes human contact all too rare. For every single male over 65 who has difficulty making interpersonal connections, there is a new mother struggling with health, nutrition, and transportation challenges.

Millions of people across the United States face significant disparities in health, quality of life, and lifespan for reasons that are within our power to address. There are solutions for each of these challenges, whether their nature is social, economic, or physical. The challenge lies in effectively applying these solutions for people and determining how to make the necessary investments in ways that will improve health outcomes.

There is significant reason for encouragement and optimism, given the progress seen in both the public and private sectors. These advances, though, are still largely episodic. The answer lies in developing systemic, data-driven, broad-scale approaches to social determinants of health that will make a lasting impact on population health and well-being.

Four Keys to Success

Coordinating Healthcare and Social Services Outreach

Bridging Incentives Across Health Services

Integrating the Voices of Patients

Improving Data Strategies

In May 2019, 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 roundtable forum in Washington, DC, involving more than 60 organizations from the healthcare, public policy, academia, non-profit, patient advocacy, and private industry spheres. The objective was to share ideas and build consensus around a common understanding of the importance of social determinants of health; identify the greatest barriers to addressing social determinants of health; and identify high-impact actions and solutions that both the private and public sectors could implement at the federal, state, and/or local levels. The solutions laid out in this document were generated by the roundtable participants.

1. County Health Rankings model
2. Holt-Lunstad et al. *Perspectives on Psychological Science*, March 2015.
3. Kaiser Permanente
4. The Commonwealth Fund
5. Bradley et al. *Health Affairs*, May 2016
6. *Ibid.*
7. Kaiser Permanente
8. HealthCare Executive Group and Change Healthcare
9. Garg et al. *Pediatrics*, April 2019
10. Kaiser Permanente
11. HealthCare Executive Group and Change Healthcare

For full reference citations, please see the online version of this document at www.hlc.org.

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