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Maximizing Federal Investments To Address Social Determinants of Health

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Strengthening Health, Health, Social Determinants of Health

In its response to a request for information from the Congressional Caucus for Social Determinants of Health, CAP outlined challenges in addressing the social and economic conditions that affect health and actions Congress can take to improve them.

A resident-in-training physician gets a high-five from a 5-year-old patient as the patient's mother sits by at a health center in Washington, D.C., February 2012. (Getty/Jahi Chikwendiu/The Washington Post)

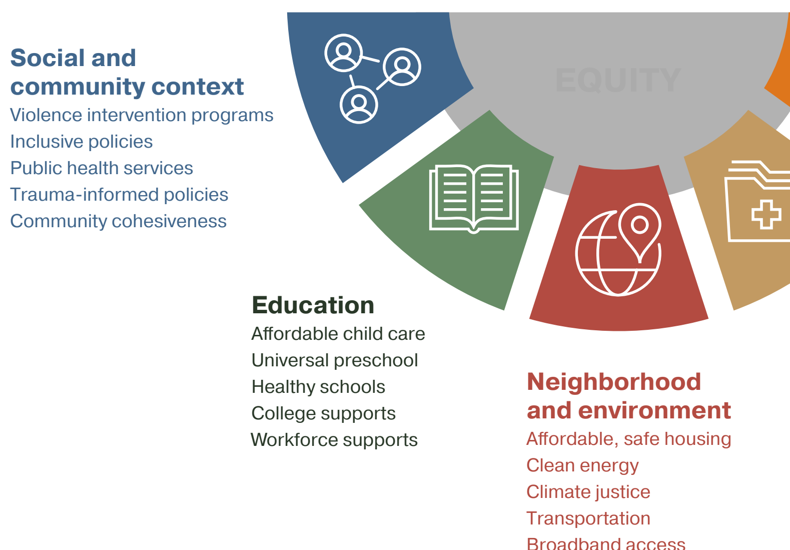
Social determinants of health (SDOH)—the conditions in which people are born, live, learn, work, play, worship, and age—play a major role in people's health and well-being.[1] In fact, many experts agree that social determinants

contribute more to promoting good health than medical intervention.[2] Now, as health continues to decline in the United States compared with other industrialized countries, the need to tackle SDOH has become more urgent than ever.[3] Addressing these social determinants can also improve health and racial disparities by promoting equity across social systems.

There are five major domains of SDOH: social and community context, education, neighborhood and environment, health care, and economic stability. (see Figure 1)

Figure 1

Social determinants of health



In order to inform federal policymaking in this area, the Center for American Progress responded to a request for information by the new Congressional Caucus for Social Determinants of Health, formed in summer 2021.[4] Work around SDOH falls across many congressional committees and federal programs.[5] The caucus recognizes this reality and, therefore, comprises members across different jurisdictions and political parties in hopes of advancing coordination and maximizing federal efforts to improve health outcomes.

In September 2021, the caucus requested feedback on a number of questions around federal opportunities to improve data and coordination, funding, programmatic policies changes, potential partners, and any best practices available to further SDOH work. The full list of questions is available online.[6]

Drawing on expertise across several policy areas that overlap with SDOH, CAP responded to the caucus's request for input on federal government efforts to improve health outcomes and advance social well-being. This issue brief is adapted from the response that CAP submitted to the caucus on September 21, 2021.

Congressional action can help address challenges in improving SDOH

The policy landscape creates the conditions that lead to good or bad health. Without developing policies that address SDOH—such as education, economic stability, health care access, environmental harm, neighborhood safety, and other forms of systemic disadvantage—it is impossible to improve individual and population health outcomes.[7]

It is critical that policy efforts aimed at addressing SDOH also deliberately and explicitly address discrimination at the intersections of race, gender, LGBTQI+ status, and disability.

