PRIORITY 5: Address the Non-Medical Drivers of Health to Improve the Nation's Health Outcomes.

Whether referred to as social determinants of health (SDOH) or non-medical drivers of health, these terms refer to non-medical factors influencing individuals' health and well-being, including the conditions in the environments where people are born, grow, work, live, and age.[190] For example, economic disadvantage often creates nutrition insecurity, which in turn raises the risk of chronic diseases such as hypertension and diabetes.[191] Unstable housing negatively affects physical and mental health and makes it more difficult to access healthcare.[192] Such adverse conditions contribute to excess healthcare costs[193] and decreased life expectancy and contribute significantly to health disparities.[194] Primary prevention of diseases, injuries, and health inequities requires addressing the upstream drivers that contribute to poor health. For these reasons, *Healthy People 2030* has an increased focus on addressing these conditions as a means to improving population health and eliminating health disparities.[195]

During the COVID-19 public health emergency, elected officials and agency leaders at all levels of government observed the longstanding connections between health outcomes and housing instability,[196] unstable employment and income, and food access.[197,198] The policy responses to the COVID-19 pandemic – intended to bolster economic security during disruptions in employment and education – provide real-world evidence of the positive health impacts of addressing non-medical drivers of health. For example, expansion of the Child Tax Credit in 2021, which temporarily reduced child poverty by a staggering 46 percent,[199] also resulted in improved parental mental health[200] and reduced food insufficiency.[201,202] Leadership of the U.S. Department of Health and Human Services of both political parties have identified social determinants as a driver of the nation's poor health outcomes and high healthcare costs.[203,204]

THE PROBLEM

A growing recognition that non-medical factors are a significant contributor to much of the nation's poor health outcomes has not yet been matched by policy action and sustained program investment. The nation's health and economic security depends on moving further upstream to prevent disease and reduce health disparities.

THE SOLUTION

The public health sector must be intentionally incorporated into the planning and execution of health-related initiatives to better align disparate systems and approaches to improve population health. Additionally, community members and those with lived experiences must be full partners in creating, designing, and implementing initiatives to address pressing health challenges. Policymakers should also extend policies proven to alleviate poverty and other non-medical drivers of poor health.

Public health and healthcare each have important, complementary roles to play in addressing both SDOH and health-related social needs (HRSN). To attend to immediate, individual-level needs, healthcare systems and payers are increasingly screening patients for HRSN, such as housing and food security, referring patients for services, and in some cases, paying for those services.[205] Private and public payers are both recognizing the promise of such interventions, including a return on investment. The Centers for Medicare and Medicaid Services (CMS) is offering mechanisms and guidance for states to pay for health enabling services such as housing and nutrition supports through Medicaid managed care, Section 1115 demonstration waivers, Home and Community Based Services authorities,[206] and Children's Health Insurance Program (CHIP) mechanisms.

