

THE ROOT OF THE ISSUE

America's Social Determinants of Health

SYMPOSIUM PROCEEDINGS

By: Laura Summers, Senior Health Care Analyst | Kem C. Gardner Policy Institute

February 2019



THE ORRIN G. HATCH CENTER FOR CIVILITY AND SOLUTIONS

The mission of the Hatch Center is built on the four pillars that have defined Senator Hatch's 42 years in Washington. They are:

- The courage to do what's right for America*
- The wisdom to uphold civility*
- The integrity to respect others*
- The confidence to listen*

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Helping people live the healthiest lives possible.®

Its mission reflects Intermountain's expanding role as it focuses even more strongly on prevention and wellness, and strives to improve the health of those who live in Intermountain Healthcare's communities.

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Introduction

On November 14, 2018, the Orrin G. Hatch Center and Intermountain Healthcare jointly hosted the 2018 Hatch Center Policy Symposium “The Root of the Issue: America’s Social Determinants of Health.” The symposium focused on strategies and innovations for addressing social determinants of health, the conditions in which people are born, live, work, and play that affect their health risks and outcomes.

This proceedings report summarizes information presented at the symposium, outlines key observations, and poses next steps for consideration. The goal of the report is to help U.S. policy and health care leaders better understand and make informed decisions about addressing social determinants of health.

Symposium Speakers



Alex M. Azar II

Key Note Speaker
Secretary of the U.S.
Department of Health and
Human Services (HHS)



Senator Orrin G. Hatch

President Pro Tempore
of the U.S. Senate



Adam Boehler

Senior Advisor to the
Secretary of HHS Centers for
Medicare & Medicaid Services
Deputy Administrator and
Director of the Innovation Center



Karen DeSalvo, MD

Former Acting Assistant
Secretary of Health at HHS
Co-Convener of The National
Alliance to Impact the Social
Determinants of Health



Marc Harrison, MD

President and Chief
Executive Officer
Intermountain Healthcare



Mikelle Moore

Senior Vice President,
Community Health
Intermountain Healthcare



Vince Ventimiglia

Chairman, Leavitt Partners
Board of Managers

What are Social Determinants of Health

“What are social determinants of health?” Vince Ventimiglia, Chairman of Leavitt Partners Board of Managers, noted that while the phrase is increasingly being used, not everyone has a clear understanding of what it means.

In broad terms, social determinants of health are the conditions in which people are born, live, learn, work, play, worship, and age that affect their health risks and outcomes.¹ Vince Ventimiglia and Dr. Karen DeSalvo, co-convenor of the National Alliance to Impact the Social Determinants of Health, presented research showing that non-medical factors, such as a person’s living and working conditions, social environment, economic situation, and healthy behaviors, account for up to 60 percent of their health outcomes, while genetics and the health care system comprise the remaining 40 percent (Figure 1). These non-medical factors are known as social determinants of health (Figure 2).

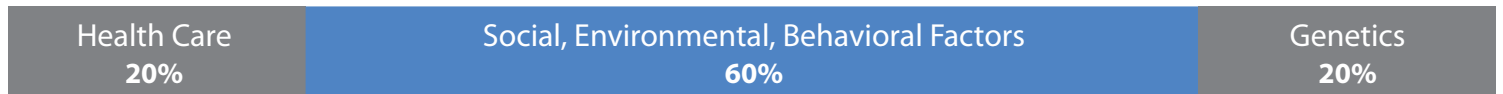


Dr. Karen DeSalvo presents on building health beyond clinical excellence and addressing social determinants of health.

Figure 1: Non-Medical Factors Account for 60 Percent of a Person’s Health

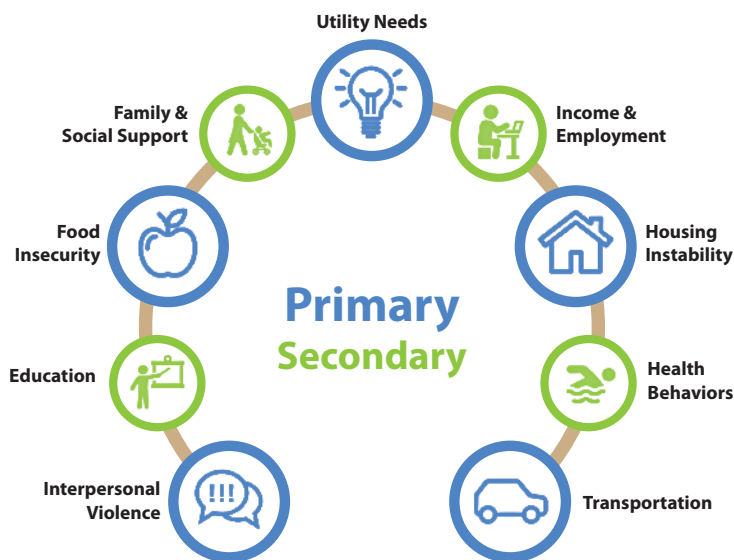
Presented by Karen DeSalvo, M.D.

