



## Session 1: The Social Determinants of Health

**Social determinants of health are societal, economic, and environmental factors that influence health but are, in some respects, outside the control of the health system.**



**Strategy #1: Invest in community health resources that complement the personal health activities of members**

- Support efforts to increase consumer access to healthy options (ex: fresh food, exercise)
- Invest in preventative care, including school-based prevention models (ex: asthma, smoking)

→ **Many factors combine to affect the health of individuals and communities.**<sup>1</sup> There is growing recognition that a broad range of social, economic, and environmental factors shape individuals' opportunities and barriers to engage in healthy behaviors.<sup>2</sup> While health care is essential to maintaining good health, research shows that health care alone is not a strong determinant of health outcomes.<sup>3</sup> Despite annual health care expenditures projected to exceed \$3 trillion, health outcomes in the United States continue to fall behind other developed countries.<sup>4</sup> Although overall spending on social services and health care in the United States is comparable to other Western countries, the United States spends disproportionately less on social services and more on health care.<sup>5</sup>



→ **Social determinants have a significant impact on health outcomes.**<sup>6</sup> Social determinants of health are "the structural determinants and conditions in which people are born, grow, live, work and age."<sup>7</sup> They include factors like socioeconomic status, education, the physical environment, employment, and social support networks, as well as access to health care.<sup>8</sup>

→ **Housing is a key determinant of health.**<sup>9</sup> Homelessness is a significant barrier to good health. Poor nutrition, inadequate hygiene, exposure to violence and weather-related illness and injury, increased risk of contracting communicable diseases, and the constant stress of housing instability all contribute to the health issues faced by homeless individuals and families. Without housing, simple cuts become infected, routine colds develop into pneumonia, and manageable chronic diseases such as hypertension, diabetes, and HIV become disabling, life-threatening, and costly conditions. Homeless persons die on average 30 years sooner than their housed counterparts.

→ **Violence has direct and indirect impacts on health.** The health consequences of violence can be immediate and acute, long-lasting and chronic, and/or fatal.<sup>10</sup> In addition to the direct effects of physical injury, there can be indirect physical, mental, and emotional effects for victims and witnesses of violence. The observation of violence in childhood has been associated with higher levels of smoking, alcohol abuse, depression, and poorer health in adulthood.<sup>11</sup> Common long-term health consequences of violence against women include chronic pain syndromes; sexual and reproductive health complications; and a greater risk of adverse mental and behavioral health outcomes, including depression, anxiety, and post-traumatic stress disorder.<sup>12</sup>



**Strategy #2: Take a leadership role in establishing and building upon multi-sector partnerships, including social services, housing and health providers, to:**

- Coordinate community health efforts
- Improve primary care delivery to individual/family members
- Invest in opening Family Resource Centers
- Engage consumers where they are and learn from their lived experiences

→ **Personal health and community health are interconnected.** According to the Centers for Disease Control and Prevention, working at the community level to promote healthy living and prevent chronic disease brings the greatest health benefits to the greatest number of people in need.<sup>13</sup> Community health care can complement personal health activities and address the social, economic, and environmental factors that may serve as barriers to individual health and wellness.



**Strategy #3: Develop and utilize community-based care management teams (nurses, social workers, community health workers) to provide in-home care for high utilizers with physical and behavioral health needs**

- Create a “health conductor” role to focus on addressing the social determinants of health with a focus on interventions, awareness, and changes that improve member health outcomes
- Provide behavioral health workers with training in strengths-based, trauma-informed care
- Facilitate connections to primary care providers
- Provide consumers with a bridge to telephonic care to manage health care needs

→ **Addressing social determinants of health is important for achieving greater health equity.**<sup>14</sup> 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.”<sup>15</sup> This definition recognizes that health disparities are rooted in the social, economic, and environmental context in which people live.<sup>16</sup> Achieving health equity will require addressing these social and environmental determinants through both broad population-based health care approaches and targeted health care approaches focused on communities experiencing the greatest disparities.<sup>17</sup>



**Strategy #4: Improve utilization of the Community Health Needs Assessment to identify and assess health needs for members, including the social determinants of health**