SOCIAL DETERMINANTS OF HEALTH AND HEALTH-RELATED SOCIAL NEEDS

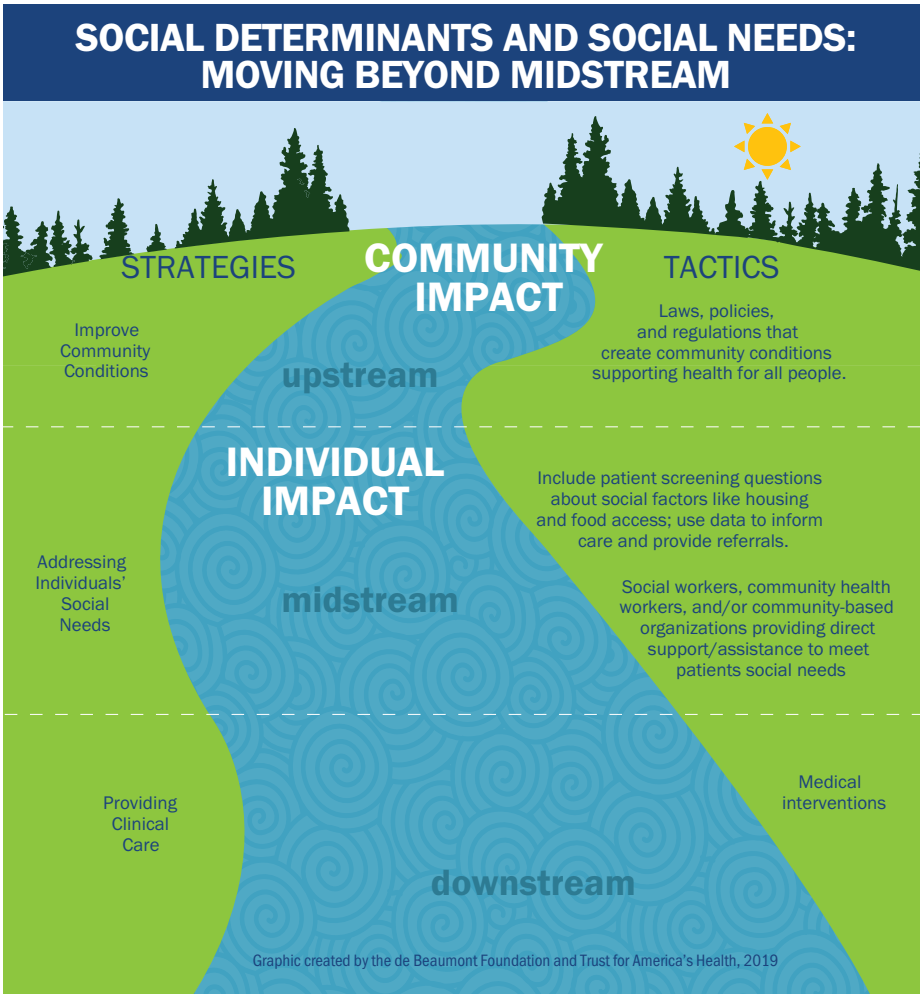
The terms "social determinants of health" and "health-related social needs" are sometimes used interchangeably, but they have different meanings and implications.

Social Determinants of Health (SDOH)/Non-Medical Drivers of Health (NMDOH) refer to the conditions in which people are born, live, learn, work, and age that impact their health and well-being.[207,208] SDOH may impact an entire group, population, or community, such as the built environment, economic stability, education access, and polluted air and water. Addressing SDOH requires systemic, multisector approaches.

Health-Related Social Needs (HRSN) indicates an individual's unmet adverse social, economic, or other non-medical needs that affect that individual's health. These requirements may include food security, housing stability, or access to reliable transportation.[209] Assistance for meeting these individual needs does not address the underlying economic or social conditions that lead to social needs.

However, there are obstacles to addressing HRSN through healthcare alone. First, interoperability limitations hinder coordination between healthcare, public health, and social services data systems, making it more difficult to screen and refer patients for services. Greater interoperability and incorporation of SDOH data in electronic health records could improve patient referrals to social services.[210] Second, a patient may be referred for services that are not available in a community, such as in areas with lack of affordable housing (a social determinant of health). These challenges highlight the need for multisector approaches.

Public health is poised to expand its efforts to move upstream, but siloed, disease-specific funding prevents many health departments from taking further action on SDOH. Already, health departments are successfully engaging across sectors to promote policy, systems, and environmental changes. For example, they are contributing to community changes that promote healthy living, such as tobacco-free policies, community-clinical linkages, and improved food access.[211] CDC envisions four primary roles for governmental public health to address SDOH: 1) as a changemaker, to support and inform policy efforts and lead interventions; 2) as a convener, to bring together multisector partnerships; 3) as an integrator, to provide important data from health and non-health sectors; and 4) as an influencer by using scientific expertise to inform community actions.[212] With appropriate resources, communities across the country could leverage partnerships and resources to focus on upstream drivers of poor health.



