

# THE SOCIAL DETERMINANTS OF HEALTH: TAKING ACTION BEYOND THE SYSTEM OF CARE



How have hospitals and health systems addressed the social determinants of health?

## Overview

The social determinants of health (SDOH) are defined by the World Health Organization (WHO) as “the conditions in which people are born, grow, live, work and age.” Hospital and health system programs that address the SDOH provide services beyond medical care, such as housing, food and transportation, to manage the upstream causes of adverse health conditions that result in costly downstream utilization of high-acuity health care.

Although provider initiatives are in their early stages, evidence shows that when appropriately funded, planned and executed, these interventions can reduce downstream acute care utilization and improve health outcomes. Providers continue to push the boundaries of how they can address the SDOH by working with diverse community and nontraditional partners to increase the size and scale of their efforts.

As providers and their partners gain experience addressing the SDOH, and as the health care landscape shifts to value-based care, governments, payers and private organizations are likely to increase their financial investments in SDOH programs. Their increased investment will create opportunities for providers to expand their efforts to meet the needs of their communities and achieve their strategic goals.

## Understanding the SDOH

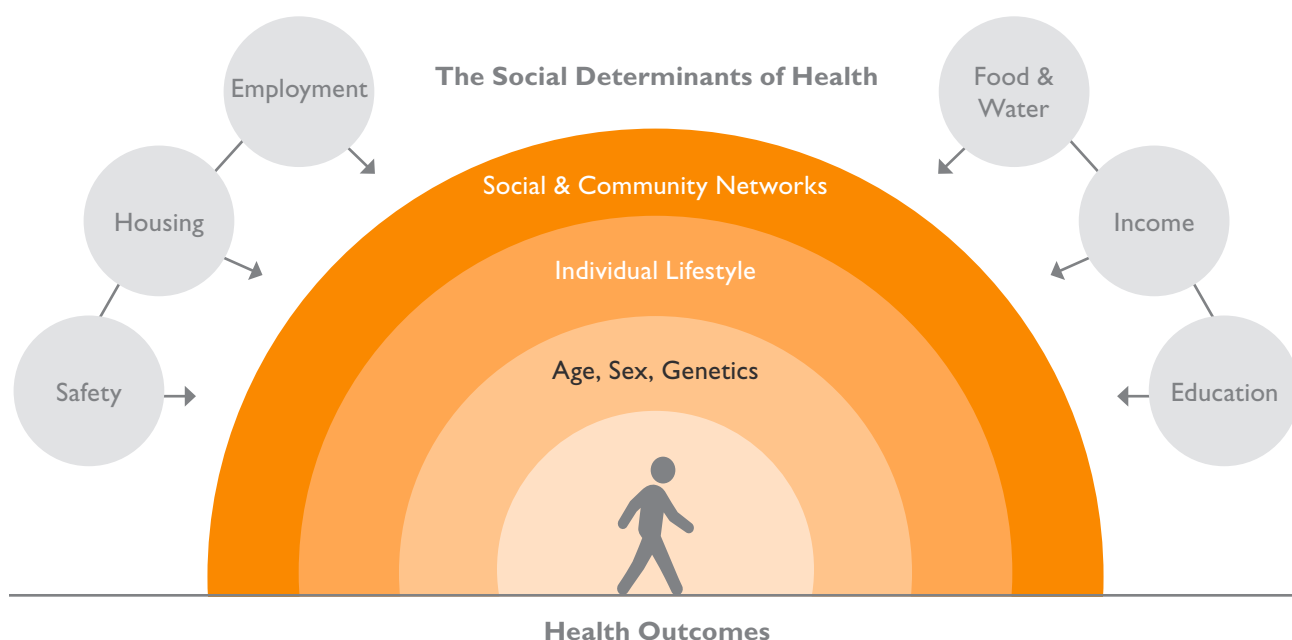
The pathology of disease often, but not always, is understood in a direct, linear way; it begins with an infection, a malfunction or a trauma and progresses to the symptoms of disease. How the SDOH manifest into disease, however, is not always as straightforward. The SDOH, products of broader economic, political, social and environmental forces and systems, are dynamic and affect people in different ways and degrees at various times.

