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Correspondence Memorandum

Date: October 21, 2021

To: Group Insurance Board

From: Renee Walk, Lead Policy Advisor
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Subject: Initial Analysis of Social Drivers of Health (SDOH)

This memo is for information purposes only. No Board action is required.

Background

In 2019, the Group Insurance Board (Board) approved a series of initiatives to improve the health of the population enrolled in the Group Health Insurance Program (GHIP) (Ref. GIB | 11.13.19 | 6). One of these initiatives was to examine the role social determinants or drivers of health (SDOH) play in the health and wellbeing of GHIP members. This memo provides a summary of literature related to SDOH, what is known currently about SDOH and impacts to the GHIP, data limitations, and possible next steps and avenues of exploration.

Definition of SDOH

SDOH are all the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[1] SDOH includes, for example, access to health care, the gap in insured rates among different racial and ethnic populations, access to transportation, employment, and education.

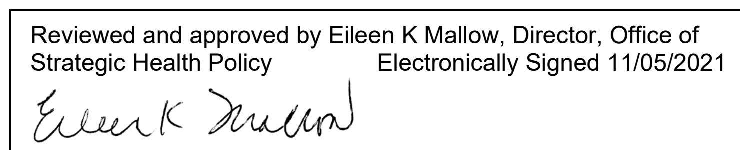
Key Social Determinants of Health

SDOH literature categorizes the social determinants of health in five key domains:

1. Economic stability: income, employment, medical bills and expense, support.
2. Education: literacy, early childhood education, vocational training, higher education.
3. Neighborhood and built environment: housing, transportation, zip code/geography, safely, recreation.

[1] Healthy People 2030 (n.d.). *Social Determinants of Health*. U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy   Electronically Signed 11/05/2021



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4. Health care system: access to health care, quality of care, health coverage, provider coverage, provider availability, provider linguistic and cultural competence.
5. Social context: support systems, community engagement.

An effective intervention to impact SDOH must work collaboratively across sectors to address the unique needs of the population at risk.

The Wisconsin Department of Health Services (DHS) further divides the drivers of health into "essential" and "supplemental" domains as follows.

SDOH Domains[2]	
Essential	**Supplemental**
Food Housing Safety Transportation Financial Resources Demographic Information	Childcare Education Employment Social Supports Health Behaviors Behavioral/Mental Health

These divisions are helpful when considering how SDOH impact the health and wellbeing of members. If needs are not met or if there are disparities within the Essential domain, it may be more difficult to impact those in the Supplemental domain.

Importance to the Board's Programs and Membership
There is an overall increase in chronic disease prevalence in the United States. Research shows that 60% of American adults currently live with at least one chronic condition; 42% have more than one.[3] In the Board's population, roughly 46,500 members have at least one chronic condition.

As has been regularly reported to the Board at prior meetings, healthcare expenditures are increasing, and chronic conditions account for hundreds of billions of dollars in health care spending each year in the U.S.[4] Members in the GHIP who had one of the five primary, manageable chronic conditions (asthma, coronary artery disease, diabetes, hypertension, or depression) in 2020 cost an average of $4,446 per member to manage the condition itself, and $11,989 in costs from other comorbid conditions.

Traditional pathways for improving health through medical benefits appear to have limited effect. It is critical for understanding the healthcare landscape in its totality and from the users' perspective to consider those factors that affect health beyond the healthcare setting. Understanding SDOH allows for understanding health in the context

[2] Department of Health Services, 2021
[3] Hayes, T. O., & Gillian, S. (2020). *Chronic disease in the United States: a worsening health and economic crisis*. American Action Forum.; Rand Review, 2017.
[4] *Ibid.*

of the whole person.[5] Identifying the connections between social determinants and health outcomes is critical to developing insights to create targeted policies for the management, mitigation, and prevention of chronic diseases. This in turn has the potential to minimize the risks and costs of chronic conditions.

