

# SFHSS and Social Determinants of Health Introduction

# Agenda

- Aims and Rationale
- Social Determinants of Health Framework
- Whole Person Health
- What does the data tell us?
- SFHSS Sphere of Influence

# Presentation Aims

- What are Social Determinants of Health and why are they important?
- Understand how interconnections between member demographics and SDOH affect health outcomes
- Relevance and direction for SFHSS Membership

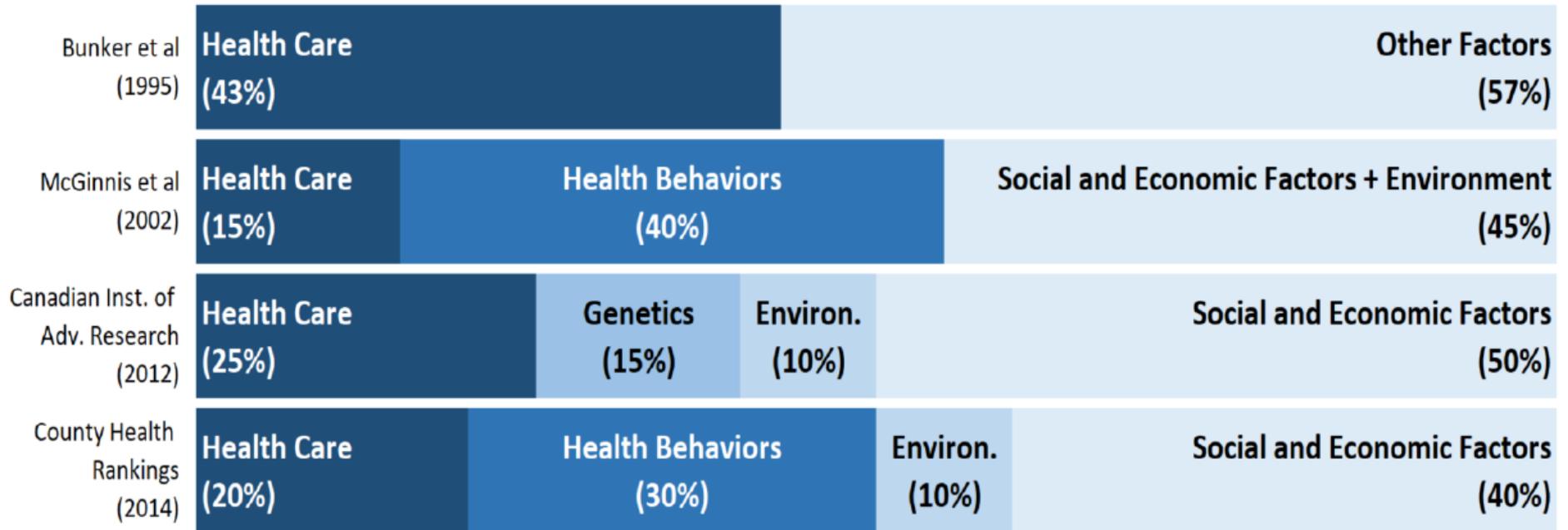
## **Our Mission**

*Dedicated to preserving and improving sustainable, quality health benefits and to enhancing the well-being of our members and their families*

## **Our Vision**

*Respects the whole person's well-being in offering supportive programs and services that enable positive engagement and health experience*

