

# The National Alliance to Impact the Social Determinants of Health

AN ALLIANCE CONVENED BY LEAVITT PARTNERS

November 29, 2019

Committee Chairman Richard E. Neal

Committee Ranking Member Kevin Brady

Task Force Co-Chairs Danny Davis, Terri Sewell, Brad Wenstrup, Jodey Arrington

U.S. House of Representatives Committee on Ways and Means

Rural and Underserved Communities Health Task Force

Dear Chairman Neal, Ranking Member Brady, and Task Force Co-Chairs Davis, Sewell, Wenstrup, and Arrington:

On behalf of the National Alliance to Impact the Social Determinants of Health (NASDOH), we commend the U.S. House of Representatives Committee on Ways and Means and the Rural and Underserved Communities Health Task Force for your efforts to identify strategies to address the challenges that contribute to health inequities in urban and rural underserved areas.

We commend your bi-partisan and inclusive approach to address challenges in financing and delivering health care and impact-related social determinants in urban and rural underserved areas. We are thankful for the opportunity to provide feedback and serve as a resource to the Committee and Task Force. In this document, we offer a perspective reflective of the multi-sectoral viewpoints from NASDOH as we respond specifically to your questions related to the non-medical drivers of health, often referred to as the social determinants of health.

NASDOH is a group of stakeholders co-convened by Governor Mike Leavitt and Dr. Karen DeSalvo working to systematically and pragmatically build a common understanding of the importance of addressing social needs as part of an overall approach to health improvement. NASDOH brings together health care, public health and social services expertise, local community experience, community-convening competence, business and financial insight, technology innovation, data and analytics competencies, and policy and advocacy acumen to assess and address current regulatory frameworks, funding environments and opportunities, and practical challenges to implementing and sustaining social determinants of health efforts. We seek to make a material improvement in the health of individuals and communities and, through multi-sector partnerships throughout the nation, advance holistic, value-based, person-centered health care that can successfully impact the social determinants of health.

Rural communities face different circumstances that need to be considered in initiatives to address social determinants of health at the community level, as well as how the health care system deals with the consequences. These include factors in rural economies as well as population demographics. For example, rural populations often experience greater risk of occupational injury, with implications for economic viability as well as medical treatment. Rural populations tend to be older, with

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implications for demand for connectivity in health and social services, yet are less likely to be covered by integrated care systems or Medicare Advantage plans than areas with larger populations. With lower population density, problems with access to care (including transportation) are amplified. The opioid crisis has highlighted the lack of capacity for behavioral health services in rural communities, particularly those with economic disadvantages. One approach to meeting these needs is to work with the Center for Medicare & Medicaid Innovation (the Innovation Center) on pilot projects that allow for the pooling of different sources of funding to address the social needs of communities both urban and rural.

Overall, NASDOH is encouraged by the inclusion of the social determinants of health in the Committee and Task Force's approach to improving health outcomes in rural or underserved communities. In Part I of this document, we have provided responses to your specific questions related to the social determinant of health.

In Part II of this document, we provide links to additional resources that might be useful to the Committee and the Task Force. We look forward to the opportunity to engage in further dialogue on these issues and welcome any questions or request for additional information.

Please contact Liz Wroe at [Elizabeth.Wroe@leavittpartners.com](mailto:Elizabeth.Wroe@leavittpartners.com) and Lauren Ward at [Lauren.Ward@leavittpartners.com](mailto:Lauren.Ward@leavittpartners.com) for additional information.

## **PART 1- SPECIFIC RESPONSES**

- 1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?**

[Social determinants of health](#)<sup>i</sup> (SDOH) include a broad array of domains that impact the conditions in which people live, learn, work, and play, and are major drivers of health and well-being. The five key social determinants of health are: economic stability, education, social and community context, health and health care and, neighborhood and [built environment](#).<sup>ii</sup> Examples within the 5 areas include access to healthy, affordable food, transportation, housing, incarceration and recidivism, employment and wage, safety, education, and other community-based and environmental conditions. There is increasing evidence that [social determinants contribute](#)<sup>iii</sup> to health disparities between [geographic area](#)<sup>iv</sup>, and [neighborhoods in which people live](#)<sup>v</sup>, and the associated social consequence, strongly predict health. However, the specific SDOH and ways they affect health varies by rural, suburban and urban areas. A 2007 study outlines the differing impact of SDOH by setting in [key SDOH and their measurement](#).<sup>vi</sup> [The National Academies of Science, Engineering and Medicine](#)<sup>vii</sup> describe evidence on health disparities and the prevalence of SDOH in rural and urban places (2017). The [Center for Disease Control and Prevention](#)<sup>viii</sup> maintains an inventory of publications demonstrating how neighborhood and built environment are connected to health and well-being.

