Social determinants of health hugely influence patient outcomes. So providers and payers alike have taken broader approaches to the delivery of care—with promising results.
Health is about much more than health care.

That simple but profound idea is gaining steam among providers and managed care organizations alike, as they rethink how our health care system treats and interacts with patients. A growing body of research shines a light on all the factors beyond the confines of clinical delivery systems that impact a person’s well-being—the conditions where people are born, live, learn, work, play and age. These are the social determinants of health (SDOH): things like financial security, addiction, air and water quality, and access to healthy food.

Increasingly, social determinants are moving toward the center of our understanding of what drives health outcomes and overall well-being. Medical care accounts for only 10-20% of health outcomes, while the remaining 80-90% are rooted in SDOH. Those are sobering statistics to anyone familiar with the U.S. health care system, which is mostly focused on treating illness. Given how many medical ailments begin as nonmedical concerns, this reactive approach—called a “sick care” system by some—can only do so much.

“Think of diabetes, hypertension, obesity and depression. These conditions can be affected by limited access to healthy foods, inconsistent meals and exposure to community violence impacting the ability to feel safe,” says Dr. Fred Hill, senior vice president of population health at AmeriHealth Caritas. “Your mental state impacts your physical health. If you’re constantly worried about financial security or physical safety, it impacts your health status.”

The reality is that SDOH-related challenges are widespread. Nearly 70% of patients have at least one SDOH issue, according to a 2018 survey by the health care technology firm Waystar. Fifty-two percent have a moderate-to-high risk in at least one of the following categories: financial insecurity, social isolation, housing insecurity, addiction, transportation access, food insecurity and health literacy.

Medicaid and Medicare beneficiaries had the largest high-stress share of all patient groups, with one-third of these patients having high stress in three or more social determinants, Waystar found. Patients in this category are 50% more likely to need treatment for chronic conditions. The most commonly reported SDOH issues across all income classes were financial insecurity and social
isolation, though prevalence and severity differed.

“It’s not just those impacted by lower socioeconomic status that have these issues,” Dr. Hill says. “Even at the higher socioeconomic levels, there is significant stress and significant obesity; however, members of the former group are more likely to be negatively impacted by social determinants of health.”

With all this as background, more than 90% of Medicaid managed care organizations report activities to address SDOH, according to the Kaiser Family Foundation. And a growing number of state governments now require Medicaid managed care organizations to screen beneficiaries for unmet social needs and help them address those needs. (Twenty-four did so as of early this year.) Momentum around SDOH extends beyond insurers and governments, though. In July, pharmacy giant CVS announced it would launch a new platform to connect people with social services that can improve overall health. It will be offered in some states to Medicaid beneficiaries and people qualifying for both Medicaid and Medicare.

What’s emerging is a vision of health care that extends far beyond a patient’s relationship to doctors and clinical facilities. It’s a vision that shifts the health care paradigm away from simply treating illnesses as they arise, toward a community-based patient engagement approach that coordinates care between doctors who can address specific medical problems and social service providers who can address broader challenges like food and housing insecurity.

It all raises the question of whether the more than $3.5 trillion ($11,212 per person in 2018) spent on health care in the U.S. could be used more effectively. Indeed, the shift toward addressing SDOH is happening in concert with the health care sector’s shift away from the traditional fee-for-service model and toward value-based care models, which reward health care providers with incentive payments for the quality, rather than the quantity, of care they provide to patients.

But addressing SDOH and achieving related savings can only happen if patients and providers are able to focus on these issues. That can prove challenging, for a few different reasons.

THE FIVE KEY SOCIAL DETERMINANTS OF HEALTH

- Economic stability: employment, food insecurity, housing instability, poverty, etc.
- Education: early childhood development, higher education level, language skill, literacy, etc.
- Social and community environment: civic participation, discrimination, isolation, etc.
- Health care: access to health care and health insurance, health literacy, etc.
- Neighborhood environment: living conditions, access to transportation, crime rate, access to healthy food/clean air/clean water, etc.

