



THE AAHC SOCIAL
DETERMINANTS OF
HEALTH INITIATIVE

**Academic Health Centers and
the Social Determinants of Health:
Challenges & Barriers,
Responses & Solutions**



Association of Academic Health Centers

Leading institutions that serve society

THE AAHC SOCIAL DETERMINANTS OF HEALTH INITIATIVE

An individual's health prospects are shaped by a variety of factors beyond what has been inherited (genetics) and the medical care that is received. These other factors are called the social determinants of health and include an individual's social circumstances, environment, and behavioral patterns. While academic health centers have traditionally focused on medical care, and are working hard to learn more about genetics in health and disease, there is increasing interest in broadening their approach to more directly address the social determinants of health. AAHC is engaging member institutions (<http://www.aahcdc.org/About/Members.aspx>) to further develop approaches to individual and population health that include these underlying social determinants.

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INTRODUCTION AND OVERVIEW

On March 9-11, 2014, the Association of Academic Health Centers (AAHC)—in partnership with Georgetown University Medical Center; the Centers for Disease Control and Prevention; Des Moines University-Osteopathic Medical Center; Northeast Ohio Medical University; the University of Maryland, Baltimore; Florida International University; the University of Tennessee Health Sciences Center; and The University of Texas System—hosted its third national conference of selected leaders, titled *Academic Health Centers and the Social Determinants of Health*. The meeting was held at the Georgetown University Hotel and Conference Center, on the Georgetown University Campus, in Washington, DC, and support for this conference was provided by a grant from the Robert Wood Johnson Foundation.

The meeting program examined the role of academic health centers in addressing the social determinants of health, including (but not limited to) how to incorporate initiatives addressing social determinants in health professions education and clinical practice, and how to encourage interprofessional and interdisciplinary education and collaboration. The conference convened an array of stakeholders to engage in small-group dialogs focused on identifying barriers to addressing the social determinants of health and proposing constructive, collaborative solutions.

This report summarizes the conference's small-group breakout sessions, as well as relevant portions of plenary sessions, and synthesizes the discussion to identify consensus challenges and barriers to addressing the social determinants of health and propose responses and solutions. It focuses, in particular, on the role of academic health centers working in collaboration with other stakeholders.

FRAMING THE DISCUSSION: PLENARY SESSIONS PRECEDING SMALL-GROUP BREAKOUT DISCUSSIONS

The small-group breakout sessions to discuss challenges and barriers to addressing the social determinants of health, and proposed responses and solutions, were framed by a series of plenary sessions covering a range of interrelated topics, including:

- Educating upstream professionals;
- Innovative approaches to educating the public on the social determinants of health;
- Metrics and measuring success;
- How interprofessional education and collaborative practice can help address the social determinants of health;
- Views from the ground (social determinants of health activities at Georgetown University Medical Center); and
- A consideration of specific barriers and challenges to addressing the social determinants of health.

A number of recurring themes were woven throughout these plenary sessions, including:

- The lack of understanding among the public, professionals, and policy makers of the nature and full extent of social determinants on individual, community, and population health.
- The need for more effective messaging regarding social determinants' impact on health, both inside and, especially, outside the healthcare system.
- The need for more evidence as to which interventions make a measurable difference regarding individual, community, and population health, as well as the need for data systems to collect and disseminate data to support that research.
- The detrimental consequences of siloed responsibilities and resources within and between public and private stakeholders at the local, county, state, and federal level.
- The need for the evolving healthcare system to place greater emphasis on primary care, prevention, and interprofessional (and interdisciplinary) teams, including public and private reimbursement methods that support this increased emphasis.

During the small group sessions, conference participants were asked to respond to the following questions:

- There is a general consensus that the collaborative, interprofessional practice of healthcare could improve the health of the population. What are the practical and policy barriers to the practice environment moving in a more collaborative direction?
- Besides moving towards a payment system driven more by quality than quantity, what are some possible incentives and policy changes that could encourage a more collaborative practice environment?
- What are the five most significant barriers to a healthcare system that does more to address the upstream causes of disease?
- What are some of the significant barriers for academic health centers? Governmental public health? Community organizations? Foundations?
- Consider the barriers identified in the earlier session. Which of those barriers have policy solutions? Discuss the possible policy solutions.
- What are the levers available to each of the different stakeholder groups (e.g., academic health centers, government public health officials, community health centers, other healthcare providers, community organizations, foundations) to achieve these policy solutions?
- What areas of education still need to be tackled in order to achieve these solutions?

