# Federal Efforts to Address SDOH and Health-Related Social Needs

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U.S. Department of Health and Human Services

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# What is ASPE?

- ASPE serves as principal advisor to the Secretary on policy development
- What does the Office of Health Policy do in ASPE?
  - Conduct internal/contracted research to inform policy development related to health care financing, spending, access and quality, and data infrastructure
    - Both quantitative and qualitative (e.g., key informant discussions, case studies, TEPs)
  - Engage in and lead strategic planning for the Department
  - Co-chair Department's legislative development process
  - Provide input on a variety of clearances including regulations, program proposals, reports, correspondence, grant announcements, media materials, etc.
  - Help foster new programs and initiatives

# Discussion Topics

- Context – Why do SDOH and Health-Related Social Needs matter?
- HHS SDOH Action Plan and Current Policies/Programs
- Implications for Maternal/Infant Health

# Context

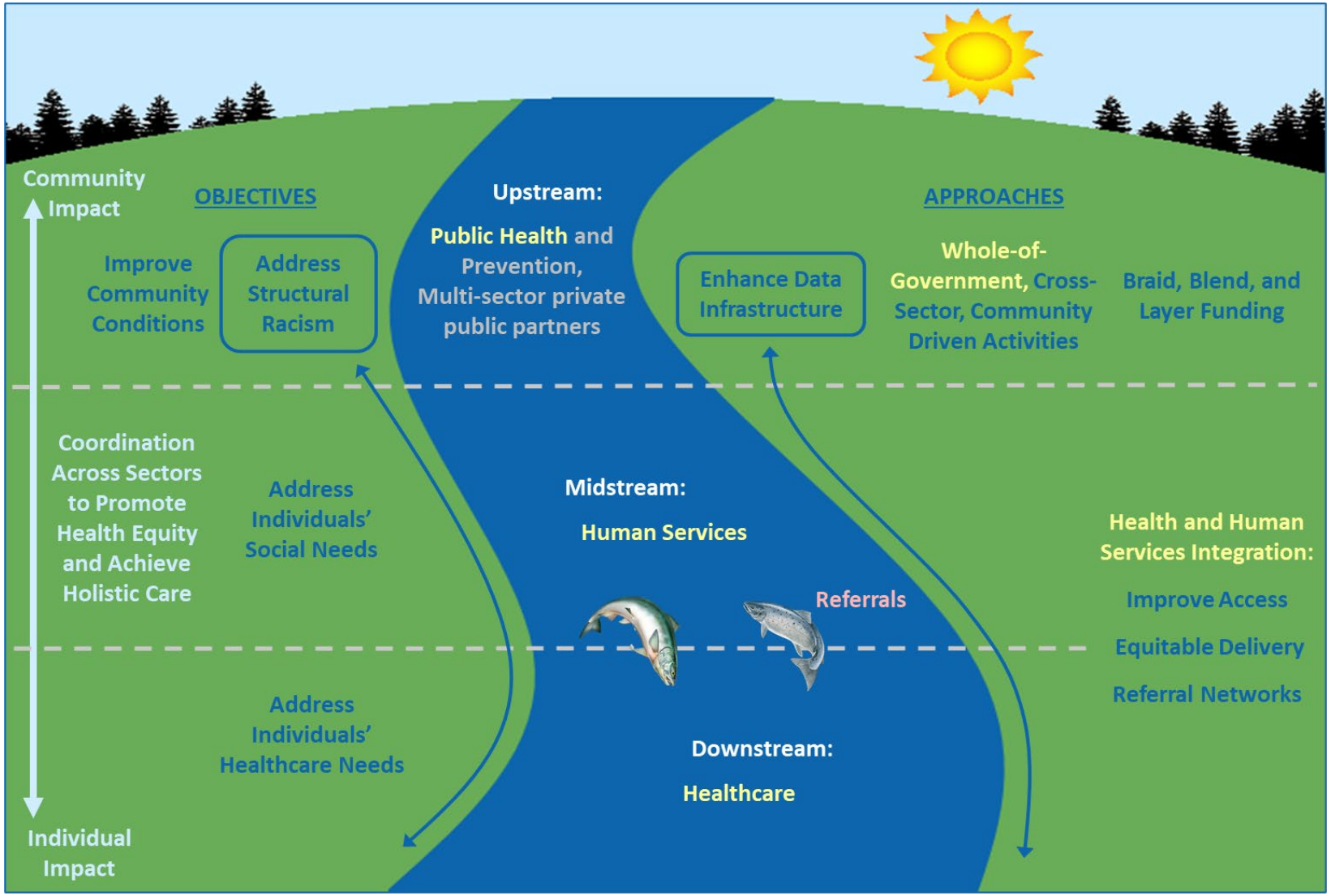
# What are SDOH and HRSNs?