Disproportionate Impacts

The effects of the social determinants of health are more pronounced among marginalized racial and ethnic groups and people from low-income households, who are more likely to live in places that carry social risk factors such as food insecurity, housing instability, economic hardship, and limited access to care. Marginalized groups are more vulnerable to social risk factors, as they are more likely to face inequalities and financial insecurity, to live in crowded conditions, and rely on public transportation. In a 2021 study published by the Journal of the American Medical Association (JAMA) Network, researchers found that "county-level sociodemographic risk factors as assessed by the Social Vulnerability Index were associated with greater COVID-19 incidence and mortality."[6]

Another report by the DHS and *Healthiest Wisconsin 2020*, the Wisconsin state health plan for the decade 2010-2020, provides baseline data for Wisconsin's statewide health status and highlights disparities experienced by selected populations in the state. The *Healthiest Wisconsin 2020* Baseline and Health Disparities Report also provides information to document a range of health disparities found for some of the populations and communities in Wisconsin.[7] The key findings of the report indicate that "racial/ethnic minority populations, people with lower incomes and less education, people with disabilities, LGBT populations, residents of Milwaukee County and of rural areas experience disparities in socioeconomic status, health risk behaviors, and health outcomes."[8]

The Robert Wood Johnson Foundation describes health equity to mean "increasing opportunities for everyone to live the healthiest life possible, no matter who we are, where we live, or how much money we make."[9] Groups that are traditionally disenfranchised and discriminated against lack health equity.

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[5] Kataoka, S. H., Ijadi-Maghsoodi, R., Figueroa, C., Castillo, E. G., Bromley, E., Patel, H., & Wells, K. B. (2018). Stakeholder Perspectives on the Social Determinants of Mental Health in Community Coalitions. *Ethnicity & disease*, *28*(Suppl 2), 389–396.

[6] Karmakar, M., Lantz, P. M., & Tipirneni, R. (2021). *Association of social and demographic factors with COVID-19 incidence and death rates in the US*. JAMA Network. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775732

[7] DHS (2020). *Healthiest Wisconsin 2020 Baseline and Health Disparities Report.* https://www.dhs.wisconsin.gov/hw2020/baseline.htm

[8] *Ibid.*

[9] Robert Wood Foundation (2021). *Achieving Health Equity: Why health equity matters and what you can do to help give everyone a fair shot at being as healthy as they can be*. https://www.rwjf.org/en/library/features/achieving-health-equity.html

Health Assessment Data from Health Plans on SDOH
In early 2020, ETF requested information from health plans on what they were doing to address SDOH. Below are summaries of a few of the responses received from plans who have begun to look at SDOH. Of the plans responding, many noted that they are looking at options to obtain better data and complete analysis on SDOH in their programs. They are working to forge community partnerships, and some are exploring ways that they can adjust existing benefits or, in the case of Medicare Advantage plans, offer supplemental benefits (e.g., food, transportation, etc.) to members.

Other State Approaches
In other states, government entities who have begun to consider how they could impact SDOH are typically Medicaid agencies. Wisconsin Medicaid, for example, has issued a tool kit, referenced earlier in this memo, that describes different ways that healthcare providers can screen and improve outcomes for patients based on SDOH. There are a few examples from other states that have begun to use their contracts for Medicaid managed care organizations to influence SDOH; these are highlighted below for consideration.

The Michigan Department of Health and Human Services issued a series of requirements for its Medicaid managed care plans beginning in 2019 related to SDOH. Plans were required to propose population health management interventions using a template document. The template required that plans report relevant literature used to develop the intervention, their data collection strategy, barrier and gap analysis, and health equity training requirements for staff. Michigan also required that plans develop and document community partnerships and explain how those partnerships would be leveraged to implement programs.

The State of Massachusetts directs Medicaid Accountable Care Organizations (ACOs) to conduct health needs assessments that include social determinants, including:

- Housing stabilization and support services
- Housing search and placement
- Utility assistance
- Physical activity and nutrition
- Support for attributed members who have experienced violence

Massachusetts uses this information for reporting and to find opportunities for care improvement, though limited information is available on their website.

