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Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity

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Introduction

Efforts to improve health in the United States have traditionally looked to the health care system as the key driver of health and health outcomes. The Affordable Care Act (ACA) increased opportunities to improve health by expanding access to health coverage and supporting reforms to the health care delivery system. While increasing access to health care and transforming the health care delivery system are important, research demonstrates that improving population health and achieving health equity also will require broader approaches that address social, economic, and environmental factors that influence health.

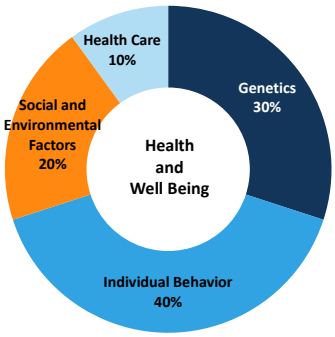
Recently there has been increased recognition of the importance of these factors to health. Moreover, the ACA includes provisions to help bridge health care and community health. It provides for enhanced focus on prevention and primary care, including the creation of the National Prevention Council and a National Prevention Strategy; support for testing and spreading of new delivery and payment arrangements; initiatives to foster increased workforce diversity, and a new requirement for not-for-profit hospitals to conduct community health needs assessments. Reflecting the increased focus and new opportunities provided under the ACA, a growing number of initiatives are emerging at the national, state, and local level to address broader determinants of health. Given Medicaid's longstanding role serving a diverse population with complex health, behavioral, and social needs, efforts to address social determinants of health are emerging through many Medicaid delivery and payment initiatives. This brief provides an overview of the broad factors that influence health and describes emerging efforts to address them, including initiatives within Medicaid.

Determinants of Health

Many factors combine to affect the health of individuals and communities. Despite annual health care expenditures projected to exceed $3 trillion, health outcomes in the United States continue to fall behind other developed countries.[1] Recent analysis shows that, although overall spending on social services and health care in the United States is comparable to other Western countries, the United States disproportionately spends less on social services and more on health care.[2] Though health care is essential to health, research demonstrates that it is a relatively weak health determinant.[3] Health behaviors, such as smoking and diet and exercise, are the most important determinants of premature death (Figure 1).[4] Moreover, there is growing recognition that a broad range of social, economic, and environmental factors shape individuals' opportunities and barriers to engage in healthy behaviors.

Figure 1

Impact of Different Factors on Risk of Premature Death



SOURCE: Schroeder, SA. (2007). We Can Do Better — Improving the Health of the American People. *NEJM*. 357:1221-8.

Social determinants have a significant impact on health outcomes.[5] Social determinants of health are "the structural determinants and conditions in which people are born, grow, live, work and age."[6] They include factors like socioeconomic status, education, the physical environment, employment, and social support networks, as well as access to health care (Figure 2). Based on a meta-analysis of nearly 50 studies, researchers found that social factors, including education, racial segregation, social supports, and poverty accounted for over a third of total deaths in the United States in a year.[7] In the United States, the likelihood of premature death increases as income goes down. Similarly, lower education levels are directly correlated with lower income, higher likelihood of smoking, and shorter life expectancy.[8] Children born to parents who have not completed high school are more likely to live in an environment that poses barriers to health. Their neighborhoods are more likely to be unsafe, have exposed garbage or litter, and have poor or dilapidated housing and vandalism. They also are less likely to have sidewalks, parks or playgrounds, recreation centers, or a library.[9] In addition, poor members of racial and ethnic minority communities are more likely to live in neighborhoods with concentrated poverty than their poor White counterparts.[10] There is also growing evidence demonstrating that stress negatively impacts health for children and adults across the lifespan.[11] Recent research showing that where a child grows up impacts his or her future economic opportunities as an adult also suggests that the environment in which an individual lives may have multi-generational impacts.[12]

Figure 2

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education			Quality of care
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Addressing social determinants of health is important for achieving greater health equity. The presence of health disparities is well established in the United States. Longstanding research has consistently identified disparities experienced by racial and ethnic minority, low-income, and other vulnerable communities. The Department of Health and Human Services defines health disparities as "differences in health outcomes that are closely linked with social, economic, and environmental disadvantage."[13] Healthy People 2020 goes on to state that "health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[14] These definitions recognize that health disparities are rooted in the social, economic, and environmental context in which people live. Achieving health equity—defined by Healthy People 2020 as the highest level of health for all people—will require addressing these social and environmental determinants through both broad population-based approaches and targeted approaches focused on those communities experiencing the greatest disparities.

Addressing Social Determinants of Health

Recently there has been increasing recognition of the importance of social determinants of health. A growing number of initiatives are emerging to address these broader determinants of health and develop integrated solutions within the context of the health care delivery system. In particular, a number of efforts to link health care to broader social needs are emerging through many Medicaid delivery and payment initiatives. The following sections highlight examples of some of these efforts, including initiatives within Medicaid.

