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Enhancing the health and well-being of all Americans

The Root of the Problem: America's Social Determinants of Health

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Social determinants of health is an abstract term, but for millions of Americans, it is a very tangible, frightening challenge: How can someone manage diabetes if they are constantly worrying about how they're going to afford their meals each week? How can a mother with an asthmatic son really improve his health if it's their living environment that's driving his condition? This can feel like a frustrating, almost fruitless position for a healthcare provider, who understands what is driving the health conditions they're trying to treat, who wants to help, but can't simply write a prescription for healthy meals, a new home, or clean air.

As Prepared for Delivery

Thank you for that introduction, Sen. Hatch. Good afternoon, everyone, and thank you for having me here today.

It's an honor to join all of you for this gathering, and it is an honor to be invited here by Sen. Hatch and the Hatch Foundation. Sen. Hatch has been a presence throughout my career in Washington and in healthcare. Each of the three times I have appeared before the Senate to be confirmed for jobs at HHS, he has introduced me before the Senate Finance Committee, and in all of my time at HHS, he has been a wise counsel and a thoughtful counterpart.

We at HHS have great appreciation for the work he has done to improve the health and well-being of Americans over his career, from designing the Children's Health Insurance Program, which today provides low-cost insurance to more than 9 million American kids, to the role he played in designing Medicare Part D.

With both programs, Sen. Hatch showed that smart policy can help deliver better healthcare for Americans, and the Hatch Foundation today will help future generations think about the difficult health questions we face.

One of them is the topic of today's event, the root cause of so much of our health spending: social determinants of health. Social determinants would be important to HHS even if all we did was healthcare services, but at HHS, we cover health and human services, all under one roof. In our very name and structure, we are set up to think about all the needs of vulnerable Americans, not just their healthcare needs.

Unfortunately, that's not always how things work. HHS spends over $1 trillion a year on healthcare for elderly and vulnerable Americans through Medicare and Medicaid, which far outstrips any other investments the federal government makes in Americans' well-being outside of healthcare. There are a variety of reasons why the federal government takes the lead on financing healthcare, and that is not about to change. But we believe we could spend less money on healthcare—and, most important, help

Americans live healthier lives—if we did a better job of aligning federal health investments with our investments in non-healthcare needs.

One reason this doesn't happen already is the sheer complexity of our health and human services system. Many federal programs for low-income Americans, like nutrition and housing, do not live within HHS. Moreover, human services and healthcare programs for vulnerable Americans are often administered at the state level—states run Medicaid, cash welfare, subsidized childcare, Head Start, and many more such programs. On top of all that, much of the support our country provides to struggling Americans does not flow through government: It's provided by churches, charities and other nongovernmental organizations, which are frequently tasked with helping the sick and poor navigate the eligibility requirements, application timelines, benefit thresholds, and other complicated elements of our nation's safety net programs.

Now, you could look at the complexity and diversity of this system as a challenge. But we're here at a solutions summit, so I want to encourage all of you to look on the bright side: There are ways that the unique nature of our system can be brought to bear on social determinants of health.

It probably won't surprise you to hear that this administration is thinking about how to improve healthcare and social services while preserving what is unique about our American system: its decentralized nature and the key role played by the private sector and civil society.

But it may surprise you that we are thinking about this very specifically in the context of social determinants of health.

We are deeply interested in this question, and thinking about how to improve health and human services through greater integration has been a priority throughout all of our work. I want to go into some detail today about several ways we are working on integrating services and addressing social determinants through several different models being run at the Center for Medicare and Medicaid Innovation, under Adam Boehler, and then in other parts of our system.

Social determinants of health is an abstract term, but for millions of Americans, it is a very tangible, frightening challenge: How can someone manage diabetes if they are constantly worrying about how they're going to afford their meals each week? How can a mother with an asthmatic son really improve his health if it's their living environment that's driving his condition? This can feel like a frustrating, almost fruitless position for a healthcare provider, who understands what is driving the health conditions they're trying to treat, who wants to help, but can't simply write a prescription for healthy meals, a new home, or clean air.