CONSENSUS CHALLENGES AND BARRIERS

Before the conference participants could address the responses and solutions best suited to collaborations between academic health centers and other stakeholders, they first had to conduct an environmental scan identifying the barriers and challenges created by the interaction of public and private stakeholders, including the relative contribution of institutional policies¹ (both private and public) toward social determinants of health. A broad consensus emerged from the small group sessions regarding significant challenges and barriers to addressing the social determinants of health.

INCOME AND HEALTH DISPARITIES. Discussants started with the observation that any public or private institutional policy that has the effect of increasing income/wealth disparities also impacts health disparities. Given the current deficit-driven budget environment at all levels of government, fiscal austerity is likely to make progress in addressing social determinants more difficult.

Even where resources are available, the lack of ultimate accountability for health disparities at any specific level of society undermines the effectiveness of any intervention. This lack of accountability is compounded by the fact that resources, when available, often reside in public and private institutions far removed from the particular communities that need them. *Moreover, income and health disparities are often not measured and reported at the proper level, with aggregation of data at levels higher than census tracts concealing significant pockets of income and health disparity that exist within larger communities and populations.*

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¹ The line between public policies that influence private behavior, and private behavior that influences public policy is often blurry. Therefore, small group discussants tended to interpret “policy” broadly when considering challenges and barriers, as well as responses and solutions. Specifically, “institutional policies” refers broadly to the prevailing practices of public and private institutions, not to particular laws and regulations.

ALLOCATION OF SOCIAL SERVICE SPENDING VIS-À-VIS HEALTHCARE SPENDING.

Relative to most other industrialized economies, the United States spends relatively less on publicly- and privately-funded social services, and relatively more on publicly- and privately-funded healthcare. In effect, our society prioritizes its spending to address diseases after they have arisen, rather than before they develop. This back-loaded approach exacerbates the impact of the social determinants of health and makes them more difficult to address.

SILOED RESPONSIBILITIES AND RESOURCES. Responsibility for addressing the social determinants of health, as well as available resources to do so, are highly fragmented. These include (but are not limited to):

- insufficient federal interagency cooperation and planning;
- insufficient federal, state, county, and local government cooperation and planning;
- insufficient cooperation and planning among public and private stakeholders; and
- insufficient interprofessional and interdisciplinary collaboration.

Many institutional policy decisions affecting social determinants of health—

- transportation,
- housing, and
- economic development,

to name a few—are made without taking their impact on individual, community, and population health into account.

In particular, lack of coordination of community health needs assessments was frequently cited as evidence of siloed responsibility and resources. Although a number of different entities are required by federal or state law to perform health needs assessments, the lack of common definitions and metrics leads to inconsistency and redundancy. Similarly, failure to ensure adequate community input into planning and decision-making processes can result in community priorities being overlooked when they are different from what top-down decision makers assumed. Categorical funding, which siloes resources, is far more common than integrated funding.

Siloing is problematic well beyond the government sphere. For example, there is a gap between the interprofessional education curriculum and actual practice, in part because the curriculum is rarely developed at an institution-wide level across all health professions schools (much less across health and non-health disciplines), with concomitant siloing of associated resources, which results in graduates being ill-prepared to function in high-performing interprofessional and interdisciplinary teams.

WORKFORCE. The complex nature of the social determinants of health can best be addressed by interprofessional and interdisciplinary teams. Such teams need to include not just an appropriate mix of health professionals, but non-health professionals (e.g., social workers, insurance navigators, lawyers) as well. While we are used to talking about shortages and excess supply in individual health professions, the larger and longer-term problem is establishing reliable professional pipelines to create and staff effective teams, as teams lacking key components will be far less effective.

- The insufficient supply of interprofessional and interdisciplinary teams to provide primary and preventive care has significant downstream consequences, increasing emergency room use and resulting in treatment being provided later in the disease progression.
- Lack of diversity in interprofessional and interdisciplinary teams (especially among health professionals) makes it more difficult for such teams to understand and fully appreciate the ways in which ethnic and cultural diversity can impact and sometimes magnify the effects of social and health habits.
- The disparity between the diversity of teams and the diversity of the communities they serve undermines the effectiveness of the care and services provided.