Health Generators



Source: HealthyPeople.gov, Office of Disease Prevention and Health Promotion. Adapted from James Rubin, TAVHealth. Leavitt, M., DeSalvo, K. (2017 September 23). Guest Commentary: Value-based care’s success hinges on attention to social determinants. *Modern Healthcare*. Retrieved from <http://www.modernhealthcare.com/article/20170923/NEWS/170929957>.

Figure 2: Social Determinants of Health



Source: Intermountain Healthcare.

Alex Azar, Secretary of the U.S. Department of Health and Human Services (HHS), noted that while social determinants of health is a broad, and somewhat abstract term, it is a very tangible challenge for millions of Americans. For example, how can someone manage diabetes if they are constantly worrying about how they’re going to afford their meals? How can a mother with an asthmatic son really improve his health if their living environment is worsening his condition? Secretary Azar noted that addressing social determinants of health can be frustrating for a health care provider who understands what is driving the health conditions he/she is trying to treat, but can’t write a prescription for healthy meals, a new home, or clean air.

Given the impact social determinants of health have on our personal health, “our zip code affects our health more than our genetic code.”

Karen DeSalvo, MD

Why Is It Important to Understand Social Determinants of Health?

Dr. DeSalvo presented an overview of the research showing that people who have economic instability, unsafe neighborhoods or environments, poor social or community support, and a lack of access to education, healthy food, or the health care system tend to have poor health outcomes. This includes increased readmission rates, non-adherence to a doctor's recommended care plan, and decreased satisfaction with the health care system.

Based on these outcomes, addressing social determinants of health becomes key to improving people's health and lowering health care system costs. For example, a demonstration conducted in 2016 found that simply connecting people to social services resulted in a 10 percent reduction in health care costs—equating to a decrease in mean expenditures of \$2,400 for the group who had their social needs met.² A growing body of research mirrors these results and affirms that social determinants of health should be addressed in order to achieve large and sustained health care system improvements.³

Improving Health Care Outcomes

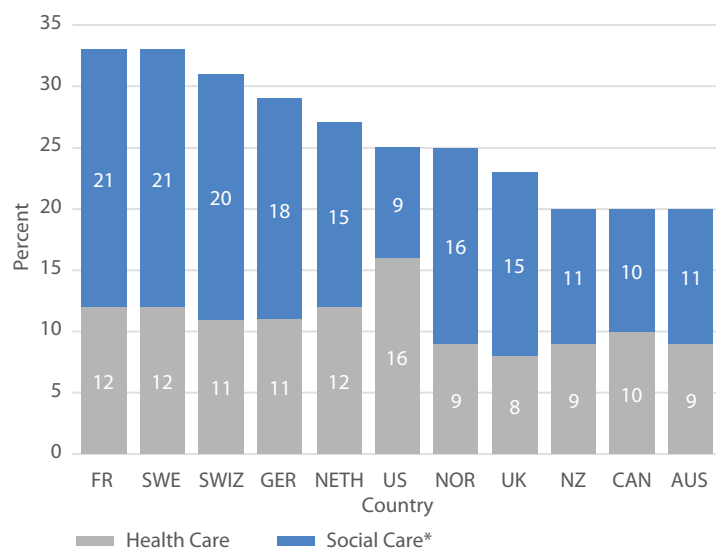
Dr. DeSalvo shared data that shows the United States far outpaces other industrialized countries in health care spending, but that our country's life expectancy has been rising at a much slower rate. She noted this is a surprising outcome given the significant progress the U.S. health care system has made with promoting quality and safety standards, improving the patient experience, increasing the use of technology and availability of data, and bending the cost curve.

That said, the United States has the lowest ratio of social service spending to health care spending among industrialized countries (Figure 3). Dr. DeSalvo noted that countries with a lower ratio of social service to health care spending have worse health outcomes even if a significant amount of dollars are spent on health care.⁴ This is because every dollar we spend on health care is a dollar not being spent on other initiatives that may have more of an impact on health.

Dr. Marc Harrison presented data further illustrating this divergence in health care spending. Access to medical care represents only six percent of a person's health and well-being. However, more than 90 percent of U.S. health care spending is directed toward medical services, with only nine percent being spent on initiatives that promote healthy behaviors (Figure 4).

Figure 3: Health and Social Care Spending as a Percent of GDP, 2005

Presented by Karen DeSalvo, M.D.



* Examples include rent subsidies, job training programs, nutritional support, family assistance, and other non-health services.

