Social Determinants of Health Caucus – Request for Information

Economic and social conditions – like stable housing, reliable transportation, and access to healthy foods – have a powerful impact on our health and wellness. Known as social determinants of health (SDOH), a focus on these non-medical factors has the potential to improve health and well-being and to increase the government's return on investment in both health and social services programs.

Congressional responsibility for programs to address SDOH is divided among many Committees, while programs addressing health and social needs are splintered across multiple federal agencies. As such, we have convened the bipartisan **Congressional Social Determinants of Health Caucus** to bring together members of Congress from disparate jurisdictions to highlight the opportunities for coordination across programs, to improve health outcomes, and to maximize existing and future federal investments in health, food, housing, transportation, and other important drivers of health. Leadership is needed to break down the barriers that impede better coordination between health and social services programs.

Please share feedback to the following questions on challenges and opportunities, which will be shared with all participants in the SDOH Caucus:

Experience with SDOH Challenges

• What specific SDOH challenges have you seen to have the most impact on health? What areas have changed most during the COVID-19 pandemic?

The social determinants of health that have the greatest impact on the health of the residents of the kinds of communities that safety-net hospitals serve are income/poverty, race, education, immigration status, food insecurity, inadequate housing, exposure to violence, access to health care, and mental health challenges. Homelessness is particularly a problem because it often encompasses many of these challenges.

The COVID-19 pandemic has not so much changed these problems as it has magnified them: the impact of poverty, food insecurity, inadequate housing, limited access to health care, and others have seemed greater in the context of the pandemic. Loss of income has proven to be a particular problem: some residents failed to successfully navigate the path to federal unemployment benefits when they lost their jobs because of COVID-19 and many workers in what might be called the "underground economy," not to be confused with so-called gig workers, did not have access to those benefits at all. The same has been true for those who were concerned about their immigration status, especially when the recently rescinded public charge law was in force and they felt it was a matter of self-preservation for themselves and their families to avoid applying for government aid.

• What types of gaps in care, programs, and services serve as a main barrier in addressing SDOH in the communities you serve? What approaches have your organization, community, Tribal organization, or state taken to address such challenges?

Safety-net hospitals encounter a number of barriers to addressing social determinants of health in their communities. In many places there are not enough providers, especially primary care providers and pediatricians, because low state Medicaid payments discourage such professionals from seeking to build practices in such communities. This is part of a much larger problem: in too many states Medicaid pays so poorly for care that it is difficult to find physicians willing to serve Medicaid patients. This is a problem Congress has the ability to address.

Many of the patients community safety-net hospitals serve are not aware of the various health care and social programs and supports that may be available to them. Such programs come from numerous sources: hospitals, local governments, county governments, state governments, community-based organizations, the federal government, religious organizations, and others. Many communities have many such programs, but finding out that these programs exist and then pursuing access to their benefits has proven to be a real challenge for many who need such assistance.

Several factors impede efforts to identify and pursue such services: literacy, language skills, cultural barriers, lack of transportation, lack of access to day care services, and more. Many residents in search of such assistance often have behavioral health and substance abuse problems that complicate their efforts to seek assistance as well. Compounding this challenge, as noted, is the fragmentation of services: different services offered by different levels of government and different community-based and religious organizations and the lack of formal, effective coordination of such programs.

One approach that we are aware of that has proven helpful in connecting hospitalized patients to other government programs and community-based resources is currently under way in the emergency departments of some NASH hospitals. These hospitals employ care coordinators to work with low-income emergency patients, helping those patients identify appropriate resources for follow-up services, whether that involves directing them to community-based doctors, giving them information about day care programs or food banks or social services or subsidized transportation or other services that the coordinator, based on a conversation with the patient, identifies as those the patients need. Many of these patients are covered by their state's Medicaid program but those programs do not reimburse providers for this service so at least for now, the hospitals are paying for the coordinators themselves. This is not a financially sustainable approach and not an option for many community safety-net hospitals but it reflects a better way of serving people whose lives have been affected by social determinants of health. NASH believes it would be appropriate for Congress to make care coordination, in hospital emergency rooms and perhaps other settings as well, a covered Medicaid benefit for which providers would be reimbursed. Doing so would represent a meaningful effort to employ a new and better approach to addressing social determinants of health.

• Are there other federal policies that present challenges to addressing SDOH?

Other federal policies that present challenges to addressing social determinants of health include the fragmented system of state and federal benefits; different criteria for qualifying for different programs and services; low Medicaid reimbursement that discourages many providers from serving Medicaid patients or practicing in communities with large numbers of Medicaid patients; and HIPAA requirements that in certain situations impede the kind of sharing of information about individuals among services providers that is a key to ensuring that people have access to all of the benefits and services available to them.

• Is there a unique role technology can play to alleviate specific challenges (e.g. referrals to community resources, telehealth consultations with community resource partners, etc.)? What are the barriers to using technology in this way?

