Conduent Health
Government Healthcare Solutions

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Getting the Full Picture of Health with Social Determinants

A Foundation for Integrated Service Delivery

Imagine someone living in an extremely rural area. Without adequate transportation to visit a doctor or the health IT infrastructure needed for advanced diagnoses, they may be unable to receive appropriate or timely treatment.

What do we mean by "health"?

Healthcare programs of all types are dedicated to improving health, both for individuals and entire populations. But doing so effectively involves answering a greater question: What exactly is health?

Health is more than an individual's disease state.
Socioeconomic factors including living conditions, nutrition, mental illness, community environment, lifestyle and employment status can affect a person's health as well as their ability to access the care needed to improve it.

In a presentation at the 2014 National Academy for State Health Policy Conference, Elizabeth Bradley, Ph.D., Professor of Public Health at Yale School of Public Health stated that the determinants of the nation's health comprised these components and related percent of impact:

- Genetics: 20 percent
- Healthcare: 20 percent
- Social, environmental and behavioral factors: 60 percent

Non-healthcare issues (often called social determinants of health) are seen in similar proportions as the predominant factor affecting premature deaths in the United States. The J. Michael McGinnis report "The Case for More Active Policy Attention to Health Promotion"[1] reported that social, environmental and behavioral factors comprised 60 percent of the causes for early death, with healthcare contributing only 10 percent. (Genetic factors made up the remaining 30 percent.)

How do social determinants affect a person's health?

How social determinants affect health can be readily observed. For example, a homeless person may have a chronic condition that is exacerbated or even caused by a lack of adequate housing (often further complicated by behavioral health or substance abuse). Or, imagine someone living in a "frontier" or extremely rural area. Without adequate transportation to visit a doctor or the health IT infrastructure needed for advanced diagnoses, they may be unable to receive appropriate or timely treatment.

In both cases, these people could develop more costly medical issues that could have been prevented if the non-medical factors of housing and transportation were addressed in an integrated plan of care that included and addressed socioeconomic factors. The homeless person could be referred to a housing program and taken out of a setting that is detrimental to their health and contributes to their emergency room use. Likewise, a more comprehensive plan of care for the rural member could arrange transportation to a qualified provider or connect them with telehealth services. This holistic approach of leveraging and acting on both medical and non-medical factors can help programs better address the sources of health problems and treat them before more severe and costly conditions can develop.

The Senior Care Options program in Massachusetts coordinates delivery of social support services to patients with chronic conditions and adults with disabilities. The Commonwealth reported that "...hospital days per 1,000 members were just 55 percent of those generated by comparable patients not receiving the program's extended services."

Examples of Social Determinants in Government Programs

Many programs on the federal, state, county and local levels that assist underserved populations are making a difference in patient and member well-being and care by addressing social determinants as well as medical factors. Today there are many examples of government programs that are evolving to deliver services to members holistically by addressing organizational, operational, funding, IT support, workforce and other issues. Rhode Island created the Executive Office of Health and Human Services to manage the organization, design and delivery of integrated health and human services. New York City developed HHS Connect to integrate multiple, disparate data systems and unite fractured client demographic and engagement data. And in Montgomery County, Maryland, the Process and Technology Modernization Program is integrating service delivery models in order to treat clients holistically and cost-effectively.

Medicaid managed care plans have also evolved to treat more than just their members' healthcare needs. For instance, the Health Plan of San Mateo provides supportive housing for individuals transitioning from long-term care facilities back into their communities. The same plan has also provided grant funding to support a county-wide mobile farmer's market, an urban community farm and easily accessible nutritional education.

Across the United States, programs are launching based on expected and real outcomes. In the State of Washington, the Corporation for Supportive Housing (CSH) developed a white paper[2] describing the policy and implementation opportunities available for using its resources more efficiently and improving outcomes for its most vulnerable populations by creating a housing benefit. In that state, those without supportive housing accounted for a disproportionate share of healthcare costs.

Washington's Fiscal Year 2012 data show that 1,412 people with housing needs had average annual healthcare costs of $107,959 per person. CSH believes that the state "is well-poised to create a supportive housing services benefit" and that "state agencies have recognized supportive housing as a tool for improving care, improving health and reducing costs...Stakeholders across the state are increasingly engaged in an effort led by the Washington Low Income Housing Alliance to create a Medicaid supportive housing services benefit."

Massachusetts has experienced positive results, reporting that its coordinated efforts to identify and meet the social needs of patients can lead to lower healthcare use and costs as well as better outcomes for patients. Its Senior Care Options program coordinates delivery of social support services to patients with chronic conditions and adults with disabilities. The Commonwealth reported that "...hospital days per 1,000 members were just 55 percent of those generated by comparable patients not receiving the program's extended services."[3]

There are also results of addressing the social determinants of health are coming from outside the United States. For example, in India there was such an effort from April 2005 to March 2012 in 18 states and 264 districts that were identified on the basis of poor health and demographic indicators. State/District Health Missions, Village Health, Sanitation and Nutrition Committees, and Village Health and Nutrition Days focused on other determinants of health, especially nutrition and decentralized action. In urban states with larger populations, the Infant Mortality Rate fell by 15.6 points between 2004 and 2011 in rural areas and 9 points in urban areas. Similarly, the maternal mortality rate in those states declined by 17.9 percent compared to 14.6 percent in other states.

Integrating Social Determinants into Service Delivery

It can be a daunting undertaking to address the issues associated with integrated care, from how to organize it through the delivery of services to program members. But it is not impossible.

A Commonwealth Fund issue brief[4] listed coordinating mechanisms for managing collaboration across services and data-sharing tools as two of the keys to successful integrated service delivery. The third key was implementing “payment and financing methods that support and reward effective service integration.”

It may also seem impossible to collect and disseminate the socioeconomic and medical data needed for these comprehensive plans of care and coordination. However, most of the data has already been collected; it is just spread out among agencies – not only in Medicaid and CHIP programs, but also in TANF, SNAP, WIC, LIHEAP and other state programs, as well within county and local programs. Integrating this data across health and human services programs is also possible, and there are several ways to accomplish it.

States can leverage existing human service program infrastructures, use MMIS or All Payer Claims data, expand or implement health information exchanges, use public health data or other existing assets to gather and share data on both medical and non-medical factors. The 2014 Tech America white paper entitled “The Role of Data in Health Care Reform”[5] contains many examples of how data can be used across programs.

Adopting a holistic picture of needs and required services will help ensure that states deliver better outcomes for their citizens with appropriate services and expenditures. In today’s environment of more complex populations receiving services, this expanded view of the individual can ensure that their health is the best it can be so that resources used to provide health and human services can provide the greatest good possible.

References

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