ARTICLE

Fostering a Culture of Equity

"Social determinants of health (SDOH) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes."[1] The COVID-19 pandemic has renewed debate about the importance of social determinants such as living conditions, socioeconomic status, occupation and access to healthcare, as the risks for COVID infection, hospitalization and death for blacks (1.1x, 2.8x and 1.9x, respectively) and Hispanics (2.0x, 3.0x, 2.3x, respectively) are substantially higher than for whites.[2]

In this article, we suggest a role for health-care providers that focuses on population health, improved access to care, enhanced quality of care and creating a culture of equity aligned with an organization's mission, vision and strategic plan.

Health inequities exist

Health inequities exist across populations of diverse racial and ethnic backgrounds. Hospitalizations for ambulatory care sensitive conditions—"for which timely and effective outpatient care can help to reduce the risks of hospitalization by either preventing the onset of an illness or condition, controlling an acute episodic illness or condition, or managing a chronic disease or condition"—are far higher for the adult black population.[3] Inequities also exist for black children, as evidenced by a hospital admission rate for asthma more than four times that of white children. And despite similar rates of mammography screening, more black women than white women had advanced-stage breast cancer when diagnosed.[4]

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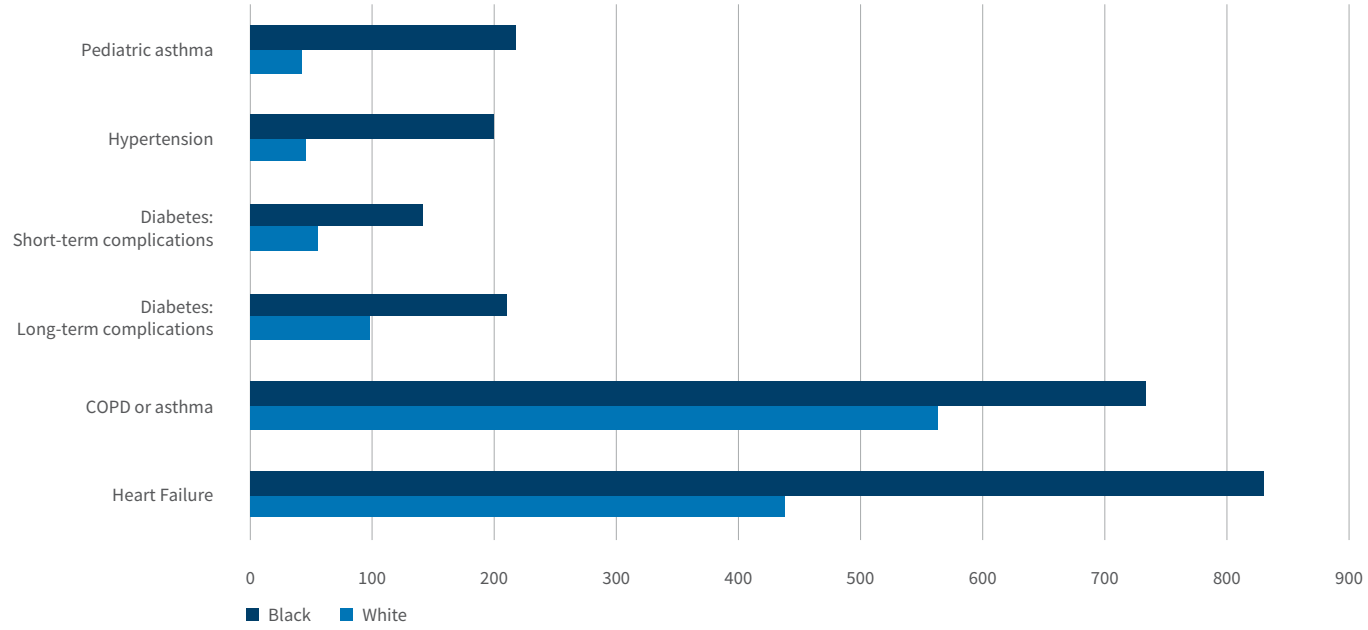
[1] Social Determinants of Health: Know What Affects Health. Centers for Disease Control and Prevention https://www.cdc.gov/socialdeterminants/index.htm

[2] Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity. Centers for Disease Control and Prevention; April 23, 2021 https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

[3] Concept: Ambulatory Care Sensitive Conditions. University of Manitoba Centre for Health Policy http://mchp-appserv.cpe.umanitoba.ca/viewConcept.php?printer=Y&conceptID=1023