It is also imperative that policy solutions are targeted to assist marginalized communities. As emphasized by the COVID-19 pandemic, inequities are rampant in nearly every system within U.S. society, and their compounding effects lead to poor health, excess medical costs, reduced productivity, and economic loss.[8] It is critical that policy efforts aimed at addressing SDOH also deliberately and explicitly address discrimination at the intersections of race, gender, LGBTQI+ status, and disability.[9] Some policies that already accomplish this include increasing investments in minority-serving institutions; diversifying the workforce in every sector of social services; expanding inclusive, accessible, affordable services for marginalized communities; and providing funding for community-led projects that advance environmental justice in climate change-affected areas.[10]

In addition to broader policy agendas, addressing SDOH requires policymakers to identify the unmet social needs of individuals and to connect them to services —although the ability to do this is complicated by limited data collection and sharing capabilities as well as limited cross-sectional funding and policy opportunities. Some states have made slow gains in improving coordination among health care providers, social services providers, and public health agencies to meet the needs of families and individuals.[11] However, the ability to expand and scale interventions is limited by the avenues available for funding—for example, Medicaid waivers.

There are several legislative actions that Congress can take immediately to help address SDOH. Indeed, pending legislation has real potential to improve health outcomes. In particular, the caucus should support the Improving Social Determinants of Health Act of 2021 (S. 104/H.R. 379),[12] the Social Determinants Accelerator Act of 2021 (H.R. 2503),[13] the Leveraging Integrated Networks in Communities to Address Social Needs Act (S. 509),[14] the Black Maternal Health Momnibus Act of 2021 (H.R. 959),[15] and the Public Health Infrastructure Saves Lives Act (S. 674),[16] among other pieces of legislation. These legislative efforts provide additional funds to address SDOH and public health; improve technology linking medical and social services providers; extend coverage of social support programs to reduce health disparities; and create more opportunities for interagency collaboration—all of which should be the aim of any SDOH solution. Legislative efforts that prioritize mitigating the effects of climate change and advancing environmental justice also align with addressing SDOH.[17]

Programmatic opportunities to address SDOH exist at the federal level

One of the most significant challenges to addressing SDOH is the siloed nature of approaches to policy and funding at the federal level—and these siloed solutions ultimately trickle down to the state and local levels. Yet addressing SDOH requires making investments in one area to accrue savings in other areas. The distinct funding streams between different social supports hinder collaboration that would actualize financial savings and gains in health outcomes. Cross-agency approaches that combine funding are necessary to go beyond the SDOH screening and case management services currently covered under current Medicaid authorities.[18] An example of this would be utilizing U.S. Department of Housing and Urban Development (HUD) and Medicaid funds to ensure that people have access to healthy, nontoxic, and stable homes as well as the tenancy supports and supportive services needed to remain housed.[19] Federal agencies should also align eligibility and benefits policy across federal health, nutrition, housing, environmental, and social supports to ensure that people are connected to the full range of assistance needed to improve health. This includes sustaining authorities linked to the public health emergency that provided pathways for streamlining eligibility and enrollment processes.[20]

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In addition to cross-agency approaches, other opportunities exist within agencies to address SDOH. For example, the U.S. Department of Health and Human Services (HHS) and Center for Medicare and Medicaid Innovation (CMMI) should develop demonstrations and grant-funded programs that focus on SDOH and improve coordination of services across health and social sectors for vulnerable communities and individuals. In particular, the CMMI can build on its Accountable Health Communities Model, which focuses on the gap between clinical care and community services.[21] Demonstrations should provide flexibility for braiding and blending funds and should employ a longer-term savings time frame. Such programs should link data across service providers to properly measure impact on the health of participants and track cross-sector savings. Data sharing across these programs and demonstrations can also help build on best practices in addressing SDOH.

Underutilized funding opportunities and data challenges undermine improvements in SDOH

There are several opportunities to maximize investment in SDOH. First, federal agencies can make it easier for states to use innovative funding approaches. By providing funding that is more community-focused than disease-specific, federal agencies can facilitate the flexibility needed for states to create models that blend or braid funds under a broadly shared goal such as equity.[22] This would allow states the chance to develop interventions that are not only more holistic in improving population health but also targeted to local needs. Additionally, formalizing cross-agency waiver authority with blended funding to SDOH would

make it easier for states hoping to improve public health.[23] Relevant agencies include the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, HUD, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Environmental Protection Agency, and the U.S. Department of Agriculture. In creating this type of waiver authority, a longer evaluation time frame would be necessary to realize savings and the impact of SDOH improvements on health outcomes.