**HHS defines SDOH as:**
"…the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."

**These community-level social factors influence a variety of individual health-related social needs (HRSNs) such as:**

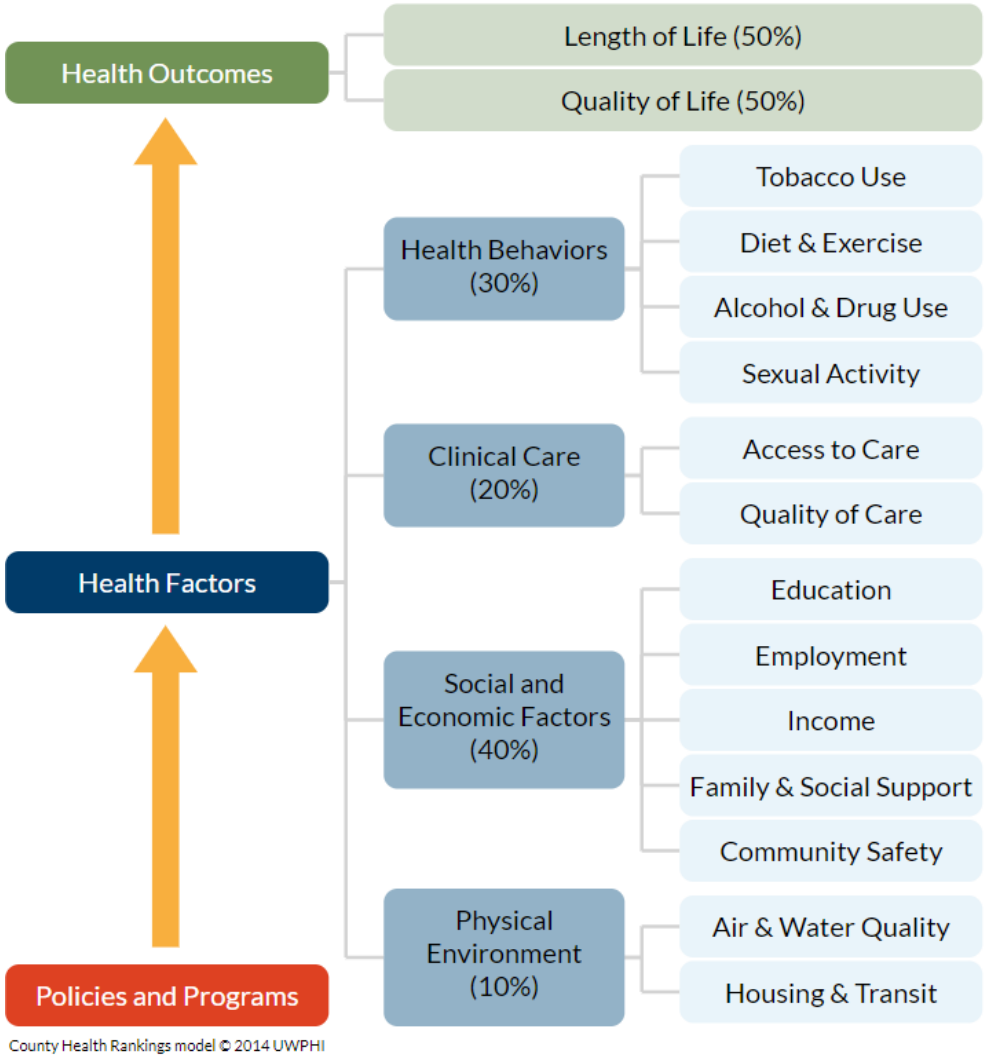
- Financial strain
- Housing stability
- Food security
- Access to transportation
- Educational opportunities

# SDOH Ecosystem




**Source:**
Adapted from Castrucci B, Auerbach J, Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health, Health Affairs Blog, January 16, 2019

# Why are SDOH and HRSNs important?




- Health care is essential to addressing medical conditions when they arise…
- …but access to health care alone is not sufficient to achieve optimal health outcomes
- SDOH account for as much as 50% of county-level health outcomes
- Within SDOH, socioeconomic factors such as…
  - Poverty
  - Prevalence of jobs paying a living wage
  - Education availability

