Proposal: CDC Capacity-Building Support of Local Partnerships to Address Social Determinants of Health

Social and economic conditions such as those in housing, employment, food security, and education have a major influence on individual and community health.[1] These conditions – often referred to as the Social Determinants of Health (SDOH) – are receiving increased attention from insurance companies, hospitals, healthcare systems, and governmental agencies interested in improving health outcomes and controlling costs.[2] In 2018, U.S. Secretary of Health and Human Services (HHS), Alex Azar, highlighted the necessity of addressing social determinants of health in HHS's work, including at the Centers for Medicare & Medicaid Services (CMS).[3] For example, the CMS Innovation Center's Accountable Health Communities (AHC) pilot program funds 31 health systems to identify unmet health-related social needs of their patients and create referral mechanism to address them.[4] Its goal is "testing whether systematically identifying and addressing the health-related social needs of CMS beneficiaries will impact health care costs and reduce health care utilization."

However, while clinicians can identify non-medical social needs and make referrals to other organizations, they cannot ensure that there are adequate resources and policies in place to meet the needs of the referred. In addition, many of the social determinants that are being supported by health care systems are short term – temporary housing, nutrition, or transportation – and do not necessarily address the underlying economic and social factors in communities beyond the individual patient.[5] AHCs and other payer-supported models need support from public health and other sectors to create the communication mechanism, collaborations, programs, and policies to assure that patients' social needs are met. Public health departments are uniquely situated to build these collaborations across sectors, identify SDOH priorities in communities, and help address policies that inhibit health (see Figure 1).

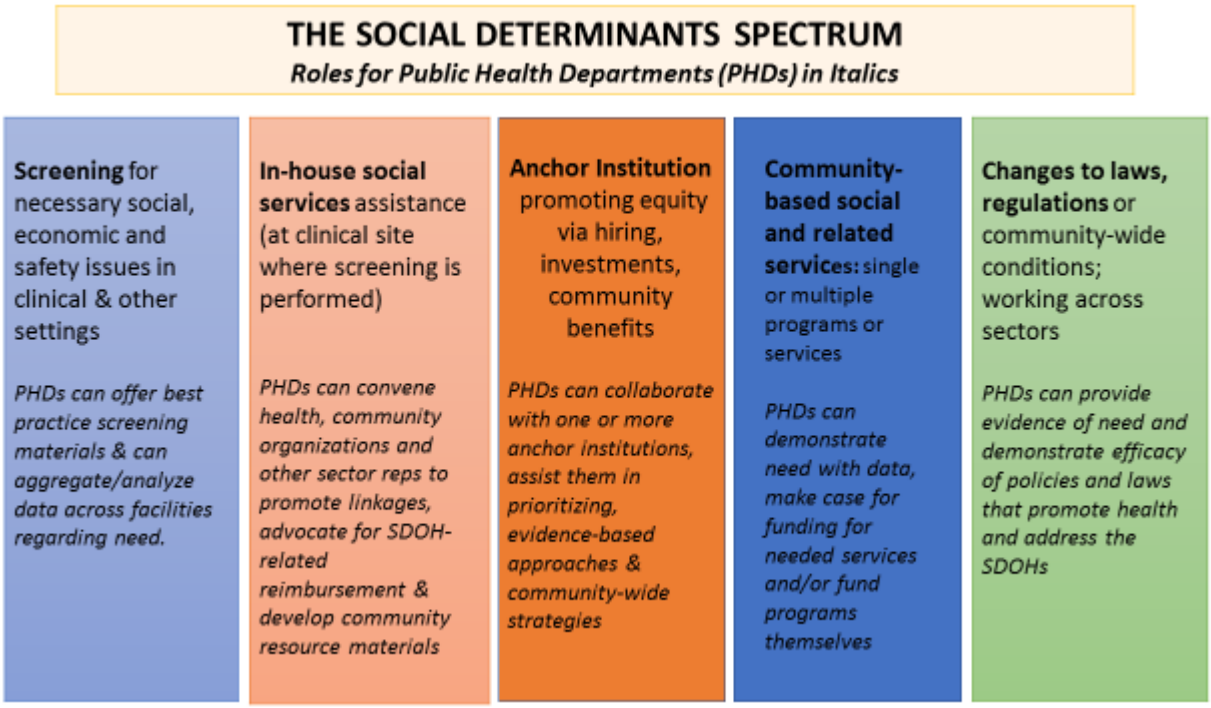

Figure 1. Source: Trust for America's Health

Authorization and Appropriations

Authorize and fund a CDC program to support local and state public health or other appropriate agencies to convene across sectors, gather data, identify priorities, establish plans, and take action steps to address unmet non-medical social needs and underlying community conditions such as those related to housing, food, utilities, safety, and transportation.

The goals of the program would be to improve health outcomes and reduce health inequities. The program could support the following action steps:

1. *Develop local and state partnerships between public health agencies, healthcare systems (such as those supported by CMS's AHC grantees), and other stakeholders to identify and address social needs of patients and communities and opportunities for collaboration,*

2. *Convene relevant local and state organizations, agencies, community-based organizations and coalitions and policymakers from multiple sectors to review, plan and implement community-wide interventions strategies to advance health-promoting social conditions, and*

3. *Enable CDC to provide national training and technical assistance to grantees and other interested parties in the evidence-based approaches to improving health, reducing inequities and reducing healthcare costs by addressing social determinants.*

Eligible organizations could include local and state health departments and others deemed appropriate by CDC. In addition, CDC would be authorized and funded to promote and coordinate the SDOH work across the agency.

Currently, most local and state health departments lack funding and tools to support these cross-sector efforts and are limited in doing so by disease-specific federal funding. Given appropriate funding and technical assistance, more communities could engage in opportunities to address social determinants of health that contribute to high healthcare costs and preventable inequities in health outcomes.

Citations:

[1] Taylor, L et. al, "Leveraging the Social Determinants of Health: What Works?" Yale Global Health Leadership Institute and the Blue Cross and Blue Shield Foundation of Massachusetts, June 2015 https://bluecrossmafoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf

[2] See Social Interventions Research & Evaluation Network (SIREN) at University of California, San Francisco for evidence of effective programs for identifying and addressing social risk in healthcare settings. https://sirenetwork.ucsf.edu

[3] Azar, AM. The Root of the Problem: America's Social Determinants of Health. *HHS*. November 14, 2018. https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the_-root-of-the-problem-americas-social-determinants-of-health.html

[4] Accountable Health Communities Model." CMS. 2019. https://innovation.cms.gov/initiatives/ahcm/

[5] Castrucci, B. & Auerbach, J. "Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health." Health Affairs Blog. January 16, 2019. https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/