Data Availability and Limitations in the ETF Population
While data suggests the SDOH-targeted interventions may help increase the impact of healthcare interventions, there are limitations in the data currently available to ETF and the Board. The table below describes different opportunities to add data, as well as the limitations of the data sets identified.

Table 1. Data Opportunities and Limitations

Opportunity	Limitations
Employer salary data reported in State agency and University systems, potential to import and coordinate with Board analytics.	Data would not reflect household income if employee lives with a partner who is working. Salary data available for some, but not all employers.
Use Area Deprivation Index (ADI) to analyze conditions where members live and may be seeking care. 95% of the Board's population has an attributable ADI score.	The current data only shows the overall ADI score of the area where a member lives; it does not show the specific income of the member or other individual risk factors.
WebMD health assessment includes questions regarding demographics (race, ethnicity, preferred language, education level, marital status, employment status) and access to transportation, housing, food, and other SDOH-related resources.	The new WebMD health assessment file is not maintained in the data warehouse.
Annuitant payment information available from the Wisconsin Retirement System (WRS) provides the incomes for retirees, along with some demographic information. Data is already owned by ETF and may be easier to combine with Data Analytics and Insights (DAISI) data.	Data gaps exist on race ethnic, education, etc.

The Medical Informatics Association has also advocated for the development of a comprehensive coding system to aid interested parties (including clinical and SDOH providers, measure developers, informaticists, electronic health record (EHR) industry stakeholders, and researchers) in identifying codes related to social risk factors and SDOH.[10] The ICD-10-CM coding system includes a series of codes for documenting SDOH, but since these codes are typically not associated with different reimbursement, they are not always documented on claims. If those codes are provided, however, the DAISI data warehouse would capture them.

[10] Arons, A., DeSilvey, S., Fichtenberg, C. & Gottlieb, L. (2019). *Documenting social determinants of health-related clinical activities using standardized medical vocabularies*. American Medical Informatics Association. Vol 2, 81 – 82.

Some electronic health records are set up to document SDOH. One example of this in the state of Oregon used an electronic health record-based SDOH screening tool in a national network of more than 100 community health centers to coordinate data.[11] Currently the DAISI data warehouse does not intake EHR data, but ETF continues to investigate ways to incorporate more robust information to improve monitoring and policy development.

Possible Interventions

Based on the above assessment of the current state of SDOH and the Board's population, as well as a review of the relevant literature, ETF has identified the following approaches as possible interventions to improve member health and wellbeing.

Promoting health equity through program design

The concept of health equity is based on the argument that a person may not have access to the best healthcare because of factors outside their control. To create health equity is to ensure that everyone has the chance to be as healthy as possible[12], or simply, to live their healthiest lives. Several initiatives have proven useful in addressing social risk factors within and outside the healthcare system. Some approaches are aimed at shaping policies and practices in non-health sectors to promote health and health equity. These methods include models for Medicare and Medicaid Innovation, Medicaid delivery system and payment reform initiatives, and activities by managed care plans to identify and address social needs. In 2017, 19 states required Medicaid managed care plans to screen for and/or provide referrals for social needs.[13]
The 2019 Wisconsin Health Disparities Report was developed by the Wisconsin Collaborative for Healthcare Quality, in collaboration with the UW Health Innovation Program. The report presents recent data from 25 Wisconsin health systems for measures including vaccinations, screenings, disease risk factors and chronic disease by race/ethnicity and rural/urban residence and identifies where disparities in health outcomes and care exist in Wisconsin.[14]