- Broaden the definition of health in the Community Health Needs Assessment to more successfully bridge gaps across sectors and bring various partners on board
- Utilize funding from Community Health Needs Assessment to further investment in addressing social determinants of health

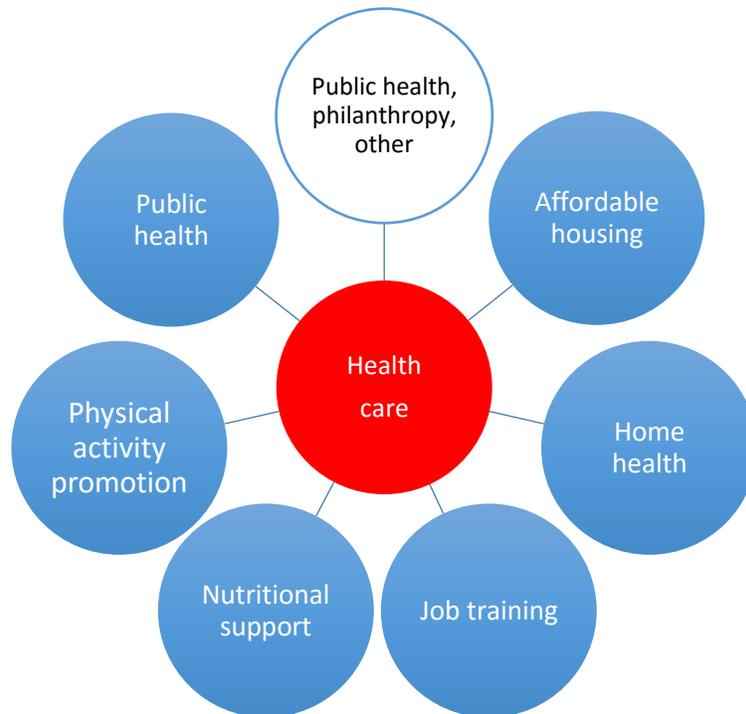


## The Role of Health Care in Addressing the Social Determinants of Health

### Two Models of Coordination to Address Population Health and Social Determinants of Health<sup>18</sup>

The following visuals demonstrate two different models for structuring population health activities to address social determinants of health. Both take the form of a hub-and-spoke, where the hub allocates funding to and coordinates activities of spokes.

#### Health care-centric model



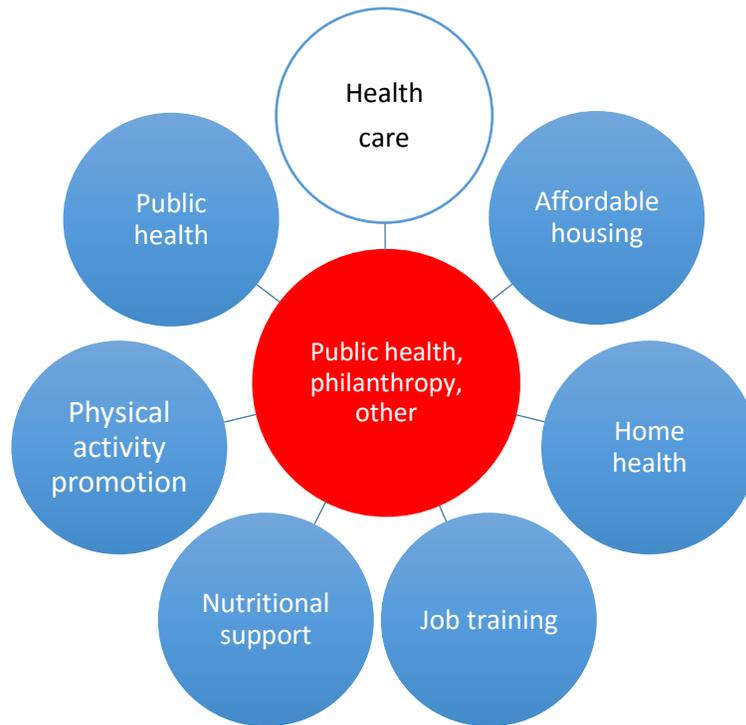
→ **In the health care-centric model**, health care organizations at the hub would contract or manage health promotion activities and social service delivery by purchasing or contracting for these services from community organizations, providing the services themselves, or some combination of these approaches. Health care organizations may be motivated to take on the hub role given the financial risk for outcomes in accountable care and the need to collaborate to achieve improved outcomes in social determinants. Health care organizations also have expertise in structuring and managing contractual relationships with service providers. Additionally, many health care organizations are expanding the focus of their organizations to address the overall health of consumers, including social determinants of health, rather than focusing exclusively on the provision of health care services. For health care providers, accomplishing this goal of addressing a broader definition of “health” may include widening care coordination efforts to include social services.