To help providers confront this challenge, last year, CMMI launched the Accountable Health Communities model. Under the model, participating providers screen high utilizers of healthcare services for food insecurity, domestic violence risk, and transportation, housing and utility needs. If needed, patients are set up with navigators, who can help determine what resources are available in the community to meet the patient's needs. Like all CMMI models, this will be carefully assessed to see whether this is an effective way to meet these non-health needs, and whether making these connections improves health and decreases health spending.

A model like this can take advantage of two key aspects of our decentralized, flexible system: the individualized approach it enables and the incentives we can offer to private-sector service providers.

One approach to social determinants of health would be, for instance, to say that we should identify a couple of the most common needs—like nutrition or housing—and really focus on investing in those.

But that's not going to be of great use to someone in, say, a rural area, where food and housing may be affordable but finding a ride to their healthcare provider is the real challenge. That's why we don't believe in a rifle-shot approach to human services: You can't focus on one or two needs to the exclusion of others.

Just like how every patient is different in healthcare, 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.

Second, significant interest in the Accountable Health Communities model has come from accountable care organizations and Medicaid managed care organizations, which stand to benefit if the model drives down healthcare costs. As part of our efforts to deliver value-based healthcare, we are moving more toward a system where providers can take on more risk. This will, in turn, broaden the opportunities for providers to benefit from addressing social determinants of health. Throughout the world of social services, there is great interest in paying for success, and, happily, that is exactly where we want to head in healthcare too.

Now, you might think, if these models are really going to save money, why aren't providers already trying them out themselves? Well, one answer is that at least one person did figure this out, delivered success in a wide range of states, and then we hired him to run CMMI. But in all seriousness, we have seen accountable care organizations engage on social determinants of health already, and the results have been encouraging. One of the most acute issues, for instance, is nutrition, which I know has been an area of interest for ACOs like Intermountain.

Data from the Agency for Health Research and Quality at HHS found that Americans with malnutrition are twice as costly to treat at the hospital as those who come in well-nourished. In fact, malnutrition is involved in 12 percent of non-maternal, non-neonatal hospital stays—$42 billion each year in healthcare spending. Naturally, a number of private health providers and payers have already tried addressing this issue: One ACO in Chicago, for instance, began screening high-risk patients for malnutrition, and then supporting them after discharge from the hospital with follow-ups, referrals, and nutrition coupons. The savings were huge: more than $3,800 per patient.

So there are encouraging innovations occurring, but we also constantly face new healthcare challenges. Consider the interconnected problems of chronic illness and non-health needs, which so many of you are familiar with—and insert addiction into that picture. For someone struggling with a substance use disorder, it is that much harder to manage nagging health conditions and to secure housing, food and other necessities of life. The pressures can have deadly consequences: Neglecting treatment for a chronic condition can be bad enough, but skipping a dose of suboxone because you're worried about where your next meal will come from could be deadly.

So through two models at CMMI, we are actively addressing how to better treat and prevent substance use disorder through a more holistic approach. In the Maternal Opioid Misuse, or MOM model, state Medicaid agencies, front-line providers, and healthcare systems will work to coordinate clinical care and integrate support services for pregnant and postpartum women with opioid use disorder and their infants. Currently, while various clinical services and social and community supports for pregnant and postpartum women exist, those with a substance use disorder often face particular challenges in gaining access to

medication-assisted treatment and recovery supports, like housing. This is unacceptable, and we are directly confronting that challenge with the MOM model.

The other model we've launched to tackle substance use is the Integrated Care for Kids model, which will help prevent and treat behavioral and mental health conditions, including substance use disorder, in children. Mental and behavioral health issues in children are often a symptom of instability in another part of their lives. Therefore, we need to do a better job of identifying and screening for potential mental and behavioral health issues among our kids and address the challenges they or their families are facing, before more serious challenges develop. Under the InCK model, when mental and behavioral health challenges arise, there is a full set of crisis services available to handle the needs of kids and their families.

Well in advance of the launch of both of these models, we worked to alert states so that they could begin engaging with their philanthropic and community organizations, to determine what resources could be marshalled to support the efforts.

Substance use disorder is a particularly acute challenge today, but it is hardly the only mental health condition that drives poor physical health outcomes and sky-high spending. Another stubborn challenge is serious mental illness, which drives an extraordinary amount of spending in our healthcare system and in social services and law enforcement.

