

Health Systems Tackling Social Determinants of Health: Promises, Pitfalls, and Opportunities of Current Policies

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In 2005, Seattle's Downtown Emergency Service Center opened 1811 Eastlake, a supportive housing program for homeless residents with chronic alcohol addiction.¹ The goal was to reverse the treatment-first paradigm, addressing the debilitating social need (homelessness) before the medical disease (addiction). After a year, societal costs were approximately \$40,000 lower for residents enrolled in this Housing First program, with cost savings driven, in part, by healthcare spending reductions. Other social interventions have shown similarly promising effects on health outcomes. In a randomized controlled experiment in 5 large US cities, low-income individuals who received vouchers to move from high-poverty to low-poverty neighborhoods had lower rates of obesity and diabetes.² These 2 examples are part of the accumulating evidence that supportive interventions directed toward the social and environmental barriers faced by patients—the social determinants of health—can influence health outcomes and healthcare spending.

Given the mounting evidence, a growing number of policies are beginning to direct the healthcare sector toward playing a more substantial role in addressing these social determinants with a population health lens. New requirements for nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) create a mechanism for public accountability of tax-exempt healthcare providers. New payment models, such as shared savings programs, make overall health—and thereby, social determinants—a part of the financial equation for health systems. Lastly, new models being tested by CMS, like the Accountable Health Communities program, explore the impact of bridges created between social services and the healthcare sector.

All of these policy initiatives lead the public and the medical community to believe we have reached a moment in healthcare where population health is part of the healthcare sector's mission. Indeed, in recent years, healthcare has begun incorporating "population health" in the strategic plans at a growing number of hospitals; however, many population health programs fall short of addressing social determinants.³ Instead, they often limit their fo-

cus to disease-specific initiatives or quality and spending goals set by payers. The discordance between the promise of health policies and the current practice of population health creates the following signal: although these policies may drive the healthcare systems toward improving population health, in their current form, they will not sufficiently change our system of delivering care.

Community Health Needs Assessment

Tax-exempt, nonprofit hospitals are required to file a Section H form with the Internal Revenue Service (IRS), detailing how they benefit the community, with a so-called community benefit standard threshold required to receive nonprofit tax exemption. Historically, nonprofit hospitals defined "community benefit" loosely, often reporting charity care or lost revenue due to lower payment rates from public insurance programs rather than direct investments in social services or contributions to organizations addressing the social determinants faced by their patients. In 2009, hospital-led initiatives that focused locally on the health and infrastructure needs of their community constituted just 8% of current community benefit spending, representing less than 1% of total hospital expenditures.⁴

In response, the Affordable Care Act modified the nonprofit tax code to encourage more socially focused initiatives, requiring nonprofit hospitals to conduct a CHNA every 3 years by convening local public health and community leaders. CHNAs have a number of strengths, including defining a community by the geographic area served, rather than patients currently served by a specific hospital, and making needs assessments and implementation plans explicit and public. However, CHNA requirements could go further by requiring certain types of community needs to be assessed, particularly initiatives that are evidence-based, like housing. Moreover, current IRS guidelines do not require hospitals to actually implement these plans to meet the community benefit standard. The CHNA could be strengthened by improving the transparency around the requirements to address those identified needs as part of the standard for nonprofit tax exemption.

TAKE-AWAY POINTS

We propose modifications to 3 policies driving health systems toward intervening on social determinants of health, but fall short because of the passive role required of health systems:

- ▶ The Internal Revenue Service should strengthen the Community Health Needs Assessment program by requiring nonprofit hospitals to address identified needs as part of the standard for nonprofit tax exemption.
- ▶ Value-based payment models should incorporate financial support for at-risk hospitals implementing strategies to address social determinants because of their influence on quality-of-care outcomes.
- ▶ The Accountable Health Communities program by CMS should test and evaluate models that allow health systems to fund social services directly.

Payment Models

New payment models, such as shared savings programs, intentionally or unintentionally insert social determinants into the financial equation facing healthcare systems. These models emphasize outcomes, like 30-day readmissions for the Hospital Readmission Reduction Program, which are significantly impacted not only by the quality of care, but also by the out-of-hospital social needs of patients. Current policy debates have focused on whether to risk-adjust these performance measures with socioeconomic factors to avoid financially penalizing hospitals that disproportionately serve lower-socioeconomic populations.⁵ We believe this represents a false choice between adjusting away important social differences versus applying financial penalties to address outcomes like readmissions. Alternatively, CMS could reapply funds from penalties to support at-risk hospitals that are implementing strategies to address social determinants that influence quality-of-care outcomes, such as reliable transportation services and improved food security.⁵

Accountable Health Communities

The new Accountable Health Communities program by CMS works toward public health engagement by supporting experimental models that strengthen the linkages between the health sector and public health. Although encouraging, funding does not allow hospitals to experiment with providing services or material needs for patients directly. As a result, the scalability of successful models relies heavily on the existence of sustainable, well-resourced services being widely available, which is not the case in many communities.⁶ In addition to testing models that link the healthcare system to existing social services, there is a severe need to evaluate models that allow health systems to fund these services directly.

Conclusions

The predominant view of healthcare's role has been providing high-quality medical care and delivering biomedical cures. As

a result, health systems have deferred addressing the social and economic needs of patients to public health departments and the government in general. Although improving the quality and delivery of clinical care is important, in order to improve the overall health of the population, the healthcare sector requires a broader strategy that develops and tests direct interventions targeting social determinants. We have highlighted the potential of current policies to integrate social determi-

nants into the business of healthcare; however, these policies fall short because they ask health systems to play a passive role. For meaningful change to occur, the health sector must lead the effort to address the health-related social needs of patients.

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