**Strategy #5: Utilize a hub-and-spoke approach to address the Social Determinants of Health, centralized around Mayor’s Office and with spokes including Fire, EMT, Police Department, Department of Education, Housing Authority, etc.**



## Public health and/or philanthropy-centric model



- **The public health/philanthropy-centric model** offers an alternative vision in which health care organizations would take on the role of a spoke alongside other community actors, leaving another organization to take up the hub position. In some communities, this coordinating role could be played by the local government. In other communities, cross-sector collaborations among a range of different organizations may be explored, with the potential for local foundations or organizations to take the lead in communities.



**There is only one assumption you should make for every patient: Everybody wants to be healthy. We have started looking not just at who the patient is, but what conditions they return to at home.**

**We need to create environments that give people the capacity to be healthy. People cannot be healthy unless they are safe.”**

- Kathleen Reeves, Senior Associate Dean of the Office of Health Equity, Diversity, and Inclusion at the Lewis Katz School of Medicine at Temple University



- **Both hub-and-spoke models are currently in practice in the United States:**
  - In **Baltimore, Maryland**, Bon Secours Health System has taken on a hub role to coordinate population health efforts, focusing on increasing the stock of affordable housing in its neighborhood and helping coordinate the efforts of other organizations to increase access to education, job training, and community activities.
  - Nationwide Children’s Hospital in **Columbus, Ohio** has served as a hub organization in developing a Healthy Neighborhoods, Healthy Families network to address underlying health disparities in the Southside neighborhood adjacent to the hospital.
  - In **Spartanburg, South Carolina**, a local family foundation, the Mary Black Foundation, has taken the lead in a large community health investment project, and has coordinated work among health care organizations, local government, non-profits, and local businesses to improve community health.
  - Some **local public health departments** have used Affordable Care Act-mandated community health needs assessments as runways to longer-term collaboration among health systems and community partners.

**Emerging Efforts to Integrate Social and Environmental Needs into the Health Care System<sup>19</sup>**



**Strategy #6: Expand use of Medicaid to encompass housing as a health need**

- **Leverage Medicaid to pay for outreach and housing support services**
- **Maximize utilization of State Innovation Model (SIM) initiative to address social determinants of health**

→ **State Innovation Model Initiative:** The State Innovation Models (SIM) Initiative is operated by the Center for Medicare & 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. Through the SIM Initiative, several states are engaged in multi-payer delivery and payment reforms that include a focus on population health and recognize the role of social determinants.

→ **The District of Columbia’s SIM Plan** includes the short-term goal of implementing a second Medicaid health home benefit in D.C. (called Health Home 2 or HH2) where primary care providers coordinate and integrate care for high-need residents with certain chronic physical health conditions and social needs that impact health, such as homelessness. D.C.’s long-term goal is to systematically transition to a more cohesive, “whole person” approach to care that is underpinned by alternative methods of payment linked to outcomes.<sup>20</sup>



