ISPOR: Spotlight Session 3

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Centers for Disease Control and Prevention

National Center for Chronic Disease Prevention and Health Promotion

NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Our mission is to help people and communities **prevent chronic diseases and promote health and wellness for all.**

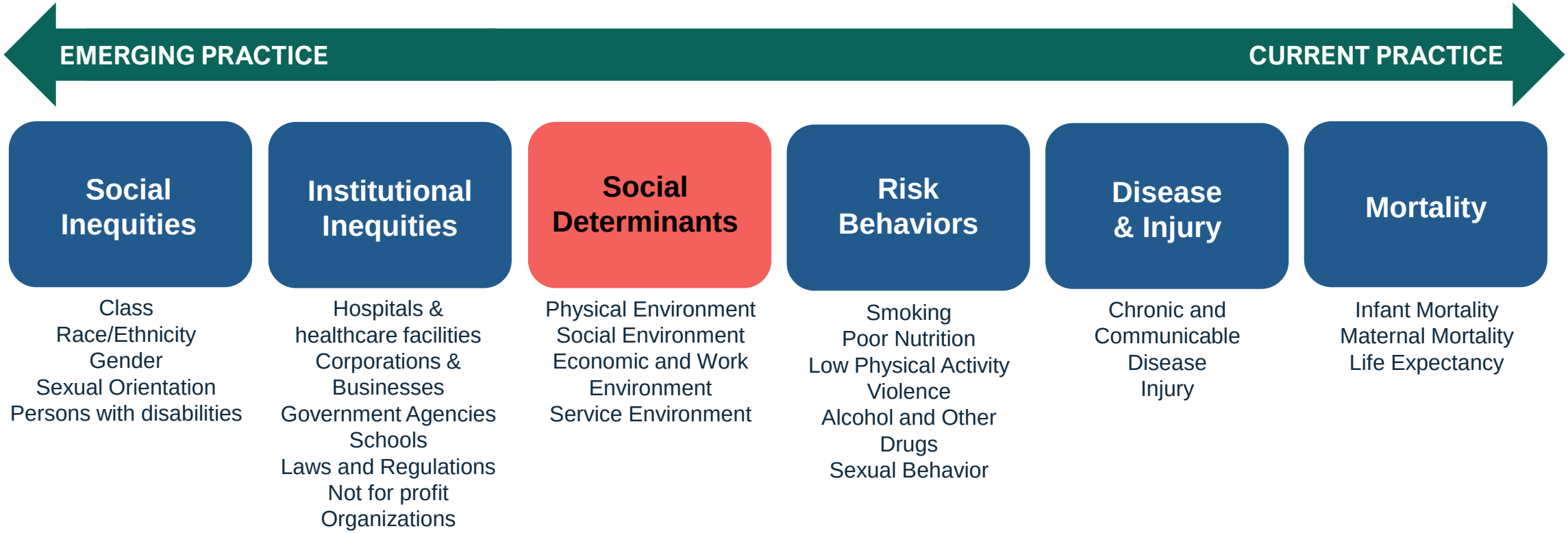
We work to make our vision of **healthy people living in healthy communities** a reality.

Health Equity & Social Determinants of Health

Health equity (HE) is when everyone has an equal opportunity to be as healthy as possible.

When we refer to **social determinants of health – or SDOH –** we are speaking about the non-medical factors that influence health outcomes.

Addressing Social Determinants of Health is a Strategic Priority



Health equity can be achieved by addressing not only SDOH but also the sustained commitment to acknowledge and address root causes of health disparities, such as structural racism, that have hindered all Americans from achieving optimal health.