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The effects of the SDOH on human health are real, measurable and observable, as evidenced by health inequities across race, income, age, sex and gender, and legal status that are unexplained by genetics or personal behavior. The SDOH are the main factors responsible for differences in health outcomes across populations, including disability, morbidity, health expenditure, mortality and life expectancy. As shown in Figure I, at any given time between birth and death, an individual's health status is significantly affected by the aggregate positive and negative effects of the SDOH, the impact of which can change throughout one's life.

FIGURE I. THE MAIN DETERMINANTS OF HEALTH



Sources: Göran D and Whitehead M. *Policies and Strategies to Promote Social Equity in Health. Background Document to WHO—Strategy Paper for Europe.* Institute for Futures Studies. 2007; Sg2 Analysis, 2018.

## Why the SDOH Are Relevant to Providers

Addressing the SDOH has traditionally been the responsibility of governments (local, state and federal), nonprofit organizations, philanthropies, community organizations and individuals themselves. However, across the US, many of these traditional actors have been unable to address the SDOH adequately, often owing to a lack of funding. Some state governments have reduced their level of involvement or abdicated their responsibility.

The SDOH have not been areas of focus for hospitals and health systems, whose efforts have mainly focused on the delivery of medical care. However, with their influence as anchor institutions within communities, their level of autonomy and their access to capital, hospitals and health systems can influence the SDOH within the communities they serve.

Clinically, the SDOH are relevant to providers in that their adverse effects can create access barriers and limit the effectiveness of medical care. The mismanagement of chronic disease and overutilization of acute care by underinsured and uninsured populations can overburden facilities, creating inefficiencies that affect health system costs and revenue.



An evolving health care landscape that values the health outcomes of patients while reducing costs and improving patient and provider experiences has pushed providers to assume greater responsibility for patient health outcomes. Health systems that have assumed financial risk under value-based contracts, that operate provider-sponsored health plans or that have undertaken population health initiatives (eg, accountable care organizations) are financially incentivized to mitigate the costs associated with the adverse health effects of the SDOH.

However, several health systems, usually under the direction of an executive or a clinical leader, have taken an increased role in addressing the SDOH to fulfill their mission as health care organizations and meet their commitment to the health and well-being of their communities, especially in underserved areas where policies and efforts by traditional actors have been fragmented, inadequate or unsuccessful. This role reflects the ongoing cultural shift within health care of taking greater responsibility for the overall health of patients.

## The Role of Providers in Addressing the SDOH

Although community and philanthropic initiatives by hospitals addressing the SDOH have existed for decades, these efforts have often been inadequately funded, have lacked performance metrics, or were not tied to patient outcomes or the health system's strategic objectives.

Because the SDOH reach beyond the boundaries of health care, providing necessary care to patients is often insufficient in addressing the root causes of patients' conditions. As such, providers that want to address the SDOH have had to expand the scope of their services beyond providing medical care, with the goal of mitigating or preventing the negative effects of the SDOH.

These negative effects include:

- Overutilization of the emergency department and inpatient care
- Mismanagement of chronic conditions, resulting in acute episodes
- Missed appointments for preventive or wellness care
- Avoidance of necessary urgent care
- Inability to take necessary medications

To address the SDOH, hospitals and health systems have developed programs, projects and initiatives for certain populations. These programs operate with clearly defined objectives that are tracked against metrics and usually involve multiple partners, especially community-based partners located where the target population lives or works. Programs can span multiple departments within the health system but are commonly housed in population health or innovation departments.

## Types of Programs Addressing the SDOH

The complexities of the SDOH and the fact that addressing them is relatively new for most health systems mean devoting limited resources to pilot programs. As such, prioritizing the SDOH to be addressed and identifying the target patient population are key steps. Typically, hospitals and health systems have focused on the populations that have been adversely affected by the SDOH, such as low-income people or the uninsured.