Some community safety-net hospitals are located in states that use the "Aunt Bertha" platform. Aunt Bertha has proven to be an effective tool, although limited in some ways. It features lists of local and low-cost and free resources that the public, community-based partner agencies, and providers can pursue. Providers use Aunt Bertha, after screening patient social determinants of health – often using the THRIVE screening tool – to connect patients to resources that can help address their needs. Aunt Bertha also can be used to send electronic referrals to community partners that participate on the site.

Aunt Bertha is not without shortcomings. Community-based partners must claim their page on the site and be active on the site for the referral process to truly be seamless. Participating agencies need better training on how the platform works and how to use it. Some community partners lack the technology to participate as effectively as possible. Privacy concerns also are an issue: when hospitals are involved and patients become part of their network they must respect HIPAA requirements, which means there are limits to the kinds of patient-specific data they can share.

Whether it is Aunt Bertha or some other platform, what is needed is a platform that is more widely used, if not universally. Hospitals cannot make that happen and community-based organizations cannot make that happen. States have limited ability to do it, but ultimately, this is the kind of concept that only the federal government can drive.

Improving Alignment

• Where do you see opportunities for better coordination and alignment between community organizations, public health entities, and health organizations? What role can Congress play in facilitating such coordination so that effective social determinant interventions can be developed?

One way to improve coordination and alignment between community-based organizations, public health entities, and health care organizations is to abandon the current siloed approach and develop joint community health needs assessments and community health improvement plans: a single plan that documents challenges, identifies priorities, and chooses strategies to pursue. Such an approach should include outreach, education, and preventive health care measures. A key to doing this successfully is to improve data collection and, after the data has been collected, foster an appropriate degree of sharing of this data among participants.

• What potential do you see in pooling funding from different sources to achieve aligned goals in addressing SDOH? How could Congress and federal agencies provide state and communities with more guidance regarding how they can blend or braid funds?

Some states have implemented Medicaid 1115 waivers that provide for limited coordination of housing supports and nutrition assistance along with health care. These efforts need to be broader.

The first step in effectively braiding funds is to identify other available funding streams and existing gaps and cliffs between them. Guidance to states and communities should provide detailed information about federal funding sources; examples and case studies of how other states and communities have identified gaps and potentially braidable programs surrounding those funding sources; and information about how states and communities have successfully altered policies to eliminate identified gaps through braiding.

• How could federal programs such as Medicaid, CHIP, SNAP, WIC, etc. better align to effectively address SDOH in a holistic way? Are there particular programmatic changes you recommend?

Federal programs such as Medicaid, CHIP, SNAP, WIC, and others could be aligned more effectively to address social determinants of health through the development of a streamlined system through which one application results in consideration for, and in many cases approval for, participation in some or all of these programs. Currently, depending on the jurisdiction, individuals must apply for some or all of these programs individually. A streamlined application process would reduce the burden associated with pursuing assistance and result in a better, faster, more coordinated approach to addressing the challenges individual applicants face.

Some states already have this but others do not. It also would be helpful for the federal government, either through Medicaid or another mechanism, to underwrite the cost of employing health and social service navigators to help guide patients and clients through this complex system.

• Are there any non-traditional partners that are critical to addressing SDOH that should be better aligned with the health sector to address SDOH across the continuum from birth through adulthood? What differences should be considered between non-health partners for adults' social needs vs children's social needs?

Many people who face challenges as a result of social determinants of health are gainfully employed, and NASH believes their employers could help them at a minimal cost through measures such as encouraging their workers to obtain preventive health services and permitting time off specifically for health visits that does not count against their sick time or earned time off. Employers also should be encouraged to make information available about community-based resources such as affordable housing, food assistance, and especially affordable child care on-site or near the workplace.

• What opportunities exist to better collect, understand, leverage, and report SDOH data to link individuals to services to address their health and social needs and to empower communities to improve outcomes?

Government at all levels and private-sector organizations should work better and more closely to share the resources they have for the benefit of the communities they serve. This should begin with increased and improved collaboration between and among local leaders, community-based groups, public health entities, and health care providers. All of these entities and more, including state and federally funded programs such as Medicaid, FQHCs, PACE programs, and others have data that they could and should share more readily and openly. Those involved in the direct provision of care should use their clinical experience and, when available, results from research to advocate public policies that better meet the needs of those they serve. Public agencies and health care providers should work more closely together on community needs assessments and with the planning that follows based on such assessments. It also would be helpful if providers and agencies of all types used standard screening tools when seeing patients and clients so that the work and objectives of these entities can be aligned based on a common understanding of the challenges their patients/clients face and their objectives for addressing those challenges.

• What are the key challenges related to the exchange of SDOH data between health care and public health organizations and social service organizations? How do these challenges vary across social needs (i.e., housing, food, etc.)? What tools, resources, or policies might assist in addressing such challenges?