Adapted from Bay Area Regional Health Inequities Initiative, Enlarged Framework | BARHII

Public Health Plays 4 Key roles in SDOH Work

Convener

Foster sustainable multi-sectoral, multi-level partnerships

Integrator

Collect data, evaluate to build the evidence base and determine outcomes, and translate ideas across systems

Influencer

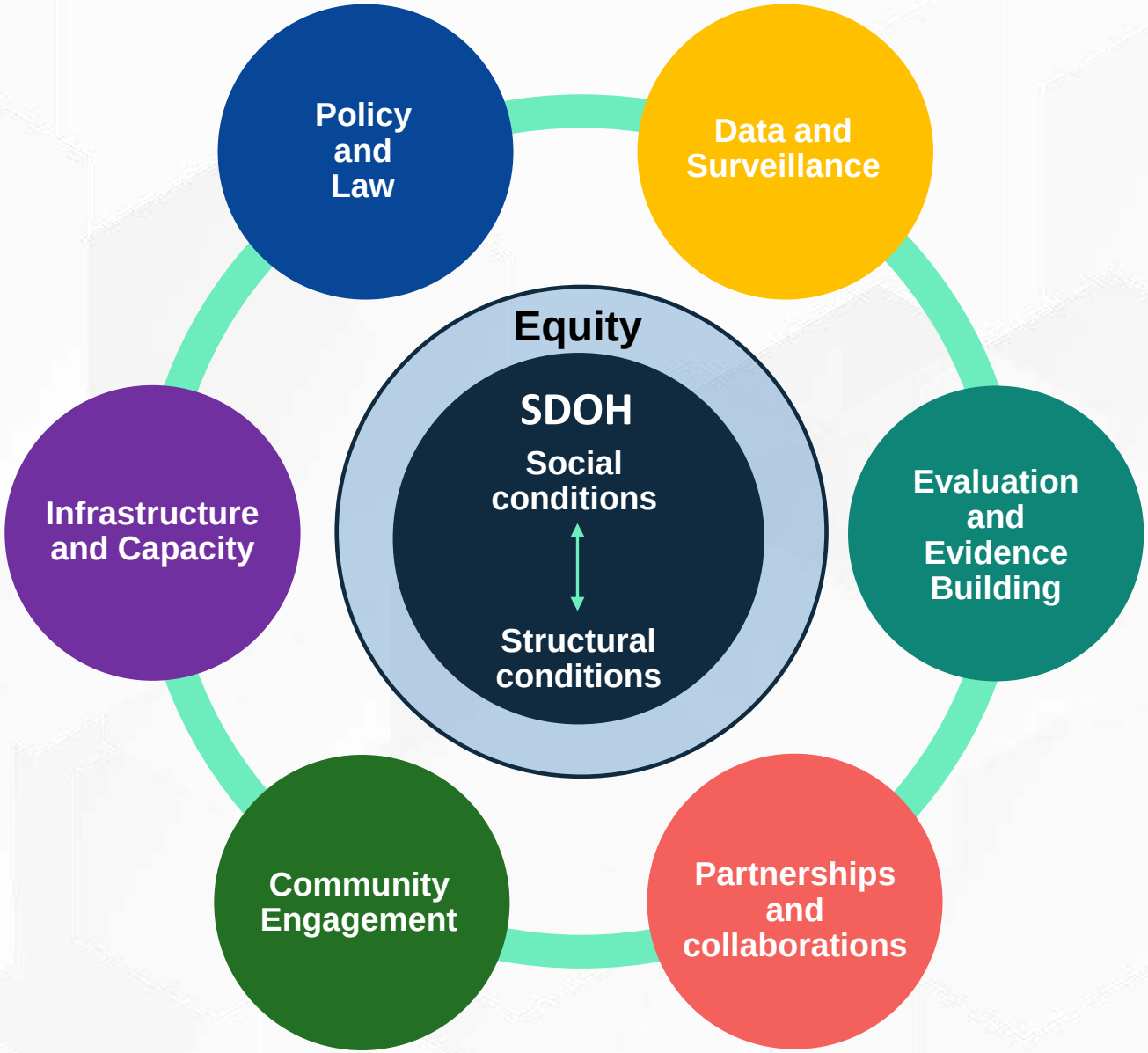
Lead approaches to develop upstream policies and solutions; direct funding to implement and scale up priority actions

