

## Congressional Social Determinants of Health Caucus

### ***Request for Information (RFI) on challenges and opportunities related to social determinants of health***

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### **What specific SDOH challenges have you seen to have the most impact on health? What areas have changed most during the COVID-19 pandemic?**

Children's health and well-being can be dramatically affected by both upstream social determinants of health (SDOH) (which are structural factors that can influence health on the population level, such as neighborhood conditions and access to income, education, and employment), and downstream health-related social needs (factors that can influence health on the individual or family level, such as food insecurity or housing instability). Inequities caused by social need have long existed, but they have been laid bare and exacerbated by the COVID-19 pandemic.

For example, [a recent Kaiser Family Foundation poll](#) found that more than half of Black parents (53%) and parents with lower household incomes (51%) say they or another adult in their family left a job or changed schedules in order to care for their children during the pandemic. Virtual schooling, lack of reliable child care, and a surge in mental health needs for both caregivers and children alike have created extraordinary challenges for families. Policies and interventions that could address these challenges, such as improving access to the internet, behavioral health care services and supports, and flexible paid leave for working parents and caregivers have not kept pace with the needs of families.

Community resource mapping is one way of understanding data patterns in order to identify population-level community needs. A multi-disciplinary team at Children's Hospital of Philadelphia (CHOP) recently launched a resource map website, [Resource Connects](#), which is an electronic, searchable database of community-based organizations that providers, patients, and families can use to find resources by social need category and by geographic location. This platform not only allows us to provide families with a resource targeted to their unmet social needs, but also permits us to track searches for resources as a way of measuring broader social need at the population level.

Since launching this platform in March 2020, searches for food resources have consistently made up the majority of activity on the site. During the first wave (April – July 2020) and second wave (November 2020 – January 2021) of the pandemic, food resources made up 50% or more of searches on the site, peaking at 62% of searches in May 2020. This aligns with national data on increases in food insecurity during the pandemic. Wage reductions, long-term unemployment, supply chain disruptions, and high food prices have all posed challenges for both families who previously struggled, and for millions of new families. School closures also restricted access to the school lunch program for 29.6 million children who depended on it as a daily source of nutrition. This has culminated in a [projected 30% increase](#) in household food insecurity since 2019. The effects of COVID-19 on food insecurity are magnified in families with

children, and in high-poverty cities like Philadelphia, which already had high levels of childhood food insecurity before the pandemic.

After food, the other top search categories on Resource Connects have consistently been housing, clothing/supplies and utilities. As the federal housing eviction moratorium became more uncertain and eventually ended, we saw searches for housing increase on the site from approximately 10% of searches in April 2021 to nearly 20% of searches in August 2021.

While looking at data from a community resource platform is one way to better understand population level needs, we emphasize that it is also vital to engage with and listen to community residents, and to co-design interventions with them to address their most pressing needs. Health systems and policymakers must engage with and empower community residents and stakeholders.

### **What types of gaps in care, programs, and services serve as a main barrier in addressing SDOH in the communities you serve? What approaches have your organization, community, Tribal organization, or state taken to address such challenges?**

Responding from our vantage point as a pediatric health care system, health care systems lack robust, evidence-based means of identifying and addressing patients' immediate social needs at the point of care. While social needs screening can be valuable, there are potential unintended consequences. In a recent CHOP PolicyLab [issue brief](#), we articulated those risks and how they may be avoided in order to ensure that screening for unmet social need in pediatrics is both family-centered and effective.

One significant issue is that resources are not always available to address identified needs. For instance, social needs screening mandates have often suggested screening for housing needs, but housing support is sparse for families. According to [data from Children's Defense Fund](#), nearly 1 in 3 children (31%) live in households burdened by housing costs, meaning more than 30% of their family income goes toward housing. Federal housing assistance is extremely helpful for families that receive it, but these programs are woefully underfunded and do not come close to meeting the need. For instance, 5.9 million children live in families with "worst-case housing needs," meaning they are extremely rent burdened, have low income and receive no housing assistance from the government. Medical Legal Partnerships (MLPs) such as CHOP's [Family Justice Partnership](#) are essential and can offer families some support around issues such as unjust eviction and housing repairs, but cannot fill the gap left by inadequately funded federal housing assistance.