Source: Bradley, E.H., Taylor, L.A., Fineberg, H.V. (2013), The American Health care Paradox: Why Spending More is Getting Us Less. Public Affairs. Chart adapted from The Commonwealth Fund. Retrieved from <https://www.commonwealthfund.org/chart/2015/health-and-social-care-spending-percentage-gdp>.

Lowering Health Care Costs

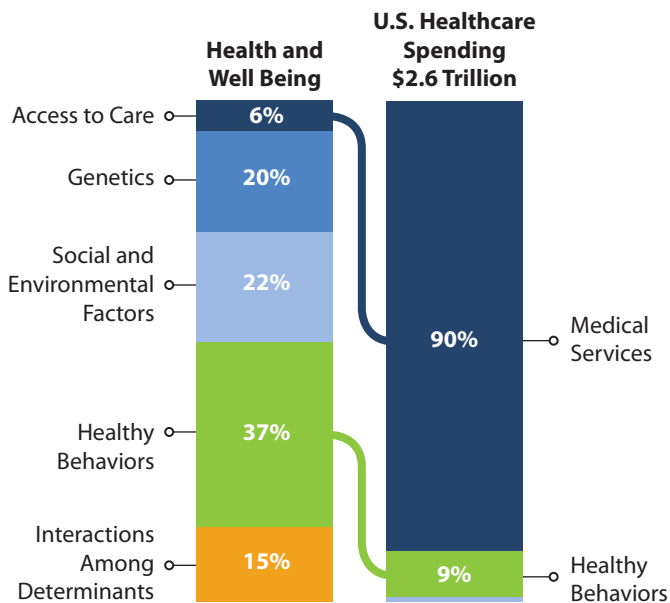
Dr. DeSalvo noted that a small share of the U.S. population accounts for almost 50 percent of total health care spending. To reduce overall costs, it is critical to understand who comprises this small group of individuals, why they are utilizing the health care system, and ultimately create a different system to more effectively address their social and health care needs.

As an example, Dr. DeSalvo shared data showing 52 percent of adults with three or more chronic diseases and functional limitations have income below 200 percent of the federal poverty level (FPL). Helping these individuals effectively manage their chronic diseases may extend beyond providing excellent clinical care to less costly options such as ensuring they have access to nutritious food, a safe environment, and tools or persons to help them navigate the complex health care system.

Dr. DeSalvo believes that addressing social determinants of health is a frontline effort to creating a new health care system and bending the cost curve.

Figure 4: Mismatch Between Drivers of Health and Spending

Presented by Marc Harrison, MD



Source: Harrison, M. (2018 November 14). Influencing Lives Earlier, More Effectively, and More Affordably. Intermountain Healthcare. Presented at the 2018 Hatch Center Policy Symposium, Washington, D.C.

“To more effectively address rising costs, the health care system needs to look beyond clinical evidence to social determinants of health.”

Marc Harrison, M.D.

Secretary Azar expressed similar sentiment noting that HHS spends more than \$1 trillion a year on health care for elderly and vulnerable Americans through Medicare and Medicaid. This spending far outstrips all other investments the federal government makes in Americans’ well-being outside of health care. He believes the U.S. could spend less money on health care—and, most important, help Americans live healthier lives—if the government did a better job of aligning federal health investments with its investments in non-health care needs.

What is Being Done To Address Social Determinants of Health?

Formal initiatives testing the effectiveness of social determinant of health interventions are beginning to emerge. An increasing number of states, hospitals, insurance companies, and provider groups are investing in systems and processes to address social determinants of health.⁵ This is building an evidence-base of experience, which is being cataloged and shared by research institutions.⁶ Dr. DeSalvo noted that technology is available to help health care entities assess community and individual health care needs, use predictive analytics to develop social risk scores,

and automate resource connectivity and closed loop referrals. UBER and Lyft’s ride share technologies are being used to provide medical transportation and Amazon’s delivery network is being touted as a possible way to provide direct food assistance and better address food insecurity.

Utah Alliance for the Determinants of Health

An example of a frontline initiative that includes a robust evaluation process with an aim to assess, produce, and share replicable outcomes is the Utah Alliance for the Determinants of Health (the Alliance). The primary goals of the Alliance are to coordinate health care and social services to improve health care outcome measures and lower healthcare costs to make health care more affordable for all.

The Alliance’s work, which is organized and led by Intermountain Healthcare, will begin with SelectHealth Medicaid members in Washington and Weber counties (Figure 5). The two participating communities were identified through a rigorous data analysis, which revealed that Medicaid members in these areas have lower life expectancy, higher rates of behavioral health concerns, and

While an increasing number of social determinant of health initiatives are being developed and tested, “more prospective studies with replicable outcome measures are needed.”

Karen DeSalvo, M.D.



Dr. Marc Harrison presents on Intermountain Healthcare's Utah Alliance for the Determinants of Health.