- 2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health**

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(particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/ telemedicine/ telemonitoring?

The [Rural Health Information Hub](#)<sup>ix</sup> collects resources demonstrating the prevalence of SDOH in rural areas and by population. Further, they disseminate evidence-based, and promising projects, which have shown to be effective in rural locations. This includes models and innovations to address [transportation](#)<sup>x</sup>, [housing and homelessness](#)<sup>xi</sup>, and [food insecurity and nutrition](#)<sup>xii</sup>.

There are also several technology-based tools and interventions that have the potential to reach underserved populations, both in rural or urban areas. For example, St. Vincent Infirmiry in Little Rock, Arkansas used [TAVHealth](#)'s cloud-based collaboration platform, TAVConnect, to address vulnerable patients who became reliant on the emergency department (ED). Through their Health Connections Initiative (HCI) pilot program, TAVConnect increased coordination, collaboration, and managed social determinants of health among participants. TAVHealth identified the most vulnerable members through hot spotted zip codes and integrated the highest ED utilizers and their demographics in the TAVConnect platform. As a result of this initiative, a 30 percent reduction was seen in 30-day hospital readmission rates, 35 percent reduction in inpatient rehab admission, a 17 percent reduction in cost per patient admission and a 10 percent reduction in the length of inpatient admissions. In addition, patients reported an increase in their confidence to manage their health, more meaningful relationship with their PCP, and reduced symptoms of depression.

**5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?**

Washington, DC is just one urban area focused on transportation as a means to connect underserved populations with needed health care services. AmeriHealth Caritas District of Columbia has long recognized that access to affordable, convenient and reliable transportation plays a crucial role in member access to important preventive health services. In November of 2017, AmeriHealth set out to address this situation by forming a relationship with Lyft to provide on-demand transportation services to AmeriHealth Caritas DC members. Today, as part of this relationship, AmeriHealth uses Lyft in two ways. AmeriHealth members can call into the AmeriHealth Caritas DC Community Outreach Solutions Team which can book rides directly for members through the Lyft Concierge online portal. Rides booked through this channel are focused on transportation to and from plan sponsored health promotion programs, health education classes and related valued added services. And when members want to schedule rides for medical services, they call the non-emergency transportation (NEMT) toll-free number on the back of their membership card, which connects them to AmeriHealth's transportation broker, Access2Care. Access2Care has significant experience in the NEMT space and it has extensive experience in working with Lyft, booking services through their customized Lyft portal. Preliminary analysis revealed a significant reduction inpatient stays, ER admissions, and emergency ambulance transportation utilization for those members taking Lyft trips during the initial launch of the Lyft program.

8. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

Improvement in data definitions and data elements to identify causes of health disparities, and the collection of data is needed. The [National Academy of Medicine<sup>xiii</sup>](#) identified a number of social risks which impact healthcare outcomes. NAM's framework indicates that identifying and collecting information on socioeconomic position (e.g. income, education, wealth, occupation), race, ethnicity and cultural context (e.g. race, ethnicity, language, nativity, acculturation), gender identity, sexual orientations, social relationships (e.g. marital or partnership status, living situation, emotional or social support), and residential and community context (e.g. neighborhood deprivation, urbanicity, housing, other environmental measures) could be of value to address disparities. However, among factors where there are already defined data elements (e.g. race/ ethnicity and language) there is [evidence<sup>xiv</sup>](#) to suggest this data is largely incomplete. For those factors for which data definitions do not exist, there needs to be agreement on clear definitions and standards for that data. In addition to identifying disparities, collecting social risk and social need data, like food insecurity, homelessness, transportation, and capturing this information in a standardized and structured way using standardized terminology is essential to facilitate communication and care coordination, and effective resource allocation.

NASDOH has a particular interest in advancing the availability of data, and two NASDOH resources (listed below) are relevant to monitoring, action, and evaluation in rural communities. Our discussion of principles and strategies focus on an overarching national framework that is flexible enough to address the needs of all communities, including rural and urban areas.

