Health Policy Commission
50 Milk Street
Boston, MA 02109

October 19, 2016

To the Members of the Health Policy Commission,

Thank you for the opportunity to attend and testify at the HPC's Annual Hearing on Cost Trends. I am submitting a written version of my comments presented to the Commission on Tuesday afternoon, October 18.

I am a nurse and public health professional who has spent much of her professional career helping health care systems more effectively partner with diverse populations of patients and community members to improve individual and population health and health outcomes. Developing individual and system-level strategies to address social determinants of health (SDH) have been an important component of my work for many years. I was pleased to hear so many important aspects of this work thoughtfully addressed in Tuesday's hearing by the knowledgeable speakers and panelists who presented. Based on my experience on the front lines of this work, I'd like to offer a few additional comments as well as a recommendation for the Commission's consideration.

1. Health is much broader than health care outcomes. There are many upstream social determinants that have a significant effect on health and health care costs that are beyond the scope of referrals to community services and long-term social supports, or targeted health improvement programs by health care ACOs. These key social determinants of health are supported by social, environmental, economic, community and governmental infrastructures and include economic opportunity, healthy physical environments, public safety, access to health promoting factors (such as good nutrition, physical activity, education, and quality health care), social justice and equity, and community members' sense of connection, meaning and belonging. These foundational social determinants have long term impacts on preventing disease across the lifespan, as well as improving outcomes for people who experience illness. They generally have their impact in the context of a geographical community population which often does not correlate directly with health care panel populations that are the focus of health care ACOs. Today's presentation about SDH and health care costs suggested that there are benefits to healthcare outcomes and cost by shifting the current ratio of state spending on health care compared to social dimensions of health, so that social dimensions of health have a larger share of funding resources. I offer several questions:
    - Who will be responsible for planning strategy and overseeing and monitoring this foundational level of SDH and its impact on health care costs and health equity for community populations across the state? There currently are a variety of governmental, private, and charitable resources that focus on aspects of this work. How could they be engaged in more coordinated and strategic ways?
    - How will the foundational SDH that impact long term health care costs and outcomes be addressed and financed in evolving health care financing structures and future state health policy?

2. Addressing social determinants of health has become a new "buzz word" in health care. Given the importance of this emerging field to health care financing in the state, it is important that investments of resources be applied in an evidence-informed and efficient manner.

I encourage the state to build and support infrastructure (for example, a learning community and/or a clearinghouse) that would enable health care systems, community organizations and advocates, ACOs, researchers, and others working on effective strategies to address SDH to learn from one another, share promising and best practices (as well as important lessons on what doesn't work), and develop and/or share transferable resources. Areas for shared learning can include:

- **Specific interventions to assess and address SDH in different populations along with lessons learned.**
- **Effective delivery practices.** (As one panelist noted, SDH interventions are not one size fits all and need to be adapted to different communities, populations, and systems)
- **Training strategies for clinical and community staff** that support effective collaboration to achieve desired outcomes for diverse and higher risk populations. Example: Community based staff often express the need for more training on working with clients with mental health challenges.
- **Infrastructure tools and models that support high quality integration between health care and community services.** Examples include: IT technology, along with templates for clinical/community staff training, workflows, policies, and contractual agreements that support high quality EMR referrals between clinical care and community services; components of effective partnerships and communication between clinical and community organizations that foster shared power and accountability; strategies and tools to vet the quality of available community services and to build a community-based organization's capacity to participate in a health care ACO.
- **Collaboration models within the ACO context that support community population level** (vs. health care panel population level) **SDH interventions that support desired health care panel outcomes.** These models could include strategic partnerships among different ACOs whose patients come from the same geographical community, ways to leverage the business side of an ACO (e.g. employment and job training practices, employee wellness programs, land use and environmental practices, billing and collection policies) to promote community level health, collaborations with public and community health agencies and advocates, and SDH-related policy advocacy.
- **Ways to collect and share data that identifies important SDH needs of a patient population that are connected to larger actionable policy issues outside of healthcare, along with how to share this data effectively to promote policy and program change that could improve patient health outcomes and costs**. One example: Substance abuse is a significant factor in driving high utilization and costs in health care. Research suggests that employment correlates positively with long term recovery from substance abuse. However, people with substance abuse histories may have criminal records that present significant barriers to getting a job, as well as insufficient access to vocational counseling services tailored to their needs and challenges. Vocational training and CORI reform are not typically the purview of health care, but SDH data sharing that supports policy change in these areas could have an important long-term positive impact on patient well-being and health care costs.

Thank you again for the opportunity to share this testimony with the Commission.

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