As a health system serving residents of West Philadelphia, a community with some of the highest rates of childhood poverty in the United States, CHOP also prioritizes engagement with local community members about their sources of strength and needs. For instance, CHOP is designing a neighborhood council to inform its new Center for Health Equity. The neighborhood council will consist of CHOP staff and community members who live and work in the communities we serve.

Additionally, as health care systems and payers shift toward value-based care, there may be an opportunity for innovation in partnerships between health care systems and community-based organizations to address underlying social determinants of health for the populations they serve. Better integration of previously siloed health and social service systems could provide a powerful catalyst for improving health equity in the United States.

### **Is there a unique role technology can play to alleviate specific challenges (e.g., referrals to community resources, telehealth consultations with community resource partners)? What are the barriers to using technology in this way?**

It is essential to continue testing the use of technology to assist interdisciplinary teams in screening and referral. [Research](#) has shown that written, paper-based screening, or tablet-based electronic screening is acceptable to families, and makes it more likely that an individual will disclose social needs. However, the move toward tablet-based screening may leave behind populations with literacy challenges. Furthermore, in terms of referrals, families often prefer resources that are searchable, electronic, and geographically tailored based on their location. Technological interventions have promise, but it is essential to ensure that they meet the needs and preferences of diverse populations.

Technology could also help streamline communication within and across health and social service care teams (e.g., electronic social needs screening, the electronic health record) and could ensure that families are connected with the most appropriate resources (e.g., via searchable electronic resource maps). While they do not replace the need for interdisciplinary interventions, technology-based resources such as electronic resource mapping tools have the potential to increase the efficiency of resource referrals through centralized databases of accurate community services, improved electronic referral mechanisms, and bi-directional communication with community-based organizations.

As noted elsewhere, in partnership with other local health systems, CHOP built and is maintaining the use of [an electronic resource mapping website](#) to serve as a centralized community resource directory for staff and patients. The main purpose of the website is to provide accurate and easily searchable information on community services, and eventually to make direct referrals through the site. Our utilization numbers reflect a clear need for such a tool. Still, more work is needed to support the capacity of community organizations to meet patient need and to develop workflows that allow them to engage with the resource mapping platform.

Collaboration is essential to ensure that online resource repositories and referral systems are not duplicative and difficult to navigate for patients, health care systems and community-based organizations. Health care systems in Philadelphia have sought to address this by partnering to design and implement the electronic resource mapping and referral tool just mentioned. When this is not possible, it is essential to have data sharing across platforms to ensure consistency of resources and documentation, while also protecting patient privacy.

### **Where do you see opportunities for better coordination and alignment between community organizations, public health entities, and health organizations?**

Sustainable funding channels are needed to build and maintain support for a workforce that includes social work support, community health workers, and community-based services who can partner with families and connect them to long-term support programs. Health care systems must have the in-house infrastructure to facilitate strong connections within the community and with community-based organizations to address unmet social needs once they are identified.

In addition, planning for successful implementation of social care interventions requires working outside of the health care system, in partnership with community organizations, to better understand their preferred referral practices and capacity for addressing families' needs. As previously mentioned, health care systems also need to collaborate in order to establish an aligned mechanism of referrals to community-based organizations, in order to minimize the need for these community partners to develop different plans, partnerships and platforms with each institution. This type of collaboration requires sustained federal and/or state investment and support, which has been lacking to date.

### **How could federal programs such as Medicaid, CHIP, SNAP, WIC, etc. better align to effectively address SDOH in a holistic way? Are there particular programmatic changes you recommend?**

Access to Medicaid in childhood has shown [lifelong benefits](#) related to educational attainment and earning potential. And with Medicaid and the Children's Health Insurance Program (CHIP) insuring nearly 40% of children, they are key programs to leverage and innovate within to address unmet social needs and to ensure greater stability for families into the future. Unfortunately, a high proportion of currently uninsured children are eligible for Medicaid or CHIP but not enrolled. Enrollment outreach, assistance, and streamlining eligibility and enrollment with other public programs (see below) should therefore be a top priority for federal efforts.