PROGRESS MILESTONES

- In 2023, the Administration released the first-ever *U.S. Playbook to Address Social Determinants of Health*, highlighting actions federal agencies are taking to address SDOH.[213] The companion document, HHS's Call to Action to Address Health Related Social Needs serves as a resource to promote cross-sector partnerships to create a more integrated health and social care system.
- *Healthy People 2030*, which sets data-driven national objectives to improve the nation's health and well-being over the next decade, identified SDOH as a priority area, including by creating a HHS work group dedicated to developing and tracking progress toward the objectives related to SDOH.[214]
- Beginning in 2021, Congress funded CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) to build capacity to address non-medical drivers of health.[215] To date, CDC has funded 71 recipients to develop multisector, implementation-ready Accelerator Plans to address SDOH.[216] These planning grants help accelerate action around domains such as food and nutrition security, community-clinical linkages, and the built environment. Through additional support from Congress, CDC is also supporting implementation of these plans through three-year Addressing Conditions to Improve Population Health (ACTion) projects.[217]
- To inform future and ongoing SDOH work, CDC studied successful multisector community partnerships (MCPs) across the country as part of the Improving Social Determinants of Health — Getting Further Faster (GFF) initiative. Researchers found that of the 42 GFF partnerships evaluated, 90 percent of them contributed to community changes that promote healthy living. Of the 29 partnerships that reported health outcomes data, their programs are projected to save $644 million in medical and productivity costs over 20 years.[218]
- The Improving Social Determinants of Health Act was introduced in Congress in 2021[219] and again in 2024[220] to provide a statutory framework and to fiscally support CDC's SDOH work, including authorizing multisector grants to address upstream drivers of health and coordinate activities across CDC.
- CDC's PLACES data provides health data by county, ZIP code tabulation areas, places, and census tract. In 2023, PLACES added nine measures at four geographic locations to help identify the geographic distribution of health inequities and help prioritize investment in areas with the greatest need.[221]
- In 2022, CMS provided guidance on how states can address HRSN through Medicaid Section 1115 demonstration waivers.[222] The number of Medicaid Section 1115 demonstration awards related to addressing HRSN continues to increase. As of July 2024, 21 states had approved waivers for HRSN, and 16 more had pending waivers.[223]
- In 2023, CMS released a detailed framework outlining coverage of HRSN in Medicaid and Children's Health Insurance Program (CHIP).[224] This included guidance for state Medicaid managed care plans to offer services, like housing or nutrition supports, as substitutes for standard Medicaid benefits (i.e. "in lieu of services").[225]
- CMS introduced the HRSN Screening Tool and guidance from the Accountable Health Communities (AHC) Model to promote universal HRSN screening.[226]
- The American Rescue Plan Act (ARPA) expanded the federal Child Tax Credit to families with low- and moderate-incomes, temporarily lifted 2.9 million children out of poverty, reducing child poverty to a record low.[227,228] The expiration of the expanded tax credit resulted in a record rise in poverty in 2022.[229]
- ARPA temporarily extended the Earned Income Tax Credit (EITC) for workers without a qualifying child, resulting in a significant decrease in housing hardship, food insufficiency, and difficulty with expenses.[230]
- Some states and localities used ARPA State and Local Recovery Funds to increase the supply of affordable housing,[231] and Economic Impact Payments provided many individuals with increased food sufficiency and decreased difficulty with expenses.[232]

IMPACT STORIES

Multisectoral Partnerships to Promote Food and Nutrition Security in Rural Illinois

With assistance from CDC SDOH planning (Accelerator) and implementation (ACTion) grants, Illinois's Ogle County Health Department is addressing food and nutrition security for residents in four rural counties across the state. The health department partnered with local organizations and conducted needs assessments to create a cohesive plan.[233] The health department established mini food centers to increase access to healthy food options and is launching a TV and radio media campaign to raise awareness of food insecurity and reduce stigma associated with receiving food assistance. It is also partnering with University of Illinois extension offices to offer a nutrition curriculum for individuals and families. To ensure sustainability, the food centers will be managed by "hosting centers"- partner organizations that will incorporate sponsorships from different businesses and companies within their area to help fund them. Four mini food centers opened between May and June 2024, providing 24/7 access to food for roughly 30,000 community members across Lee, Ogle, Carroll, and Whiteside counties, and three more mini food centers are scheduled to open by October 2024.[234]

Leveraging Public and Private Resources to Reduce Disparities in Muskogee County, Oklahoma

With assistance from a CDC SDOH accelerator grant, Muskogee County Social Determinants of Health Consortium led a multisector partnership to develop and implement an SDOH plan for Muskogee County. The Consortium collected data from 260 county residents and conducted 75 key informant interviews to inform the SDOH Accelerator Plan's focus on social connectedness and community-clinical linkages. The plan addresses a critical need for greater access to care due to poverty, low availability of local primary care physicians, distance to existing providers, and limited access to transportation. To date, Saint Francis Health Systems has committed $100,000 to implement the plan, improving the health of nearly 69,000 rural residents of the county.