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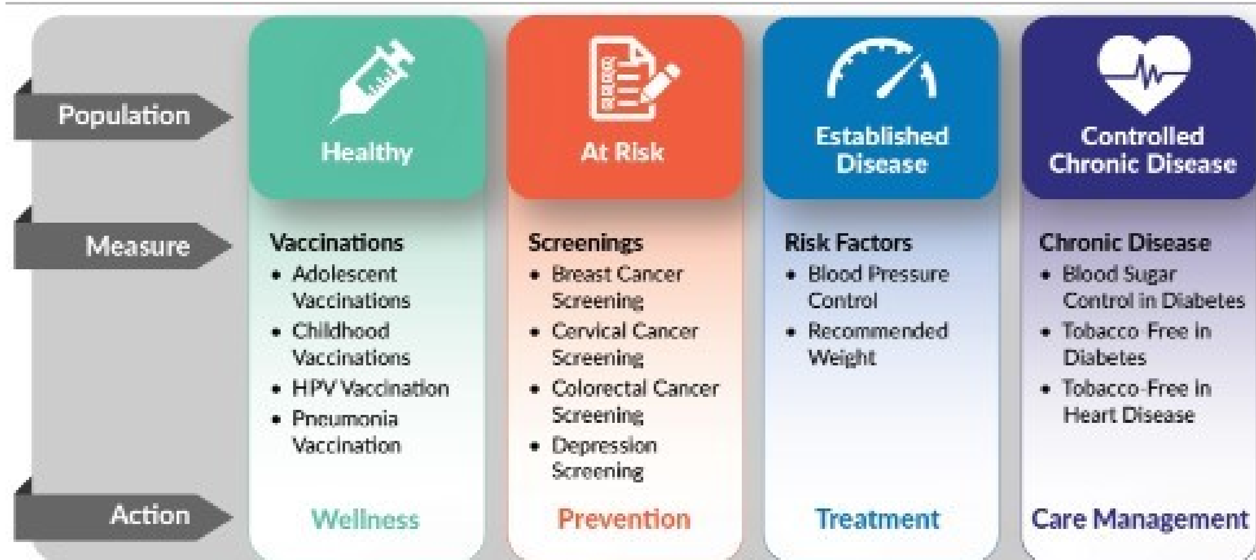
[11] Cottrell, E. K., Dambrun, K., Cowburn, S., Marino, M., Krancari, M., Gold, R… Mossman, N. (2019). *Variation in Electronic Health Record Documentation of Social Determinants of Health Across a National Network of Community Health Centers*. American Journal of Preventive Medicine. https://www.ajpmonline.org/article/S0749-3797(19)30322-8/fulltext

[12] Nall, R. (2020). *Health equity: Meaning, promotion, and training*. Medical News Today. https://www.medicalnewstoday.com/articles/social-determinants-of-health

[13] Artiga, S. & Hinton, E. (2018). *Beyond health care: The role of social determinants in promoting health and health equity*. Kaiser FamilyFoundation (KFF). https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

[14] Population Health Sciences (2019). *The 2019 Wisconsin Health Disparities Report*. UW-Madison School of Medicine and Public Health. https://pophealth.wisc.edu/2019/09/19/the-2019-wisconsin-health-disparities-report/



Source: Population Health Sciences: UW-Madison School of Medicine and Public Health

The infographic above summarizes the approach used by 25 Wisconsin health systems for measures including vaccinations, screenings, disease risk factors and chronic disease by race/ethnicity and rural/urban residence and identifies where disparities in health outcomes and care exist in Wisconsin.

The Board and ETF could further examine the payment models referenced above and could also work with plans to determine how to incorporate SDOH screenings into health care encounters for members. ETF has begun to include more equity impact analyses in policy development by integrating a racial equity and social justice review into its policy development pathway, based on a framework developed by the City of Madison.[15]

Prioritizing Data Sharing

In order to reduce barriers to an effective implementation of SDOH programs and interventions, social services, health organizations, and providers must engage in a robust exchange of information and data about available services, unmet needs, and costs associated with treatment, care, and services.[16] A more robust information exchange between accountable stakeholders of the Board's programs about the social determinants of health would facilitate effective care management, inform prediction models, fill health IT gaps, and give patients and providers access to more data with which to make informed care choices and decisions. As the State of Wisconsin continues to battle the COVID-19 pandemic, data sharing can boost effective collaboration across all sectors involved in the state's response to the pandemic. Data