Change-maker

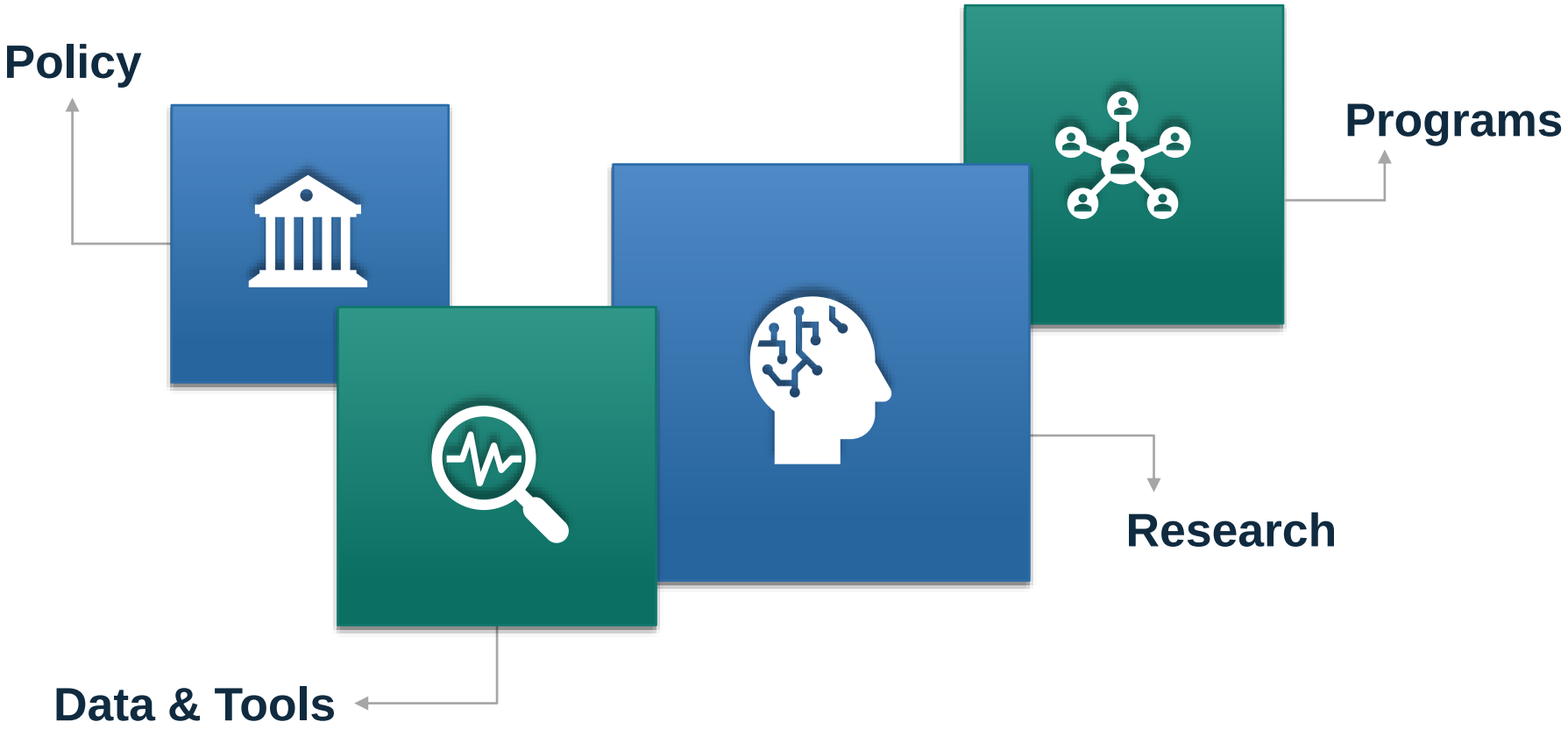
Generate solutions, take action, and collaborate with others to implement activities

DeSalvo KB, Wang YC, Harris A, Auerbach J, Koo D, O'Carroll P. Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century. Prev Chronic Dis 2017;14:170017.
DOI: http://dx.doi.org/10.5888/pcd14.170017