Focusing on 1 health determinant within a select patient population allows for a clearer assessment of the impact of the program. However, because many of the SDOH are interrelated, focusing on only 1 determinant may limit the impact of the intervention. Clearly defined goals for the program will help guide how ambitious the program's efforts should be.

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Some of the SDOH on which hospital and health system programs focus include:



## Housing Instability

Provide referrals to homeless shelters or temporary housing.



## Food Insecurity

Refer patients to community food banks and pantries or provide food directly.



## Transportation

Provide patients with nonemergency medical transport through vouchers or complimentary shuttle services.



## Legal Aid

Provide patients with legal resources through medical-legal partnerships to address problems that may affect their health, such as keeping utilities running in their homes.



## Social Support

Provide counseling, addiction services and home visits for patients who are socially isolated.



## Education

Provide literacy and language classes as well as health education.



## Safety

Mediate interpersonal violence and address safety concerns in communities.



## Employment

Connect patients who are unemployed or have part-time work to employment services.

Efforts to address housing instability, food insecurity and transportation are detailed below.

## Housing Instability

In 2017, [over half a million people were homeless on any single night](#)—approximately one-fifth of whom were children. Housing instability, which includes chronic or temporary homelessness, can cause or exacerbate health conditions, making care management difficult. The chronically homeless face high rates of morbidity, in the form of increased rates of chronic and infectious conditions, such as pneumonia, and increased mortality. Housing instability can also lead to behavioral health conditions and, in children, developmental delays. Furthermore, a lack of stable housing can decrease the effectiveness of health care, as with patients who do not have a place to recover after surgery or to properly store medication.

Programs often refer homeless patients to community organizations, such as homeless shelters. Programs may also develop housing resources, such as short-term transitional housing for homeless patients to recover after an acute episode. In areas that lack housing, programs have developed permanent affordable housing units for homeless individuals who are also high utilizers of care. The goals of housing programs are to reduce ED and hospital utilization, length of stay, and readmissions and to decrease the cost of care for this population.

### CASE STUDY

#### Better Health Through Housing

University of Illinois Hospital & Health Sciences System, Chicago, IL

Following a cost analysis of its patient population, the University of Illinois Hospital & Health Sciences System (UI Health) discovered that approximately 200 of its [chronically homeless patients had an annual per-patient cost in the range of \\$51,000 to \\$533,000](#). In 2015, UI Health's leaders responded to this finding with Better Health Through Housing, a program to provide 25 to 27 chronically homeless people with stable housing and supportive services.

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[Hospital leadership directed \\$250,000 in funding](#) from the hospital's budget to the initial pilot project. UI Health partnered with Chicago's Center for Housing and Health, 27 supportive housing agencies, and 1 outreach agency. The goal of the program was to identify chronically homeless patients who frequently visited the ED, move them directly from the ED into housing and provide a support system to help integrate the patients back into the community.

Patients were usually referred to the program by a provider, after which eligibility was determined by a multidisciplinary team of physicians, social workers and other experts. Once a patient was deemed eligible and accepted housing, he/she was moved into a transitional housing unit while case managers worked with housing agencies to secure a permanent 1-bedroom unit.

**Sources:** American Hospital Association (AHA). Social determinants of health series: housing and the role of hospitals. August 25, 2017; Morrison R and Wojcik A. *Social and Financial ROI: Novel Programs to Recognize and Address Health-Related Social Needs*. UI Health. October 2017.

## RESULTS

Within the first year, the hospital saw a **35% reduction in ED visits** from this population, with a **cost reduction of 67%** for 16 patients after removing 1 outlier who needed end-of-life care. After 2 years, **90% of the individuals** continue to be in stable housing.