Source: Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services
REMOVING BARRIERS

For starters, screening for SDOH-related issues can be difficult. “Patients are often embarrassed to talk about some of the areas that they’re struggling with,” Dr. Hill says. “Lack of food, lack of finances, domestic violence—it’s very difficult to get people to share that information.”

Waystar found that only 22% of patients with SDOH stress have discussed the topic with their physician. Remarkably, of the patients in the “high risk” category, 60% have never discussed it with their health care provider or health insurer.

Patients can also be reluctant about participating in SDOH-screening programs. For a study published in the September/October 2018 issue of Annals of Family Medicine, researchers analyzed screening programs at three separate clinics and found that the majority of patients were not interested in receiving help from clinicians. Only about 20% of patients indicated they would like a clinician’s help in addressing their SDOH condition. This finding echoes the Waystar survey, which found that nearly half (46%) of patients declined to participate in programs and services to help address their SDOH stresses when offered.

There are good reasons for nonparticipation. For example, undocumented people may be hesitant to ask for help, particularly in light of the new rules from the Trump administration that could jeopardize access to green cards for immigrants who use public assistance programs such as food stamps and nutritional assistance programs for Women, Infants and Children (WIC). “Even if they’re eligible for services, they may be fearful of involvement with local, state or federal governments,” says Dr. Laura Gottlieb, associate professor of family and community medicine at the University of California, San Francisco, who was a co-author of the screening program study. Other reasons that many people may choose not to participate in SDOH linkage programs include stigma around receiving public benefits, challenges related to literacy and filling out paperwork, and job obligations that make additional office visits difficult. “Many people are just getting by. They can’t miss a day of work in order to go to the doctor’s office,” Dr. Gottlieb says.

Improving the patient participation process requires a two-fold strategy, Dr. Hill says. “Providers need to actively survey their patients through routine screenings, and then also be able to provide the agency referral resources within the office.”

Dr. Gottlieb says that ensuring providers are comfortable with having conversations about SDOH-related challenges will require a “massive cultural shift. Providers often don’t want to ask about an issue unless they can do something about it,” she says.

AmeriHealth Caritas’ new health care delivery model, the Next Generation Model of Care, aims to provide whole-person health care in part by helping providers connect patients with resources beyond traditional medical services. Building on a long-standing approach to members’ health that addresses physical health, behavioral health and pharmacy needs, the Next Generation Model of Care integrates programs that address the root causes of poverty.

Part of the approach is a program called Let Us Know. “Providers are encouraged to contact us if they identify issues with their
patients so we can assist them in providing resources,” Dr. Hill says. “We have our member services staff trained in social determinants. They have access to our database of resources, so if a provider calls in, whether they call our clinical area or the customer service area, we’re prepared to respond to their needs.”

AmeriHealth Caritas’ focus on addressing SDOH aligns with the federal government’s. The Centers for Medicare & Medicaid Services’ Accountable Health Communities Model, launched in 2017, provides support to community organizations to test delivery approaches aimed at linking beneficiaries with community services that address SDOH.

“We are deeply interested in this question (of SDOH impacts), and thinking about how to improve health and human services through greater integration has been a priority throughout all of our work,” U.S. Secretary of Health and Human Services Alex Azar said late last year. He suggested the administration may take a holistic approach to SDOH care in the future. That could involve increasing flexibility in how a health care organization uses federal funds—for instance, paying rent for a Medicaid or Medicare beneficiary in unstable housing or ensuring a diabetic has access to affordable, nutritious food.

Such moves at the federal level could accelerate movement toward a health care system that takes a broader, SDOH-informed approach to patient engagement.

**BENDING THE COST CURVE**

The move toward SDOH dovetails with efforts by the federal government and the health care sector to control costs. A growing body of research shows that hospitals and other provider organizations can cut costs substantially and improve clinical outcomes by connecting people to services that address SDOH, such as secure housing, financial assistance and healthy food.