[4] Comparing Breast Cancer Screening Rates Among Different Groups. Susan G. Koman Foundation https://ww5.komen.org/BreastCancer/RacialEthnicIssuesinScreening.html?ecid=social:285

Hospital Admissions per 100,000 Population



Source: 2019 AHRQ Healthcare Quality and Disparities Report

Social determinants of health contribute to inequities

The social determinants of health can be categorized in six domains: economic stability, neighborhood and physical environment, education, food, community and social context, and the health care system. These domains are affected by public policy, governance, values and other factors.[5]

Health care system determinants include health coverage, provider availability, provider linguistic and cultural competency and quality of care. In the United States, 75.4 million Americans receive Medicaid, a 27.6% increase since implementation of the Affordable Care Act in 2014;[6] 28.9 million people are uninsured primarily because of the high cost of coverage;[7] and 83 million people reside within 7,325 Health Professional Shortage Areas, many within low income areas. As a result, primary care access is somewhat limited for those residents.[8] Among practicing physicians, 47.9% reported receiving cultural and linguistic competency training in medical school or residency; 66.3% received training at some point during their careers.[9] The quality of healthcare provided to African-Americans is worse in 42% of the 182 metrics measured in the National Healthcare Quality and Disparities Report.[10]

[5] Implications of COVID-19 for Social Determinants of Health. KFF; April 15, 2021 https://www.kff.org/coronavirus-covid-19/issue-brief/implications-of-covid-19-for-social-determinants-of-health/

[6] National Health Expenditures, Table 17. Centers for Medicare & Medicaid Services https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected

[7] J. Tolbert, K. Orgera, and A. Damico. KFF Issue Brief: Key Facts About the Uninsured Population; Kaiser Family Foundation, November 6, 2020 https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=However%2C%20beginning%20in%202017%2C%20the,2016%20to%2010.9%25%20in%202019

[8] Health Workforce Shortage Areas; Health Resources & Services Administration https://data.hrsa.gov/topics/health-workforce/shortage-areas

[9] Mainous AG, Xie Z, Yadav S, Williams M, Blue AV, Hong Y. Physician Cultural Competency Training and Impact on Behavior: Evidence From the 2016 National Ambulatory Medical Care Survey. Family Medicine 2020; 52(8): 562-569 https://journals.stfm.org/familymedicine/2020/september/mainous-2020-0060/

[10] 2016 National Healthcare Quality and Disparities Report, Agency for Healthcare Research and Quality https://www.ahrq.gov/research/findings/nhqrdr/nhqdr16/quality.html

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Source: https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Social determinants lead to at-risk behaviors, disease and injury

Despite smoking fewer cigarettes per day, blacks are more likely than whites to die from smoking-related diseases such as heart disease, cancer and stroke.[11] Blacks tend to have a greater prevalence of a poor diet score than whites;[12] 47.9% of blacks are obese: 38.0% of men and 56.0% of women.[13] The prevalence of physical inactivity is higher in blacks (30.3%) than in whites (23.4%).[14] Blacks are over-represented for nonfatal violent crimes, accounting for 36% of the total in the United States.[15] The prevalence of substance use disorders are similar across racial lines, though blacks have higher rates of incarceration.[16] These metrics are critical, as behavioral (lifestyle) patterns and social circumstances represent 40% and 15%, respectively, of the contributors to premature death.[17]

[11] Smoking and Tobacco Use: African Americans and Tobacco Use. Centers for Disease Control and Prevention https://www.cdc.gov/tobacco/disparities/African-americans/index.htm

[12] Kris-Etherton, P.M., et al. Barriers, Opportunities, and Challenges in Addressing Disparities in Diet-Related Cardiovascular Disease in the United States. *Journal of the American Heart Association*; March 23, 2020 https://www.ahajournals.org/doi/10.1161/JAHA.119.014433

[13] Health, United States 2018; Table 26. Centers for Disease Control and Prevention https://www.cdc.gov/nchs/data/hus/hus18.pdf

[14] Physical Inactivity is More Common among Racial and Ethnic Minorities in Most States. Centers for Disease Control and Prevention, Conversations in Equity, April 1, 2020 https://blogs.cdc.gov/healthequity/2020/04/01/physical-inactivity/