Symposium attendees engage in a discussion with Dr. Marc Harrison and Dr. Karen DeSalvo.

higher rates of visits to the emergency department for ambulatory care visits.

The Alliance seeks to improve health by focusing on non-medical factors such as housing instability, utility needs, food insecurity, interpersonal violence, and the lack of transportation. The Alliance is also exploring ways to promote personal capacity building, such as helping people develop long-term plans for the future. Intermountain researchers conducted ethnographic interviews with members in the selected areas that revealed that

there is a lack hope and drive for a better future among many of the participating members.

The Alliance is working closely with community partners in each of the areas to ensure that the selected interventions align with the areas' needs. The evaluation process will assess the effectiveness of the interventions as well as identify how to sustain this work over time with an intent to initiate similar work throughout Utah and share learnings across the country.

Figure 5: Utah Alliance for the Determinants of Health

Presented by Marc Harrison, M.D.



Certain communities in these counties were identified as having lower than average life expectancy, higher rates of behavioral health concerns, and higher rates of emergency department visits for non-emergent needs. They were also identified as having strong community assets such as social resources and engaged community partners. The communities are committed to working with the Utah Alliance for the Determinants of Health to positively impact the social determinants of health.

Source: Harrison, M. (2018 August 17). Influencing Lives Earlier, More Effectively, and More Affordably. Intermountain Healthcare. Presented at the 2018 Kem C. Gardner Policy Annual Symposium, Salt Lake City, UT.

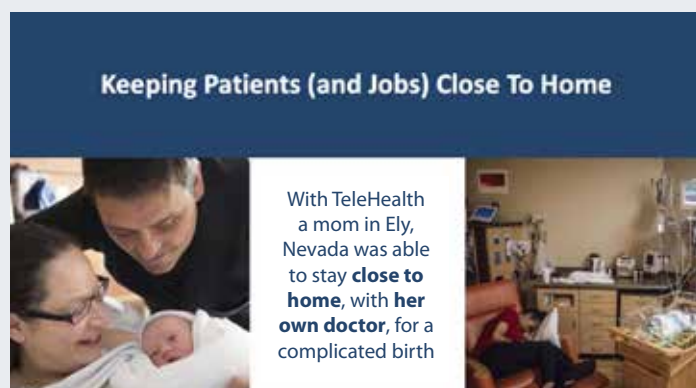
Intermountain Healthcare: Helping People Live the Healthiest Lives Possible

Intermountain Healthcare is committed to “helping people live the healthiest lives possible,” which includes a strong focus on social determinants of health and building a complete view of a population.¹⁵ Dr. Harrison presented on several Intermountain initiatives that support this commitment, including initiatives that address:

Deaths of Despair

The declining life expectancy in the U.S. is largely driven by “deaths of despair,” which are drug overdoses, alcohol poisoning, and suicide. Dr. DeSalvo presented data showing working class, middle age Americans are now dying at faster rates than minority groups. A key part of addressing social determinants of health is making changes at individual, social, and clinical levels to reduce these “deaths of despair.”

Intermountain Healthcare recognizes the impact that opioid abuse has on people’s personal health and economic situation and set a specific goal of reducing opioid prescriptions by 40 percent by 2018 as a way to help mitigate these negative effects. To address Utah’s high suicide rate, Intermountain is working with community partners to promote universal social norms around help-seeking and gun storage that can dramatically reduce risk; improve access to and coordination of effective behavioral health treatment; and institute evidence-based interventions that can ensure safety and uphold a commitment to “Zero Suicides” among its patients.



Source: Harrison, M. (2018 November 14). Influencing Lives Earlier, More Effectively, and More Affordably. Intermountain Healthcare. Presented at the 2018 Hatch Center Policy Symposium, Washington, D.C.

Rising Prescription Drug Costs

Intermountain is one of seven health systems or hospitals that came together to address the rising cost of prescription drugs, which is preventing many people from obtaining necessary medications. The organizations formed a not-for-profit generic drug company, Civica Rx—an FDA approved drug manufacturer that will either directly manufacture generic drugs or sub-contract manufacturing to contract manufacturing organizations.¹⁶ The goal of Civica Rx is to stabilize the supply of generic drugs administered in hospitals, provide more predictable supplies in the future, and ultimately lower costs. Civica Rx expects to have its first products on the market as early as 2019.

Rural and Financial Health Care Disparities

Intermountain is committed to supporting Utah’s rural area health workforces by promoting telehealth services and capabilities. This allows patients to receive care close to home, reduces transportation needs, allows rural hospitals to retain patients and revenue in their areas, and supports and sustains the local workforce and economy. Today Intermountain is partnering with 11 rural health care systems and is in discussion with 40 more.