→ **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.<sup>21</sup>

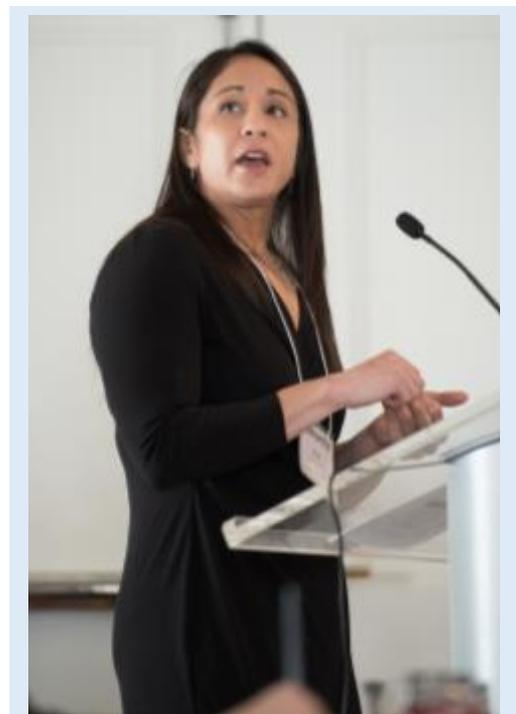


- **Connecticut's** SIM plan seeks to promote an advanced medical home model that will address the wide array of individuals' needs, including environmental and socioeconomic factors that contribute to their ongoing health. Its plan also includes community health improvement efforts that will coordinate efforts across community organizations, providers, employers, consumers, and local public health entities.<sup>22</sup>



**Strategy #7: Identify data and common languages being used across the health care system (hospitals, FQHCs, providers, etc.) and work to establish a standardized framework for data collection**

- **Medicaid Delivery and Payment Reforms:** Given Medicaid's longstanding role serving a diverse population with complex needs, several Medicaid delivery and payment reform initiatives include a focus on linking health care and social needs.
  - **Colorado** and **Oregon** are both implementing Medicaid payment and delivery models that provide care through regional entities. 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.
  - **Medicaid programs** are addressing broader factors influencing health through the health homes option established by the Affordable Care Act. Health home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support, and referrals to community and social support services.



**Strategy #8: Build relationships with care providers and others who can intervene to meet member behavioral health needs and other care needs as they emerge in a seamless and instantaneous manner**

- **Provider 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.

**“Coverage gains under the [Affordable Care Act] provided a strong foundation for moving beyond health care to improve health and advance health equity. This is a new avenue to connect with individuals and address their health needs.”**

- Samantha Artiga, Director of the Disparities Policy Project at the Henry J. Kaiser Family Foundation and Associate Director for the Foundation's Program on Medicaid and the Uninsured



- 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, developed and launched the **Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)**, a tool to help health centers and other providers collect the data needed to address patients' social determinants of health.<sup>23</sup>



**Strategy #9: Utilize a standardized tool that can assess the demographics of communities and needs of members**

- Adapt the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) to assess members for select social determinants of health
- Develop interventions for members based on assessment results

- **Health Plan Efforts:** 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.

- 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 and 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.<sup>24</sup>



**Strategy #10: Create more opportunities like the AmeriHealth Caritas Leadership Convening for cross-sector discussion and planning, supported by individual follow-up meetings**

- Improve coordination of existing cross-sector convenings, task forces, and work groups to continue identifying strategies, move forward on action steps, and track progress
- Bring alternative partners to the table partners that might be willing to give back to the communities that they are impacting (ex: developers, businesses)
- Partner with local leaders to give voice to community needs

<sup>1</sup> Harry J. Heiman and Samantha Artiga, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, (The Henry J. Kaiser Foundation, November 4, 2015), <http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

<sup>2</sup> Heiman and Artiga, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, The Henry J. Kaiser Foundation.

<sup>3</sup> J. Michael McGinnis and William H. Foege, "Actual Causes of Death in the United States," *The Journal of the American Medical Association* 270, no. 18 (Nov. 10, 1993):2207-2212, doi:10.1001/jama.1993.03510180077038 and Ali H. Mokdad et al., "Actual Causes of Death in the United States," *The Journal of the American Medical Association* 291, no. 10 (March 10, 2004):1238-1245, doi:10.1001/jama.291.10.1238.

<sup>4</sup> David Squires and Chloe Anderson, U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries (New York, NY: The Commonwealth Fund, October 2015), [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/oct/1819\\_squires\\_us\\_hlt\\_care\\_global\\_perspective\\_oecd\\_intl\\_brief\\_v3.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/oct/1819_squires_us_hlt_care_global_perspective_oecd_intl_brief_v3.pdf)

<sup>5</sup> Elizabeth H. Bradley and Lauren A. Taylor, *The American Health Care Paradox Why Spending More is Getting Us Less* (New York, NY: Public Affairs, 2013).