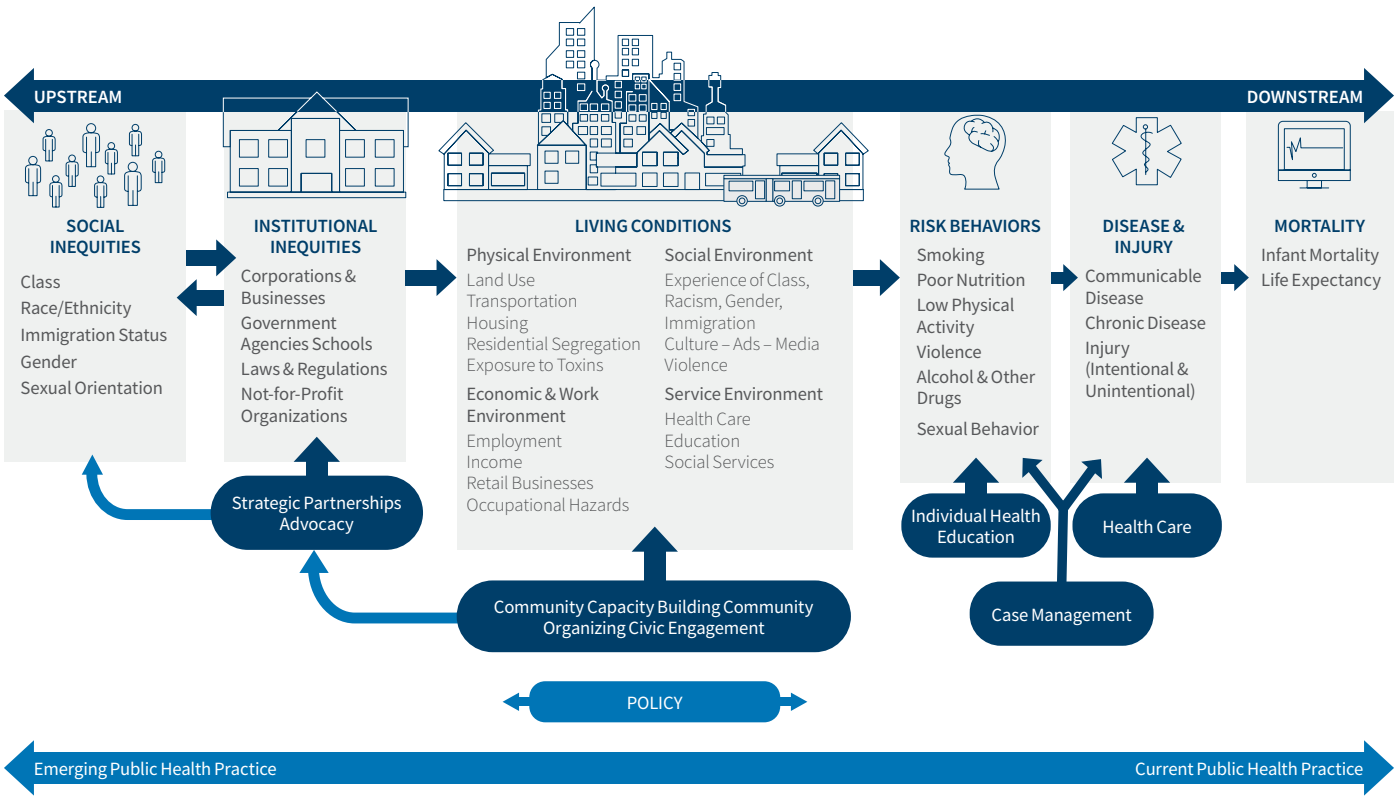
[15] Beck, A.J. Race and Ethnicity of Violent Crime Offenders and Arrestees, 2018. U.S. Department of Justice Statistical Brief; January 2021 https://www.bjs.gov/content/pub/pdf/revcoa18.pdf

[16] Position Statement on Addressing Racial and Ethnic Health Disparities in Substance Use Disorder Treatment in the Justice System. American Psychiatric Association; December 2019.

