What Should the Healthcare Sector’s Role Be in Addressing Adverse Social Drivers of Health?

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Questions and Comments from the Q&A

* Can you give us access to Sherry's article?
	+ https://jamanetwork.com/journals/jama-health-forum/fullarticle/2808719
* Re Dr Glied's point about resource allocation in hospitals towards social needs and whether they would address the issue in the way we would want it to be addressed - can we learn something about whether in Europe there is actually enough interaction between how social services impacts health outcomes? Perhaps there is something to be gained by integrating healthcare and social services more in general.
* "Have you considered the UK as a more relevant point of reference, compared with the EU? Healthcare people there are talking more about “social prescribing” in a way that is similar to the focus on “referrals” here – but I suspect that’s in part because their healthcare system is being Americanized, essentially unbundled, or as some might say: dismantled.
* But yes in Europe broadly they seem to be concerned about “social determinants” in the context of things like workforce development etc etc – but less so a focus on health. Perhaps because their healthcare systems are relatively more equitable by design?"
* What about the role of community health centers, federally qualified health centers (FQHCs) that serve the medically underserved, predominantly Medi-Cal population?
* Should the use of community benefit programs be more prescriptive and focused on sdoh.
* Isn't the underlying driver of turning to Medicaid/health system to address social needs about political practicality? In this country, demands for poverty-focused 'hand out' programs confront an uphill battle, at least at the federal level. Health care plays somewhat differently (though only somewhat) and Medicaid is a secure revenue stream (though perhaps hanging on by a thread, and variable from state to state).
* How do you see housing, which is a HUGE need and is something we struggle with to afford people optimal health or even safe recovery after surgery? Incidental things like PT, etc are one thing but we have systemic issues that can be solved by rebalancing funding. Transportation would be a great example as well. Such as offering ongoing/constant financial support for public transportation systems as well that people can easily get to preventive care, the grocery store, etc.
* Non-profit health systems keep their non-profit status in large part by investing in social service programs and CBOs. There is debate about whether these "non-profit" health systems deserve that tax break. What do you think about this and rather than providing a tax break through giving to social services they were required to pay taxes that then, potentially, governments could spend on support for social services?
	+ This would help all persons in a community rather than only patrons of their networks perhaps. Or patrons with the entities they fund through their community benefit.
* Dr Berkowitz’s perspective results in poor people with medical needs get access to certain social services but poor people without don’t. The funds now come from Medicaid because it remains an entitlement. Housing is not. If we fix that, then we can keep health care funding’s narrow modern focus on medicine. Elsewhere do we get funds to address social needs?
	+ This was my thinking too. Some housing first models for instance provide housing to individuals with the highest number of hospital encounters. What if someone needs housing but does not have the need to visit the hospital so much, or simply chooses not to go versus someone who does visit often? This second individual would not save the hospital money (if the thinking is that housing will reduce hospital use) but their life would still be improved if they received housing.
* I don’t think anyone who is serious in this space (like Seth and Stacy) is saying or believing, for example, that housing should be allocated based only on medical concerns — it isn’t either or and this feels like a straw man argument.
* That is a great point. There is a great book called "Letting Go" that I was provided as part of a meeting such as this and it is all about funders and how they are often not of the population who need the support to live a healthy and safe life. This speaks to Sherry's point. We see this all the time.
	+ I’m dismayed that the conversation so far has yet to acknowledge the cultural aspect of social care in the United States. In the US we do not accept that people need housing because it’s a basic need, or even a human right. In that context, doctors and the healthcare system are gatekeepers to social resources to ensure people aren’t ‘abusing’ the system. In other cultures and countries, doctors and healthcare systems can partner w social systems.
* Our healthcare system is heavy on billing, coding, administration and expensive, thus taking lot of money from patients. If healthcare works in the human services sector it needs to do the opposite. It needs to be nimble, inexpensive and does not pass on cost to citizens. Can it make the transition?
* "How can we dispel the confusion and inequity that results from loose use of the phrase “social determinants of health”?

This jargon was initially coined to explain systemic factors affected by \*policy\* and \*culture\* – not organizational service delivery – and the original WHO report about it explicitly warned against applying this lens to individual matters in micro-level contexts.

Somehow in the US it has become commonplace in health wonk spaces to incorrectly apply the phrase “SDOH” to ‘downstream’ contexts in ways that obscure what’s being discussed. A person does not have “determinants of health” and service delivery does not “address SDOH.”