Value-based payment (VBP) models also provide the needed flexibility to invest in SDOH;[24] by tying financing to overall population health improvements, they create an incentive to invest in social services. A variety of VBP initiatives currently exist across both private and public payers.[25] States are already using certain Medicaid authorities to develop VBP models that address SDOH. For example, North Carolina's Healthy Opportunities Pilots program, set to begin in spring 2022, will use Medicaid funds to cover the cost of approved services related to housing, food, transportation, interpersonal safety, and toxic stress.[26] North Carolina has also developed a platform to facilitate referrals and communication between health care and social service providers.[27]

The use of managed care organizations and accountable care organizations within Medicaid also provides some flexibility needed to address nonclinical needs.[28] Rhode Island's Accountable Entities program, for example, requires provider organizations to screen for and address domains of social need—including housing stabilization and support, education, food security, safety and domestic violence, employment, and transportation.[29] Entities can receive infrastructure incentive funds to help address these unmet needs. However, in the first year, a portion of those funds must be used to develop partnerships with community-based organizations. More flexibility in Medicaid authorities is needed to increase integration of VBP models that advance improvements in SDOH.

While promising, many VBP innovations available through Medicaid reforms are often too short-term to properly track the long-term change associated with investments in SDOH.[30] Additionally, data collection and sharing between health care organizations and social services providers present challenges that limit the ability to fully account for the impact of VBP models.[31] Often, data tools that assess social needs and outcomes are not standardized enough to allow for sufficient data exchange.[32] Different regulatory requirements between health care and social service providers—for instance, the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA)—add to the challenge of data exchange.[33]

Efforts to standardize existing tools and integrate unmet social needs into medical records can help strengthen opportunities to address SDOH. Meanwhile, guidance is needed on how VBP models can work within data privacy statutes across varying sectors.[34] Finally, investments in efforts that expand and standardize data collection across demographic indicators—including but not limited to sexual orientation, gender identity, and race/ethnicity—are also needed to inform interventions targeting SDOH.

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The community benefit requirement for nonprofit hospitals under the Affordable Care Act is yet another avenue for addressing SDOH. Currently, there is a wide array of activities that qualify as community benefit. And in many cases, the requirement is met indirectly through medical training and facility upgrades. However, hospitals in Michigan, Missouri, and Minnesota have used their community benefit funds to create innovative programs addressing social isolation, food insecurity, and more.[35] By providing guidance on how nonprofit hospitals can use community benefit funds for nonclinical services, the federal government can encourage deeper collaboration between the medical sector and the social services sector in order to address unmet community needs.[36] Moreover, the community benefit requirement for SDOH encourages localized efforts that are tailored to the most important needs within the community.

The potential for such tailoring is made more real by the prerequisite that nonprofit hospitals meaningfully engage with their local communities to develop needs assessments.[37] Efforts to strengthen and enforce this community engagement requirement will help preserve the value of including communities as partners in SDOH work, which allows those who are most affected to play a role in identifying needs and developing meaningful solutions to community issues.

SDOH work must include partners across a variety of sectors

Because health is affected by nearly every other social system, nonhealth sector partners are key to addressing social determinants. The work of these partners often sets up the building blocks for good health. To maximize their impact on individual health, however, it is important to develop these partnerships at the outset of any initiative. Some of those key, often underutilized, partnerships are discussed below.

Adequately capturing the voice of a given community is a necessary part of doing work for that community.