“By addressing those needs, you can definitely decrease inappropriate inpatient utilization, inappropriate emergency room utilization and better manage the disease states that directly impact cost,” Dr. Hill says.

One study of Medicaid and Medicare members published in 2018 found a 10% utilization and better manage the disease

More and more states are integrating the social determinants of health (SDOH) into their respective Medicaid programs. About 40 states now incorporate SDOH-related activities into managed care contracts (or Section 1115 demonstration waivers). These encompass a wide range of services, touching on areas like housing, food access and quality, employment, education, transportation and violence/abuse support services.

Exactly how states are attempting to address SDOH via Medicaid varies. But broadly speaking, there is movement toward connecting enrollees to social supports, expanding interventions to address social issues and building networks of community-based organizations—all while evaluating the effectiveness of SDOH-related approaches.

Here is how some state Medicaid programs are evolving:

**STATES OF COVERAGE**

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Here is how some state Medicaid programs are evolving:

Quality care coordination starts with risk assessment of members to better allocate resources according to needs.

- **Ohio** requires managed care organizations (MCOs) to include social determinants and safety risk factors in risk stratification frameworks.
- **Similarly, Michigan** requires MCOs to incorporate social determinants into database processes to improve health management.
- **Wisconsin** requires programs to use a health needs assessment that evaluates socioeconomic barriers facing members—things like housing instability and transportation.

Some MCOs offer a value-added service as a cost-effective substitute for the covered service.

- In **Texas,** “value-added services” can be health care services, benefits or incentives that the state determines will promote healthy lifestyles and improve health outcomes; for example, transportation benefits, cellphones and home health services. Value-added services can be added or removed only by written amendment of the contract.

New technology infrastructure is in the mix in some states to support integration with community-based organizations.

- **Louisiana, Minnesota** and **Arizona** have developed policies to require implementation of health information exchange technologies allowing standardized information to be shared among community-based organizations.
- **Washington** is developing a “clinical data repository” to allow authorized HIPAA entities, including community-based organizations such as housing providers, to share information on common members.

MCO contracts vary in the amount of specificity used to describe SDOH activities. Some are quite specific about services they want addressed.

- **New Mexico’s MCO contracts** contain extensive terms. For example, MCOs are required to maintain a “full-time supportive housing specialist” who provides training to care coordination teams.
- **North Carolina’s contracts** specify social determinant activities in a broad array of categories including: care coordination and management requirements, quality and performance improvement, value-based payment and medical loss ratio calculations. The state also has three specific tools for MCOs to use:
  - the North Carolina Resource Platform, a comprehensive database and referral platform
  - the North Carolina “Hot Spot” Map, which uses geographic technology to map resource needs in the state
  - standardized screening questions about health-related resource needs, such as food, housing/utilities, transportation and interpersonal safety
NEW APPROACH, SAME VALUES

With the goal of reversing the cycle of poverty while improving health outcomes, some organizations are rethinking their model of care, opting instead for a more holistic approach.

As the impact of social determinants of health becomes clear to both health care providers and payers alike, some organizations are rethinking their approach. AmeriHealth Caritas’ new health care delivery model, the Next Generation Model of Care, is one such example. Addressing the social determinants of health is fundamental to the model, which focuses on physical health, behavioral health and social well-being.

“As health care becomes more complex and as those most in need face increasing social barriers to achieving health and wellness, managed care organizations need to be more agile and nimble in addressing members’ specific challenges,” said AmeriHealth Caritas Chairman and CEO Paul Tufano.

As part of the new model of care, the managed care organization collaborates with its community partners on a number of programs that focus on the social determinants of health. In the District of Columbia, the organization partners with Mom’s MealsTM to provide in-home delivery of meals to members with various health challenges. The meal plans are designed to address the specific dietary needs and preferences of the culturally diverse members within the District’s six most prevalent ethnic groups.