CDC SDOH Approach



Strong Foundation for Addressing SDOH Across CDC



NCCDPHP'S Targeted Social Determinants of Health

Food and Nutrition Security

Tobacco-Free Policy

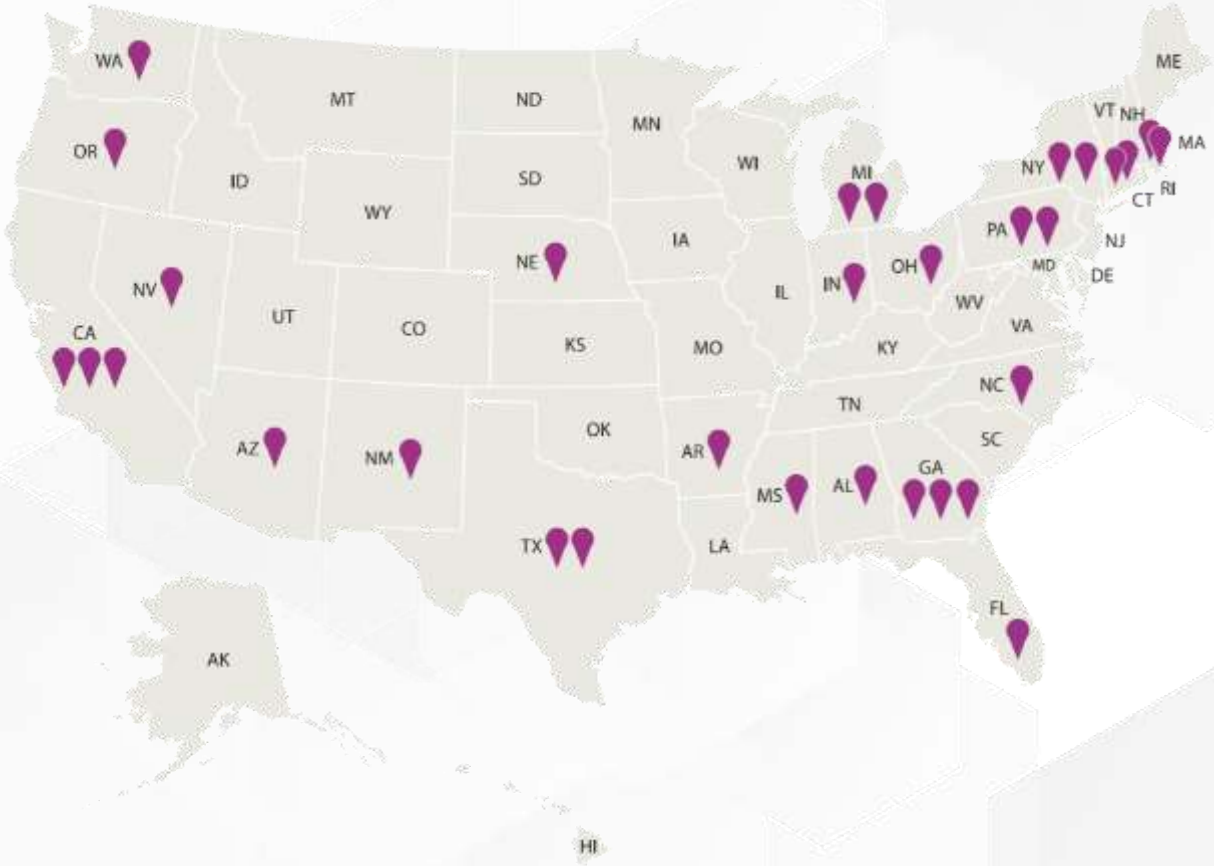
Built Environment

Social Connectedness

Community-Clinical Linkages

WHAT NCCDPHP IS DOING TO ADDRESS SDOH

- **Over 2.9 million people** have better access to healthy foods and beverages
- **Over 322,000 people** have benefited from smoke-free and tobacco-free interventions
- **Approximately 1.4 million** people have more opportunities to be physically active
- **Over 830,000 people** have access to local chronic disease programs that are linked to clinics