[15] City of Madison. *Racial Equity and Social Justice Tool Process Guide.* https://www.cityofmadison.com/civil-rights/documents/RESJIprocessguide.pdf

[16] Daniel-Robinson, L. & Moore, J. E. (2019*). Innovation and Opportunities to Address Social Determinants of Health in Medicaid Managed Care*. Institute for Medicaid Innovation. https://www.medicaidinnovation.org/_images/content/2019-IMI Social_Determinants_of_Health_in_Medicaid-Report.pdf

sharing among stakeholders can support public health efforts including contact tracing, case investigation, disease surveillance, and other activities to slow the spread of the COVID-19 and other diseases.[17] The collaboration that has occurred as a result of COVID-19 mitigation can be used as the foundation for future data gathering that supports SDOH work.

The Board has promoted data sharing within the programs that it manages through the implementation of the DAISI data warehouse provided by IBM Watson Health. ETF will continue to explore where non-health data related to SDOH is already being collected and how to incorporate that data into the analytics being done for the Board's programs.

Social Determinants of Health Assessment

Healthcare providers can adopt additional vital signs to screen for the nonmedical factors that influence health. Health plans and providers can create new assessment tools to better capture patients' social needs and barriers to care.
Examples of these screening tools include:

- Social Determinants Screening Tool (Access Health Spartanburg)
- Self-Sufficiency Outcomes Matrix (OneCare Vermont)
- PRAPARE Tool (Redwood Community Health Coalition)
- Community Paramedicine Pilot Health Assessment (ThedaCare)
- Social Needs Assessment (Virginia Commonwealth University Health System)18
- Performance Improvement Plan (PIP) Drivers of Health Toolkit (Wisconsin Department of Health Services)19

For such assessments, the Board and ETF are not likely to be the best positioned to complete them since they do not provide direct healthcare services; however, the Board could consider policies and/or incentives to encourage care providers and health plans to complete these assessments, and to encourage plans to standardize their data capture.

Health in All Policies (HiAP) Approaches

Social determinants of health research emphasizes the need for a cross-sector approach to addressing social risk factors that influence health outcomes. HiAP is a formal process for integrating health considerations into policies across multiple sectors with the goal of addressing the social factors that influence health outcomes. Key elements of HiAP include:

- Defining goals that provide benefits to many sectors and stakeholders.

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[17] PEW, 2021

[18] Thomas-Henkel, C. & Schulman, M. (2017). *Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations*. Center for Health Care Strategies. https://www.chcs.org/resource/screening-social-determinants-health-populations-complex-needs-implementation-considerations/

[19] Wisconsin Department of Health Services. *Drivers of Health – Data Collection and Sharing Information HMO and Partner Clinic Toolkit*.
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality_for_BCP_and_Medicaid_SSI/pdf/PIP_DoH_Toolkit_032021.pdf.spage

- Engaging a range of stakeholders, including community members who will be affected by the policies under discussion.
- Creating permanent changes to the way that agencies make decisions to ensure that commitments addressing health are sustained over time.
- Recognizing the ways that inequity contributes to negative health outcomes and incorporating equity considerations into policymaking.[20]

The Board will only have direct impact on the policies created by ETF, but there are opportunities for encouraging other agencies to adopt programs, policies, or strategies to improve health outcomes by influencing SDOH. ETF could support information sharing, either by providing or supporting a platform for engagement to share knowledge (e.g., Well Wisconsin Champion Network), share policy frameworks and references for partner agencies, and find areas where partner agencies can create complementary programs and approaches.

