TRANSCRIPT:

An Introduction to Social Determinants of Health

Hi, I'm Sarah Glasheen. I am the Senior Director of Policy and Strategic Initiatives at UnitedHealthcare Community & State. I am part of our national policy and strategy team and I spend my time working on a variety of projects related to social determinants of health including projects for housing and screening and referral tools.

What are Social Determinants of Health?

It is widely acknowledged that your health is impacted by far more than just your medical care. You've probably heard the term social determinants of health or SDOH used more commonly in health care conversations, so what does that exactly mean? Social determinants of health as defined by the World Health Organization are the conditions in which you are born, grow, live, work and age and the wider set of forces that shape your daily life. These are the broad systemic forces that can have a long-term impact on a community that will influence your ability to access healthy foods or quality education or affordable housing. So, your physical and built environment along with your ability to access those supports and services can really have a large influence on your overall health.

What are Social Needs?

While similar and related, social determinants of health are factors that influence, can impact at a community level whereas social needs can be thought of more at a family or individual level. These are things that can impede an individual or family's ability for health, well-being and safety, so things like the risk of eviction or access to food or even personal risk as a result of interpersonal violence. These are all things that can be thought of as immediate social needs. It's important to distinguish between the two because the approaches for addressing immediate social needs and longer-term social determinants are very different.

What are some tools to identify what social needs are?

Under current federal regulations, Medicaid managed care organizations are required to assess a member’s needs within the first 90 days of enrollment. Typically, these screenings include health-related questions and did not address social aspects of an individual's life except for perhaps a subset or targeted population. However, more recently Medicaid managed care organizations and state partners are interested in gathering this information to get a more holistic view of a member’s health and social situation. There are a variety of ways to collect the data. Like I mentioned, there are screening tools.

Also, data can be collected through ICD-10 or Z-codes through claims systems. And also, there is often face-to-face member engagement through case managers, social workers and community health workers. So, while the methods may vary across these different areas, what's consistent are the domains that are covered including: housing, nutrition, transportation and employment.

What are some barriers to addressing SDOH in Medicaid?

One barrier is the structure of Medicaid funding. Typically, Medicaid funding does not allow for the reimbursement of non-medical and non-clinical services. So for example, if a Medicaid managed care organization is managing the care of a child with asthma, that organization could pay for things like doctor visits, prescriptions, visits to the emergency room, if necessary. However, if it's determined that the asthma is being triggered by allergens in the home, so things like dust or mold, typically Medicaid does not pay for the replacement of carpeting that is old and in need of repair.

What are some opportunities associated with a focus on SDOH in health care?

So, there are several opportunities. The first one is around connecting members to resources. Through the efforts and tools we discussed previously, we now have more information about what our members needs are and we can connect them to resources that may be able to assist them with that particular issue that they may be experiencing. The second opportunity is around data and infrastructure. So as the conversation around social determinants of health has been elevated and expanding, there is an opportunity to talk with other stakeholders across health care and community organizations and government to look at standardizing data collection around social needs and analyzing that information so that we have a more holistic and longitudinal view of what the needs may be in a community. And then the third opportunity is around gaps. So, using that data and analyzing it, we can have a better understanding of where there are gaps in services and how do those match up with our members or communities' needs. And in working with our stakeholders across multiple sectors, we can collaborate to come up with proactive solutions that can address those gaps.