…have the largest impact

# How do disparities in SDOH/HRSNs contribute to disparities in outcomes?

- Systematic and structural inequities such as:
  - Limited employment and educational opportunities
  - Lack of affordable and safe housing
  - Low availability of nutritious foods
  - High rates of exposure to environmental health hazards

  …can jeopardize health and well-being

- For instance, people of color have higher rates of diabetes, hypertension, obesity, asthma, and premature death compared to non-Hispanic Whites due in part to social and economic factors*

* *Racism and Health*. (2021, November 24). Centers for Disease Control and Prevention. https://www.cdc.gov/minorityhealth/racism-disparities/index.html

# How do SDOH/HRSNs contribute to maternal health outcomes?

- More room for evidence generation on the contribution of social factors to maternal/infant health outcomes
- Some examples of social factors found to be associated with maternal and infant health outcomes include:
  - **Poverty**
    - Pregnancy-associated death and severe maternal morbidity [1,2]
    - Infant mortality and preterm birth [1,3,4]
  - **Educational attainment**
    - Maternal mortality and severe maternal morbidity [5]
    - Preterm birth [3]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# How do SDOH/HRSNs contribute to maternal health outcomes? (Continued)

- **Housing**
  - Housing instability: Preterm birth and low birthweight [6,7]
  - Housing instability: Maternal hypertensive disorders, anemia, hemorrhage, substance use, and depression [8,9]
  - Rental housing costs: Severe maternal morbidity [10]
  - Lead exposure: Preterm birth and low birthweight [11]
  - Supplemental fact: Infancy is period of life when a person is most likely to live in a homeless shelter [12]
- **Racial segregation**
  - Infant mortality, preterm birth, and low birthweight for Black mothers [13,14]
- **Nutrition**
  - Gestational diabetes and hypertension, preeclampsia, and obesity-related complications [15]
  - WIC participation: lower risk of infant mortality, preterm birth, and low birthweight [16]
- **Environment**
  - Air pollution: Postneonatal infant mortality, preterm birth, low birthweight [17, 18, 19]
  - Air pollution: Pregnancy hypertensive disorders and gestational diabetes [20, 21]

# Citations for prior slide


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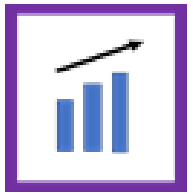
# HHS SDOH Action Plan and Current Policies/Programs

# HHS SDOH Working Group and Action Plan

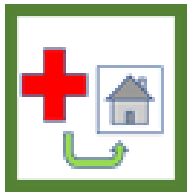
- Co-chaired by CMS Office of Minority Health and ASPE
- 130+ members from 9 OpDivs and 9 StaffDivs
- SDOH materials published April 2022
  - Landing page: Addressing SDOH in Federal Programs
    - JAMA Health Forum essay
    - Two-page summary of Action Plan
    - Review of evidence-based strategies and federal efforts

# SDOH Action Plan goals



**Goal 1**

***Enhance data infrastructure and utilization of data***



**Goal 2**

***Improve access to and affordability of health care services, and support partnerships between health care providers and community-based organizations to address social needs***

**Goal 3**

***Align cross-government approaches, public-private partnerships, and leverage community engagement to address SDOH and enhance population health***

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# Priority groups

- **Health and social care coordination**
- **Social care referral and SDOH data interoperability**
- **Measurement and data collection**
- **Community and peer health workers**

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# Health and social care coordination

- **Focus:** Articulate a vision and an intra-agency approach to coordinating key HHS policies and programs that can drive alignment of health and social care
- CMS incentivizing screening for health-related social needs
  - Hospital Inpatient Quality Reporting (IQR) and Merit-based Incentive Payment Systems (MIPS) program SDOH screening rate and test positive measures
- While screening is critical, it (and even referral) is certainly not sufficient… If you build the bridge, it should lead somewhere
- CMS is providing opportunities in some instances to finance social care
  - Medicaid 1115 demonstrations and State Plan Authority (In-Lieu of Services and Settings) can pay for certain services to address housing instability, food insecurity, and lack of transportation
- And new quality measures like the IQR severe obstetric complications and low-risk Cesarean section measures, as well as the Birthing Friendly designation, may drive further change

