

### Social Determinants of Health (SDOH) Program

# Centers for Disease Control and Prevention (CDC) National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) FY 2024 Labor HHS Appropriations Bill

	FY 2022	FY 2023	FY 2024 President's Request	FY 2024 TFAH Request
Social Determinants of Health	\$8,000,000	\$8,000,000	\$100,000,000	\$100,000,000

#### **Background:**

Non-medical factors that impact a person's health—often referred to as Social Determinants of Health (SDOH) — such as housing, employment, food security, education, and transportation, have a major influence on individual and community health. These factors are estimated to contribute 80-90 percent to a person's health outcomes, while healthcare only accounts for 10-20 percent. For example, a person may not be able to eat healthy because they cannot afford nutritious foods or because there are no nearby grocery stores. In turn, this raises a person's risk of several health conditions, such as obesity, heart disease, and diabetes.

Payers and healthcare systems are increasingly starting to screen, identify, and make referrals to other organizations for patients' non-medical social needs but are not necessarily addressing the underlying economic and social factors in communities beyond the individual patient.<sup>3</sup> While healthcare focuses on treatment of disease, public health increasingly focuses on social determinants of health to prevent disease and promote optimal health. A recent study on health care entities collecting non-medical needs data demonstrates that more work is needed to standardize SDOH data and increase cohesion for referrals to community services.<sup>4</sup> Health departments and public health organizations are uniquely situated to do this work by gathering data from multiple sources, identifying gaps in services, building collaborations across sectors (including with the healthcare sector) and with community-based organizations, and addressing policies that inhibit overall health and well-being (see figure). Public

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Roles for Healthcare	Screening for necessary social, economic, and safety issues in clinical & other settings	In-house social services assistance (at clinical site where screening is performed)	Anchor institution promoting equity via hiring, investments, community benefits	Community-based social and related services: single or multiple programs or services	Changes to laws, regulations or community-wide conditions; working across sectors		
Roles for Public Health Departments (PHDs)	PHDs can offer best practice screening materials and can aggregate/ analyze data across facilities regarding need.	PHDs can convene community organizations and other sectors to promote linkages, develop materials & advocate for SDOH-related reimbursement.	PHDs can collaborate with one or more anchor institutions, assist them in prioritizing, evidence-based approaches & community-wide strategies.	PHDs can demonstrate need with data, make case for funding for needed services and/ or fund programs themselves.	PHDs can provide evidence of need and demonstrate efficacy of policies and laws at promote health and address the SDOHs		

health's expertise in working across sectors and partnering with communities can ensure that programs have the greatest impact possible.

## **Impact:**

Given appropriate funding and technical assistance, more communities could engage in opportunities to address social determinants of health that contribute to higher healthcare costs and preventable inequities in health outcomes. For FY 2022, CDC is funding 36 jurisdictions to develop plans to help accelerate proven public health actions to prevent and reduce chronic diseases. To build the evidence base for future SDOH work, CDC evaluated existing multi-sector coalitions that are working to advance health equity through SDOH-centered solutions. In a first-year evaluation, CDC found that of 42 SDOH community partnerships evaluated, 90% of them contributed to community changes that promote healthy living. Of the 29 partnerships that reported health outcomes data, their programs are projected to save \$644 million in medical and productivity costs over 20 years.<sup>5</sup>

Map: 2022-2023 Award Recipients

Closing the Gap With Social Determinants of Health Accelerator Plans



TFAH proposes building on this initial investment by appropriating \$100,000,000 in funding to support the implementation of a Social Determinants of Health program with goals to:

- 1) Increase capacity of public health agencies and community organizations to address social determinants of health in communities;
- 2) Award grants to local, state, territorial and tribal, public health or other appropriate agencies to support interventions promoting better health with culturally tailored interventions to reduce health inequities in communities.
- 3) Award grants to nonprofit organizations, institutions of higher education, and other

groups to conduct best practices research, provide technical assistance, and disseminate best practices.

4) Improve health outcomes and reduce health inequities by coordinating social determinants of health activities across CDC;

Over 480 organizations supported the Improving Social Determinants of Health Act of 2021 (S. 104/H.R. 379), which would authorize and delineate the specifics of a SDOH program at CDC.<sup>5</sup> Given the demonstrated impact of existing public health SDOH work, this program contains enormous potential to streamline services, promote equity, and improve community health outcomes.

# **FY 24 Appropriations Recommendation:**

TFAH recommends that a Social Determinants of Health program in CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) be funded at \$100 million for FY 2024. This level would enable CDC to expand SDOH activities in all states and U.S. territories. TFAH recommends that funding for a SDOH program is made in the context of an overall increase for NCCDPHP, which is critically needed to address chronic disease conditions that account for more than 90% of the nation's \$4.1 trillion in annual healthcare costs.<sup>6</sup>

<sup>&</sup>lt;sup>1</sup> 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://www.bluecrossmafoundation.org/publication/leveraging-social-determinants-health-

what-works

<sup>2</sup> Magnan, S. 2017. Social Determinants of Health 101 for Health Care: Five Plus Five. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/201710c

<sup>3</sup> 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/

<sup>4</sup> https://ahima.org/media/03dbonub/ahima\_sdoh-data-report.pdf

<sup>5</sup> https://www.cdc.gov/chronicdisease/programs-impact/sdoh/pdf/GFF-eval-brief-508.pdf

<sup>&</sup>lt;sup>6</sup> https://www.cdc.gov/chronicdisease/about/costs/index.htm