Threats of unsafe housing or housing loss, income instability, and deportation lead to toxic stress and poor health outcomes, regardless of medical intervention. To address this, medical-legal partnerships (MLPs) have become increasingly common throughout the country in clinics serving low-income patients. Lawyers serve as invaluable partners in addressing SDOH among adults[38] and are embedded in clinics and accessed through physician referral to

help patients with a variety of legal issues—including evictions, immigration proceedings, and the ability to access public benefits such as unemployment and Supplemental Security Income.[39] These types of partnerships also help to serve the needs of children by securing education accommodations.[40] Data have shown that MLPs not only reduce stress and improve mental and physical health but also lead to fewer missed medical appointments.[41] Likewise, investing in supports to navigate the legal system helps advance housing security, employment, family stability, consumer protection, and public safety.[42]

Even so, funding for these programs is typically temporary and inconsistent, making it difficult to sustain their impact.[43] States such as Colorado and North Carolina are paying for these legal services funds through their Medicaid waiver authority.[44] Additionally, prior partnerships between HHS and the U.S. Department of Justice's (DOJ) Office for Access to Justice—established under the Obama administration—facilitated the integration of legal aid in HHS-funded health centers.[45] However, this office was closed under the Trump administration, and formal federal support for these health center-based partnerships ended.[46] The caucus should consider how to highlight and encourage MLPs while also identifying federal funding opportunities to sustain them, including supporting efforts to reestablish the DOJ's Office for Access to Justice.[47]

Likewise, partnerships with education and child care providers are integral to addressing the needs of children, as healthy childhood development leads to improved health outcomes. One example of such a partnership exists in Oregon, where health care providers and child care centers have a shared goal of school readiness and both conduct regular developmental screenings.[48] These screenings are used to provide follow-up and learning support for families.[49]

Another unique partnership is the Fruit and Vegetable Prescription Program in New York City.[50] This initiative allows doctors and local food vendors to work together to expand access to affordable healthy foods. Participants are given prescriptions that can be used for the purchase of fresh fruits and vegetables. Such efforts that address food insecurity for entire families are multigenerational and comprehensive in improving children's health. Children are affected by their environments in ways that influence both their current and future health.[51] Therefore, improving conditions for caregivers, guardians, and parents means improving the health of children.

Along with these nontraditional partners, there is a continued need for partnerships with social service providers—such as benefit coordinators, housing advocates, reentry and justice advocates, environmental justice advocates and academics, and others. Most importantly, meaningful engagement with the community in need is key to any effort to address SDOH; adequately capturing the voice of a given community is a necessary part of doing work for that community. Therefore, community organizers and activists are invaluable partners in SDOH work.

SDOH work must address the unique needs of families

As stressed above, addressing the needs of families requires a multigenerational approach that accounts for the needs of both adults and children simultaneously. The health and well-being of children is intertwined with that of their primary caregivers. For example, the stress of living in poverty—routinely struggling with economic instability, environmental hazards, food, and housing insecurity—can affect children's brain development.[52] Meanwhile, adverse

childhood experiences, such as experience with and exposure to violence and parental incarceration, are associated with chronic health problems, mental health disabilities, and an increased likelihood of engaging in high-risk behaviors such as substance use and violence in adulthood.[53] Therefore, interventions that address the needs of adults—for example, housing, employment and income, child care, and safety—improve the chances of healthy childhood development.[54]

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Of course, comprehensive reform to child care services and early education access is necessary to address major economic and child development barriers for many families.[55] However, adult-focused efforts such as closing the Medicaid gap, making health insurance more affordable, creating quality jobs with livable wages, supporting nutrition assistance, and promoting housing stability are not to be discounted in conversations of child health.[56] Tackling these interventions concurrently will help create healthy families where children can thrive while also reducing the trauma that leads to negative health and economic consequences downstream.

Conclusion

The coronavirus pandemic has brought to light many issues in the country's social institutions—such as housing insecurity and underemployment, to name a couple—and how deeply linked they are to the ability to remain healthy. With the U.S. health care system strained, it is important to focus on making sure social systems support individuals before illness occurs, particularly for more vulnerable and marginalized communities. The policy and programmatic recommendations outlined in this issue brief can go far to improve the country's approach to social determinants of health. As such, the Congressional Caucus for Social Determinants of Health's and the federal government's work to implement these and other salient recommendations is both necessary and urgent.

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