Even if this wasn't incorrect usage, it's bewildering to people unfamiliar with the jargon, and explicitly frames discussions around the interests of healthcare institutions in ways that seem to be coming at the expense of communities’ agency. How can we correct the use of this jargon to instead use plain language terms like “social care,” “social needs,” etc."

* + Please can we liberate ourselves from this jargon phrase.
* I think we are talking about a variety of different models- models that are designed to do a better job connecting families to social services - (w relative lower expenditures to the healthcare system) vs. using healthcare systems to provide the actual social services.
* Biggest barriers to addressing social drivers via referrals has been funding (not enough capacity from both parties), siloed referral/data systems which attributed to the inability of developing closed loop/bidirectional referrals. Do you have any suggestions in how to address the closed loop referrals?
* In Europe they put more $ into social services and less into the health care, with about similar total spending as we have in the US where we put far more $$ into healthcare.
	+ Agreed 100% and we need to advocate and argue for this approach... and yet we're in the U.S. with different paradigm (right now) where healthcare reigns (financially)...
* I see the point about Europe not having medicine support social needs but that's also because they have stronger social safety net. I think leveraging health care as a large, funded system is a workaround but a necessary one as the government doesn't provide an actual social safety net
* What about providing low interest loans to build affordable housing? I think Catholic Hospital Systems has done this.
* Tracy Kidder's book Rough Sleepers is a good resource to get some boots-on-the-ground insights into the relationship between housing insecurity and healthcare needs.
* Dr. Glied’s argument is convincing. Moreover, institutionalized racism and mistreatment of non-white people have been integral to the development of US healthcare and healthcare policy, creating a persistent lack of trustworthiness.
* I think the train may have left the station with programs like CalAIM in California - and lots of challenges have emerged with having health care being the anchor institution. Is there more inquiry to do about if/how to set up partnerships so health care is \*not\* holding the reins?
* Could ARPA-H's HEROES program be one mechanism to do the kind of testing and experimentation Dr. Lindau is talking about?
* I would love to hear the speakers discuss the power dynamics between these systems and how that analysis can inform how these systems do or do not come together at the policy and implementation levels.
	+ Thank you for this comment. I do feel that there's an additional observation that given the power of biomedicine there is the potential for a re-direction of resources to healthcare that further undercut support for social service providers.
* Thank you for this presentation. I agree with Sherry’s concerns. I will also add that I worry that initiatives such as food as medicine, often ignore children, because there is no immediate cost savings- although investing in children will result in long-term cost savings.
* I think the issue of not trusting healthcare systems to do this work doesn’t acknowledge that extractive profit-making does not only exist in the healthcare system! I think most listening to this would support that our country provides for social needs through our social systems. We don’t. If there is some way to help people access food, housing, and basic needs through healthcare systems in a way that is additive, we should do it.
* What do patients think? Do we have any indicator that patients prefer that the health care sector do or don't do work toward actually addressing social needs?
	+ Just chiming in that there has been good research on this and patients generally feel positively about the health care sector addressing social needs. There are over a hundred studies on this and SIREN has done a good job on their website summarizing some of those for those who are interested (I have no affiliation with SIREN, just a fan!)
	+ I think the evidence SIREN has gathered on this is actually rather mixed. it seems to heavily depend on context.
	+ yes, many patients want healthcare to address these things, some come to hospitals seeking meals, a bed, diapers, and safety when they say they have no place else to go...but there is no realistic alternative place for them to go, given our weak social care sector..., if we switch paradigm, would have to 'retrain' and reframe how/where people seek these care
	+ Indeed, here are hundreds of studies on this. Some have been more negative. My read overall is that there are more positive than negative but the devil is always in the detail — it depends a lot on how interventions are done, what they are, in what larger context, etc. Also it should be noted that some of the studies are relatively small / not the best quality but there have been large national (multi-site) studies done by Emilia Demarchis and others that are worth looking up.
	+ SIREN summarized this evidence in their 2022 SCREEN Report: <https://sirenetwork.ucsf.edu/sites/default/files/2022-07/Sect%203%20Erika.Laura%20slide%20decks_0.pdf>
* The focus here is on "cost savings", and maybe we will evolve the conversation to a different "outcome" yet isn't the idea to transform the community be healthier overall? The outcome of interest is "health" - and cost savings would be a secondary outcome? Or is the discussion about the merits of whether or not we can count the "cost savings' as a win for healthcare? Thank you all for this panel. It's a very important conversation.
* So we need to prove that food and housing are necessary for well being ? I don’t think so . Do we need to see if delivering through health care is more or less efficient than other ways ? Sure .