Improving Health in High-Risk Neighborhoods

This includes, but is not limited to, implementing initiatives, and coordinated strategies across different sectors and with key stakeholders in neighborhoods with social, economic, and environmental barriers that create health disparities.[21] Disparities can be reduced by focusing on communities at greatest risk; building multisector partnerships that create opportunities for health equity and healthy communities; increasing access to quality prevention services; increasing the capacity of individuals in the affected communities and the health care and prevention workforce to address disparities; conducting research and evaluation to identify effective strategies and ensure progress; and implementing strategies that are culturally, linguistically, literacy- and age-appropriate.[22]

Broad neighborhood interventions may be outside of Board's scope, but awareness is key. ETF and the Board can continue to raise awareness and look for opportunities that the state more broadly can support.

Including Social Determinants in Prediction Models

Predictive modeling is a healthcare systems approach that uses data mining, machine learning, and statistics to identify patterns in data and recognize the chance of certain outcomes occurring. "Predictive modeling offers the potential for healthcare

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[20] Artiga, S. & Hinton, E. (2018). *Beyond health care: The role of social determinants in promoting health and health equity*. Kaiser FamilyFoundation (KFF). https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

[21] *Ibid.*

[22] National Prevention Council (2011). *National Prevention Strategy*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. https://www.hhs.gov/sites/default/files/disease-prevention-wellness-report.pdf

organizations to improve service delivery and patient outcomes."[23] In a study to determine whether US minority Medicare beneficiaries had disproportionately low costs compared with their clinical outcomes and whether adding social determinants of health (SDOH) into risk prediction models improves prediction accuracy, researchers concluded that including social risk factors in prediction models could improve equity in preventive care by more accurately targeting interventions to people at the highest clinical risk.[24]

Research indicates that since there are systemic differences in access to care, cost may not be an appropriate surrogate for predicting clinical risk among vulnerable populations[25], and that a good approach to improving the accuracy of risk models among racial and ethnic minorities, for example, and for guiding the use of preventive strategies is to adjust for SDOH. In a study to examine the impact of social determinants of health on predictive models for potentially avoidable 30-day readmission, the researchers concluded that "patients from certain subgroups may be more likely to be affected by social risk factors." The researchers suggest that incorporating SDOH into predictive models may be helpful to identify patients with the greatest exposure to social risk factors and reduce health disparities associated with vulnerable social conditions.[26]

Possible Engagement Strategies
A crucial element in any intervention related to SDOH will be support and engagement from stakeholder groups. These include institutional stakeholders as well as patients.

Institutional Stakeholder Engagement
In a research study conducted to examine how integrating SDOH into electronic health records may improve individual and population health, the researchers reviewed efforts to integrate SDOH into EHR in the U.S. and Canada. Eight out of 20 articles reviewed mentioned stakeholder engagement. All eight articles reported engaging with healthcare and social services staff (i.e., providers and administrators), and two reported engaging with patients or clients.

In one study, researchers convened a panel of subject-matter experts from government healthcare agencies, EHR vendors, nonprofits, and national medical organizations and professional societies, which nominated SDOH domains to prioritize. The panel rated the candidate measures according to select criteria and reconvened all stakeholders in

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[23] Bonderud, D. (2021). *How Predictive Modeling in Healthcare Boosts Patient Care*. HealthTech. https://healthtechmagazine.net/article/2021/04/how-predictive-modeling-healthcare-boosts-patient-care-perfcon
[24] Hammond, G., Johnston, K., Huang, K., and Maddox, K.E. J. (2020). *Social Determinants of Health Improve Predictive Accuracy of Clinical Risk Models for Cardiovascular Hospitalization, Annual Cost, and Death*. AHA Journals. https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.120.006752
[25] *Ibid.*
[26] Zhang, Y., Zhang, Y., Sholle, E., Abedian, S., Sharko, M., Turchioe, … Ancker, J.S. (2020). *Assessing the impact of social determinants of health on predictive models for potentially avoidable 30-day readmission or death*. PubMed.gov. https://pubmed.ncbi.nlm.nih.gov/32584879/

a town hall style meeting who reviewed the candidate domains and measures identified and selected one final measure for each domain. The researchers stated they would continue stakeholder engagement with patients and providers to assess their impression on the suitability of the selected domains and measures.