CULTURAL AND GENERATIONAL OBSTACLES TO INTERPROFESSIONAL AND INTERDISCIPLINARY COLLABORATIVE PRACTICE. Within the healthcare community, the health professions continue to work toward true interprofessional education and collaborative practice, but that goal has yet to be fully realized. There are many reasons for this limited success, including lack of flexibility and support from accrediting bodies, licensing agencies, and reimbursement policies. To successfully address the social determinants of health, the definition of team needs to be extended even further beyond the health professions to include other disciplines, such as social work, housing assistance, and legal assistance. Doing so raises challenges similar to those the health professions are already grappling with, but on an even broader scale.

EROSION OF PUBLIC HEALTH'S ROLE, STATUS, AND RESOURCES. At various times, public health policy has shifted focus from eradication of communicable disease to providing primary and preventive care to the underserved to pandemic surveillance. While there have been notable successes regarding some objectives (e.g., eradication of polio and smallpox, population-wide immunization rates, reductions in tobacco use), there have also been failures to successfully address others (e.g., asthma, infant mortality, sexually transmitted infections, obesity, etc.) in a consistent and coordinated manner. Moreover, many local health departments do not have the capacity to address the range of needs identified by their communities. The absence of a clearly-defined ongoing role, combined with inadequate funding, has often undermined public health's status as a key component of effective multi-stakeholder response to addressing the social determinants of health.

REIMBURSEMENT METHODS. The prevailing reimbursement methods of public and private payers are strong drivers of “pay for process” rather than paying for outcomes and population health. Even with the payment reforms included in the Affordable Care Act (ACA), incentives for primary, preventive, and team-based care in the public and private domains of the healthcare system remain weak. The failure of public and private health plans to reimburse non-health support services necessary to ensure optimal clinical outcomes for those impacted by the social determinants of health undermines the effectiveness of treatment and raises healthcare costs over the long term.

For healthcare providers to effectively respond to upstream causes of disease, payment systems must allow and incentivize them to address the social determinants of health. Lack of coordination of reimbursement methods among

- public payers (Medicare, Medicaid, state programs), and
- private payers (insurers, self-funded large employers, insurance marketplaces/exchanges)

is a significant obstacle to aligning the healthcare system along these lines.

Although the ACA has taken some steps in the direction of holding providers

accountable for population health, such as shared savings for Accountable Care Organizations (ACOs) that achieve superior results, it does so in a manner that may make addressing the social determinants of health more difficult rather than less difficult. *Providers with a case mix that includes a disproportionate number of patients adversely impacted by the social determinants of health (e.g., safety net hospitals) will be at a competitive disadvantage relative to other providers with a more favorable case mix in achieving superior results. In the absence of some form of risk adjustment that takes the social determinants of health into account, current health reform may effectively punish providers who seek to serve those most negatively impacted by social determinants.*

LACK OF COMMUNITY INFRASTRUCTURE. Failure to invest in community infrastructure (e.g., affordable housing, adequate public transportation, clean environment, etc.) directly and indirectly affects health status. Even where public and private decision makers are addressing infrastructure needs, they rarely think about these needs in terms of their impact on individual, community, and population health.

INADEQUACY OF NEEDED DATA. The availability of data regarding social determinants of health, including metrics for measuring population health, are far from ideal. Access to private data is often limited due to concerns about Health Insurance Portability and Accountability Act (HIPAA) liability, or the belief that sharing data voluntarily means forfeiting a competitive advantage. Public data sources are fragmented and inadequately coordinated. The methodology for measuring far upstream is underdeveloped. Although the value of primary and preventative care is increasingly recognized, the absence of a coordinated national approach to health data, together with the limitations of current data sets and methods, makes it difficult to quantify community needs or justify funding interventions.

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COMMUNICATION, MESSAGING, AND ADVOCACY. The protracted belief that healthcare is the predominant determinant of health status (as opposed to personal choice, lifestyle, environment, and prevention) is, to a significant extent, the result of the absence of a coherent dialog among public and private stakeholders at the national, state, and local level. In the absence of such dialog, stakeholders tend to see issues from a myopic perspective, without taking longer-term and system-wide implications into account. Among the potential pitfalls of such dialog is the tendency, in the currently partisan political environment, for significant policy debates to be oversimplified and politicized.