# Rationale: Health is much more than Health Care



Source: County Health Rankings and The King's Fund

# What are the Social Determinants of Health?

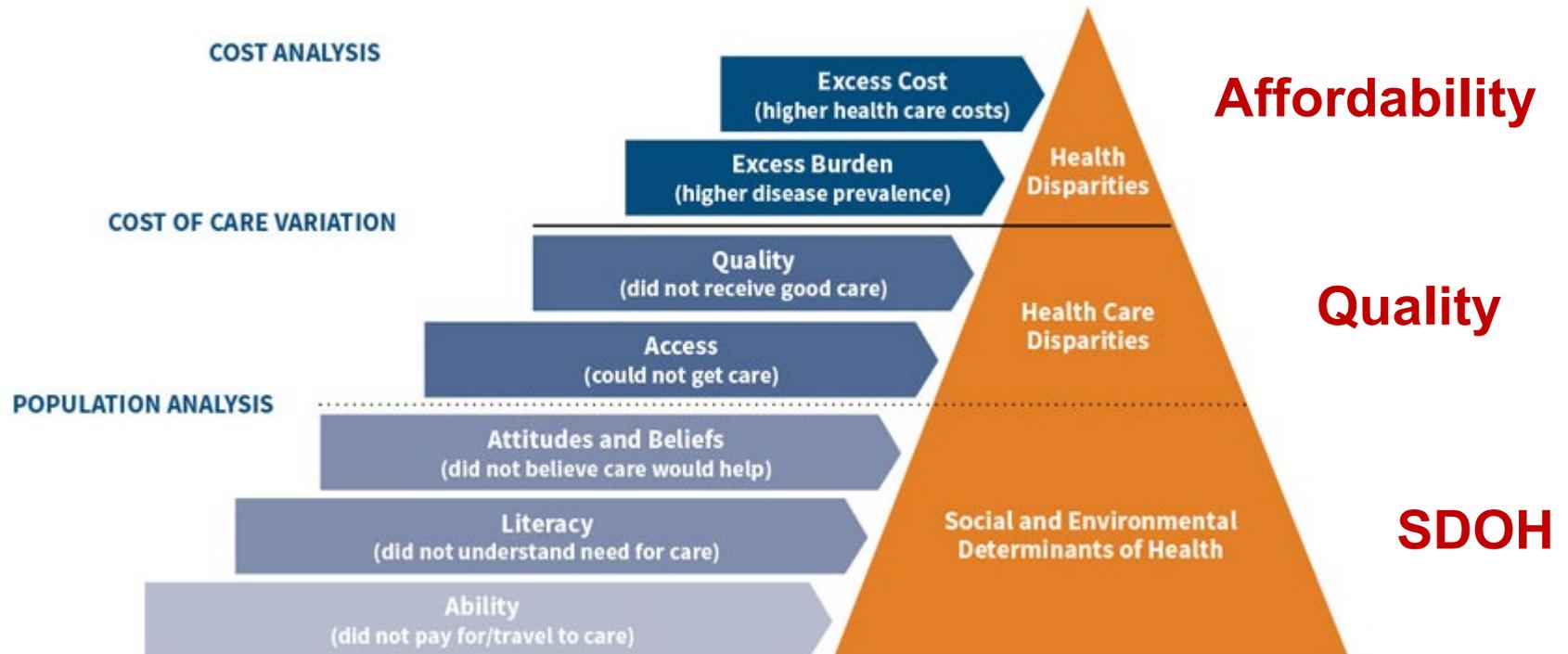
Born, Live, Play, Learn, Work, Worship , Age, +

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
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Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