Another study conducted online discussions with providers, patients, and policymakers to select candidate measures that fit their SDOH domains. A third study convened a committee of experts to compile its recommendations, including primarily academics and educators working in medical informatics, behavioral health, primary care, pediatrics, medical schools, epidemiology, and public health, or those with an expertise in research methods and measurement. The committee also received and included input from invited health experts in government (e.g., from the National Institutes for Health or Centers for Disease Control and Prevention or State health agencies), medical insurance, and health-related non-profits.

Increased Healthcare Consumer Engagement

To nurture connection and build trust with health plan members and patients, healthcare organizations and providers must have more frequent healthcare consumer engagements via existing methods such as live phone calls, interactive voice responses, emails, and text messaging. To maintain relevance of the effort, providers should revise patient engagement strategies to include efforts to overcome social risk factors and barriers, by identifying specific needs among patient populations using community health needs assessments.[27]

Community Healthcare Partnerships

Traditional patient engagement strategies – patient activation, self-management, and patient-provider communication – must be strengthened by initiatives to address the social determinants of health.[28] In 2017, the American Hospital Association's (AHA) Health Research & Education Trust released a playbook that details how healthcare organizations can create community healthcare partnerships to drive continuous patient engagement and an overall culture of health. The playbook is a part of AHA's strategy to address the social determinants of health and improve community and population health.[29]

In this 2017 playbook, the AHA detailed the following steps to creating a community health partnership:

- Identify partners and their assets.
- Host community collaborative meetings.
- Define roles and responsibilities in a collaborative.

[27] Carenet Health (2020, November 12th). *2021 Healthcare Consumer Engagement Forecast*. https://carenethealthcare.com/2021-healthcare-consumer-engagement-forecast/
[28] Heath, S. (2017). *AHA Playbook Details Community Healthcare Partnerships*. AHA. https://patientengagementhit.com/news/aha-playbook-details-community-healthcare-partnerships
[29] *Ibid.*

- Address common goals in a collaborative.
- Create an action plan.
- Measure partnership effectiveness.
- Overcome obstacles.

Community Health Conversations

Communication with communities should be two way. The recommended approach is to conduct community health conversations to help identify the needs of the community and potential partners, such as schools, faith-based organizations, housing and urban development offices, service organizations, local businesses, and public health organizations. Efforts should also be directed towards identifying the specific skills and assets each partner brings to the project, with the view to leveraging these skills for efficiency and cost-effectiveness.[30]

Engagement via Telehealth Utilization

The Board's health plans are all required to provide telehealth services and coverage to members, but the types of services may vary. Providers offering 24-hour telehealth connections (via care coordinators, registered nurses, and online physician consults) can explore obstacles and discuss situations that might be impacting a person's health.[31]

It is important to note that telehealth is not a panacea — other access and screening options may be necessary for rural residents and people who may not have access to adequate technology due to financial constraints or technological literacy. The Board has already taken steps toward ensuring better access to telehealth by clarifying their telehealth coverage policy to include coverage for various modalities (e.g., audio/visual, audio-only, store-and-forward, etc.) based on specific member need.

Key Stakeholders

SDOH requires a multi-stakeholder approach. Research evidence suggest that "payers, employers, local government entities, anchor institutions, and others have much to gain financially and otherwise by making investments to address social needs"[32], and stakeholder engagement will be useful for supporting acceptability, sustainability, and scale of SDOH initiatives that would be adopted by employers and health plans.[33] The U.S. Department of Health and Human Services developed national guidelines, Healthy

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[30] Heath, S. (2017). *AHA Playbook Details Community Healthcare Partnerships*. AHA. https://patientengagementhit.com/news/aha-playbook-details-community-healthcare-partnerships

