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TAPPING MEDICAID FUNDS TO TACKLE SOCIAL DETERMINANTS OF HEALTH

By Mario Paredes

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THE US STILL LAGS BEHIND OTHER DEVELOPED NATIONS when it comes to research into the impact of the so-called Social Determinants of Health (SDH), key social factors to consider in providing quality care to the poorest citizens. Increasingly, however, SDH are at the forefront of Medicaid reform.

SDH include, for example, patients' housing situation, as well as their economic, employment and educational status. The New York State Department of Health (NYSDH) estimates that SDH—such as the level of access to healthy foods, safe housing, and reliable transformation, for example—account for some 80 percent of factors impinging on a person's both physical and behavioral health.

For example, the Department has reported that indigent households will often choose to pay rent over buying food, seriously affecting the health of the family, particularly of the youngest children; and rent and housing instability is shown to put mothers at a 200 percent higher risk of depression; then there is the impact of mold, lead paint, and pest infestations.

An important 2019 book by Robert Kaplan, Adjunct Professor, Medicine—Primary Care and Population Health at Stanford University, "More than Medicine: The Broken Promise of American Health" (Harvard University Press), pinpoints what the author considers to be a fatal flaw in the American approach to healthcare: "the tendency in the United States … to double down on fighting disease at the cellular level." Too much money, he charges, is going toward biomedical research, which reflects reliance on "a fundamentally mistaken, mechanistic view of the human."

He continues: "Our tendency is to impute great power to a system driven by medical interventions, and to deemphasize the effects of social and behavioral risk factors." Among other social factors such as race and poverty, he singles out the impact of education, or the lack thereof, as a key Social Determinant of Health. He reports that "the difference in life expectancy between those with less than a high school education and those with an advanced degree is 10 to twelve years"—and "ensuring that everyone gets a high school education could prevent an estimated 240,000 deaths a year." The more education a person has the less likely he or she is to smoke, neglect exercise, indulge in an unhealthy diet and become obese, etc. Kaplan believes that "education is more important to health than are other social effects."

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Kaplan argues that a "socially conscious approach" to healthcare "is a simple matter of doctors and nurses asking patients the right questions"—questions that go beyond medical conditions, questions that probe a person's family situation, educational background, housing conditions, employment and/or educational status, etc.

Inner-city, community-based primary care doctors really getting to know their patients must include an awareness of SDH in their lives. This intimate knowledge, acquired with the help of Community Health Workers as doctors' eyes and ears in the community, is a hallmark of New York State's transformative Medicaid reform venture, the Distribution System Reform Incentive Payment (DSRIP) program, which concluded a first five-year term in 2020. The program is driven by the Value-Based Payment formula, which stipulates that providers are compensated not according to the traditional Medicaid fee-for-service formula but according to the longer health outcomes of patients.

DSRIP gave birth to SOMOS Community Care, a network of 2,500 mostly primary care providers serving some 900,000 of New York City's most vulnerable Medicaid recipients with superior, comprehensive care. SOMOS doctors—and patients!—have demonstrated that non-clinical issues directly impact physical as well as mental health and must be taken into consideration as part of the provision of quality care designed to produce lasting results.

Under the old regimen, with the doctor simply administering tests, the role of SDH in the patient's life would barely come into the picture. The minimal interaction between physician and patient simply does not allow for any meaningful discussion about critical conditions in patients' social environment that may significantly impact their health.

The rich relationship between SOMOS doctor and patients is sustained by trust, with the provider playing the role of the family doctor of old who is a leader in the community. Taking on that leadership role in addressing the SDH requires that doctors seek out community-based organizations that specialize in helping the poor overcome social challenges that affect both their physical and behavioral health, again: socio-economic status, employment, education, health insurance, access to fresh foods, food insecurity, etc.

The vision of DSRIP architect Jason Helgerson, the former New York State Medicaid director, calls for the primary care provider to convene community-based organizations and galvanize joint action to meet the social needs of the most vulnerable patients.

But what if doctors could take that role to a new level—one that would enable them, in collaboration with community-based organizations, to directly use both state and federal Medicaid funds to address and remedy particular social ills? *The New York Times* reports that 27 states have used Medicaid funding to pay for housing support for the homeless, many of whom deal with mental illness: furniture, security deposit, rent—in conjunction with behavioral-health services.

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In the case of SOMOS doctors, for example, the primary care provider could take the process a step further and help identify deserving housed candidates who could be eligible for rent subsidies to make it through rough patches; or vouchers to pay for the delivery of healthy groceries; or mini grants for professional training; or daycare for working parents, etc.

The SOMOS doctor is in an ideal position to advocate for patients' genuine social needs and SOMOS could help manage the administration of the social benefits awarded by doctors' practices. Managing social benefits at the neighborhood level will improve upon the cold, bureaucratic and prone-to-fraud process in place.

Meeting patients' most acute social needs with tailored aid, combined with excellent medical and behavioral care, makes for healthier individuals and families. This keeps people out of emergency rooms and hospital beds, translating into great savings for taxpayers and millions of lives transformed.

Mario Paredes is CEO of SOMOS Community Care, a network of 2,500 independent physicians—most of them primary care providers—serving close to a million of New York City's most vulnerable Medicaid patients.