Social Determinants and Health Care: Getting to Root Causes

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It is well established that conditions in the places where people live, learn, work, play, and age significantly influence the health outcomes they experience. Health care providers, policy makers, and funders across the United States increasingly recognize that addressing these conditions, or social determinants of health (SDOH), is necessary to treat the root causes of disease and reduce health disparities. As growing evidence unravels the complex causal pathways from social determinants to health outcomes, however, the role of health care in addressing SDOH is far from clear.

To date, payment reform initiatives and service delivery innovations have focused on strategies to address patients' social needs through screening, linking to community resources, and providing navigation support. While connecting patients to resources that address non-medical needs is an important shift for health care delivery systems, such efforts do not address the broader environmental, economic, political, and structural forces of which individual social needs are a product. Systematically addressing social needs still does not equate to addressing social determinants of health. This distinction is critical for shaping the role of health care systems in achieving health equity, now and in the future.

Current Models to Address Social Needs

The Affordable Care Act of 2010 (ACA) established financing mechanisms to incentivize and reward delivery system innovations that address patients' social needs. Within health care, these interventions tend to involve three components.

Screening

By identifying patients who have unmet social needs, screening is intended to help improve clinical decisions, inform treatment plans, and ultimately improve outcomes and reduce costs. Systematically collecting social needs data by incorporating screening into standard clinical practice also provides health systems with a population-level perspective on risk factors. Tools like the Centers for Medicare & Medicaid Services' (CMS) Accountable Health Communities (AHC) non-medical health-related social needs (HRSN) screening tool; the National Association of Community Health Centers' (NACHC) Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE); the Health Leads Screening Toolkit; and the American Academy of Family Physicians' EveryONE Project Social Needs Screening Tool differ in the domain areas emphasized and in the structure of certain measures,

but there is substantial overlap. All are designed to be evidence-based, easy to administer, and efficient yet comprehensive of important social needs such as housing stability, food security, utility and financial assistance, transportation, and safety.

Community-clinical linkage

By creating referral procedures and data sharing agreements with community-based organizations, social service agencies, and other non-medical partners, health care providers aim to better coordinate with existing resources to meet patients' social needs. In the eleven states that were awarded grant funding in the current round of the Center for Medicare & Medicaid Innovation (CMMI) State Innovation Models (SIM) program, all incorporate non-medical referral partnerships into state-wide, multi-payer strategies to improve population health, strengthen quality of care, and control costs. The launch of the Accountable Health Communities (AHC) model by CMMI reflects the growing level of interest and investment in community-clinical linkage. Over five years, the model is intended to address "upstream determinants" of health by "building community capacity" in a defined geographic region. There are 31 organizations participating in the model under two tracks, designed to focus on assisting high-risk patients with accessing services related to social needs, or to develop alignment among partner organizations to ensure the availability and responsiveness of services.

Navigation and support

To bolster screening and community-clinical linkage, health care systems may also invest in navigation and support services for patients. By leveraging Section 1115 waivers, state Medicaid contracts with managed care organizations, or statewide all-payer reforms made possible through the ACA, health systems have developed mechanisms for providing navigation services related to social needs, such as referral, accompaniment, and support provided by community health workers.

Evidence of the effectiveness of social needs interventions is still emerging, but there are promising examples. At Hennepin Health, a safety net accountable care organization (ACO) in Minnesota, an intensive "housing first" intervention targeting homeless patients has resulted in improved access to primary care, reductions in hospital admissions and emergency department visits, and modest improvements in diabetes care, vascular care, and asthma care. In Ohio, the Pathways Community HUB model empowers community health workers to address complex social needs, and has led to reductions in rates of low birth-weight babies. One review article of 25 social needs interventions in Medicaid managed care organizations found wide variation in sub-populations of patients targeted, with most focusing on high cost, high need patients such as those with chronic conditions. Among interventions that reported results, some

positive outcomes were seen in reductions in hospital admissions, reductions in emergency department visits, cost reductions, and increases in patient satisfaction, but results were mixed and often not rigorously evaluated. Understanding how to best address social needs to achieve improved health outcomes, patient experience, and cost reductions is a high priority in the health care sector.

Assumptions of Current Approaches

Despite this interest in social needs, it is worth noting that screening, resource connections, and navigation support are largely individual level interventions. The design and implementation of such interventions certainly require procedural changes within health care systems, and new modes of collaboration with partners. But, these interventions are also predicated on several assumptions about the broader systems that frame patients' lives. First, there is an assumption that community-based resources and opportunities exist to meet the social needs of patients. Second, that patients with social needs are in fact eligible for available services. Third, that fulfilling social needs is a matter of providing the necessary resources. The reality may look quite different across communities and areas of need.

The Supplemental Nutrition Assistance Program (SNAP), for example, currently serves about 83% of people who are eligible. But, that figure varies widely across states. From a peak of 47.6 million in 2013, recent declines in SNAP enrollment point to individuals who do not meet stricter, post-recession work requirements being dropped, and those who lack immigration documentation being fearful of having family members who are citizens apply, despite being eligible. Furthermore, disparities in access to healthy foods along socioeconomic, racial, and geographic lines mean that even families who receive SNAP benefits may not be able to meet their nutritional needs.