[31] Carenet Health (2019, November 25th). *Telehealth Services as a Patient Engagement Solution*. https://carenethealthcare.com/telehealth-as-a-patient-engagement-solution-how-virtual-care-can-produce-better-outcomes/

[32] Nielsen, R., Muhlestein, D., & Leavitt, M.O. (2021). *Social Determinants of Health: Aggregated precision investment*. Health Affairs Blog. https://www.healthaffairs.org/do/10.1377/hblog20210610.928520/full/

[33] Freore, J. (2020). *Addressing Social Determinants of Health requires a strategic approach in an evolving healthcare environment*. Avalere. https://avalere.com/insights/addressing-social-determinants-of-health-requires-a-strategic-approach-in-an-evolving-healthcare-environment

People 2010 (HP 2010), for addressing health disparities, with the overarching goals of 'increasing the quality and years of healthy life and eliminating health disparities.'[34] Addressing SDOH is an approach to addressing health disparities, and HP 2010 acknowledges "that communities, States, and national organizations will need to take a multidisciplinary approach to achieving health equity ..."[35], and that any such approach will require "developing partnerships with groups that traditionally may not have been part of public health initiatives, including community organizations and representatives from government, academia, business, and civil society."[36]

The key stakeholders in the approach to address SDOH can be divided into accountable and impacted stakeholders. Accountable stakeholders are the key stakeholders who have control in decision-making, and funding. These include the State of Wisconsin, employers, Wisconsin Department of Health Services (DHS), State Legislature/Legislators, and ETF/GIB. The stakeholders most impacted by social risk factors include employees and retirees and their beneficiaries as provided for in the Wisconsin Retirement System. Other stakeholders and partners include healthcare organizations and providers, who will identify high-risk patients, fund sources, care coordinators or caseworkers, and community-based organizations (CBOs) who will help carry out interventions.

Stakeholder Outreach Framework

The plan to effectively engage stakeholders should be informed by the stakeholders' ideas for engagement. Stakeholders should be directly involved in defining priorities, collecting data, interpreting findings, and developing resources and community advocacy plans. Stakeholders should be educated on the project's goals so they can make informed decisions about how they like to be engaged. For example, educating all stakeholders on the importance of collecting data on SDOH and how that information will inform care and services would help them plan well and choose the right strategy for collecting data and for engaging with their communities. ETF could provide such messaging materials for stakeholders. For example, ETF could provide a short script emphasizing that collecting SDOH data will help the employers better understand their employees' needs and offer plans to provide better care; or a message that the agency must start somewhere, that collecting SDOH data is key and the first step. ETF could also hold meetings with stakeholders to solicit advice and feedback and identify how and where the project fits into the agency's overarching goals.

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[34] Brennan Ramirez, L.K., Baker, E.A., Metzler, M. (2008). *Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/sdoh-workbook.pdf

[35] *Ibid.*

[36] *Ibid.*

Stakeholder Outreach Plan

In the first stage of stakeholder outreach, ETF hopes to identify the focal internal staff who will lead outreach. The outreach team would then identify the first group of participants from the key stakeholders list above to engage with. ETF would begin internally, and then in the second stage move outward to employers, health plans, practitioners, members, advocacy groups, and the community as appropriate. This approach would ensure that not only there is buy in for the programs identified, but that programs reflect the needs of members as they see them.

Staff will be available at the Board meeting to answer questions.

Resources to Learn More

1. Tools to Assess and Measure Social Determinants of Health. https://www.ruralhealthinfo.org/toolkits/sdoh/4/assessment-tools
2. Strategies to Empower Communities to Reduce Health Disparities. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5554943/
3. Addressing the Social Determinants of Health through Academic-Community Partnerships. https://www.ethndis.org/edonline/index.php/ethndis/issue/view/31
4. Evaluation Strategies and Considerations for SDOH Programs. https://www.ruralhealthinfo.org/toolkits/sdoh/5/evaluation-considerations
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