ACOs and Health Equity: Linking Clinical Care and Social Services

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ACOs Lead Equity Efforts

During the pandemic, ACOs have seen firsthand how social determinants of health (SDOH)—the conditions where people live, learn, work and play—can drive racial and ethnic disparities. By any measure—COVID-19 cases, hospitalizations, and deaths—Black, Indigenous, and people of color (BIPOC) across America have fared worse, underscoring longstanding structural and systemic inequities facing marginalized communities.

As community-based and patient-centered organizations, ACOs—local physicians, hospitals and others working together to improve quality and keep costs down—have been leaders in adopting practices to improve care management, including identifying patients with health-related social needs like housing and food insecurity and linking them to community resources. Moving forward, ACOs, with their strong community roots, increasingly are looking for opportunities to address health inequities further upstream by moving beyond patient-level interventions to community-level SDOH initiatives aimed at food insecurity at a population level.

Moving from Health Care to Health

Compared to other developed nations, the United States spends much more on health care and much less on social services proportionately—for example, for every $1 in health care spending, other industrialized nations spend $2 on social services, while the U.S. spends about 60 cents, according to Alice Chen, M.D., M.P.H, medical director of Covered California and a presenter on health equity at a NAACOS conference earlier this year. And yet all that extra health care spending doesn't deliver better health, Chen said, adding, "It's become pretty widely accepted that if we do want to improve health, we need to look outside our walls."

Social Needs vs. Social Determinants

With their focus on population health and care management, ACOs are leading efforts to address how unmet social needs like food and housing insecurity impact health. "ACOs very much have led the way…have really focused on the issue of health-related social needs in a pretty organic way, because truly…as soon as you start talking to your patients, as soon as you start doing care management, population health, you start bumping up against issues like food insecurity, lack of transportation, financial stress, marginal housing," Chen said. At the same time, Chen urged ACO leaders and others to use precise terms and avoid conflating health-related social needs—food and housing insecurity, for instance—and SDOH, or the broader social context and environmental conditions, including racism, in which people live, learn, work and play (see Exhibit 1 and ***Defining Equity and Disparity*** on page 2 for more detail).

Exhibit 1. Social Determinants of Health

Source: Centers for Disease Control and Prevention

Race, Place, Poverty and Health

Both Chen and co-presenter Rick Gilfillan, M.D., former CEO of Trinity Health, pointed to structural racism and the generational fallout on wealth and health for members of marginalized communities, especially Black Americans. "Every city in America has an avenue you can follow to find people who live longer on one side versus the other," Gilfillan said. Using maps of San Francisco, Chen pointed to the legacy of "redlining," a practice in the mid-1900s that declared certain neighborhoods too risky for federally insured loans and that effectively

denied homeownership, the greatest source of generational wealth in America, to many minorities, but especially Black people. In example after example, the redlined map from the 1930s was an almost perfect overlay of neighborhoods today with worse health outcomes. "In a very tangible way, race is tied to place, poverty and health," Chen said. For larger ACOs with hospitals, Chen urged exploration of place-based investment with local governments, with hospitals serving as anchor institutions in disadvantaged communities to help address, for example, the built community and environment on a larger scale.

ACOs in Action

Equity in Access. Wake Forest Baptist Health, a partner in a Medicare ACO, has prioritized investing ACO savings in community-based initiatives to address health-related social needs. For high-risk patients, the system has designed the Care plus program to provide comprehensive screening for food, housing and transportation needs. These patients also can access longer, more frequent visits and home visits, and care management staff will contact them if they miss appointments to check on them. The system also operates a mobile clinic throughout the Winston-Salem area to bring care to people where they live.

Targeting High-Risk Beneficiaries. Anchored by the University of Texas Southwestern Medical Center, Southwestern Health Resources coordinates care for about 700,000 patients in North Texas, including 100,000 beneficiaries attributed to a Medicare Next Generation ACO. Through a team of licensed social workers and community health workers, the ACO screens beneficiaries receiving care management services for housing instability, food insecurity, transportation problems, utility assistance, family and community support, behavioral health, and healthcare financial strain. After identifying a social need, the team taps a database of community resources to assist patients in meeting their needs.

Bridging Medical and Social Needs. AMITA Health, a large faith-based health system and Medicare ACO serving greater Chicago, jumped at the opportunity to scale efforts to integrate screening and referral for social services into clinical settings. Through the federal Accountable Health Communities model, AMITA serves as a "bridge" organization to screen and link thousands of Medicare and Medicaid beneficiaries to needed social services, including housing, utilities, food, transportation, and interpersonal violence.

Defining Equity and Disparity

Healthy People 2030 defines ***health equity*** as "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." A ***health disparity*** is "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage."

Social determinants of health (SDOH) are the conditions 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. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

— Adapted from Healthy People 2030