Given the complexity of issues surrounding the social determinants of health, building support for effective interventions requires

- clear messaging,
- effective communication of the message, and
- consistent and coordinated advocacy

regarding the nature and full extent of social determinants' impact on health—both inside and, especially, outside the healthcare system. Unfortunately, public and private stakeholders do not always see or define public health and social determinants issues from compatible perspectives or advocate in a consistent and coordinated manner. The resulting fragmented and under-resourced public discourse has so far been unable to raise awareness and knowledge about the social determinants of health to needed levels.

RIGIDITY OF ACCREDITATION AND LICENSURE. Accreditation bodies have proved to be a barrier, despite being made up of faculties that understand and regularly face the underlying problems and frustrations of accreditation. Their priority is establishing performance standards and certifying performance to that standard, not promoting disruptive innovation to support a paradigm shift in how academic institutions think about team-based care and its relevance to addressing the determinants of individual and population health. Licensure processes, as well, have proven to be barriers to advancing collaborative care.

CUMULATIVE IMPACT ON ACADEMIC HEALTH CENTERS. Academic health centers are unique among stakeholders with respect to the social determinants of health in that they are deeply involved in health professions education and pipeline development, research related to data collection and analysis, and delivery of healthcare services. Thus, they are directly or indirectly affected by every challenge and barrier identified above.

Health reform's transition to value-based and population-based reimbursement leaves academic health centers fiscally vulnerable. Competition between health providers and systems creates barriers to collaboration. Because they often serve as safety-net providers, academic health centers have a case mix that includes a disproportionate number of patients adversely impacted by the social determinants of health. *In payment systems where outcome measures are adjusted for health risk but not risks attributable to social determinants, academic health centers are systematically undercompensated for the true cost of care, and the resultant downward pressure on clinical margins makes it even harder to invest in interventions to address social determinants.*

Not all barriers affecting academic health centers are the result of policies external to the institution. Historically, faculty tenure and promotion committees have been more focused on achievements related to publications in prestigious journals and success in securing NIH funding than on community-based or collaborative activities and research. Thus, faculty have not been incentivized to focus on activities likely to have a bearing on the social determinants of health.

Similarly, many academic health centers have missed opportunities to promote collaboration with health profession schools outside the academic health center (e.g., many allied health professionals and nurses are not trained in academic health centers). The same can be said for collaborations with non-health professions schools (e.g., social work, law, public policy) that produce graduates with skills and expertise relevant to addressing the social determinants on a broad basis.

CONSENSUS RESPONSES AND SOLUTIONS

The next step in the consensus-building process was to ask small group participants to identify priority responses and solutions, and determine whether those responses and solutions were best addressed by public institutions, private institutions, or a combination of both. The small group sessions produced a broad consensus regarding policy responses and solutions to many (though not necessarily all) of the challenges and barriers previously identified.

DATA COLLECTION, SHARING, AND COORDINATION. HIPAA created a number of actual and perceived barriers to collection, sharing, and dissemination of data needed to coordinate information and services between public and private stakeholders seeking to address the social determinants of health. That data is needed both to

- support research to identify the most effective interventions, and
- guide the targeting of those interventions.

A comprehensive review of HIPAA and related privacy/confidentiality laws and regulations at the federal and state level should be conducted to clarify what can be undertaken to facilitate data collection, sharing, and analysis, for purposes of addressing the social determinants of health within the constraints of current public policy, while appropriately protecting privacy and confidentiality.

Improvements to data access requires improvement to data collection processes down to the level of electronic health records (EHRs) and associated dashboards. EHRs are rich with data, but data access is often difficult. Because software vendors are poorly incentivized to increase access, and the public is poorly informed about the importance and value of such access, a multi-stakeholder initiative is needed to develop a minimum standard of data availability from EHRs that appropriately takes into account meaningful use, models of care, and clinical outcomes.

The power of data grows as the size of the reservoir of information expands. Thus, it is important, with appropriate safeguards, to promote data sharing and aggregation—not just within individual institutions, but among key components of the healthcare system. Because needed data resides with both private (providers, commercial insurers) and public (Medicare, Medicaid, state and local health agencies) entities, and their goals regarding the social determinants of health are not fully aligned, a multi-stakeholder initiative designed to facilitate coordinated data-sharing among public and private entities is needed.

Productive use of the data depends, in part, on development of consensus outcomes measures. Because the data will be used by both private and public entities, and their current outcomes measures are not fully aligned, a multi-stakeholder initiative designed to facilitate development of consensus outcomes measures is needed with respect to patient experience, transactional measures, and improving health.