* "I think the evidence base for universal services and universal benefits is pretty established. Can we imagine a healthcare system that advocates for universal basic income? Can we imagine a healthcare system that advocates for a right to shelter, for a right to civil counsel, for universal childcare? These are ways to address social determinants of health.
* Making a referral to a social worker for someone who is being evicted – this is not addressing the social determinants of health. It’s irresponsible to pretend otherwise."
* We will need to be in the business of providing social services and find out "savings" of the whole person approach after the fact with the transition to value based care
* The kind of financing needed for social services, for example housing, is of a different nature. To build or rehab affordable housing government needs to provide capital funding backed by the issuance of debt. That is not a role that the healthcare system can take on (which isn't to say that health plans or hospitals can't invest in affordable housing). The development of affordable housing is chronically underfunded and mechanisms such as the low-income housing tax credits are far less available to smaller metropolitan areas/counties. My point is: our current system for growing supply of affordable housing is far outside of the health system's purview.
* To Sherry's point, the question isn’t really who provides, but who pays, yes? Is social care activity a net increase to the healthcare ledger, or not?
* With my work with Safety Net Medicaid Health Plans, I see them trying more to address the social drivers that are the symptoms of inequality, racism, poverty, etc. E.g., trying to connect their members to housing, food resources, transportation, etc. (and they have been doing it for years). Plus, they do expend substantial resources (when the nonprofit plans don't have a lot of margin). What they can't really do well is try to go further upstream to address the root causes of those social needs - and that certainly should not be under the sole purview of the health care system/plans. I agree with Stacy - it's a "both/and." I generally don’t quote Jerry Garcia but he noted: [when commenting on environmental issues] "Somebody's got to do something, and it's a damned shame that it has to be us!" And agree with Sherry - I have worked with our plans to be good partners with the other organizations/sectors in their community to move forward.
* There are proposed quality measures for hospitals that will require the "resolution" of social drivers for patients. This squarely places the accountability in healthcare.
* It seems to me that as long as homelessness remains such a crisis in the US with no end in sight, and that housing development is left primarily to the private market, hospitals will continue to be the first line of defense in meeting the needs of patients experiencing homelessness. If we don't address that issue first, not providing additional resources to hospitals for these patients and their social needs would, I think, be truly negligent.
	+ You might be right, but that doesn’t mean such initiatives should be described as “solutions” that “address” homelessness. The risk there is indefinitely obscuring and deferring the hard and urgent conversations about structural solutions.
	+ No one is saying these are solutions. Healthcare providers do not want to discharge people experiencing homelessness back out to the street. We have been having urgent conversations about this for decades.
	+ I’m definitely seeing plenty of people and institutions talking about “addressing SDOH” and deploying “SDOH solutions”!!
* A suggestion, regarding the role of healthcare, I really like the Healthcare Anchor Network approach where the economic power of the hospital is invested in the community yet doesn't replace the social services provided by the government. https://healthcareanchor.network/anchor-mission-pillars-anchor-collaboratives/
* It seems to me that philosophically there is alignment that people's full needs (bio-psycho-social) need to be accounted for in high-quality health care. The juicy part of this conversation comes when we get into implementation realities - even if health care sector does not provide the services themselves, we do have a knack for making implementation of social health screening and linkage expensive & difficult - e.g. how much $ should we spend on tech platforms to align social service & health care, develop EHR workflows to capture information, retrain workers, etc..
	+ Yes, this.....profiting on SDOH work is mind blowing.....
* I'd trust healthcare before I would trust "government writ large. Not to be snarky, but at least healthcare has a commission to be benevolent!
* We have a lot of "undoctored" people in our community and huge health systems that would overlook their needs since they are not attributed to a health system so that is problematic for populations served at large. Where does the public health system and proper funding of that fall into this discussion?
* Do you really want the Alabama State legislature making decisions about social needs spending?
* Steward health care is another example of the fallacy of for profit health care. It is still different than our margin oriented nonprofit entities
* The fact is that health is already connected to social services: the environment - housing - transportation - food - etc. And as mentioned, health care organizations have always “done social work” — it is just getting health care organizations to do a better job. And for most communities, health care organizations are the anchor institutions (largest, engaging the population at large, resources, etc.) Now, this could mean that health care organizations partner with existing social service areas and/or a multitude of options that are happening (based on capacity, ability, etc.). Hospitals must be in this space - There are many organizations that are doing this well with documented positive outcomes - lowering blood sugar levels with food pharmacies, reducing ED admissions and cost through housing strategies - again, some hospitals designing their own housing and others partnering with local shelters.