[17] Schroeder, S.A. We Can Do Better – Improving the Health of the American People. *NEJM*; September 20, 2007 https://www.nejm.org/doi/full/10.1056/NEJMsa073350

A Public Health Framework for Reducing Health Inequities

Bay Area Regional Health Inequities Initiative



A Pubilc Health Framework for Reducing Health Inequities – Bay Area Regional Health Inequities Initiative

Public health framework recently released

On September 20, 2020, a task force composed of public health experts released an action framework known as Essential Public Health Services which describes "the public health activities that all communities should undertake."[18] Activities are classified in three categories: assessment, policy development and assurance.[19] Assessment includes population health and the identification of associated root causes. Policy development includes mobilization of communities and partnerships, and assurance incorporates equitable access. *Population health, community outreach and patient access are all within the reach of providers.*

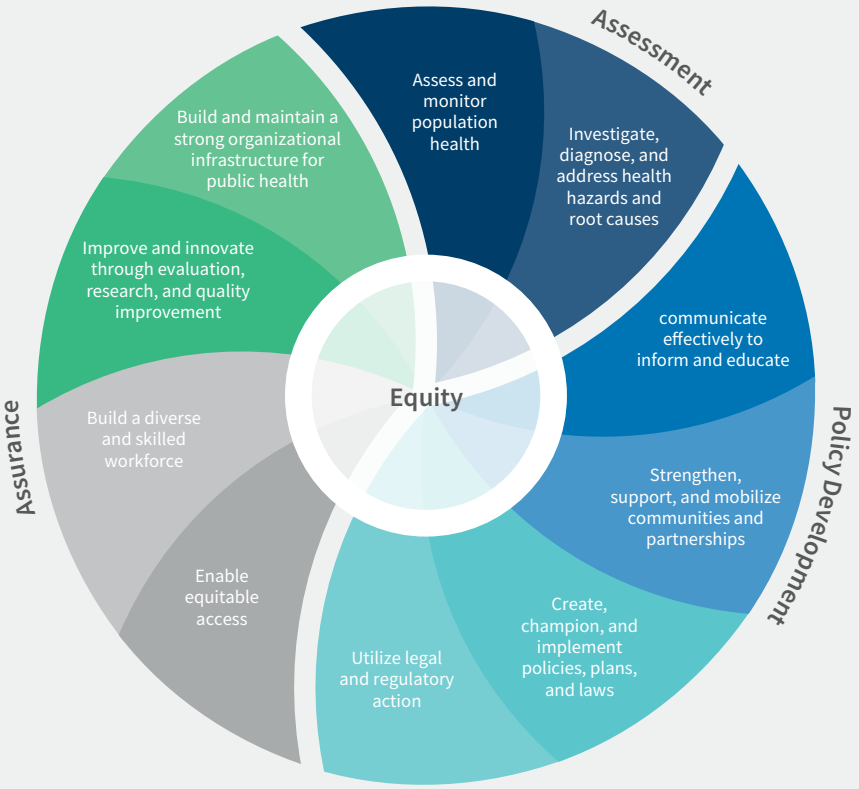
[18] Public Health Professionals Gateway: 10 Essential Public Health Services. Centers for Disease Control and Prevention https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html

[19] ibid

The 10 essential public health services

To protect and promote the health of all people in all communities

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve optimal health for all, the Essential Public Health Services actively promote policies, systems, and services that enable good health and seek to remove obstacles and systemic and structural barriers, such as poverty, racism, gender discrimination, and other forms of oppression, that have resulted in health inequities. Everyone should have a fair and just opportunity to achieve good health and well-being.



Source: https://www.cdc.gov/publichealthgateway/images/publichealthservices/10-essential-public-health-services.jpg?noicon

An estimated 10%-15% of health systems have SDOH programs

From January 1, 2017, to November 30, 2019, 57 health systems (of 626 in the United States) initiated 78 unique, multiyear programs involving at least $3.8 billion: housing ($1.6 billion, 53 programs), employment ($1.1 billion, 28 programs), education ($476 million, 14 programs), food security ($294 million, 25 programs), social and community context ($253 million, 13 programs) and transportation ($32 million, six programs).[20]

Promedica and RWJ Barnabas are two examples of SDOH initiatives:

Promedica, a 13-hospital health system based in Toledo, has focused on SDOH and "created a new model that invests in public health, encourages partnerships and implements interventions that drive individual and community health." [21] All hospitals screen patients for SDOH. Promedica operates a Financial Opportunity Center, addresses food insecurity with a basic food care package and information about community resources, and established a Green and Healthy Home initiative focused on environmental hazards such as lead.[22]

[20] Horwitz, L.I., Chang, C., Arcilla, H.N. and Knickman, J. R. Quantifying Health Systems' Investment In Social Determinants Of Health, By Sector, 2017–19. *Health Affairs*; February 2020 https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01246

[21] Redefining Health. ProMedica https://www.promedica.org/social-determinants-of-health/redefining-health/

[22] ibid

RWJBarnabas Health has launched *Health Beyond the Hospital*, "the nation's first end-to-end, universally applied, culturally tailored and fully integrated social determinants of health (SDOH) program." [23] The program includes SDOH screening and the integration of digital health tools for culturally and linguistically appropriate patient engagement and care navigation (ConsejoSano), and community organization referrals (NowPow). HBH is being integrated with electronic medical records, and rollout will be completed in 2021.