Or, consider housing insecurity, which has reached crisis proportions for millions of families. For families whose income is at or below federal poverty line or 30% of their area's median income, there is a national shortage of 7.2 million affordable rental units. More than 11 million renter households nationwide are considered severely cost-burdened, paying more than 50% of their incomes toward housing. Federal policy has been criticized for cutting aid to state and local governments to support affordable housing development, and for increasing contribution requirements for low-income families already receiving housing vouchers.

Poverty is deeply entrenched across the United States. Patients struggling to make financial ends meet may be trapped by wage stagnation that disproportionately affects low-income workers. Significant disparities in income and wealth persist along racial and ethnic

lines. Eligibility for cash assistance programs like Temporary Assistance for Needy Families (TANF) varies widely by state, and benefits typically provide only minimal support.

These few examples illustrate how the process of screening and referring patients can break down when larger structural forces are at play. If a patient is eligible for state or federal social services, and if community resources that meet the patient's needs exist (and have funding), it is possible that the system will work for them – the gap was truly one of effective coordination. Or, it is possible that without changes to eligibility criteria, funding mechanisms, or application requirements, patients may fall through the cracks in existing services. However, it is also possible that without addressing underlying social determinants of health – the political and economic structures that determine resource investment, the social structures that foster opportunity or exclusion, the laws that define criminality and justice, the physical environment of communities, and the intersections of structural racism and gender discrimination that frame systems of privilege and oppression – addressing social needs is only a near-term solution.

How can health care systems address social determinants as root causes?

The AHC model's "Alignment" track aims to build community capacity by establishing a "backbone organization" to coordinate community-wide quality improvement efforts, ensure service provision and resource adequacy, and share data to inform gap analyses. Echoing the collective impact literature, such models have gained prominence in addressing complex social and environmental challenges that require innovative collaboration, funding, and evaluation mechanisms. For this approach to work in addressing social determinants of health, AHC model participants must move beyond community-clinical coordination and align around shared goals and priorities driven by community needs. The "backbone" organization must wrestle with questions of how it can function optimally in the inherently trans-disciplinary work it is responsible for driving, and can look to the collective impact literature for how budgets can be leveraged for greater impact. The Alignment track offers an opportunity to invest in addressing root causes – including advocating for systems change and realigning resources towards upstream prevention.

Health care systems can also leverage their funding to improve the use of data across health and human service organizations. The Institute of Medicine has published recommendations for twelve measures of social and behavioral determinants of health that ought to be included in all electronic health records (EHRs). If these recommendations are adopted as part of the certification process for EHRs and objectives for meaningful use, CMS could set high standards for screening for social needs as a condition of payment incentive programs. The use of Z-level codes within the current edition of the International Statistical

Classification of Diseases (ICD-10) to capture social needs also presents an opportunity to align with other sectors.

However, there is tremendous diversity among non-medical organizations, including in monitoring, evaluation, and reporting requirements. Different disciplines may measure constructs of social needs differently, and it is important that leveraging health care funding not automatically impose a medical lens. Evidence already exists for screening methods, evaluation, and longitudinal assessment of progress on a range of social, economic, and behavioral factors. Importantly, assessment can acknowledge the non-linear nature of social needs and focus on assets, not solely deficits. The Data Across Sectors for Health (DASH) initiative focuses on aligning metrics to retain their meaning and significance across disciplines. Health care systems have the chance to utilize information and data sharing to capture the complexity of how social determinants manifest in patients' lives – a powerful tool for advocacy and systems change.

The health care sector can learn from practitioners and researchers in social work, public health, economic development, and community engagement – as well as from patients and community members themselves – and capitalize on innovative payment and financing opportunities that are simply not available in social services. Organizations like Economic Mobility Pathways (EMPath), LIFT, and others have extensive practitioner experience and deep understanding of how poverty and economic instability affect individuals and families, including from a strengths-based perspective. Investment can go beyond measurement and coordination to address knowledge management. Organizations often develop community resource guides in-house, but what if such resources were collectively informed, made accessible by search engine online, and integrated in delivery systems to improve our understanding of the complex pathways to greater health and socioeconomic well-being? Platforms like Aunt Bertha, Healthify, and One Degree exemplify how health care and community organizations develop a more cohesive knowledge management system.

Finally, and arguably most importantly, health care systems can utilize their position, funding, and power to influence policy and advance health equity. Initiatives like DC PACT, the Institute for Healthcare Improvement's Equity Initiative, and THRIVE provide examples of how health organizations can bring a racial equity and social justice lens to their work, including through coalition building, advocacy, and community engagement. With attention focused on reducing health care costs and improving health outcomes, health care organizations have an opportunity to not only address patient's immediate social needs as a means to those ends, but to influence the underlying structure – the true social determinants of health.