Two types of challenges affect the ability of health care providers, public health organizations, and social service organizations to share data on social determinants of health: technical challenges in the transmission of data and the manner in which data is collected.

Typically, data documenting social determinants of health is collected by health care providers within electronic health records (EHRs) in an unstructured format – such as free text clinical notes or in the form of zip codes, missed appointment records, or payment patterns – making it difficult to transmit between organizations in a form that will be usable by the organization receiving the data. Data collected by private-sector service organizations tends to be collected in much less formal ways, often with limited use of technology, making it difficult to share.

A far greater challenge, however, is the data itself, even when it is in a usable form. At this time there are no standards for the collection of such data; different organizations ask different questions and compile data in different ways; definitions of individual data measures may differ from organization to organization; clinical entities tend to focus on collecting clinical data while social service organizations and government entities focus largely on non-clinical data, painting incomplete pictures of the needs of clients and making it difficult to draw conclusion on the origins of individual problems; different organizations use different screening tools – a problem that arises both within types of organizations and across organization types; and HIPAA concerns are a challenge when health care providers are involved. The result is data that leaves gaps in understanding while also, at times, being contradictory, both of which affect the ability of the organizations involved to address the medical, social, and economic challenges their clients/patients face.

Best Practices and Opportunities

• What are some programs/emergency flexibilities your organization leveraged to better address SDOH during the pandemic (i.e., emergency funding, emergency waivers, etc.)? Of the changes made, which would you like to see continued post-COVID?

The COVID-19 emergency has given rise to some changes in the manner in which health care is delivered that help community safety-net hospitals address social determinants of health. Without question, greater use of telehealth, introduced to keep people from congregating needlessly and risking exposure to the virus, has enabled providers to reach physically, socially, and economically isolated patients who might otherwise not have been able to gain access to the care they needed. It has been especially helpful in addressing mental health needs – a major problem among those whose lives have been affected by social determinants of health. NASH supports the permanent easing of many of the pre-pandemic limits on the use of telehealth as a means of serving patients.

• Which innovative state, local, and/or private sector programs or practices addressing SDOH should Congress look into further that could potentially be leveraged more widely across other settings? Are there particular models or pilots that seek to address SDOH that could be successful in other areas, particularly rural, tribal or underserved communities?

NASH would like to see flexible spending programs, currently only available for some Medicaid ACO participants, expanded to include housing and nutrition support to for Medicaid and Medicare participants who meet eligibility criteria.

We also would like to see payers for government programs be given incentives to focus more on preventing medical problems and preventing the existing medical problems of their members from getting worse. Payers also need to do a better job of steering their members who are adversely affected by social determinants of health to low-cost and no-cost sources of assistance – assistance such as nutrition assistance, weight-loss programs, non-traditional therapies, and equipment that can help improve health conditions, such as air conditioners, vacuum cleaners, and air and water filters.

• Given the evidence base about the importance of the early years in influencing lifelong health trajectories, what are the most promising opportunities for addressing SDOH and promoting equity for children and families? What could Congress do to accelerate progress in addressing SDOH for the pediatric population?

NASH believes that one of the best things Congress can do to help accelerate progress in addressing social determinants of health for young people, thereby promoting health equity for children and families, is to improve access to affordable, high-quality early learning and child care programs by funding more and better programs for equal opportunity early childhood care and education. This funding must include resources for higher wages for early childhood educators and caregivers.

Transformative Actions

• Alternative payment models help to measure health care based on its outcomes, rather than its services. What opportunities exist to expand SDOH interventions in outcome-based alternative payment models and bundled payment models?

• A critical element of transformation, particularly for new models of care, is measurement and evaluation. With SDOH in mind, which are the most critical elements to measure in a model, and what differences should be considered when measuring SDOH outcomes for adults vs children?

The best way to know if a program or model is achieving its objectives is to measure its performance. NASH believes that among the changes that can advance this objective are:

- Measure changes in outcomes over time – and more than just a year or two.
- Identify and implement mechanisms to jointly reward health care organizations and communities for outcomes such as lower tobacco use, less obesity, reductions in the prevalence of diabetes, improved high school graduation rates, and other such measures.
- Empower ACOs – with resources – to respond to non-medical member needs such as transportation, housing, and food.
- Develop and implement reimbursement models for community health care organizations and workers.
- Pay for care navigation and coordination.
- Provide the most resources to those communities that face the biggest challenges with responding to social determinants of health and create specific measures to evaluate the effectiveness of efforts to address them.

• How can Congress best address the factors related to SDOH that influence overall health outcomes in rural, tribal and/or underserved areas to improve health outcomes in these communities?

• What are the main barriers to programs addressing SDOH and promoting in the communities you serve? What should Congress consider when developing legislative solutions to address these challenges?

In the experience of community safety-net hospitals, the main barriers to programs addressing social determinants of health are generally those social determinants themselves: poverty/unemployment, low education attainment/literacy levels, language and cultural barriers, and limited access to health care.