Should providers prescribe "housing for health"?

Montefiore Health System in the Bronx has been addressing housing as a social determinant for many years, with the founding of the Moshulu Preservation Corporation (focused on affordable housing) in the 1980s and Housing at Risk (focused on the homeless) in 2009.[24] Montefiore also offers a respite care program as an intermediary arrangement for patients unable to be placed in a shelter or other suitable housing. Montefiore has achieved a 300% return on its investment because of fewer readmissions and shorter stays.[25]

In December 2017, Boston City Hospital announced its intention to invest $6.5 million into affordable housing over five years. Money was allocated to organizations focused on fighting eviction and preventing homelessness.[26]

Other hospitals and health systems addressing homelessness and other housing issues (stability, affordability) include Bon Secours Health System (Baltimore), Children's Mercy (Kansas City), St. Luke's Health System and Saint Alphonsus (Boise), St. Joseph Health (California) and the University of Illinois (Chicago).[27]

Population health as a guide to SDOH

According to Kindig and Stoddart population health is the "health outcomes of a group of individuals, including the distribution of such outcomes within the group."[28] Healthcare spending is highly concentrated, with 1.0% and 5.0% of the affected population generating 22% and 50%, respectively, of total healthcare expenditures; the bottom 50% of the population accounts for just 3.0% of spending.[29] The annual spending by Medicaid for seniors, accounting for 10%-12% of Medicaid beneficiaries, is a multiple of that of other adults: $17,476 vs. $3,995. Children, accounting for 48% of Medicaid beneficiaries, have an average spending of $2,602.[30] Fee-for-service long-term care Medicaid expenditures of $130 billion are driven by home health and personal care ($79 billion) and, to a lesser extent, nursing homes ($41 billion).[31] Dual-eligible enrollees (those eligible for Medicare and Medicaid) account for 35% of Medicaid spending.[32] Given the rapidly aging baby boomer population, chronic disease management and "aging-at-home" represent strategic imperatives for Medicaid.

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[23] RWJBarnabas Health Launches Nation's First Universal Social Determinants of Health Program, RWJBarnabas Health Blog, October 13, 2020 https://www.rwjbh.org/blog/2020/october/rwjbarnabas-health-launches-nation-s-first-unive/

[24] Case Study: The Montefiore Health System Addresses Housing as a Social Determinant of Health in the Bronx. U.S. Department of Housing Office of Policy Development & Research (PD&R) https://www.huduser.gov/portal/casestudies/study-091319.html

[25] ibid

[26] Boston Medical Center to Invest $6.5 Million in Affordable Housing to Improve Community Health and Patient Outcomes, Reduce Medical Costs. BMC Press Release, December 7, 2017 https://www.bmc.org/news/press-releases/2017/12/07/boston-medical-center-invest-65-million-affordable-housing-improve

[27] Social Determinants of Health Series: Housing and the Role of Hospitals. American Hospital Association, August 2017 https://www.aha.org/ahahret-guides/2017-08-22-social-determinants-health-series-housing-and-role-hospitals

[28] Kindig, D. and Stoddart, G. What Is Population Health? *American Journal of Public Health*, March 2003 https://ajph.aphapublications.org/doi/10.2105/AJPH.93.3.380

[29] Mitchell, E.M. Concentration of Healthcare Expenditures and Selected Characteristics of High Spenders, U.S. Civilian Noninstitutionalized Population, 2017. AHRQ Medical Expenditure Panel Survey; February 2020 https://meps.ahrq.gov/data_files/publications/st528/stat528.shtml

[30] State Health Facts: Medicaid Spending per Full-Benefit Enrollee, FY2014. Kaiser Family Foundation https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-full-benefit-enrollee/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[31] State Health Facts: Distribution of Fee-for-Service Medicaid Spending on Long Term Care, FY 2014. Kaiser Family Foundation https://www.kff.org/medicaid/state-indicator/spending-on-long-term-care/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[32] State Health Facts: Dual Eligibles' Share of Medicaid Spending, FY 2013. Kaiser Family Foundation https://www.kff.org/medicaid/state-indicator/duals-share-of-medicaid-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Asthma and pre-term births represent additional opportunities for SDOH integration. There were 1.7 million emergency department visits for asthma at an average cost of $1,502 per visit; 13.8 million school days were also missed.[33,34,35] Black infants are 2.0w times as likely to be born at low birth weight (13.9% vs 7.0%) and 1.5 times as likely to be born prematurely (13.9% vs 9.1%) compared with white (and Hispanic) infants.[36]