## Food Insecurity

According to the US Department of Agriculture, an estimated **11.8% of US households were food insecure at some time in 2017**, meaning they had difficulty providing enough quality food for all household members. Food insecurity can result from an inability to afford food, a dearth of grocery stores nearby or difficulty accessing stores due to a lack of transportation. Chronic food insecurity can lead to obesity and diabetes, whereas malnutrition can increase the risk of hypertension, asthma and anemia. Food insecurity makes it difficult for patients to self-manage their chronic conditions, which can result in increased hospitalizations from acute episodes.

[Programs targeting food insecurity](#) can connect patients with existing resources, such as the Supplemental Nutrition Assistance Program or the Women, Infants and Children program, which only approximately 61% of food insecure households utilize, as well as local food pantries, food shelters and emergency food programs. Some health systems directly provide patients with food through on-site food pharmacies or food pantries or by delivering food to patients' homes. These programs often include nutrition classes that teach patients and family members how to prepare healthful meals.

## CASE STUDY | Fresh Food Farmacy Geisinger Health System, Danville, PA

In 2016, Geisinger Health System in Danville, PA, developed a program known as the [Fresh Food Farmacy](#) to improve the health of diabetic adults in the counties it serves with a diabetes prevalence above the national average. Geisinger first queried its EHRs for adults with a diagnosis of type 2 diabetes and a high hemoglobin A1c level (indicating poor diabetes control).

Geisinger then began screening this population for food insecurity, referring patients who met the criteria to a care team that could "prescribe" healthful food. Patients and their families were given access to a food pantry in one of its clinical centers. Geisinger complements the food pantry access with 15 hours of group classes on diabetes self-management.

**Sources:** Feinberg AT et al. How Geisinger treats diabetes by giving away free, healthy food. *Harvard Business Review*. October 25, 2017; Geisinger Fresh Food Farmacy website. Accessed December 2018.

## RESULTS

Within 1 year, **Geisinger enrolled 80 patients** and their families and provided 10 meals a week for approximately 250 people. Among this population, **hemoglobin A1c levels dropped from an average of 9.6% to 7.5%**, which represents a greater impact on diabetes control than use of medications.

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## Transportation

Reliable and safe transportation is essential for people to access adequate food, employment, education and health care, with an estimated [3.6 million people forgoing medical care each year](#) owing to transportation barriers. [Transportation challenges](#) may be due to place, distance, time, affordability and a lack of transportation infrastructure that may make driving, biking and walking unsafe.

Missed appointments disrupt patient care and, in turn, effective management of patients' chronic conditions, thereby costing the health system revenue. Transportation challenges can also interfere with refilling pharmacy prescriptions. Chronic delays in nonemergency care and a lack of medication access can result in increased utilization of the ED.

Programs that address transportation challenges mostly focus on [nonemergency medical transport for vulnerable populations](#). Some programs partner with taxi, livery or ridesharing companies such as Uber and Lyft, or they enlist volunteer drivers who use their personal vehicles to provide transport. Other programs operate their own complimentary shuttle service for patients or bring care closer to patients in areas where transportation needs are pronounced. Options to bring care closer include operating mobile or community clinics, delivering home care, or providing telemedicine options.

### CASE STUDY | Denver Health—Lyft Collaboration Denver Health Medical Center, Denver, CO

In 2016, Denver Health, a large urban safety-net hospital in Colorado, [collaborated with Lyft](#) to develop a platform for the hospital to order rides for patients who needed transportation. The partnership was initiated after Denver Health's leaders identified a lack of transportation as a primary reason behind high no-show rates for outpatient visits and extended waiting times after inpatient and ED discharge.

Staff are responsible for requesting and tracking a Lyft ride once the patient's discharge is complete. The service costs an average of \$7.40 per ride and is limited to 25 miles. Funding for the program comes from the Denver Health Foundation.

Denver Health found that the program was especially beneficial to patients for whom English is a second language, as it alleviated their stress of having to navigate public transportation to return home.

Source: AHA. Social determinants of health series: transportation and the role of hospitals. November 2017.