**Health Outcomes**  
 Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

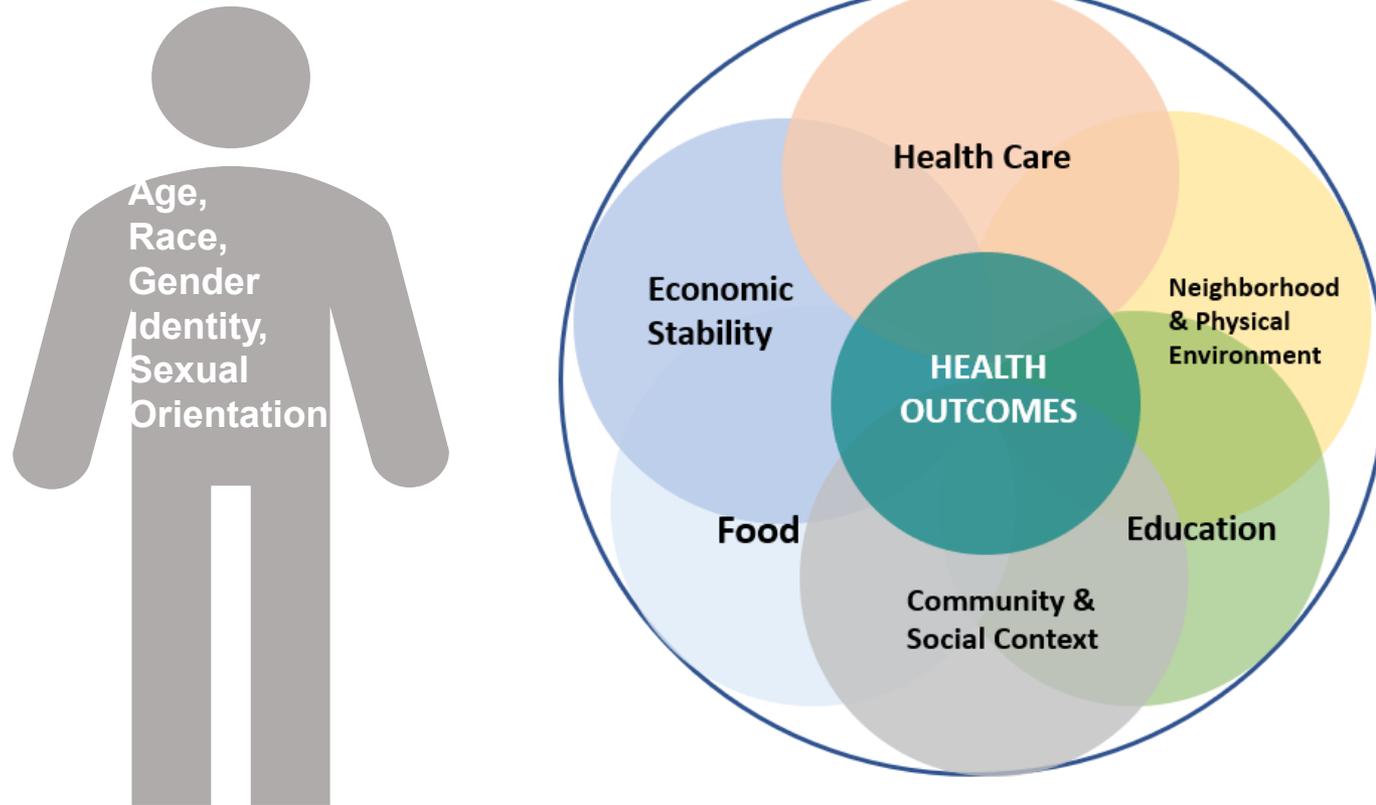


Figure 1: Causes of Excess Costs Due to Health Disparities



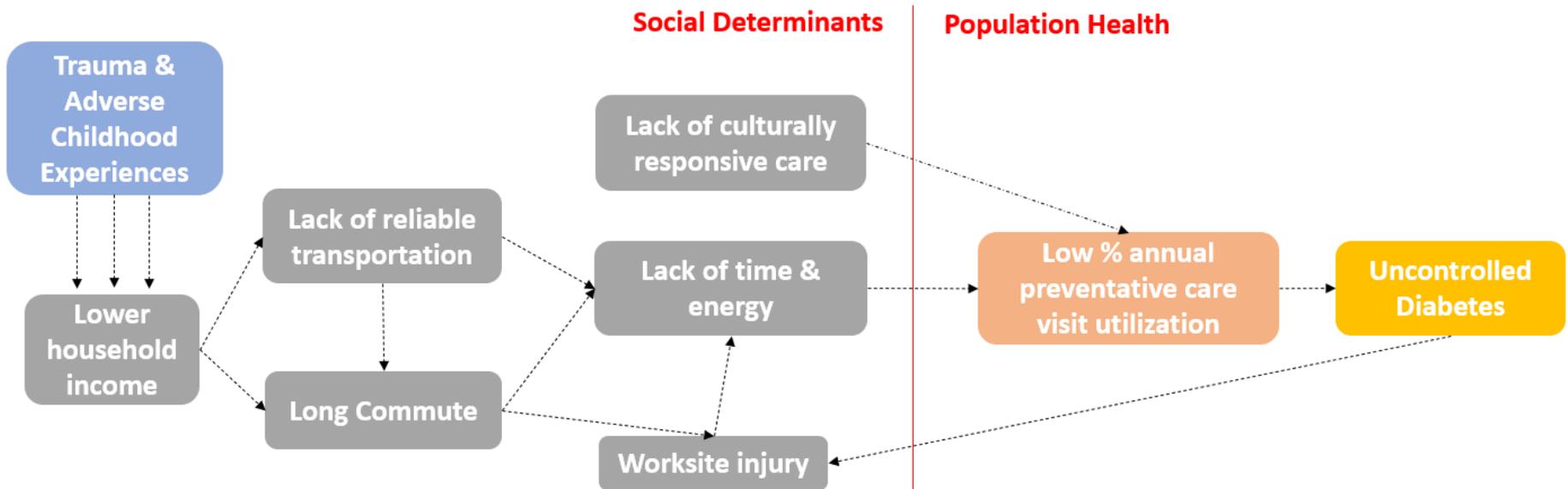
Source: Health Care Service Corporation