<sup>6</sup> Mark R. Cullen, Clint Cummins, and Victor R. Fuchs, "Geographic and Racial Variation in Premature Mortality in the U.S.: Analyzing the Disparities," *PLoS ONE* 7, no. 4 (April 17, 2012): e32930, doi:10.1371/journal.pone.0032930.

<sup>7</sup> Michael Marmot et al., "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health," *The Lancet* 372, no. 9650 (Nov. 8, 2008):1661-1669.

<sup>8</sup> Heiman and Artiga, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, The Henry J. Kaiser Foundation.



- <sup>9</sup> National Health Care for the Homeless Council, "The Health Care for the Homeless Program", Fact Sheet 2013, <http://www.nhchc.org/wp-content/uploads/2011/09/hch-fact-sheet-2013.pdf>
- <sup>10</sup> World Health Organization, "Understanding and Addressing Violence Against Women," 2012, [http://apps.who.int/iris/bitstream/10665/77431/1/WHO\\_RHR\\_12.43\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/77431/1/WHO_RHR_12.43_eng.pdf)
- <sup>11</sup> William H. Foege, "Social Determinants of Health and Health-Care Solutions," Public Health Report 2010; 125(Suppl 4): 8–10, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2882969/>
- <sup>12</sup> World Health Organization, "Understanding and Addressing Violence Against Women," 2012.
- <sup>13</sup> Centers for Disease Control and Prevention, Division of Community Health, "Benefits of Community Health," January 7, 2016, [https://www.cdc.gov/nccdphp/dch/about/benefits\\_community\\_health.htm](https://www.cdc.gov/nccdphp/dch/about/benefits_community_health.htm)
- <sup>14</sup> Heiman and Artiga, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, The Henry J. Kaiser Foundation.
- <sup>15</sup> National Partnership for Action to End Health Disparities: Health Equity and Health Disparities, U.S. Department of Health and Human Services, Office of Minority Health, accessed Oct. 28, 2015, <http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34>
- <sup>16</sup> Heiman and Artiga, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, The Henry J. Kaiser Foundation.
- <sup>17</sup> Heiman and Artiga, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, The Henry J. Kaiser Foundation.
- <sup>18</sup> Lauren Taylor, Andrew Hyatt, and Megan Sandel, "Defining the Health Care System's Role in Addressing Social Determinants and Population Health," Health Affairs (November 17, 2016), <http://healthaffairs.org/blog/2016/11/17/defining-the-health-care-systems-role-in-addressing-social-determinants-and-population-health/>
- <sup>19</sup> Heiman and Artiga, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, The Henry J. Kaiser Foundation.
- <sup>20</sup> District of Columbia State Innovation Model Advisory Committee and District of Columbia Department of Health, "District of Columbia State Health Innovation Plan," July 31, 2016, <https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DC%20SHIP%207%2031%20Final%20Web%20Version%201.pdf>
- <sup>21</sup> Kaiser Commission on Medicaid and the Uninsured, *The State Innovation Models (SIM) Program: A Look at Round 2 Grantees*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Sept. 2015), <http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-a-look-at-round-2-grantees/>
- <sup>22</sup> State of Connecticut, *Connecticut Healthcare Innovation Plan, Executive Summary* (State of Connecticut, Dec. 2013), [http://www.healthreform.ct.gov/ohri/lib/ohri/sim/plan\\_documents/innovation\\_plan\\_executive\\_summary\\_v82.pdf](http://www.healthreform.ct.gov/ohri/lib/ohri/sim/plan_documents/innovation_plan_executive_summary_v82.pdf)
- <sup>23</sup> National Association of Community Health Centers, *Health Centers Addressing the Social Determinants of Health, Protocol for Responding to and Assessing Patients Assets, Risks, and Experiences* (National Association of Community Health Centers, August 2015), [http://www.nachc.com/client//PRAPARE\\_Abstract\\_Tool\\_08\\_151.pdf](http://www.nachc.com/client//PRAPARE_Abstract_Tool_08_151.pdf) and National Association of Community Health Centers, "PRAPARE", 2016, <http://nachc.org/research-and-data/prapare/>
- <sup>24</sup> The Menges Group, *Positively Impacting Social Determinants of Health, How Safety Net Health Plans Lead the Way* (Association for Community Affiliated Plans, June 2014), <http://www.communityplans.net/LinkClick.aspx?fileticket=wcPKMzqiacQ%3d&tabid=214&mid=718&forcedownload=true>