#### RESULTS

Within the first 3 months, **Denver Health ordered more than 200 rides from Lyft**. Denver Health recorded zero patient complaints due to lack of transportation, which was a change from receiving daily complaints before the partnership.

## Developing Programs to Address the SDOH

Programs that address the SDOH vary widely in their scope and scale. Certain elements common across programs are essential to their successful development and operation.

### Community Assessment

Assessing the needs of the community is an important first step in understanding health inequities and will help inform providers which patient populations the program should target. Community Health Needs Assessments (CHNAs), which are required for tax-exempt hospitals under the Patient Protection and Affordable Care Act, are a common way for providers to determine the needs of their community. However, CHNAs can fall short of assessing the true needs of a community, which may require providers to take further steps to ensure a comprehensive evaluation of community needs.

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Community assessments also identify the resources that are currently available to the community. Community organizations and programs that address the SDOH, such as food pantries and homeless shelters, may already exist. Identification of resources will clarify the role of the health system in addressing the SDOH and help determine whether patients can be referred to existing services or new resources need to be developed.

## Partnerships

Early establishment of partnerships is essential for building increased support for the program, sharing some of the risks and responsibilities, and gaining competencies that the health system otherwise would have had to build on its own. Partnering with influential community organizations, such as local nonprofits, businesses and schools, is necessary to ensure community support.

Programs also partner with a wide array of philanthropies as well as health departments and other government bodies. These entities can help monitor and evaluate, share best practices, and provide funding through grants.

Novel partnerships with organizations that have a shared interest in addressing the SDOH, including commercial payers, private companies and other health systems, can increase the program's visibility and raise its public profile. The improved public profile can facilitate future efforts to raise more funds or scale the program. Partnerships, such as [West Side United](#) in Chicago, IL, and [NashvilleHealth](#) in Nashville, TN, have brought diverse stakeholders and even competitors together to address the SDOH and improve community health.

Whether the health system is developing resources or referring patients to community partners to address the SDOH, engaging the community at each step of the process is critical to the long-term success of the program. Doing so will help identify the areas of priority for the community, inform program planning and implementation, and help with local fundraising efforts.

Partnerships can be challenging to establish and maintain. The partnership process is rigorous and involves identifying potential partners, establishing rules and responsibilities for engagement, and defining objectives. Partnerships require excellent coordination and clear communication. The process becomes more difficult as the number of partners and the scale of the program grow. Partnerships lacking proper protocols will likely fail to achieve their objectives.

## Patient Screening

Screening for the SDOH is integral for programs to determine which patients they should target and when. Because the SDOH programs are uniquely tailored to specific populations and communities, the setting and context for screening vary widely from program to program.

Some organizations have leveraged primary care appointments or other low-acuity touchpoints to initially screen patients, whereas others screen patients across all their inpatient and outpatient sites of care. Patients can also be screened in nonclinical settings in the community (eg, community health centers, schools, workplaces, home).

Screening can involve patients filling out paper or electronic forms, as well as interviews conducted by clinical or nonclinical staff. A variety of tools are available for SDOH screening, such as the social needs screening tool and resources from the [American Academy of Family Physicians guide](#). Moreover, ICD-10 codes for the SDOH (codes Z55–Z65) exist yet remain underutilized. Training clinicians, ancillary staff and community partners to screen for the SDOH is important to capture the population in need.

Follow-up protocols after a screened patient is determined to be affected negatively by the SDOH are necessary to address the patient's needs in a timely manner. As resources are focused on addressing the SDOH, new screening tools across clinical and nonclinical sites that are better integrated with providers' EHRs may be developed.





## Measurement and Evaluation

Best practices for developing metrics are not well established, as many programs are in their early stages and involve different populations, timelines and funding sources. This diversity is further complicated by a dynamic, challenging and ongoing data collection process that spans clinical and nonclinical sites. Measurement efforts should be comprehensive and focus on [the key indicators](#) that are most important to the community. The appropriate metrics and evaluation criteria depend on which of the SDOH are being addressed, the target population and the goals of the program. Sources of funding such as government grants usually require measurement and evaluation to continue providing funding.