PUBLIC AND PRIVATE REIMBURSEMENT METHODS. The ACA's provisions creating incentives for primary, preventive, and team-based care are noteworthy first steps toward aligning public payment methods with efforts to address the social determinants of health. Additional efforts are needed to strengthen and align federal, state, and local reimbursement methods to consistently incent and support primary, preventive, and team-based care.

There is a crucial flaw in ACA provisions intended to reward care organizations that are accountable for value-based and population-based care. While current policy takes varying health risk into account, it does not take into account:

- 1 the varying life circumstance of individual patients negatively impacted by social determinants of health; or
- 2 the fact that some healthcare providers have a case mix that includes a disproportionate number of patients adversely impacted by social determinants of health, undermining both their short-term clinical outcomes and their long-term health status.

The lack of any life circumstances adjustment effectively penalizes those providers who serve patients negatively impacted by social determinants of health, putting them at a financial disadvantage relative to those who do not. Development and implementation of life circumstance adjustment mechanisms are urgently needed to protect the fiscal integrity of healthcare providers, including academic health centers that provide healthcare to populations most detrimentally affected by the social determinants of health.

A life circumstances adjustment presumes that healthcare providers are taking social determinants into account in their clinical decision-making. Two important precursors to the development and implementation of an effective life circumstance adjustment mechanism are:

- 1 medical and specialty societies expressly incorporating consideration of social determinants into standards of care; and
- 2 EMRs designed to capture social factors that influence management of disease.

Payment method reforms are likely to migrate from public payers to private payers without need for a specific public policy intervention. Private stakeholders should be consulted in the public payment reform process to promote early adoption and alignment.

COMMUNITY HEALTH NEEDS ASSESSMENTS. Multiple entities are required by different authorities to perform community health needs assessments, but there is no coordination or consistency in definitions, process, or results. A multi-stakeholder initiative should develop consensus measures, methods, and approaches to harmonize community health needs assessments and facilitate consistent decision-making.

WORKFORCE. Creating an appropriately sized and trained workforce is essential to addressing the social determinants of health. Doing so also serves as a means of community economic development. Academic health centers, working in partnership with other educational institutions and policymakers, should develop education system institutional policies that

- identify,
- support,
- admit,
- educate,
- and train students

from K level through advanced degrees with a core education that focuses on alignment of population health objectives.

SOCIAL INFRASTRUCTURE. Public and private stakeholders need to begin thinking about all investments in social infrastructure—housing, transportation, education, and economic development, among others—as having a significant impact on population health status. Funders should leverage limited resources by taking the social determinants of health into consideration when allocating investments in social infrastructure.

“Funders should leverage limited resources by taking social determinants of health into consideration when allocating investments in social infrastructure.”

ACADEMIC HEALTH CENTERS, COLLABORATIVE RESPONSES AND SOLUTIONS

The final step in the small group consensus-building process was to set aside those responses and solutions that are best addressed by government policymaking, and focus instead on responses and solutions that are best addressed by academic health centers directly or in collaboration with other private and public stakeholders. There was general consensus that there are a significant number of challenges and barriers that are not amenable to governmental intervention and must be addressed independently by academic health centers and other stakeholders.

To help fill the gaps in what can be accomplished through public policymaking, conference participants proposed the formation of a formal, ongoing academic health center collaborative to:

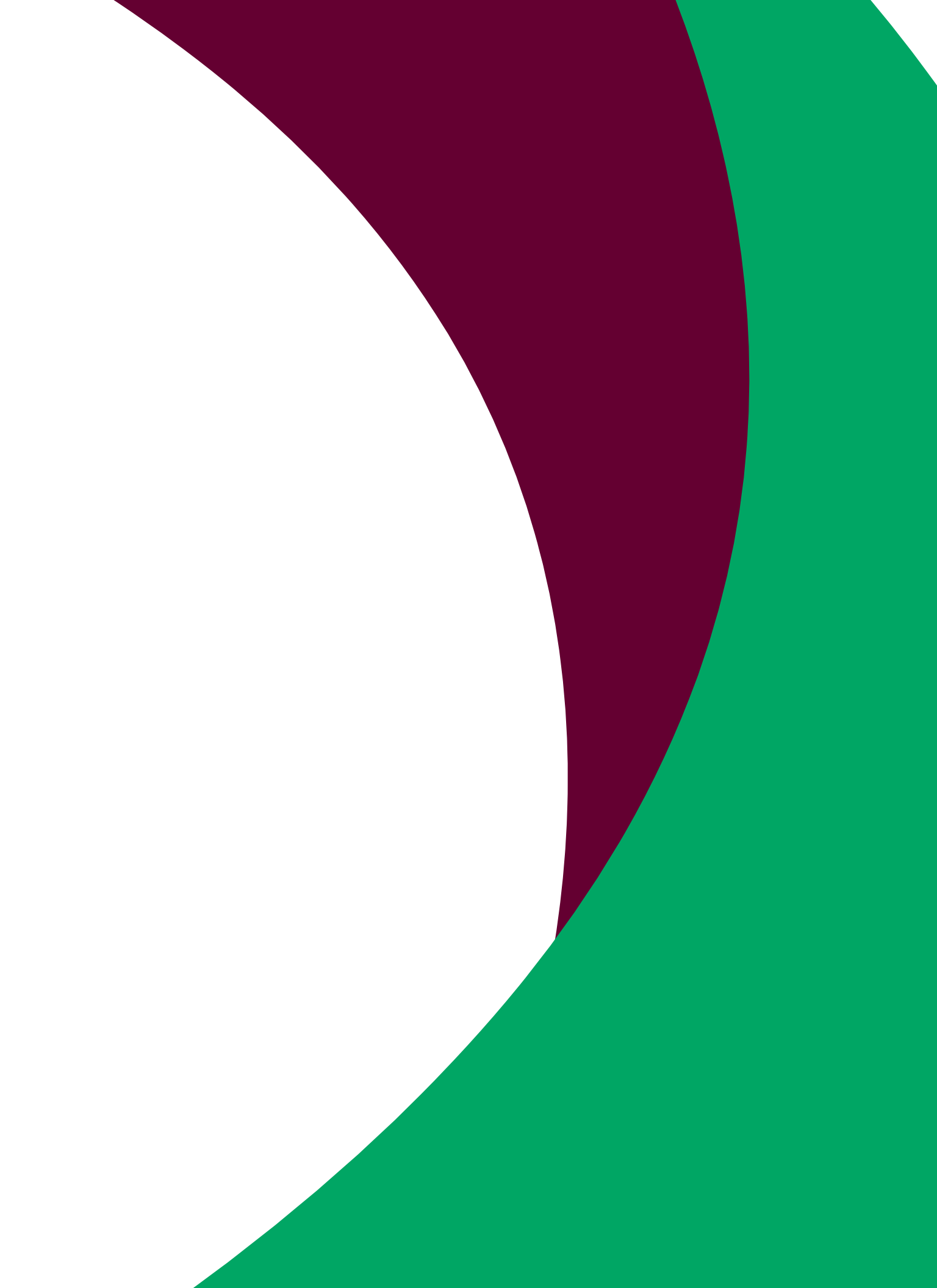
- Develop models and best practices for academic health centers establishing community-based partnerships to advance efforts to address the social determinants of health.
- Translate the best practices into a common, strong, shared message that articulates what is effective and what can be accomplished.
- Work more closely with other major public and private stakeholders to identify common interests and objectives.
- Take the lessons learned from new academic health centers that have been built from the ground up to address the social determinants of health and make those lessons learned available to guide established academic health centers seeking to improve their own commitment and impact.
- Articulate strategies to overcome cultural biases within academic health centers and foster informed leadership that provides top-down leadership responses and solutions to make addressing the social determinants of health a core value of the academic health center community.
- Assume a leadership role in developing data sources, research tools, and performance measures.
- Develop common, cohesive, effective messages that are consistently used from the local to national level to increase awareness, knowledge, and understanding of the nature and consequence of the social determinants of health by the public, other stakeholders, and policy makers.

CONCLUSION

Following the small group sessions, conference participants convened for a wrap-up session to reflect on their discussions and discuss possible next steps. There was general agreement that it was time for the academic health center community to move beyond the series of annual conferences the AAHC has organized and advance toward creation of an ongoing collaborative entity with the mission to focus exclusively on the social determinants of health.

For more information on the AAHC Social Determinants of Health Initiative, please visit: www.wherehealthbegins.org

To learn more about the Association of Academic Health Centers, please visit: www.aahcdc.org





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