# Facilitation of closed-loop referrals

- Coordination can take different forms depending on community resources and dynamics
- One promising approach is Community Care Hubs; a type of backbone organization supporting a network of community-based organizations
  - Health Affairs blog post: https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs
- Hubs offer administrative oversight and one-stop contracting with healthcare providers
- When operating at their best, other functions include:
  - Integrate funding from multiple sources to support operations and service delivery
  - Manage referrals and payments
  - Ensure service delivery fidelity and compliance
  - IT implementation and maintenance
  - Data collection for quality improvement and reporting
  - Foster community-based workforce development and training
  - Enable CBOs to engage with health care providers on community governance/planning

# Community Care Hub Conceptual Model*

- Community Health Workers may serve an important role in making connections between the various steps in this model
- Health IT is an enabling tool for the functions outlined in this model, that should be used in a coordinated and equitable manner
- Funding Sources (including Federal, State, Local, Philanthropic, and Private Funds) feed into the Community Care Hub
  - The Hub coordinates administrative functions, funding, and operational infrastructure, including enabling health care contracting on behalf of a wider CBO network, to align care, and tracks outcomes to inform quality improvement and contractual requirements.
    - Presentation: Individual engages in-person or virtually with a local entity, such as a health care provider, school, CBO, or public health or other government agency
    - Proactive Outreach: Local entity uses available data to identify individual who may have social needs and reaches out
    - Screening: A local entity screens patient for social and/or medical needs and collects social or medical needs information (or refers to another provider for screening).
    - Connection: The local entity connects patient to social or medical service provider who receives relevant social or medical needs information.
    - Service Provision: Social or medical service provider engages individual, identifies applicable funding sources, and provides relevant services.
    - Referral Feedback: Referred provider communicates to referring entity to create a feedback loop.
    - Tracking outcomes: Local entity tracks outcomes and shares them with hub to improve service delivery.

*Conceptual model is evolving and may differ between communities; in practice; individuals may not move through this model in a linear fashion.

# Related efforts

- Administration for Community Living (ACL) providing grants to Hubs and partnering with the Centers for Disease Control and Prevention (CDC) to support a National Learning Community and Center of Excellence to support the continued development and expansion of hubs
- Office of the National Coordinator for Health IT (ONC) supporting efforts to address interoperability of SDOH/HRSN data to facilitate person-centered care
- Partnership to Align Social Care brings together leaders across CBOs, health plans and systems, national associations, philanthropy, and federal agencies to co-design a multifaceted strategy to enable successful partnerships among health care organizations and hubs
- CDC's Community Health Workers for COVID Response and Resilient Communities initiative provides financial support and technical assistance to 68 states, localities, territories, tribes and tribal organizations, and American Indians and Alaska Natives health providers to put more trained community health workers into communities
- HRSA's Community Health Worker Training Program, a multiyear program focused on on-the-job training to increase the number of CHWs connecting people to care

# Related efforts (continued)

- CDC's SDOH accelerator grants to develop and implement community-based multi-sector action plans to address SDOH
- Complementary efforts
  - HHS-HUD Housing and Services Resource Center will facilitate federal and state coordination and partnerships to improve access to housing and other social care services, which can be sustained over time through hubs
  - CDC diabetes, heart disease, and stroke cooperative agreement Notices of Funding Opportunities include a focus on SDOH

# Other HHS efforts to address SDOH in the context of maternal/infant health

- NIH's Implementing a Maternal health and PRegnancy Outcomes Vision for Everyone (IMPROVE) initiative to identify biological, psychosocial, and **structural** factors that contribute to disparities in maternal health delays or disruption in maternal care
  - Incorporating community-identified needs and requiring inclusion of the community in the research plan and funding
- MMRCs and PQCs can benefit from having community engagement to better understand nonmedical risk factors that contribute to poor outcomes
- HHS working with HUD and USDA to facilitate cross-enrollment in benefit programs
- Other broader efforts such as the White House Conference on Hunger, Nutrition, and Health also have important implications for maternal/infant health

# Implications for Maternal/Infant Health

# Where do we go from here?

- Addressing SDOH/HRSNs does not address medical complications of pregnancy and childbirth after they rise
- However, evidence suggests that SDOH/HRSNs can be important risk factors for poor maternal/infant health outcomes, so addressing them can play a role in prevention
- One important opportunity to identify HRSNs is during prenatal care visits, but prevention should ideally occur across the life course
- In an environment of limited resources, how can identified social needs be addressed, since screening is only helpful if you are prepared to address the findings?
- As they potentially continue to expand, can organizations such as Community Care Hubs help facilitate social care referrals for women with identified needs?
  - E.g., the Pathways Community HUB Institute Model is a specific type of Community Care Hub that has its origins in maternal health

# Thank you for your advice!

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