In addition, Intermountain provided 10,616 vouchers for diagnostic services valued at \$8.6 million at 49 community and safety net health clinics in 2017. These vouchers allowed patients to receive diagnostic services not provided at the clinics at a nominal cost, reducing barriers to accessing care.

Transportation Needs

Intermountain convened a steering committee in 2016 that found that gaps in patients’ ability to access transportation resulted in delayed medical care and avoidable health care costs. To address these gaps, Intermountain contracted with a company to build a HIPAA-compliant platform that connects with Lyft drivers to provide non-emergency medical transportation to patients with no other options. Rides are ordered by care management staff to transport patients to and from their medically necessary appointments free of charge.

Accountable Health Communities

An important federal initiative that seeks to address social determinants of health is the Accountable Health Communities (AHC). The AHC model focuses on: (1) awareness, or systematic screening of all participating Medicare and Medicaid beneficiaries to identify unmet health-related social needs; (2) assistance, or testing the effectiveness of referrals and community navigation services on total cost of care using a rigorous mixed methods evaluative approach; and (3) alignment, or aligning partners at the community level and the implementation of a community-wide quality improvement approach to address beneficiary needs.⁷

Secretary Azar explained that providers participating in the model will screen high health care utilizers for food insecurity, domestic violence risk, and transportation, housing, and utility needs. Qualifying patients are connected with navigators, who help determine what community resources are available to meet their needs.

Evaluation of the AHC model will actuarially assess the value of providing systematic screening, referrals, and community navigation services to address beneficiaries' needs and promote community improvement. The goal of the evaluation is to provide an actuarially sound business model and estimated return on investment associated with addressing social determinants.

Center for Medicare and Medicaid Innovation

To support and sustain momentum for addressing social determinants of health over time, Vince Ventimiglia noted that initiatives should reflect the federal government's priorities and broader health care framework. Secretary Azar stated this framework is currently based on improving health care and social services while preserving what is unique about the American system: "its decentralized nature and the key role played by the private sector and civil society."⁸

The framework is also based on a concerted shift to value-based health care through "4Ps": (1) promoting patients as consumers; (2) preventing disease before it occurs or progresses; (3) helping providers become accountable navigators of the health system; and (4) paying for outcomes rather than the number of procedures provided.⁹

Secretary Azar and Adam Boehler, Director of the Center for Medicare and Medicaid Innovation (the Innovation Center) and Senior Advisor to the Secretary, discussed the administration's role in health care reform, its current priorities (the 4Ps), and how these priorities relate to social determinants of health.

Key Federal Initiatives Addressing Substance Use Disorders

Secretary Azar noted that it is that much harder for someone with a substance use disorder to manage health conditions and to secure housing, food, and other necessities of life. The pressures can also have deadly consequences. Neglecting treatment for a chronic condition is bad, but skipping a dose of suboxone because you're worried about where your next meal will come from can be deadly.

To address these issues, the Innovation Center developed two models to better treat and prevent substance use disorder through a more holistic approach. In the Maternal Opioid Misuse (MOM) model, state Medicaid agencies, front-line providers, and health care systems work to coordinate clinical care and integrate support services for pregnant and postpartum women with opioid use disorder and their infants.

The Integrated Care for Kids (InCK) model will help prevent and treat behavioral and mental health conditions in children. Mental and behavioral health issues in children are often a symptom of instability in another part of their lives. The InCK model provides a full set of crisis services to handle the needs of kids and their families when mental and behavioral health challenges arise.

"Just like how every patient is different in health care, every person has unique social service needs—and we are intent on designing models that connect them to the services they need, rather than offering a one-size-fits-all approach."

Secretary Azar



Mikelle Moore discusses innovation in health care with Director Boehler.

1st “P”: **Promoting patients as consumers.** Director Boehler believes that a lack of data operability, transparency, and long-term incentives prevent patients from engaging in the health care system. He also acknowledged that in order for patients to be better health care consumers, U.S. health care markets need to be reformed. He provided the example that when Medicare patients call 911, the responding Emergency Medical Services (EMS) may only be paid if they take the patient to the hospital (or a limited set of alternative locations)—even though a significant number of patients could be treated and released at the scene.

2nd “P”: **Preventing disease before it occurs or progresses.** If Director Boehler was setting up the health care system today, he would set it up in a way that is much more person- and prevention-focused. He noted that the design of the current health care system poses barriers that prevent more wide-scale adoption of prevention-based and social determinant of health initiatives. For example, most public and private health insurers do not include food, housing, and other social interventions in their benefit packages. As a result, treating providers cannot be paid for these types of interventions, which prevents them from being able to invest in the types of services people really need.

Secretary Azar and Director Boehler recognize these challenges and noted that the current administration is committed to removing some of these barriers. A Congressional spending bill passed in 2018 authorized Medicare Advantage plans to expand coverage for non-medical items such as groceries, the installation of home-safety equipment, and medical transportation, among others.¹⁰ Secretary Azar noted that starting in 2020, CMS will be expanding that range of benefits to include home modifications, home-delivered meals, and more.