Mapping and Place- Based Approaches

A number of initiatives are using geospatial analysis and community needs assessments to guide place-based approaches to address social and environmental factors impacting individual and community health. The importance of mapping and geospatial analysis for assessing and addressing health needs dates back to John Snow's work in 1854 to identify the source of the London cholera epidemic.[15] Today, the importance of the relationship between neighborhoods and health continues to be recognized, with zip code understood to be a stronger predictor of a person's health than their genetic code. As described in the examples below, number of initiatives in place today focus on neighborhoods with social, economic, and environmental barriers that lead to poor health outcomes and health disparities.

One example of these place-based approaches is an initiative in Camden, New Jersey that focuses on high utilizers of hospital care. The population of Camden has a high poverty rate and historically poor access to care, with a high share of emergency department and hospital visits for preventable conditions that are treatable by a primary care provider. Individuals were having difficulty accessing primary care along with a number of behavioral, social, and medical issues. In response to these challenges, the Camden Coalition of Health Care Providers created a citywide care management system to help connect high utilizers of hospital emergency departments with primary care providers. The care management team includes providers and a social worker who connects with patients in the community to help identify and address both their medical and social needs. Results show that patients managed through the initiative have decreased emergency department and hospital utilization and improved management of health conditions. The initiative has also been successful in connecting patients to primary care following a hospital discharge.[16]

The Harlem Children's Zone (HCZ) Project is a multi-dimensional, place-based approach to developing a healthy neighborhood and supporting the healthy development of children from birth to adulthood. The program focuses on children within a 100-block area in Central Harlem that had chronic disease and infant mortality rates that exceeded rates for many other sections of the city as well as high rates of poverty and unemployment. HCZ seeks to improve the educational, economic, and health outcomes of the community through a broad range of family, social service, and health programs. Programs include training and education of expectant parents, full-day pre-K, community centers that offer after-school and weekend programming, nutrition education, recreation options, and food services that provide healthy meals to students. HCZ tracks metrics across its initiatives and reports a 92% college acceptance rate across its programs.[17]

In Colorado, the Colorado Health Foundation is leading an initiative called Healthy Places: Designing an Active Colorado. This initiative aims to reduce obesity by fostering a built environment that supports physical activity and connectivity within three communities. Examples of projects implemented under this initiative include building new parks, playgrounds and walking trails; creating new family-based recreational opportunities; and increasing bicycle and pedestrian infrastructure. [18]

The Healthy Food Financing Initiative is a public-private partnership that has leveraged over $1 billion to support over 200 projects in over 30 states since 2011 to improve access to healthy foods in low-income communities.[19] Pilot studies for the Philadelphia Healthy Corner Store Initiative, now bringing healthier products to over 600 corner stores, showed a 60% increase in the sales of fresh produce. In addition, they demonstrated increased local economic activity and jobs and generation of local tax revenue.[20]

Health in All Policies

Since the early 2000s, there has been a growing movement in the public health community to adopt a "Health in All Policies" approach. This approach recognizes the need to address social determinants of health to improve population health and seeks to ensure that decision-makers across different sectors are informed about the health, equity, and sustainability consequences of policy decisions in non-health sectors. In much the same way that environmental impact assessments allow for evaluation of the environmental impact of policies, health impact assessments evaluate the health impact of policies and practices across sectors that have not traditionally considered their impact on health.

What is Health in All Policies?

Health in All Policies is a collaborative approach to improve health by incorporating health considerations into decision-making across sectors and policy areas. A Health in All Policies approach identifies the ways in which decisions in multiple sectors affect health and how better health can support the goals of these multiple sectors. It engages diverse partners and stakeholders to work together to promote health, equity, and sustainability, and simultaneously advance other goals such as promoting job creation and economic stability, transportation access and mobility, a strong agricultural system, and improved educational attainment.

Source: "Health in All Policies: A Guide for State and Local Governments," American Public Health Association and Public Health Institute, 2013, https://www.apha.org/topics-and-issues/healthy-communities/health-in-all-policies

Policies and practices in areas as diverse as education and early child development, economic and community development, transportation, and agricultural and food policy all have impacts on health and health equity. For example, providing early childhood education programs to children in low-income and racial and ethnic minority communities helps to reduce achievement gaps, improve the health of low-income students, and promote health equity.[21] The availability and accessibility of public transportation affects access to employment, affordable healthy foods, health care, and other important drivers of health and wellness. Policies and practices in food policy can also promote health by supporting healthier corner stores in low-income communities,[22] farm to school programs[23] and community and school gardens, as well as through broader efforts to support the production and consumption of healthy foods.[24]