## PART II - ADDITIONAL RESOURCES

- [About NASDOH<sup>xv</sup>](#), our [guiding principles<sup>xvi</sup>](#), and our policy activity including:
  - NASDOH's letter addressed to [Administrator Verma<sup>xvii</sup>](#) which recommendations to accelerate the work of states and providers,
  - NASDOH's recent blog in Health Affairs: [For An Option to Address Social Determinants, Look to Medicaid<sup>xviii</sup>](#), July 2019
  - NASDOH provided the [HHS Chief Data Officer with use cases and associated case studies<sup>xix</sup>](#) to inform potential action to promote transparency of, access to, aggregation of, and integration and sharing of, appropriate data and technology across sectors to assess and address SDOH at the individual and community level.
  - In March 2019, NASDOH provided Demetrios Kouzoukas, Principal Deputy Administrator and Director, Center for Medicare, [comments on the 2020 Medicare Advantage Draft Call Letter<sup>xx</sup>](#) as it related to provision of supplemental benefits. NASDOH has encouraged plans to take advantage of this new flexibility and has also supported the ability of supplemental benefit funds to be pooled with other resources to support individual and community-level SDOH interventions.
- [Identifying Social Risk and Needs in Health Care<sup>xxi</sup>](#), NASDOH, March 2019

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NASDOH outlines promising approaches to screening for social determinants of health and recommendation for continued exploration.

- [Getting to Health and Well-being for the Nation: A call for cross-sector action to impact the social determinants of health<sup>xxii</sup>](#), NASDOH, September 2019

NASDOH’s plans to bring clarity to the current understanding of the issues, challenges, and opportunities for the health care system to address social determinants in concert with communities and the public and private sector.

- [Shared Principles for Measuring Social Determinants of Health Interventions<sup>xxiii</sup>](#), NASDOH, June 2019  
NASDOH’s white paper describes framing principles to guide the development of measurement to assesses social determinants of health (SDOH) interventions.
  - The Health Center Resource Clearinghouse provides resources and tools to America’s community health centers, which provide comprehensive primary health care services as well as supportive services (education, translation and transportation, etc.) that promote access to health care and operate in medically underserved areas. A number of their resources address [SDOH<sup>xxiv</sup>](#) among other topics.
  - The University of Maryland St. Joseph’s Medical Center (UMSJMC) and Maxim Healthcare Services – a home health provider – partnered to tackle social determinants of health for the hospitals high-risk patients. Through an opt-in program, UMSJMC uses Maxim’s non-medical community health workers (CHWs) to address social determinants of health for these patients discharged from the hospital. Rather than providing medical services, CHWs harness community resources to keep patients healthy and address the behavioral and psychosocial needs of high-risk patients *in-home*. That includes transportation, housing, employment, access to medical services, and other social determinants of health, all of which can be barriers to proper care following discharge from the hospital. As a result, only 8 percent of patients who chose to participate in the program were readmitted to the hospital within 30 days of discharge. That’s compared to 18 percent of patients who opted out of the program. At 90 days post-discharge, 23 percent of program participants had returned to the hospital, compared to 34 percent of non-program participants. Following the program’s launch in 2015, there has been a [65 percent<sup>xxv</sup>](#) reduction in readmissions. Over a two-year period, the reduced readmissions have generated more than \$3 million in savings.

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<sup>i</sup> “Social Determinants of Health.” Healthy People 2020, Office of Disease Prevention and Health Promotion, <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.