Director Boehler believes changes like these provide clarity to the private sector and promote investments in social determinants of health, but do not directly dictate the types of investments that must be made. This maintains private sector innovation and accountability. He hopes that because CMS is willing to invest in social determinants of health, other health care systems will as well.

In terms of social determinants of health initiatives, the administration is currently most interested in building on its existing Accountable Health Communities model and further addressing gaps in housing, food, and transportation. Director Boehler noted several health care systems are already engaged in similar efforts and investments in housing and food have demonstrated positive returns by lowering health care costs. That said, Secretary Azar emphasized that it’s important for initiatives to be locally based and reflect local needs. HHS does not believe in a rifle-shot approach to human services: “You can’t focus on one or two needs to the exclusion of others.”¹¹

Secretary Azar and Director Boehler stressed that state-level change is enabled by CMS through waivers that allow states to develop systems that best reflect the needs of their residents. As an example, Secretary Azar cited guidance CMS recently released for state Medicaid directors, inviting them to apply for waivers from Medicaid’s exclusion on paying for inpatient mental health treatment. These waivers support treatment for substance use disorders, including opioid addiction.

Secretary Azar encouraged symposium participants to stay tuned into the Innovation Center’s activities. He stated the current administration is open to thinking big and is beginning to think about questions like: What if the Innovation Center went beyond connections and referrals? What if it provided solutions for the whole person, including addressing housing, nutrition and other social needs? What if it gave organizations more flexibility so they could pay a beneficiary’s rent if they were in unstable housing, or make sure that a person with diabetes had access to, and could afford, nutritious food?

3rd and 4th “Ps.” To help develop, expand, and scale these type initiatives, the administration is foremost committed to helping providers engage in the 3rd and 4th “Ps”, i.e., becoming accountable navigators of the health system and engaging in value-based health care.



Senator Hatch welcomes the key note speaker, Secretary Azar.



Vince Ventimiglia discusses the need to address social determinants of health.

How Do Social Determinants of Health Align with the Value-Based Health Care Framework?

The concept of value-based health care is one in which providers are paid for the value, or outcomes, of care provided, rather than the volume of services. Value-based payments are structured to reward providers for keeping patients healthy at the lowest cost rather than incentivize over-utilizing services. Examples of value-based payment models include bundled payments, upside-only shared savings, downside risk sharing, capitation, and global payments.

Symposium presenters noted that value-based payments are a key driver in advancing health care systems' interest in and ability to address social determinants of health. Secretary Azar noted that paying for outcomes means paying for the right inputs—whether they are health care services or not. He also noted that preventing disease is not just about providing the right health services, but also the right holistic approach to prevention and well-being.

By moving to value and taking on greater levels of risk for their patients, providers are financially incentivized to address the non-medical factors that keep their patients unhealthy and result in inappropriate overuse of health care services. For example, Dr. DeSalvo noted that as private payers, Medicaid, and Medicare move to value-based health care, their interest in addressing social determinants of health is increasing as well. She also noted that integrated delivery systems tend to have greater incentives for addressing social determinants of health, and are therefore

more innovative, because they are at risk for the patient across the care continuum. These systems also have access to more complete data on the patient, which can be used to determine where improvements are needed.

Dr. Harrison agreed, noting that health systems more quickly moving down the path to value-based payments and addressing social determinants of health generally share three characteristics: (1) they are an integrated system that allows them to realize the return on investment; (2) they are considered a "safety-net hospital" or system and serve a relatively high number of indigent patients; and (3) because of their role as a safety-net, they see themselves as civic leaders and have a governance board that supports their mission.

Dr. DeSalvo suggested that moving health systems to full risk is a possible solution for correcting the United States' low ratio of social service to health care spending (Figure 3). Accepting full risk for both health care and social services would combine the two categories and allow health care systems to more easily purchase and provide the health care or social services that best address their patients' needs. Dr. DeSalvo posited that it may be advantageous for Medicaid agencies to think about how to blend these health and social service funds upstream to allow for better service coordination downstream.

Key Observations and Next Steps

Public-Private Collaborations

Dr. DeSalvo stated that improving health and bringing value to the health care system requires more than clinical excellence. It requires active public-private collaborations—like the Utah Alliance for the Determinants of Health—to develop, test, scale, and disseminate initiatives that address social determinants of health.

She also noted that no one sector can do this alone. Addressing social determinants of health requires “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.”¹²

Dr. Harrison likened addressing social determinants of health to a “team sport.” He sees Intermountain’s role as convening and supporting community partners in developing effective initiatives. Director Boehler also believes public-private partnerships are key

to testing and producing effective solutions to addressing social determinants of health and supports these partnerships through the Innovation Center.