Equality does not mean equity

As healthcare transitions from fee-for-service to value-based care, providers must take into consideration their patients' unique needs and circumstances that will allow them to achieve their highest level of health. It is unrealistic to treat each patient with the same "one size fits all" approach and expect similar outcomes. To ensure health equity, providers must evaluate their patient's individual circumstances, including their family, and tailor SDOH interventions targeting the issues most responsible to close the gaps in health outcomes and access to care.

Stakeholder collaboration required for SDOH

Multiple stakeholders play an important role in identifying effective ways to leverage SDOH programs and create meaningful change. These include federal and state government agencies, public health entities, community and nonprofit service organizations, and health insurance plans and providers. Every entity, including individuals and their families, can contribute to setting up a system that addresses the SDOH challenges in healthcare. After several decades of trying to address SDOH, actual progress has been limited and deserves more attention:

1. Federal and state agencies should provide guidance along with funding to establish a more consistent and unified approach.
2. Studies should be conducted to assess and prioritize the most effective SDOH programs.
3. SDOH programs should be designed to capture and integrate data from multiple sources to measure progress towards goal attainment.
4. Incentives are needed to encourage entities to contribute to the success of any program.
5. Actuaries should be heavily involved in capturing and using data to assist in tracking and reporting on the effectiveness of each SDOH program. Risk adjustment and stratification, along with modeling and analytical tools, should increasingly be a central part of these programs.

Providers are essential partners in the SDOH journey, serving as the closest health-related connection to patients affected by one or more SDOH factors. Equipping providers with expanded assessment tools, easier ways to capture information, and an enhanced ability to follow up will enable the entire SDOH program to succeed. Partnering with health plans, regulators and community organizations will play an important role in our ability to help create a more accessible and equitable healthcare system.

[33] Rui, P., & Kang, K. (2014). National Hospital Ambulatory Medical Care Survey: 2014 Emergency Department Summary Tables. http://www.cdc.gov/nchs /data/ahcd/nhamc_semergency/2014 _ed_web_tables.pdf

[34] Wang, T., Srebotnjak, T., Brownell, J., & Hsia, R. Y. (2014). Emergency department charges for asthma-related outpatient visits by insurance status. *Journal of Health Care for the Poor and Underserved*, 25(1), 396-405. https://pubmed.ncbi.nlm.nih.gov/24509034/

[35] Asthma-related Missed School Days among Children aged 5–17 Years. AsthmaStats, Centers for Disease Control and Prevention https://www.cdc.gov/asthma/asthma_stats/missing_days.htm

[36] Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, Drake P. Births: final data for 2017. Natl Vital Stat Rep. 2018;67(8):1-50. https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_08-508.pdf

Challenges evident

We should also recognize that there are barriers to meaningful progress. Communicating effectively, establishing trust and being transparent about SDOH program goals will be critical in getting participation among people that have historical reasons to distrust the system. Cultural competencies will be an important tool for providers and other stakeholders to succeed. Provider contracts, including value-based care agreements, should create mutually beneficial terms and incentives to ensure alignment. And lastly, data from healthcare and non-healthcare sources (e.g., employment, social risks, community organizations) require integration.

Fostering a culture of equity

To successfully implement SDOH, providers need to foster a culture of equity and make it a priority. This requires strategic planning and resources throughout the organization. The following considerations are essential ingredients in achieving an organization that makes equity their priority:

1. Identify a health equity champion.
2. Align strategic plan with provider mission and vision.
3. Screen all patients for social determinants of health at various points of contact.
4. Transition from FFS model to value-based care model and align strategies.
5. Implement evidence-based health equity interventions that are measurable.
6. Implement a language access plan at each point of contact with the patient (front desk reception, exam room, call center, mailings, etc.).
7. Train all staff on the importance of delivering culturally and linguistically appropriate services.

FTI Health Solutions professionals are leaders in providing support for the important mission to study, create, and help implement innovative programs that address social determinants of health and for leveling the playing field to give all underserved populations equal access to healthcare.

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