Federal nutrition assistance programs, including WIC and SNAP, are a key source of food assistance for caregivers and children in under-resourced communities. Unfortunately, only about half of all WIC-eligible families currently receive these benefits, and we believe that this low uptake rate is in part due to administrative burdens on families (see more in related CHOP PolicyLab work [here](#)). A number of programmatic improvements could help reduce these burdens, including streamlining eligibility determination and enrollment across WIC, SNAP, Medicaid and other benefit programs. Adjunctive eligibility determination, in which WIC staff can electronically determine participants' eligibility based on their enrollment in SNAP or Medicaid and proactively contact and enroll WIC-eligible clients, is one such improvement that should be explored and incentivized for state uptake. Providing streamlined, simple, mobile-friendly online benefits enrollment applications that allow families to apply for and receive benefits from multiple programs at once could also improve participation.

In addition, while health care systems across the country are pursuing innovative strategies for identifying and addressing unmet social needs, greater alignment with and sustainable financing through Medicaid/CHIP or other vital safety net programs that serve children and families could help bring equitable, health care-based social needs interventions to scale. State-level innovations, including implementation and evaluation of different models for addressing unmet social needs, could lay the groundwork for future federal policies.

### **Are there any non-traditional partners that are critical to addressing SDOH that should be better aligned with the health sector to address SDOH across the continuum from birth through adulthood? What differences should be considered between non-health partners for adults' social needs vs children's social needs?**

Pediatrics is grounded in a family-centered approach to care delivery, which often requires and benefits from collaborating with non-traditional partners as well as those that serve to address unmet social needs of caregivers. Meeting children and families where they are is critical in cross-sector collaboration. With most children returning to brick and mortar schools and child care centers this fall, education systems are a natural space for collaboration around addressing the social determinants of health. However, inequities in school funding frequently strip districts with the highest needs of critical resources to aid and achieve cross-sector collaboration around the social determinants of health.

Other vitally important collaborators in the pediatric space include home remediation and repair agencies and faith-based organizations. Similarly, state, county and city-level departments of public health are critical allies and stakeholders in the quest to meaningfully address social needs and the social determinants of health.

### **What opportunities exist to better collect, understand, leverage, and report SDOH data to link individuals to services to address their health and social needs and to empower communities to improve outcomes?**

As evidence builds around the acceptability, feasibility, and effectiveness of social needs interventions in health care, it is essential to be proactive about efforts to minimize unintended consequences related to collecting and reporting data, particularly for families in the pediatric setting. These consequences include: potential harms related to repeatedly asking patients to recount their unmet social needs; provider bias and documentation of social needs in electronic health record systems, which could exacerbate discrimination based on race and class; and financing barriers that can be complicated by fragmented payer, provider and social service systems. Many of these potential harms could be worsened in the pediatric setting, where teams are serving whole families in addition to patients.

PolicyLab at CHOP recently convened more than 30 experts from across the United States for a virtual workshop on policy levers to address unmet social needs in the pediatric setting. Data collection and reporting was a key topic of conversation and what follows are the main points raised by the group (see full summary [here](#)).

Patients and their caregivers must clearly understand why providers are collecting data on their unmet social needs and how it will be used. While screening is an important step to assess need, it is not by itself an intervention. Without the availability of necessary follow-up services and resources (for patients or caregivers who want them), social needs screening and documentation of unmet needs in a patient's electronic health record has the potential to harm patients and families.

Recommendations on how to address these concerns include:

- Create a standardized process for garnering consent for screening from patients and caregivers, and ensure that they understand why social needs screening information is being collected and how their data will be used.
- Create a framework for screening that gathers the minimum amount of data needed, leverages community health needs assessments (or other data) to better understand population-level social needs, and focuses on screening for needs when appropriate interventions are available.
- Obtain consent for social needs assessments and give families power/control and ability to opt out of responding.
- Respect the fact that some patients and caregivers may screen positive for social needs but now want the health care sector's assistance in addresses these needs. Patient and caregiver voices should be at the forefront of intervention design, from the screener to assistance and resource access.
- Make clear the level of documentation required in the electronic health record for service reimbursement, with a focus on minimizing any unintended consequences of social needs documentation (discussed elsewhere in this response).