Vince Ventimiglia noted that there are at least 16 government agencies currently involved in social determinant of health work within the context of the federal government’s value-based health care framework (Figure 6). This level of activity illustrates a robust, multi-agency commitment from the federal government to understanding and supporting public and private-based initiatives. For example, the Surgeon General’s recent Call to Action: “Community Health and Prosperity” seeks data, information, and/or experiences from the private sector and local policy makers to demonstrate that investments in community health improve the health and prosperity of communities.¹³

Social Service Integration Framework

To help U.S. policy and health care leaders more systematically address social determinants of health, Dr. DeSalvo presented

Figure 6: Federal Activity

Presented by Vince Ventimiglia

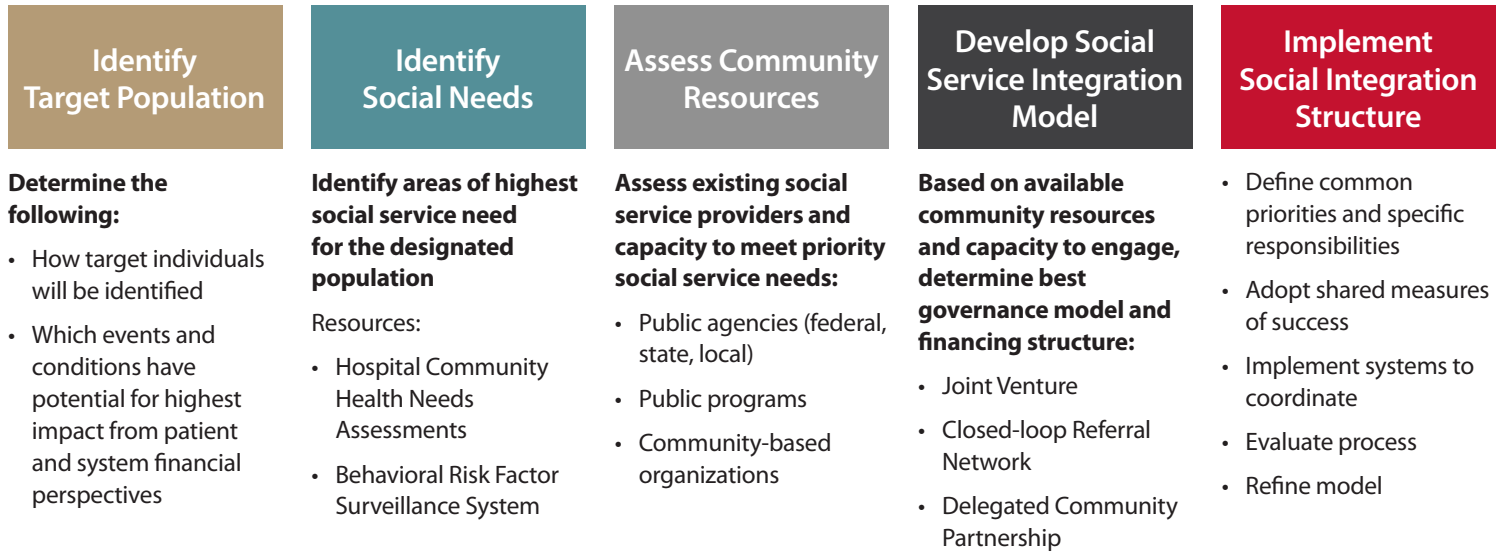


Source: Ventimiglia, V. (2018 November 14). Orrin G. Hatch and Intermountain Healthcare Policy Symposium. Presented at the 2018 Hatch Center Policy Symposium, Washington, D.C.

Figure 7: Social Service Integration Framework

Presented by Karen DeSalvo, M.D.

Integrate social services into broader care delivery and care management process



Reference methodologies: Commonwealth Fund State Policy Framework, Institute of Medicine's Community Health Improvement Process. Source: Health Care Transformation Task Force.

an example framework for integrating social services into broader care delivery and management processes (Figure 7). She suggested that groups interested in developing new initiatives should focus on health-related social needs first, such as food and social isolation, while maintaining a longer term focus on addressing social determinants of health that have a more sustained impact on a person's life, such as making positive changes to where people live, learn, work, and play. An example of a short-term objective could be providing food assistance, while a longer term objective would be finding ways to improve how food assistance is delivered in order to better target people's specific health care needs.

Shared Learnings

Vince Ventimiglia noted that addressing social determinants of health requires both a broad and narrow focus. Using the old analogy, he cautioned that you can't lose sight of the forest for the trees. Locally based initiatives are key to building an evidence-base of experience and knowledge of effective ways to address social determinants of health. Sharing the learnings and tools that emerge from these initiatives—like Intermountain and the Innovation Center is committed to doing—will help other local initiatives take root as well as propel broad momentum for addressing social determinants of health.