Racial & Ethnic Approaches to Community Health (REACH)

Getting Further Faster Initiative

Outcome	5-Year Results	10-Year Results	20-Year Results
Coronary heart disease events averted[a]	340	890	2,140
Strokes averted[a]	250	670	1,650
Deaths averted[a]	60	250	850
Medical costs averted[b]	$6,400,000	$30,500,000	$121,000,000
Productivity costs averted[b]	$27,000,000	$122,000,000	$445,000,000
Total costs averted[b]	$33,400,000	$152,500,000	$566,000,000

[a]Rounded to nearest ten [b]Rounded to nearest $100,000

Year 1: Retrospective Evaluation Of 42 Communities with Demonstrated SDOH Outcomes to Build Evidence Base

Organization Type

- 33 Non-profit Community-Based Organizations (CBO)
- 5 Local Health Departments (LHD)
- 1 State Health Department (SHD)
- 3 Non-Profit Academic Institutions

Focus Areas

- Community-Clinical Linkages – 25%
- Nutrition Security – 25%
- Built Environment – 18%
- Social Connectedness – 18%
- Tobacco-Free Policies – 14%

Data & Surveillance - PLACES & BRFSS

PLACES

Health data estimates for a large portion of the nation's population.

27 measures including:

- **5** unhealthy behaviors
- **9** prevention practices
- **3** health outcomes

BRFSS

State-based telephone survey of US adults to monitor health-related risk behaviors, chronic health conditions, and use of preventive services

Social Determinants & Health Equity (SDHE) Module:

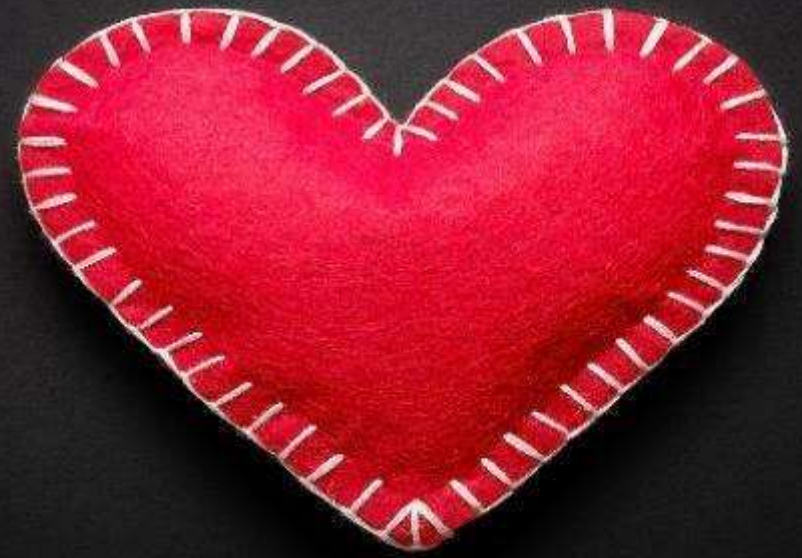
- Optional module in 2022 BRFSS Questionnaire
- 42 states included module in 2022 questionnaire

Data Modernization: Gravity Project

- Launched in May 2019 by the Social Interventions Research and Evaluation Network (SIREN)
- National public collaborative effort
- Develop data and exchange standards to represent SDOH data documented in EHRs across four clinical activities: screening, diagnosis, goal setting, and interventions
- NCCDPHP is working with the project to build a national public health use-case for SDOH

SDOH AND HEALTH CARE SYSTEMS

Social Needs vs Social Determinants



Health-related Social Needs

Addressing barriers to <u>individual</u> health:

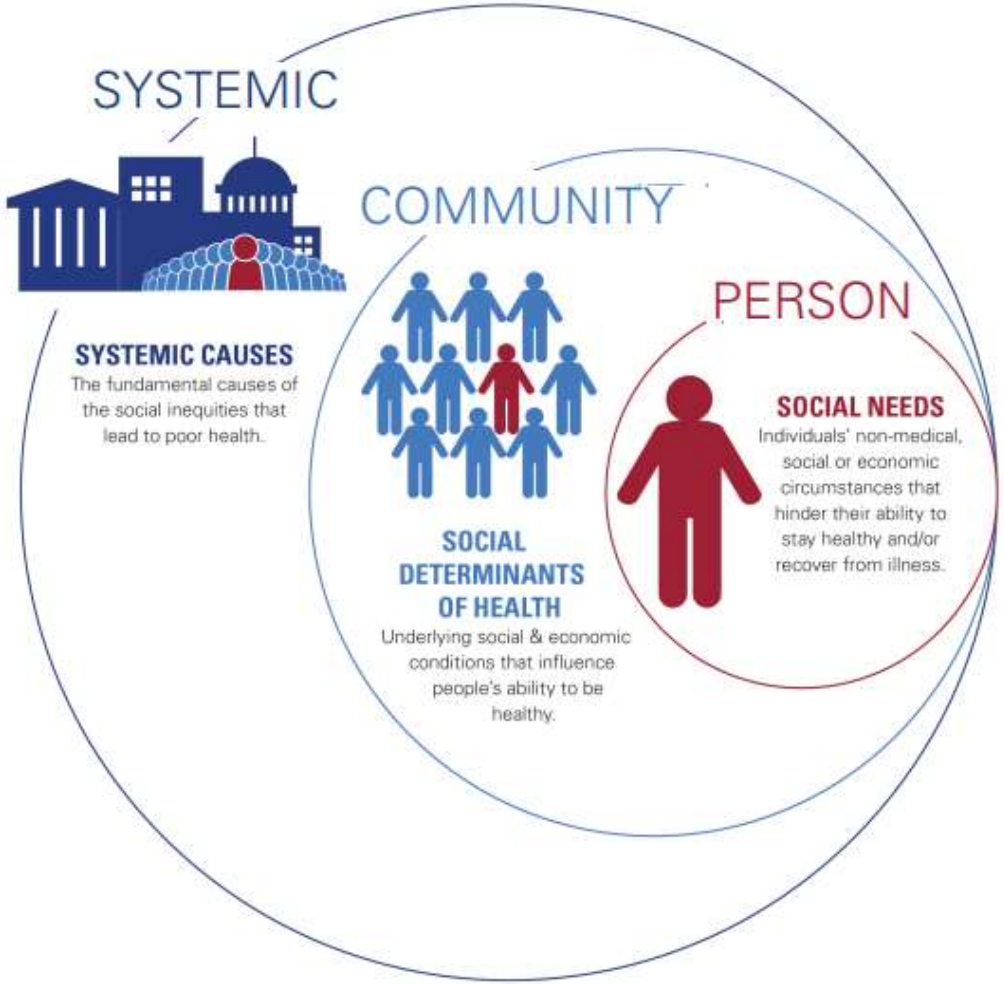
- How do I get to the doctor?
- I don't have a place to live
- I lost my job
- I can't pay for food

Social Determinants

Addressing policy, system, and environmental change to create healthy communities:

- Economic stability
- Education access and quality
- Neighborhood and built environment
- Health care access and quality
- Social and community context
- Historical context/trauma
- Racism

Societal Factors that Influence Health: A Framework for Hospitals



American Hospital Association's
Societal Factors that Influence Health: A Framework for Hospitals

Role of Health Care Systems in Addressing Social Needs & SDOH

- Developing and fostering relationships with public health departments and community-based organizations
- Investing in addressing social needs and SDOH
- Screening for social needs and SDOH

Social Needs Screening

- Universal screenings for social needs
- Identify and address specific, unmet social needs of patients
- Clinical-community linkages and health system referrals
- Proposed CMS rule: FY 2023 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS)

Together, We Can…

Thank You

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