* I've seen an increase in for-profit corporations (especially in the food/nutrition sector) getting involved in addressing patients' HRSNs - Amazon, Instacart, major grocers, Uber etc. These efforts strike me a more PR efforts with minimal or undetermined results/impact on patient outcomes. Are we seeing the rise of a "food-is-medicine industrial complex"?
* That assertion about technology sounds like magical thinking. These problems do not persist because of a lack of technology, and they don’t seem to be getting solved by dumping on more technology. Is it possible that by characterizing these problems as technology problems (rather than as problems of institutional design and political will) we are making the problems worse?
* I wonder about leveraging the power dynamic of physicians in advocacy - although an oversimplification, physicians speak and people tend to listen and trust, whereas public health or social services ask for help and there’s less willingness to engage (or, people fight back - see any vaccine or COVID effort). If physicians advocated for prevention at the policy level, and funding followed, it would render a good chunk of this conversation moot.
* As a safety net provider (legal aid in housing, benefits, education, family issues), trust is really important to helping individuals connect to necessary services. Our organization provides services to individuals who find us on their own and ALSO people who are referred to us in warm-handoffs by their medical providers. We often find that the latter camp did not have a realistic way to reach us without the help of their provider and that the provider is a critical partner as we work to address client needs. Because of this, we generally support a hybrid model-- building ourselves into any coordinated systems with healthcare providers that we can while also maintaining our general "intake" because that helps us reach the most people possible.
* I disagree with Seth - I think that by making addressing social need our lane as physicians, we change the conversation nationally and bring awareness to how social structures contribute to inequity and can potentially move conversations around policy.
	+ "Do you have any precedents in mind for this actually happening?
	+ Other people are observing that the opposite seems to be true – that the discourse is shifting away from structural policy change and toward medicalizing social needs in ways that are not commensurate to the challenges."
* Not to sound too cynical, but how can any of this necessary change or evolution happen in our current political climate? Our policy makers and decision makers are over burdened with political pressures so much that true change is often hindered.
* That and policy makers are very disconnected from reality and have no idea how vulnerable populations live and struggle.
* Also important to note there are differences in health care funding too - we seem to be talking about large hospital/health systems, but are we also expecting small, under resourced primary care clinicians to provide the same social support?
* There's significant concern from health care providers who care for inpatients about burnout and extra need due to the need to address health-related social needs. How can we frame the provision of social medicine as beneficial rather than burdensome?
* There are fabulous models where non-profits are partnering together to tackle this issues - leading, equal/equal partnerships or reduced participation. Hospitals have a responsibility to the community at large and their patients ….and it is moving more towards a financial must. It is not the best ROI for a hospital or best ROI for patients to wait until a person is in their 50s (outside of birth) to enter a hospital - when they first become ill and needing the hospital. Hospitals can’t operate in isolation. Everyone is very aware now that health is about mental - physical and social health ……it is all connected.
* "The healthcare sector is deeply entrenched in racism and capitalism. How do we ensure these social care investments in healthcare are not further exacerbating disparities (e.g. increased access for some but not others)? I appreciated SIREN's recent PCORI Evidence Synthesis on Racial Health Equity and Social Needs
* Interventions but it seems like it's difficult for health systems (or anyone) to understand the impact on health equity through social care interventions implemented in the health care sector"
* The panelists have considered european countries as positive examples, but some political scientists (Julia Lynch at Penn), have argued that social determinants and health in all policy framing have actually allowed politicians to orient policy towards more individual level interventions (e.g. a patient gets food), and away from redistributive policies -e.g. increasing minimum wage (like those Seth recommends).
* Do you have any examples of literature to share?
* Regimes of Inequality: The Political Economy of Health and Wealth
* Isn't it really YES...AND...?
* These comments are extremely insightful, would love them to be shared post webinar (anonymously is fine)
* I could be wrong, yet I hear that that the ability to address crisis/acute SDoH needs feels achievable (e.g. give food to a patient in crisis) yet once it gets outside the doors of the facility into long term/chronic social determinants it seems that there is a desire to hand off the issues....yet, hand off to who? Political and social efforts are not necessarily effective - if they were we would see the change already. It's about adding the healthcare system as an advocate to address chronic social conditions that lead people to show up more sick, and more complex in the healthcare setting. Thank you again for this very interesting and necessary panel.
* Great discussion! Apologies if noted already, but sounds like there is a big opportunity to shift to more of a public health lens and partner with local and state public health departments. This may in turn support mutually beneficial and bi-directional partnership with CBOs already on the ground addressing social needs
* This is something that should happen.....
* Re Dr. Glied’s point: Given the dire and well-documented health impacts of income inequality, why aren’t those in the health sector advocating more aggressively for social justice-informed public policy?