# Social Determinants of Health

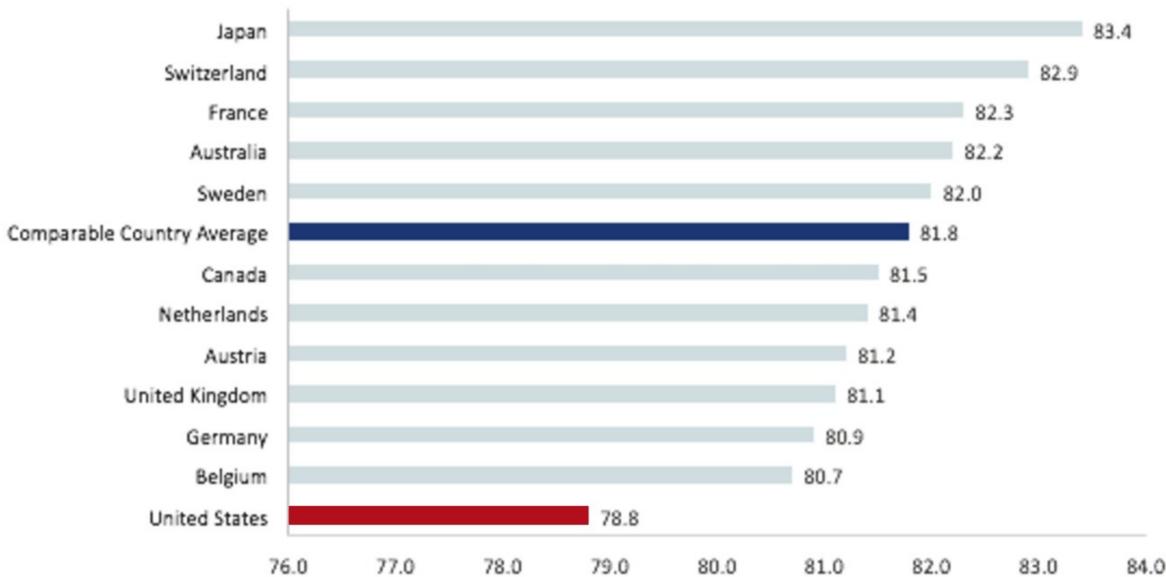
## Session 1



Despite having significantly higher health spending than comparably wealthy and sizable countries, the U.S. lags behind in several measures of health outcomes:

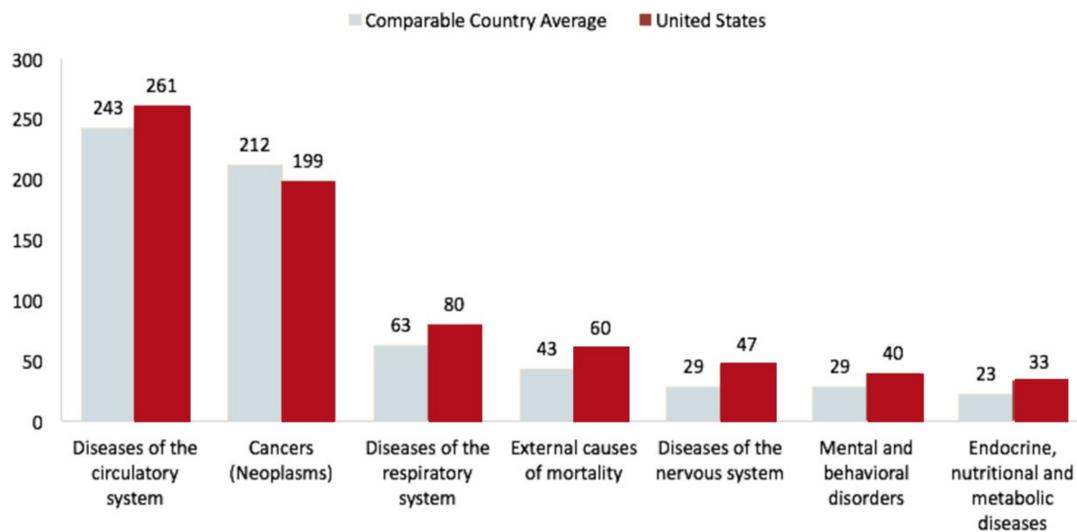
### Life Expectancy

Life expectancy at birth in years, 2013



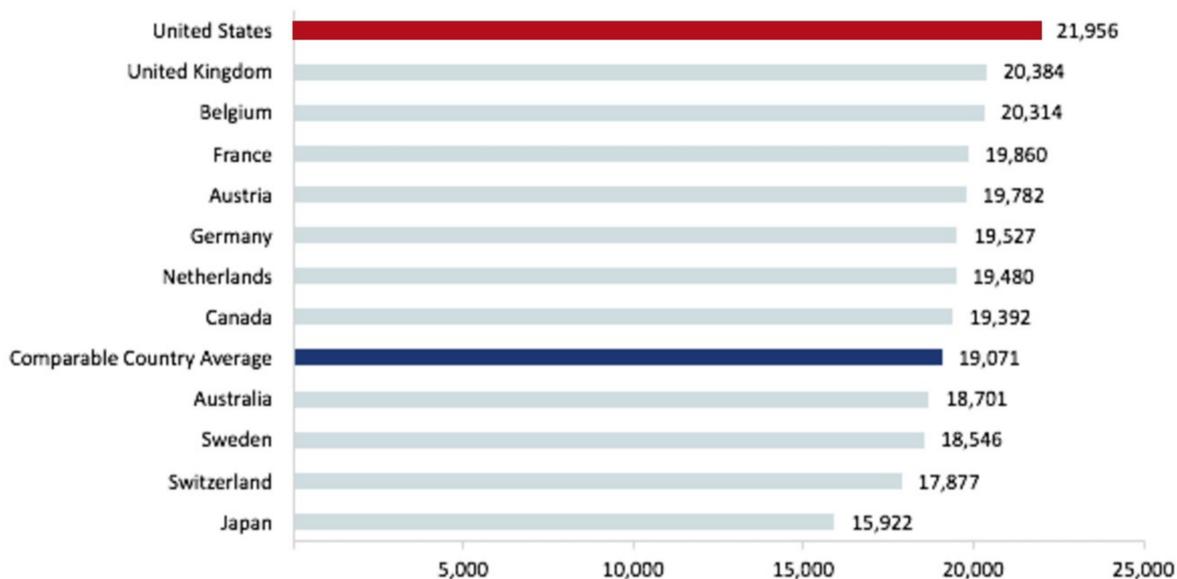
### Mortality

Age-adjusted major causes of mortality per 100,000 population, in years, 2010



### Disease Burden Rates

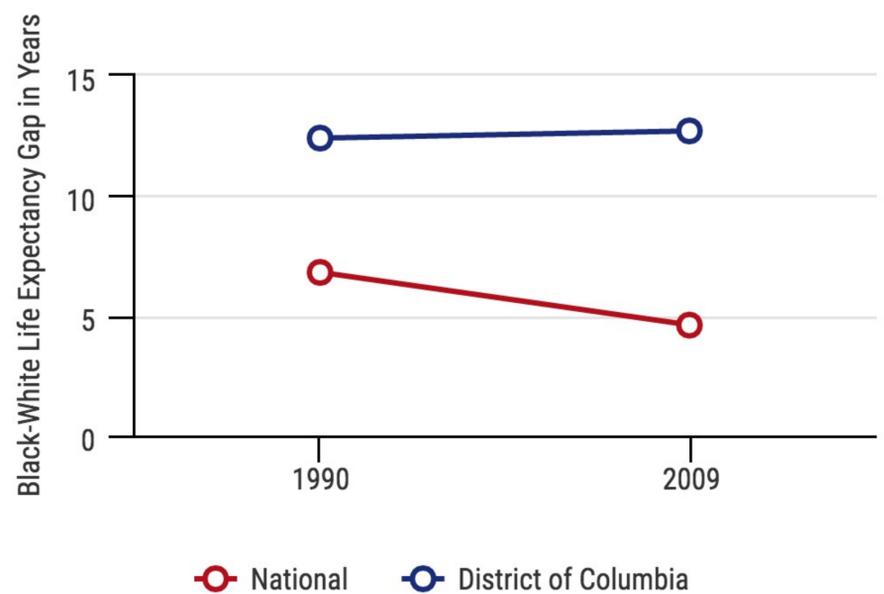
Age standardized disability adjusted life year (DALY) rate per 100,000 population, 2010