Health in All Policies approaches are being promoted and implemented at the federal level, by local and state governments, community organizations, and funders.[25] The National Prevention Council, created by the ACA, for the first time brings together senior leadership from 20 federal departments, agencies, and offices around a shared health agenda. Under the leadership of the Surgeon General, the council developed the National Prevention Strategy, identifying collaborative opportunities through a public health lens to advance health and wellness across all federal agencies. Similar approaches are being adopted at the state level. The California Health in All Policies Task Force was established by executive order in 2010 with the goal of bringing together 22 state agencies, departments, and offices to support a healthier and more sustainable California. The task force has developed interagency initiatives focused on crime prevention, access to healthy food, and active transportation.[26] In 2010, King County, Washington, adopted an ordinance that codified bringing a health and health equity lens—a "fair and just" principle—to the county's new strategic plan. Through this prioritization of health equity across all policies, the county has focused on issues ranging from educational attainment and workforce development to affordable transit.[27] National and local funders are also shifting focus to support broader policies and practices that promote opportunities for health. For example, the Robert Wood Johnson Foundation underwent a major strategic reorientation aligned with its vision of building a national "Culture of Health." This vision seeks to look beyond health care to improve population health and change the way the nation thinks about health by focusing on collective impact and cross sector collaboration in areas ranging from early childhood education to food access and community development.[28]

Integrating Social Determinants into Health Care

In addition to the growing movement to incorporate health outcomes and assessments of health impact into other policy areas, there also are emerging efforts to integrate social and environmental needs into the health care system. In particular, a number of delivery and payment reform initiatives within Medicaid address the diverse needs of the population served through an increased focus on social determinants of health.

State Innovation Models Initiative

Through the State Innovation Models Initiative (SIM), a number of states are engaged in multi-payer delivery and payment reforms that include a focus on population health and recognize the role of social determinants. SIM is operated by the Center for Medicare and Medicaid Innovation and provides financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs. To date, the SIM initiative has awarded grants to over half the states to design

and/or test innovative payment and delivery models. As part of the second round of SIM grant awards, states are required to develop a statewide plan to improve population health during the project period.

Most of the 11 states that received Round 2 SIM testing grants include plans to address social determinants of health, and they all plan to establish linkages between primary care and community-based organizations and social services.[29] For example, New York plans to use SIM funds to support the use of public health consultants who will work to spread evidence-based clinical initiatives to improve population health. They also will help providers connect their patients to community and public health resources and services.[30] In Washington State, one of the core strategies in its SIM plan is to "ensure health care focuses on the whole person." The plan calls for methods to integrate care and connect individuals with community services. It also aims to adjust how services are paid for to support care for the whole person. Regional "Accountable Communities of Health" will be formed to coordinate activities and investments across health care providers and health plans, public health agencies, local government, social service agencies, and others with a goal of improving population health.[31] Similarly, Connecticut's SIM plan seeks to promote an Advanced Medical Home model that will address the wide array of individuals' needs, including environmental and socioeconomic factors that contribute to their ongoing health. Its plan also includes community health improvement efforts that will coordinate efforts across community organizations, providers, employers, consumers, and local public health entities.[32]

Medicaid Delivery and Payment Reforms

Given Medicaid's longstanding role serving a diverse population with complex needs, a number of Medicaid delivery and payment reform initiatives include a focus on linking health care and social needs. In many cases, these efforts are part of the larger multi-payer SIM models noted above. Colorado and Oregon are both implementing Medicaid payment and delivery models that provide care through regional entities. These Coordinated Care Organizations (CCOs) in Oregon and Regional Care Collaborative Organizations (RCCOs) in Colorado focus on integration of physical, behavioral, and social services as well as community engagement and collaboration. In Oregon, each CCO is required to establish a community advisory council and develop a community health needs assessment.[33] Early experiences suggest that CCOs are connecting with community partners and beginning to address social factors that influence health through a range of projects. For example, one CCO funded a community health worker to help link pregnant or parenting teens to health services and address other needs, such as housing, food, and income.[34] Another CCO worked with providers and the local Meals on Wheels program to deliver meals to Medicaid enrollees discharged from the hospital who need food assistance as part of their recovery.[35] Similarly, in Colorado, the RCCOs help connect individuals to community services through referral systems as well as through targeted programs designed to address specific needs identified within the community.[36]

Medicaid programs also are addressing broader factors influencing health through the health homes option established by the Affordable Care Act. Under this option, states can establish health homes to coordinate care for people who have chronic conditions. Health home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support, as well as referrals to community and social support services. Health home providers can be a designated provider, a team of health professionals linked to a designated provider, or a community health team. A total of 12 states report that health homes were "in place" in Fiscal Year 2013, 14 states reported having

adopted or expanded health homes in Fiscal Year 2014, and 26 states reported plans to do so in Fiscal Year 2015.[37]