Organizations have looked to various sources to determine what metrics they should use. Metrics can involve national, state, county and city health rankings and measures, information from independent organizations, and information obtained from CHNAs and patient data. [The National Association of County and City Health Officials \(NACCHO\)](#) provides an online resource for health departments on assessing and measuring the SDOH that may be useful to providers, as does the [Prevention Institute](#).

Additional tools are available for hospitals and health systems to assess the potential financial impact of a program or an intervention. One example is the Commonwealth Fund's [ROI Calculator for Partnerships to Address the Social Determinants of Health](#), which may be a useful resource when considering different partnership options for addressing the SDOH. Regardless of the tools used, surveys or focus groups should include the population for whom the program is intended in the development of metrics.

## Funding

Most payers do not reimburse for the services provided by programs addressing the SDOH. Many such programs have been funded through government or private grants or as part of the health system's philanthropic budget. Although grants are an important funding source for pilot programs, organizations have begun to seek alternatives, such as funding from innovation and population health budgets as well as collective funding whereby several organizations invest funds for a common purpose. Recently, private equity firms have begun to infuse capital into organizations that address the SDOH as part of their care model, such as [CareMore Health](#).

As providers become more experienced at addressing the SDOH in pilot programs and as the clinical and financial benefits of these programs begin to materialize, funding from health systems, grants, and public and private payers is likely to increase. This change will be especially true for providers in markets where the shift to value-based care is already underway, because providers can demonstrate to payers the value in improving health outcomes and reducing costly utilization of acute care. An increasing focus on whole-person care from federal agencies may shift health care funding toward addressing the SDOH, specifically for Medicaid.

## Providers That Are Pushing the Boundaries

Despite lack of payment, several health systems have forged ahead and expanded their programs to address more of the SDOH or target a larger population. Some health systems have been more ambitious, trying to mitigate the negative health effects of the SDOH and address the underlying forces and systems that determine the SDOH.

The first case study that follows highlights how one health system, Baylor Scott & White Health (BSW) in Dallas, TX, partnered with the local recreation department to increase access to preventive care while providing services that addressed multiple SDOH. The second case study highlights how ProMedica is pushing the boundaries of what its program can accomplish for the Toledo, OH, community by investing directly into the community and addressing multiple SDOH across its entire patient population.



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## CASE STUDY

### Private-Public Wellness Center Baylor Scott & White Health, Dallas, TX

BSW initiated a private-public partnership with the Dallas Park and Recreation Department to develop the BSW Health and Wellness Center (HWC). The goal of the partnership was to implement upstream strategies that address both the SDOH and access to primary care in a low-income urban food desert with high ED and inpatient utilization rates and poor health outcomes.

BSW HWC consists of a primary care clinic embedded within the campus of a Dallas Park and Recreation Department facility. The clinic has a full-time physician and physician assistant who are supported by a multidisciplinary team that includes a social worker, a nutritionist and community health workers. BSW HWC also has a research and development team and several programs and services that address wellness, prevention and integration of the SDOH into health care delivery. City residents can join BSW HWC for free if they complete a health risk assessment.

The findings show that providing access to primary care with wraparound services addressing the SDOH is associated with significantly reduced ED and inpatient utilization of care and costs.

Source: Wesson D et al. *Health Aff (Millwood)*. 2018;37(4):543–550.

## RESULTS

A 2018 study of 1,055 unique BSW HWC participants found a **21.4% average reduction in ED visits** and a **34.5% average reduction in the cost of ED encounters** after the use of BSW HWC services.

## CASE STUDY

### Comprehensive Community Investment ProMedica, Toledo, OH

While developing their [population health strategy](#), ProMedica's leaders and board realized that the community was struggling to achieve improved health outcomes due to the SDOH. ProMedica's leaders committed to changing the care delivery model by screening all patients for 10 of the SDOH, including lack of housing and education. ProMedica now connects eligible patients with existing community resources or resources it developed that were previously unavailable in the community, such as a food pharmacy and a job training program.