Just consider the healthcare side: A study of the most common utilizers of emergency-room visits in Massachusetts, for instance, found that the vast majority of them were homeless, and the most common health conditions were substance use disorder and mental illness. Nearly half of the highest ER utilizers were struggling with co-occurring serious mental illness and substance use disorder. Treating these challenges in the ER setting is not just costly, but ineffective. The right answer is more appropriate treatment options and better connections to social supports.

To help address this challenge, yesterday we announced historic new guidance for state Medicaid directors, inviting them to apply for new waivers from Medicaid's exclusion on paying for inpatient mental health treatment. These waivers will be modeled on the ones we have already given to 15 states to support treatment for substance use disorder, including opioid addiction. As with the existing waivers, the goal is not just to expand access to outpatient treatment, but also to support a broader range of treatment and recovery services.

For decades now, Americans with serious mental illness have been poorly served by our health system—first, by an inhumane system of institutionalization, and now, by a system that fails to provide them with what they need to live healthy lives in the community. With these waivers and other work across the administration, we believe that can begin to change—and we can enter an era where serious mental illness is treated as effectively as any other health condition.

Now, what I've described so far largely involves addressing social determinants by forging better connections between the health system and social services. We believe that can drive significant improvements and savings.

But what if we went beyond connections and referrals? What if we provided solutions for the whole person, including addressing housing, nutrition and other social needs? What if we gave organizations more flexibility so they could pay a beneficiary's rent if they were in unstable housing, or make sure that a diabetic had access to, and could afford, nutritious food? If that sounds like an exciting idea . . . I want you to stay tuned to what CMMI is up to.

Much of what I've discussed today applies to particularly vulnerable populations, where social factors drive acute healthcare needs and healthcare spending is high.

But as we age, pretty much of all of us—even you especially healthy Utahns—will end up being high healthcare spenders, with expensive, complicated conditions.

So we are eager to think about social determinants of health throughout the Medicare program, and one of the best ways we can do that is through the flexible, accountable, individual-driven system we already have: Medicare Advantage.

Because MA plans hold the risk for their patients and they compete for their patients' business, they have an incentive to offer benefits that are both appealing to their members and that will bring down health costs—whether those benefits are traditionally thought of as health services or not.

The key is just that we need to give them the flexibility to do this, which we generally haven't done. But starting next year, plans will now be allowed to pay for a wider array of health-related benefits, such as transportation and home health visits. Starting in 2020, we are going to be expanding that range of benefits even more, to include home modifications, home-delivered meals, and more.

These interventions can keep seniors out of the hospital, which we are increasingly realizing is not just a cost-saver, but actually an important way to protect their health, too. And if seniors do end up going to the hospital, making sure that they can get out as soon as possible, with the appropriate rehab services, is crucial to good outcomes and low costs as well. If a senior can be accommodated at home, rather than in an inpatient rehab facility or a SNF, they should be.

As you can tell from what I've discussed, we are thinking about social determinants in much of the work we do. But there is a unifying reason we've made it a priority, too. As you heard from Adam this morning, social determinants are closely integrated into the priority I've laid out to move toward a value-based healthcare system—one that delivers better outcomes at a lower cost.

Think about how addressing social determinants of health benefits each of the elements of our agenda for value-based care that Adam has set out: the four Ps of patients, providers, payments and prevention. We want patients to be empowered and informed, not just to seek out the health services they need, but any necessary social supports, too. We need providers to act as accountable navigators of the health system, but we need to supplement that with navigators of the social services system. Paying for outcomes means paying for the right inputs—whether they are healthcare services or not. And we need to prevent disease not just by providing the right health services, but also the right holistic approach to prevention and well-being.

Now, delivering a value-based healthcare system probably sounds ambitious enough already. But really delivering it will require the kinds of even more ambitious transformations I just described. Thankfully, we have an ambitious president, and an ambitious administration.

One of the joys of working for President Trump is that he is never afraid to think big. Under President Trump, we have the potential to try out truly bold solutions to some of the most stubborn social problems our country faces. The American system is capable of addressing these challenges, and as I've said, I believe we are uniquely equipped to do it.

What it will take is coming together and pushing the boundaries of what we have traditionally thought possible. Under this administration, we're determined to do that—and help the Americans we serve live longer, healthier, happier lives.

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