Recently, there has been increased attention on the relationship between health and housing and how Medicaid can support housing. In June 2015, the Centers for Medicare and Medicaid Services (CMS) released an Informational Bulletin that clarifies the circumstances under which Medicaid reimburses for certain housing-related activities with a goal of helping support states in community integration efforts.[38] These include services provided under a range of authorities, including 1915 home and community based services (HCBS) waivers, the new 1915 HCBS option, Section 1115 waivers, and several other authorities. As indicated in the bulletin, while Medicaid funds cannot be used to pay for room and board, Medicaid funds can support a range of housing-related activities, including referral, support services, and case management services that help connect and retain individuals in stable housing.[39] New York has taken further steps by reinvesting savings generated from its Medicaid Redesign initiative into supportive housing. New York sought a waiver from CMS to receive federal match funds for these investments in supportive housing, but it was not approved. As such, the state is providing this support with state-only funds.[40] There also are efforts underway to support housing in Texas through a waiver. Some of the new Regional Health Plan areas established under its waiver have directed funding to support services for individuals in supportive housing or those experiencing homelessness and mental illness.[41]

Provider and Health Plan Efforts

Community health centers (CHCs) can play a key role in addressing social determinants of health given that they serve at-risk and underserved communities with broad needs. CHCs have a long history of meeting both the clinical and non-clinical needs of the patients they serve and collaborating with community and social support services. Building on this role, the National Association for Community Health Centers, in partnership with the Association of Asian Pacific Community Health Organizations, the Oregon Primary Care Association, and the Institute for Alternative Futures, recently launched a new program to implement, test, and promote a national standardized patient risk assessment protocol to assess and address patients' social determinants of health.[42] The protocol is currently being implemented and tested across a range of sites. The Michigan Primary Care Association recently adopted this protocol as part of a new grant-funded, Linking Clinical Care with Community Supports Initiative, under which it will integrate Community Health Workers into primary care teams. These Community Health Workers will assess patients' needs using the protocol, develop individualized patient plans based on the identified needs, and then help connect patients to community and social services.[43]

Some health plans also have efforts to address social determinants of health. Given that social determinants have such a significant impact on health outcomes and health status, managed care plans have incentive to help their members address their broader needs. Some plans have developed specific programs or initiatives to address those needs. The Association for Community Affiliated Plans identified a range of programs and initiatives their not-for-profit safety net health care plans are engaged in to address a broad array of factors, including housing, economic stability, education, and food security.[44] For example, CareSource, Ohio's largest Medicaid MCO, launched a statewide case management strategy in late 2012. As part of this strategy, more than 60 Patient Navigators visited the homes of more than 8,000 high-risk members, many of whom live with diabetes. After learning the challenges these members faced to healthy

eating, the plan partnered with a local community organization to create a portable, diabetic-friendly food bank, which the care management team now uses through quarterly visits with high-risk members to help educate them about their diabetes and disease self-management.[45] In Los Angeles, the LA Care Health Plan opened Family Resource Centers in underserved areas of Los Angeles County. The centers help enrollees understand their benefits and identify available providers. They also offer health screenings as well as free classes on topics such as parenting, asthma, and health management. For the broader community, they help individuals obtain health insurance coverage, provide free health classes, and connect individuals with community organizations and services.[46]

Conclusion

The ACA provides a key opportunity to help improve access to care and reduce longstanding disparities faced by historically underserved populations through both its coverage expansions and provisions to help bridge health care and community health. To date, millions of Americans have gained coverage through the ACA coverage expansions, including many individuals from low-income, racial and ethnic minority, and other vulnerable communities who have faced longstanding disparities in coverage. However, research demonstrates that coverage alone is not enough to improve health outcomes and achieve health equity. There is growing recognition of the importance of not only integrating and coordinating services across providers and settings within the health care system, but also connecting and integrating health care with social supports and services that address the broad range of social and environmental factors that impact individuals' and communities' health and well-being.

Given the importance of social determinants on health and health equity and the new opportunities provided by the ACA, a range of initiatives to address social determinants of health are emerging at the federal, state, local, and provider level. These include initiatives designed to assess and address health impacts in other policy areas as well as efforts to integrate social determinants into the health care system. In particular, many new initiatives within Medicaid include a focus on social determinants, given the program's role serving a diverse population with complex needs. Looking ahead, framing health through a broader context to include factors related to the communities in which people are born, grow, live, work and age and learning from current initiatives will contribute to increased knowledge of how to achieve broader improvements in health and greater health equity.

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