**What are the key challenges related to the exchange of SDOH data between health care and public health organizations and social service organizations? How do these challenges vary across social needs (i.e., housing, food)? What tools, resources, or policies might assist in addressing such challenges?**

As previously noted, PolicyLab at CHOP recently convened more than 30 experts from across the United States for a virtual workshop on policy levers to address unmet social needs in the pediatric setting. The topic of data availability, interoperability and exchange was a key topic of the conversation (see full summary [here](#)). It is essential to improve data sharing to reduce administrative burdens on patients and caregivers, but also to proceed with caution and prioritize patient and caregiver privacy.

Without government intervention and investment, there are few incentives that encourage and support cross-sector data sharing. The federal government should support states to build out infrastructure and create data-sharing agreements that allow data on social needs to be shared across health providers, payers and social service agencies. Data-sharing agreements should focus on serving families, facilitating connection to resources and reducing “over screening.”

Particular areas of concern and need for attention include:

- Outline clear rules around caregiver access to social needs data—considering the presence of sensitive information and which caregivers can access this information (e.g., in the case of estranged parents both serving as proxies and each having access to child's health care data).

- Explore how state-administered safety net programs can reduce the burden placed on beneficiaries deemed eligible. As we outlined in a previous answer in reference to the WIC program, developing streamlined eligibility and enrollment processes across multiple safety net programs and creating a more user-centered benefits enrollment and redemption experience are key to increasing access to benefits.
- It may be prudent to establish non-sharing protocols with child protective service agencies. Information in a patient's chart can perpetuate bias, potentially leading providers or other with access to electronic health records to view patients and caregivers through a different lens. Social needs documentation could thus exacerbate existing racial and socioeconomic biases in referrals to the child welfare system. Families may be less willing to express social need or accept help if they fear that this could trigger involvement of child protective services.

**Given the evidence base about the importance of the early years in influencing lifelong health trajectories, what are the most promising opportunities for addressing SDOH and promoting equity for children and families? What could Congress do to accelerate progress in addressing SDOH for the pediatric population?**

The pediatric setting has often been overlooked in the development and implementation of interventions to address social needs, and specifically social needs screening policies. We welcome the focus of this question in considering the pediatric population specifically. As health care systems, policymakers, and payers move toward implementing—and in some cases mandating—point-of-care social needs screening and referral, they should consider the most ethical, patient-centered approach for ensuring patients and families can be connected to the services they need. The current focus on screening obscures the difference between detection of individual social needs and recognizing upstream and community-level social determinants of health, complicating health care systems' ability to plan for meaningful interventions.

Interventions in the pediatric population are by nature intergenerational and can lend lessons for how to appropriately and effectively intervene across all patient populations and gain a better understanding of the complex web of societal interactions that contribute to unmet social needs. While adult patients are typically seen and treated as individuals, many are also parents, grandparents, caregivers, etc. As pediatricians, social workers, and child health experts, we seek to offer guidance on strategies that health care systems and providers could adopt, and that payers and regulating bodies should consider, to effectively meet families' needs.

These considerations include:

- Focus first on sustainable social needs interventions. Treating screening as an intervention in and of itself can overshadow the equal need for investment in services that address unmet social needs.
- Recognize the potential for trauma and mistrust when screening for social needs, and prioritize families' preferences when offering assistance.

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- Conduct screening and referral in a way that is family-centered, trauma-informed, and acknowledge families' potential wariness of the health care system and social support services.
- Consider privacy, confidentiality and potential bias when documenting social needs in a child's medical chart. By using electronic medical record systems to record patients' social needs, health care systems risk perpetuating and increasing existing racial disparities.
- Consider use of population-level data to inform real-time decision making around funding needs and worsening inequities (for example, aggregated search data during the pandemic and real-time survey data could highlight the needs for immediate increases in funding for child care and utilizing subsidies).