ProMedica began by mapping food deserts. It then invested in real estate for a grocery store in a food desert within downtown Toledo. The grocery store helps address food insecurity and spurs economic development in the area by providing job training to its employees, who reside within a 1-mile radius of the store.

To expand their efforts, ProMedica's leaders realized the need to work with partners in the community. ProMedica first engaged food banks, followed by nontraditional partners such as schools, churches, employers, financial institutions and nonprofit local charities, to examine the gaps in the community and determine where each organization was best positioned to help address them.

In December 2017, [ProMedica appointed a president of the SDOH](#) to oversee a 10-year, \$50 million initiative encompassing housing, education, community development and job creation in Toledo. [ProMedica has partnered](#) with the Local Initiatives Support Corporation and other community partners in Toledo to direct the investment.

Sources: The Governance Institute. *Living the Mission at ProMedica: Innovative Approaches to Improving Community Care*. NRC Health. Accessed December 2018; Local Initiatives Support Corporation. A bold new \$45 million partnership takes aim at the health gap [press release]. March 13, 2018; ProMedica Bixby Hospital. ProMedica appoints president of social determinants of health [press release]. December 7, 2017.

## RESULTS

To date, ProMedica has **reduced ED use by 4%** among patients screened for food insecurity, with a **53% reduction in inpatient readmissions**. Among patients whose screenings suggest they receive access to resources and who then are connected to those resources, **costs per member per month have decreased by 30%**. ProMedica invests less than 1% of the system's overall revenue in work related to the SDOH.



## An Evolving Landscape

Despite numerous financial and operational challenges around addressing the SDOH, the landscape continues to evolve to meet these challenges head on. Multiple-stakeholder partnerships, novel population health models, more sophisticated SDOH data collection and monitoring, and increased resources have contributed to the recent success of pilot programs.

The early success of these programs in select patient populations provides the programs with momentum to continue in the short-term, whereas in the long-term, favorable policy changes, increased involvement from payers and the shift toward value-based care will be necessary to fundamentally change the value proposition of programs addressing the SDOH and allow them to scale. Health systems thinking about developing or expanding a program should consider the following factors that may accelerate the adoption.

## Policy Support

New policies from all levels of government are opening up sources of funding and establishing requirements for screening and addressing the SDOH. In the future, supportive policies are likely to enable the adoption of successful models that can improve community health and lower health care costs by addressing the SDOH.

FEDERAL	STATE	LOCAL
<p><a href="#">Recent federal deregulatory actions</a> will allow Medicare Advantage (MA) plans to use some of their budget, starting in 2019, to provide supplemental benefits to MA beneficiaries with chronic illness. This shifting of funds will be allowed under the condition that benefits “increase health and improve quality of life, including coverage of nonskilled in-home supports and other assistive devices” and “compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable emergency room utilization.”</p> <p>Although the federal government currently restricts how federal funds are used (eg, Medicaid funds cannot be used directly to pay for people’s rent), leaders at HHS and CMS have vocalized their support for diverting funds to address the SDOH. CMS has approved Section 1115 waivers to allow flexibility in how states use their Medicaid funds, as well as Section 1332 waivers for innovative health insurance coverage strategies. CMS has signaled its intention to continue to approve these types of waivers.</p>	<p>States are already implementing changes to the requirements of Medicaid managed care contracts to incorporate the SDOH through Section 1115 Medicaid waivers. With its transition to Medicaid managed care, <a href="#">North Carolina’s recently approved Section 1115 Medicaid waiver</a> will allow the state to use \$650 million for insurers to identify and address the SDOH of high-need Medicaid beneficiaries.</p> <p>Despite current restrictions on the use of Medicaid funds, states are being creative in how they structure their Medicaid programs and use their funds. Through Section 1115 Medicaid waivers, Oregon and Colorado have restructured their Medicaid programs to integrate social services and behavioral health care. In fact, 19 states already require <a href="#">Medicaid managed care plans to screen or provide referrals for social needs</a>.</p>	<p>In addition to actions at the federal and state levels that are channeling greater resources to address the SDOH, efforts at the county and local levels are already underway. Government agencies at the local level have led SDOH initiatives and organized multiple-stakeholder partnerships.</p> <p>For example, since 2012, the Los Angeles County Department of Health Services in California has operated a <a href="#">program that targets homeless people who frequently utilize the county’s health care services</a>. The program, which offers long-term affordable housing coupled with case management services, has been successful in reducing inpatient stays, ED visits and the use of acute behavioral health care.</p>