Addressing Medicaid Beneficiaries' Non-medical Health Needs

States are increasingly leveraging Medicaid Section 1115 Demonstration Project Waivers authorizing coverage for services such as housing and nutrition support and case management.[235,236] In Arizona, for example, the state's Medicaid agency worked with CMS to develop a Housing and Health Opportunities (known as "H2O") plan to meet the housing needs of high needs/high-cost patients experiencing housing instability. A collaborative process enables the identification of eligible members, assessment, and referral for housing services such as transitional housing and tenancy services.[237]

RECOMMENDATIONS

Congress should increase funding to $150 million for the Social Determinants of Health program at CDC to expand meaningful multisector partnerships between public health and community partners that address social determinants of health including economic opportunity, housing, transportation, and access to nutritious foods.

Congress should pass the Improving Social Determinants of Health Act to authorize the expansion of CDC's SDOH work to better align initiatives and programs, including existing grants and funding streams for communities. The funding would also support the development of a unified infrastructure to enhance data collection and evaluation, policy analysis, best practices, and communities of practice related to SDOH within state, territorial, tribal, and local governments.

The Administration and relevant federal agencies should implement the *U.S. Playbook to Address Social Determinants of Health*. This implementation should include regularly updating the playbook, public reporting of progress across the domains, and presidential budget requests that support the action items therein.

The Administration should continue to build on the Centers for Medicare & Medicaid Services' (CMS) efforts to support Medicare, Medicaid, and CHIP program coverage of patients' health-related social needs (HRSN). The Administration should support CMS in building capacity to expedite the review and approval of appropriate Section 1115 waivers and state plan amendments that would ensure state Medicaid, CHIP, or Medicaid managed care organizations can reimburse HRSN, including community-based organizations and social service providers. CMS can also provide state Medicaid agencies with targeted technical assistance to further build the capacity of community-based organizations to engage with healthcare entities.

CMS should continue to incorporate screening for and addressing HRSN into CMMI models. CMS announced in 2022 that all Center for Medicare and Medicaid Innovation (CMMI) model participants will be required to have a health equity plan. These plans should include a focus on assessing and addressing social needs as a necessary approach to advance equity. In addition, CMS should ensure that CMMI models facilitate cross-sector partnership and support for the infrastructure (e.g., community care hubs) that help address HRSN.

The Administration, led by the Assistant Secretary for Technology Policy/National Coordinator for Health Information Technology, should continue to promote SDOH data interoperability to improve privacy-protected Health-Related Social Need (HRSN) data collection and sharing between healthcare, public health, and social service agencies. The Administration should facilitate technical assistance to states so they can advance HRSN data interoperability.

CMS and Congress should explore opportunities to expand the capacity of healthcare providers and payers to screen and refer individuals to social services by leveraging existing billing-code options; coordinating

care delivered among healthcare, social service, and safety net programs; sufficiently reimbursing social-services providers, and more fully integrating social needs data into electronic medical record systems.

Congress should amend tax laws to increase economic opportunity for families. Congress should expand the full Child Tax Credit (CTC) with an inflation adjustment for families with low incomes, which is estimated to benefit about 16 million children.[238] Congress should also extend the Earned Income Tax Credit (EITC) to adults without a qualifying child.

Congress should enact federal housing and place-based policies that promote housing stability and economic opportunity. Congress should support housing stability, especially among moderate-to-low-income individuals, through increasing funds to U.S. Department of Housing and Urban Development (HUD) for housing choice vouchers, housing rehabilitation, and rapid re-housing efforts.[239] Congress should also promote neighborhood improvement by increasing funding for existing place-based programs, such as the HUD Choice Neighborhood program, which leverages public and private dollars to enable neighborhood transformation and the U.S. Department of Education's (ED) Promise Neighborhoods program, which supports a continuum of solutions for communities to ensure children and youth in poverty-concentrated communities can succeed in school and beyond.[240] HUD and the Department of Education should collaborate with HHS on implementation of these programs.

Congress should expand access to high-quality early childhood education by increasing funding and reimbursement for Head Start and Early Head Start. High quality early childhood education has been proven to have numerous health and economic benefits, such as increased access to nutritious meals and exercise, improved mental health, greater likelihood of receiving dental care, improved cognitive outcomes, and reduced public spending on Medicaid and social services.[241]