In Southeastern Pennsylvania, the group works closely with MANNA, a nonprofit organization that supports the nutrition needs of people with life-threatening illnesses. MANNA provides home-delivery meal service and medical nutrition therapy to members identified by its Care Management team. The program especially benefits members returning home from a hospital stay or coping with multiple health conditions. These people may be unable to shop or prepare meals independently, or may simply need guidance on the best food choices for managing their health.

“By developing strategic partnerships with social service organizations within communities we serve, we can help members and their caregivers address the nonmedical factors that can affect their lives,” explains Dr. Fred Hill, AmeriHealth Caritas’ senior vice president of population health. “We know it’s a nontraditional approach to health care, but it is one that clearly works.”

Research shows that SDOH programs are most effectively executed in tandem with community partners such as local government agencies, social workers, community centers and religious organizations. For example, Maryland’s Health Enterprise Zone Initiative created incentives for providers to take a proactive community-based approach in addressing SDOH. The initiative was implemented by the state of Maryland in 2013 with the goal of improving access and outcomes in underserved communities while reducing costs, ER admissions and hospital readmissions. Primary care physicians and community health workers were deployed to five geographic areas and coordinated care among hospitals, health departments and community-based organizations.

Each area was provided with resources to incentivize health care providers to engage in these underserved communities. The physicians and health workers provided an array of services to residents, paying special attention to diabetes, cardiovascular illnesses, asthma, obesity and behavioral health problems. Health education services, screenings, behavioral health services, dental care and access to relevant social services were also made available.

A Johns Hopkins University study published in the October 2018 issue of Health Affairs found that from 2013 to 2016, the Health Enterprise Zone Initiative was associated with a reduction of 18,562 inpatient stays. This led to a net cost savings associated with a reduction of 18,562 inpatient stays. The study concluded that the savings “far outweighed the initiative’s cost to the state.”

Indianapolis-based Eskenazi Health offers wraparound services designed to address social determinant-related hospitalizations and ER visits. The organization partnered with Indiana University-Purdue University Indianapolis to conduct a study to determine which wraparound services were utilized most often and how effective they were in reducing costs and hospitalizations. For wraparound service patients, dietitian services were the most highly used offering, with 49% receiving counseling from a dietitian.

“There’s room for improvement in basically every link in the chain between the person and the delivery of care.”
This was followed by consultation with a social worker at 29% and behavioral health services at 10%.

According to the study, published last year, from 2006 to 2016 the association between wraparound services and patient outcomes resulted in an estimated cost savings of $1.4 million annually from potentially avoided hospitalizations. The study also found a 7% reduction in the expected number of hospitalizations in the year following the receipt of a wraparound service.

TEAM EFFORT
Governments, providers and managed care organizations are ramping up efforts to address SDOH in ways that improve health outcomes. But there is much change to come—the sector has just begun to grapple with a seismic shift in how health care is delivered to support overall well-being.

“There’s room to improve in how we identify or screen patients and design interventions,” says Melinda Abrams, senior vice president and director of the Commonwealth Fund’s Health Care Delivery Reform Program. “There’s room for improvement in how we structure our payments to encourage and incentivize greater integration of health and social needs. There’s room for improvement in basically every link in the chain between the person and the delivery of care.”

For a paradigm shift to occur around health care and SDOH, fundamental cultural change is necessary, Abrams further explains. Health care clinicians need to view the understanding of health-related social needs as essential to achieving better patient outcomes. Likewise, social service providers need to recognize how things like social isolation or housing insecurity lead to health problems. Ideally, “together in collaboration with the patient, they all need to come up with a comprehensive care plan,” she says.

In the future, a patient’s health care may not be defined and executed solely by one medical provider. “A single clinician cannot do everything,” Dr. Gottlieb says. “Increasingly, I think some payers are trying to provide more case management support, particularly for high-cost, high-complexity cases. We need to shift toward providing patients a health care team, a group of people with complementary skills.”