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## Payers

Payers have a natural financial incentive to reduce preventable utilization of acute care by addressing the SDOH. In fact, many payers already are attempting to address some of the SDOH, including [housing instability](#), [food insecurity and nutrition](#), and [transportation](#). Like providers, payers are experimenting with different partnerships and interventions. The deregulatory actions that give flexibility to MA plans and Medicaid managed care contracts will provide payers with another avenue to experiment with supplemental benefit designs for beneficiaries.

However, payers may lack presence in communities, giving providers an opportunity to take the leading role while demonstrating to payers their ability to address the SDOH. A common interest in reducing medical costs, especially in markets with a higher penetration of value-based care contracts, may provide the basis for partnership opportunities among payers, providers and community organizations.

## Value-Based Care

The onset of payment arrangements for value-based care and the ongoing cultural shift emphasizing the importance of access to high-quality, affordable care have pushed health systems to take on greater responsibility and greater financial risk to address the SDOH of patient populations.

Although the speed of the shift to value-based care has varied across the US, this transition will require effective population health management on the part of health systems. Markets with provider-owned health plans have seen faster rates of adoption of value-based care; these organizations have an incentive to manage cost of care and have the care delivery apparatus to provide high-value care.

The early success of SDOH programs in improving patient health outcomes and decreasing downstream acute care utilization will likely incentivize the integration of these programs into population health management models. The pace of the transition toward value-based care, which will differ across markets, will be a key variable in how quickly these types of programs are integrated into the providers' delivery model for standard care.

## Sg2 Outlook

The inability of traditional actors, such as governments and philanthropies, to address the SDOH has pushed providers to reexamine their responsibility to maintain the health of the people in the communities they serve. Increased pressure from policy makers and health system regulators to control costs as well as increased participation in value-based payment models are pushing providers to focus more on effectively managing chronic disease and preventing the frequent use of costly acute care.

Hospitals and health systems will not be able to address every aspect of the SDOH for all their patients over their lifetimes. However, organizations are increasingly expanding their scope of services beyond medical delivery, working with community agencies, payers and even other health systems to improve the health of their communities. For programs to be successful, they need to be tied to the organization's strategic goals and address the needs of the community.

Developing a program that addresses the SDOH requires expanding the scope of services beyond the System of CARE, first by assessing community needs and resources; then by establishing partnerships with community and other relevant organizations; and finally by developing the proper protocols for screening, coordination, delivery of services, measurement and evaluation. For organizations that already have initiatives in place, expanding efforts to address more of the SDOH across different populations and geographies and to integrate disparate programs are potential next steps in the evolution of their programs.



Increased sources of funding from the government, private payers and venture capital may make addressing the SDOH more financially viable. For providers that have a health insurance plan, that are increasingly taking on financial risk under value-based payment contracts and that are heavily involved in population health management models, addressing the SDOH will be all but necessary in a new value-based care environment.

## Sg2 RESOURCES

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- Expert Insight: Extending Health Care Beyond the Medical Campus—Addressing Social Determinants of Health
  - Expert Insight: Improving the SDOH System of CARE—Lessons From Safety Net Providers
  - Report: *Strategic Partnerships for Tomorrow's Health Care*
  - You Asked: Partnering With Federally Qualified Health Centers
  - You Asked: With the Rise of Medical Rideshare Programs, Access to Care May Improve
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