* Yes! Dr. Glied is correct, again described in Rough Sleepers. This was the finding of an experiment in Boston giving a number of free housing units to unhomed clients of a mobile health unit. It did not save money, and the people involved in the project were similarly concerned that that wasn't really the point of doing it. I agree about needing evidence for the outcome you actually want.
* But just housing alone is not sufficient. My understanding is that there is some research showing that housing plus services, i.e. supportive housing can lower healthcare costs.
* Could harm reduction be a valuable framework here?
* Yes, let's advocate for better and more humane care and support in general for our people but, in the meantime, people are still food-insecure, unhoused or living in toxic environments, and so forth. We need to help out the patients in front of us NOW.
* This goes to the big point that Stacy made earlier re: the opportunity to use data and experience we collect in healthcare to make structural change, and shift allocation of social resources. Is this a missing opportunity? Can we do more and do it more effectively?
* Curious about the e prescribing framework Stacy just mentioned?
* It's the ongoing care provider who "prescribes" the food access; not relying on those who are sick in the hospital to access food in the hospital, but relying on a trusted health advisor to help acknowledge those needs (ie. taking advantage of touchpoints 1:1 to help)
* It sounds like a program such as Health Leads, which “prescribes” social services to patients, seems to be the way to go. Thoughts?
* I think Health Leads may have stepped away from this model, as it seems to be a very limited, narrow way to understand and address these problems.
* What about the role of Community Health Workers integrated on clinical teams? They allow clinicians to practice at top of license while connecting patients with identified social needs to appropriate social services.
* I see it as “yes and” vs. “either or” ….We need the food systems in the community AND we also need a food program coming from health care organizations to reach those coming into a clinical office. I work with a cardiologists who gave pill prescriptions as well as a list of foods to buy at the local grocery store - affordable, culturally aligned AND nutritious because she saw that she could give all the pills in the world but if their diet didn’t change - health would not improve.
* Seth and Sherry’s contributions have been very helpful – thank you!
* In the setting of new broad quality measures and care standards for identifying and addressing HRSNs for all patients, are we losing the opportunity to tailor our social care interventions to best match clinical diagnoses where we think provision of specific social care services is most relevant to clinical care (e.g., medically tailored meals for patients with uncontrolled diabetes, addressing housing for lead poisoning)? Could that be a middle ground when thinking about the health sector directly providing social services beyond just providing referrals to CBOs?
* Re Sherry's comment on measuring outcomes of SDOH interventions: this is one of the hardest things we have worked on with our plans. We have tried to get them to think beyond just financial ROI and consider patient satisfaction/wellbeing, provider satisfaction, utilization of those social services, impact on other stakeholders in the community (e.g., the housing and education sectors, etc). But plans are VERY interested in what works and what doesn't - implementation science.
* One suggestion for future webinars on this topic: involve an RN and a social worker. I appreciate Dr. Lindau's discussion of the system context of the orders that physicians are giving to patients: access to a car, pharmacy, food, etc. The physician may not be able to address each of these, but they can be cognizant of the parameters and also of the resources already in place and what those resources need to truly help our patients. A lot of times the RNs, social workers, case managers, etc., are struggling against the same walls as MDs from other sides, all for the same purpose.
* It may be more influential to think of this as 'transformational' instead of "incremental" change. The healthcare sector is powerful economically - we could be transformational and go beyond the "incremental".
* Just want to state that I don’t think that anyone serious in this space believes that addressing social needs from the healthcare system will solve the larger structural issues related to SDOH. As other commenters have stated it’s a “both AND” not an “either or”
* I find this assumption all the time. Literally companies named “SDOH Solutions” that sell software for service delivery to eager clients.
* I said “serious in this space” ;)
* Would love to hear the panelists talk about the potential opportunity with ARPA-H's HEROES program in proving out (or not) the efficacy and cost effectiveness of social care interventions at the population health level.
* I'm not sure I follow the line of thinking that there's a meaningful distinction between resources flowing through managed care versus health care providers.
* Medicare Advantage already has the ability to spend directly on addressing such challenges as food insecurity and transpo to medical appointments. But it takes some vigorous case management to make it happen. That probably would better be provided by healthcare providers rather than the MA plans.
* Need to include CBPR in research
* Someone upthread suggested Julia Lynch’s work, and I just found this paper: https://www.tandfonline.com/doi/full/10.1080/09581596.2022.2036701 – from the abstract: “current debates around causal understandings risk sending the field down ‘rabbit holes’ that distract from solution.”
* I want to echo the importance of having other health care team members in this discussion!