### Racial Gap in Life Expectancy

Despite national improvement in decreasing the black-white life expectancy gap between 1990 and 2009, the racial gap in D.C. remained dramatically more unequal than in every other state.

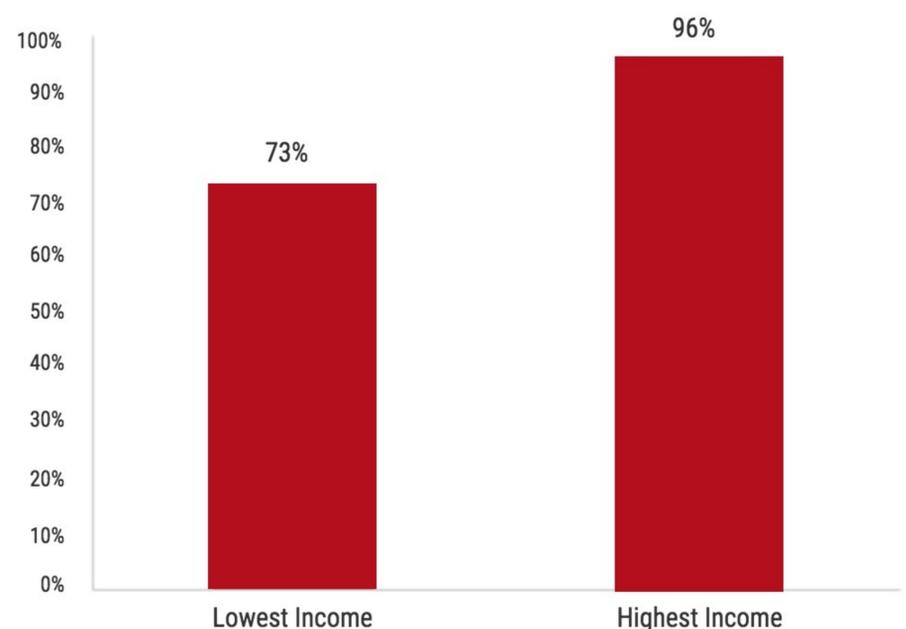
Life expectancy gap measured in 1990 and 2009, weighted by each state's total black and white population



Nationally, the life expectancy gap **decreased by 2.2 years**. In D.C., the life expectancy gap **increased by 0.3 years**.

### Income Inequality

Percent of population age 15+ reporting good health, by income quintile, 2013



Americans with lower incomes are less likely to report being in good health than those with high incomes. The least healthy American counties also tend to have higher rates of unemployment and lower graduation rates.

# Data Sources

## Life Expectancy

Kaiser Family Foundation analysis of 2013 data from Organisation for Economic Co-operation and Development (OECD), "Life expectancy at birth (indicator)." Note: Data for Canada from 2011.

Available at: <http://www.healthsystemtracker.org/2016/02/a-comparison-of-social-determinants-in-the-u-s-and-comparable-countries/>

## Mortality

Kaiser Family Foundation analysis of 2013 OECD data, "OECD Health Data: Health status: Health status indicators," *OECD Health Statistics (database)*.

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## Disease Burden Rates

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Available at: <http://www.healthsystemtracker.org/chart-collection/what-do-we-know-about-the-burden-of-disease-in-the-u-s/?slide=2>

## Racial Gap in Life Expectancy

Sam Harper, Richard F. MacLehose, and Jay S. Kaufman, "Trends in the Black-White Life Expectancy Gap Among US States, 1990-2009," (2014). *Health Affairs* (36)8: 1375-1382.

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## Income Inequality

Health at a Glance, "Perceived health status by income level, 2013 (or nearest year)," (2015). *OECD Publishing*. Accessed through Peterson-Kaiser Health System Tracker.

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