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- ii "Impact of the Built Environment on Health." Center for Disease Control and Prevention, June 2011. <https://www.cdc.gov/nceh/publications/factsheets/impactofthebuiltenvironmentonhealth.pdf>.
- iii National Center for Health Statistics (US. "Health, United States, 2011: With special feature on socioeconomic status and health." (2012).
- iv Singh, Gopal K., Michael D. Kogan, and Rebecca T. Slifkin. "Widening disparities in infant mortality and life expectancy between Appalachia and the rest of the United States, 1990–2013." *Health Affairs* 36.8 (2017): 1423-1432.
- v Graham, Garth, MaryLynn Ostrowski, and Alyse Sabina. "Defeating The ZIP Code Health Paradigm: Data, Technology, And Collaboration Are Key." *Health Affairs Blog* 6 (2015).
- vi Ompad, Danielle C et al. "Social determinants of the health of urban populations: methodologic considerations." *Journal of urban health : bulletin of the New York Academy of Medicine* vol. 84,3 Suppl (2007): i42-53. doi:10.1007/s11524-007-9168-4
- vii Baciu, Alina, et al. "The State of Health Disparities in the United States." *Communities in Action: Pathways to Health Equity*. National Academies Press (US), 2017.
- viii "CDC Research on SDOH: Neighborhood and Built Environment." Center for Disease Control and Prevention, December 14, 2017. <https://www.cdc.gov/nceh/publications/factsheets/impactofthebuiltenvironmentonhealth.pdf>.
- ix "Social Determinants of Health for Rural People – Resources." *Rural Health Information Hub*, November 2019. <https://www.ruralhealthinfo.org/topics/social-determinants-of-health/resources>.
- x "Rural Project Examples: Transportation." *Rural Health Information Hub*, October 2019. <https://www.ruralhealthinfo.org/project-examples/topics/transportation>.
- xi "Rural Project Examples: Housing and homelessness." *Rural Health Information Hub*, June 2019. <https://www.ruralhealthinfo.org/project-examples/topics/housing-and-homelessness>.
- xii "Rural Project Examples: Food security and nutrition." *Rural Health Information Hub*, September 2019. <https://www.ruralhealthinfo.org/project-examples/topics/food-security-and-nutrition>
- xiii National Academies of Sciences, Engineering, and Medicine. *Accounting for social risk factors in Medicare payment*. National Academies Press, 2017.
- xiv Ng, Judy H., et al. "Data on race, ethnicity, and language largely incomplete for managed care plan members." *Health Affairs* 36.3 (2017): 548-552.
- xv NASDOH "About us". (n.d.) Available at: <http://www.nasdoh.org/about-us/>
- xvi NASDOH. "Guiding Principles". (n.d.) Available at: [guiding principles](http://www.nasdoh.org/guiding-principles)
- xvii NASDOH. "Medicaid Letter to Administrator Verma". (2019). Available at: <http://www.nasdoh.org/wp-content/uploads/2019/04/Medicaid-Letter-to-Administrator-Verma-Final.pdf>
- xviii For An Option To Address Social Determinants Of Health, Look To Medicaid, " *Health Affairs Blog*, July 8, 2019. DOI: 10.1377/hblog20190701.764626
- xix NASDOH. "Letter to HHS Chief Data Officer: Use Cases and Associated Case Studies." (2019). Available at: [http://www.nasdoh.org/wp-content/uploads/2019/03/SDOH-CDO-Use-Case-Letter\\_Final.pdf](http://www.nasdoh.org/wp-content/uploads/2019/03/SDOH-CDO-Use-Case-Letter_Final.pdf)
- xx NASDOH. "Comments on the 2020 Medicare Advantage Draft Call Letter." (2019). Available at: <http://www.nasdoh.org/wp-content/uploads/2019/03/Comment-Letter-for-the-2020-Draft-Medicare-Advantage-Call-Letter-Final.pdf>
- xxi NASDOH. "Identifying Social Risk and Social Need in Health Care." (2019) Available at: <http://www.nasdoh.org/wp-content/uploads/2019/01/NASDOH-Social-Risks-Issue-Brief.pdf>
- xxii NASDOH. "Getting to Health and Well-being for the Nation: A call for cross-sector action to impact the social determinants of health". (2018). Available at: <http://www.nasdoh.org/wp-content/uploads/2018/09/NASDOH-White-Paper.pdf>
- xxiii NASDOH. "Shared Principles for Measuring Social Determinants of Health Interventions." (2019). Available at: [http://www.nasdoh.org/wp-content/uploads/2019/06/NASDOH-Shared-Principles-for-Measurement-White-Paper-June-2019\\_Final.pdf](http://www.nasdoh.org/wp-content/uploads/2019/06/NASDOH-Shared-Principles-for-Measurement-White-Paper-June-2019_Final.pdf)
- xxiv Health Center Resource Clearinghouse. "Resource Search: Social Determinants of Health." (n.d.) Available at: <https://www.healthcenterinfo.org/results/?Combined&ResourceTopic=Social%20Determinants%20of%20Health&Organization&Audience&ResourceType&Language&sort=Resource%20Title>
- xxv Maxim Healthcare Services. *New Data Shows Community Health Workers Significantly Reduce Hospital Readmissions and Spending*. Available at: <https://www.maximhealthcare.com/about-us/newsroom/new-data-shows-community-health-workers-significantly-reduce-hospital-readmissions-and-spending>