Figure 8: Social Determinants of Health: Federal Forest – Local Lumber

Presented by Vince Ventimiglia



Intermountain Healthcare Policy Symposium. Presented at the 2018 Hatch Center Policy Symposium, Washington, D.C.

The National Alliance to Impact the Social Determinants of Health (NASDOH) was formed for this express purpose of establishing and promoting an understanding of and commitment to addressing social determinants of health (Figure 9). Dr. DeSalvo noted that NASDOH will be publishing a report Fall 2019 highlighting best practices based on outcomes from evidence-based evaluations.

Figure 9: National Alliance to Impact the Social Determinants of Health

Presented by Vince Ventimiglia

National Alliance to Impact the Social Determinants of Health (NASDOH)

Establishing and promoting an understanding of the value proposition for the U.S. to prioritize the social determinants of health in a way that transcends partisanship, promotes inclusion of traditional and non-traditional stakeholders and partners, including the business community, and highlights the opportunity of cost and inaction.



- ✓ Consumer and patient organizations
- ✓ Employers
- ✓ Health insurance carriers
- ✓ Public health leaders
- ✓ Health care systems and providers
- ✓ Social Service leaders
- ✓ Venture capital
- ✓ Community development and urban planning experts
- ✓ Financial sector interests
- ✓ Philanthropy
- ✓ Technology sector innovators
- ✓ Thought leaders

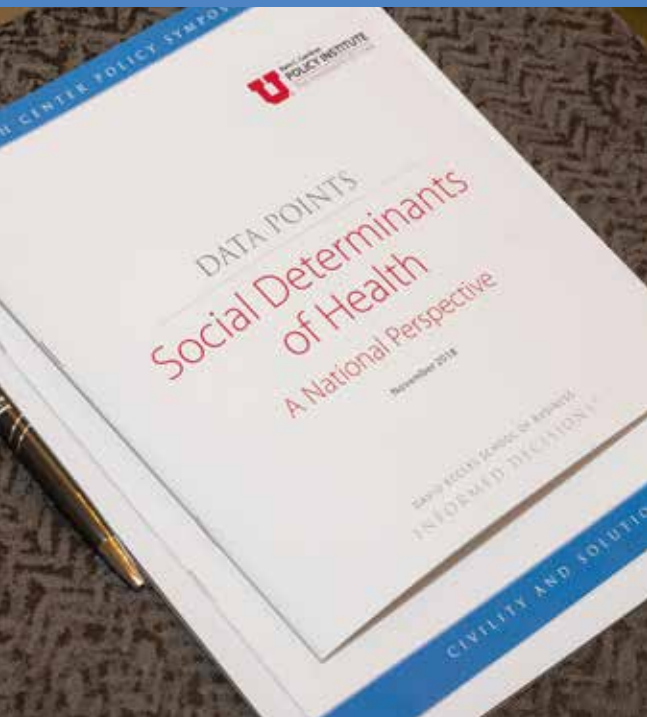
Source: Ventimiglia, V. (2018 November 14). Orrin G. Hatch and Intermountain Healthcare Policy Symposium. Presented at the 2018 Hatch Center Policy Symposium, Washington, D.C.

Conclusion

Health starts in our homes, schools, workplaces, neighborhoods, and communities.¹⁴ Even the best health care policies can become ineffective and costly if a person's social determinants of health are not addressed.

As the U.S. health care system shifts from volume- to value-based health care, there is a growing need to continue to understand social determinants of health as well as the tools and strategies that are available to address them. Speakers participating in the 2018 Hatch Center Policy Symposium noted that moving to value-based health care, allowing for greater risk, and integrating funding streams upstream will enable a more effective way of addressing social determinants of health in the long run.

U.S. policy and health care leaders have a unique opportunity to develop meaningful reform through shared dialogue, learnings, and action, however, the window of opportunity that is now open requires bold, strategic, and accelerated action.



Endnotes

- 1 Social Determinants of Health. (2018, July 25). Retrieved from <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-ofhealth>.
- 2 Pruitt, Z., Emechebe, N., Quast, T., et al. (2018, April 17). Expenditure Reductions Associated with a Social Service Referral Program. *Population Health Management*. doi: 10.1089/pop.2017.0199. [Epub ahead of print]
- 3 DeSalvo, K. (2018 November 14). Building Health Beyond Clinical Excellence. Presented at the 2018 Hatch Center Policy Symposium, Washington, D.C.
- 4 Bradley, E., Sipsma, H., Taylor, L. (2017, February 1). American Health Care Paradox-High Spending on Health Care and Poor Health. *QJM: An International Journal of Medicine*. 110(2):61-65. doi: 10.1093/qjmed/hcw187.
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