# Whole Person Health & Wellbeing: A Looking Glass



Member Demographics + Social Determinants of Health

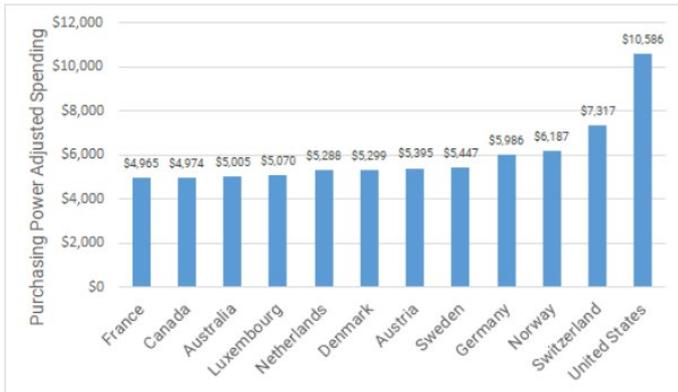
## Whole Person Health & Wellbeing: Root Causes & Web of Complexity



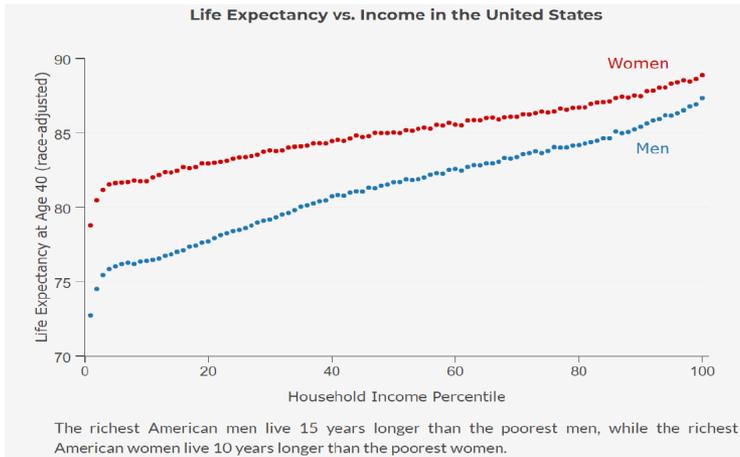
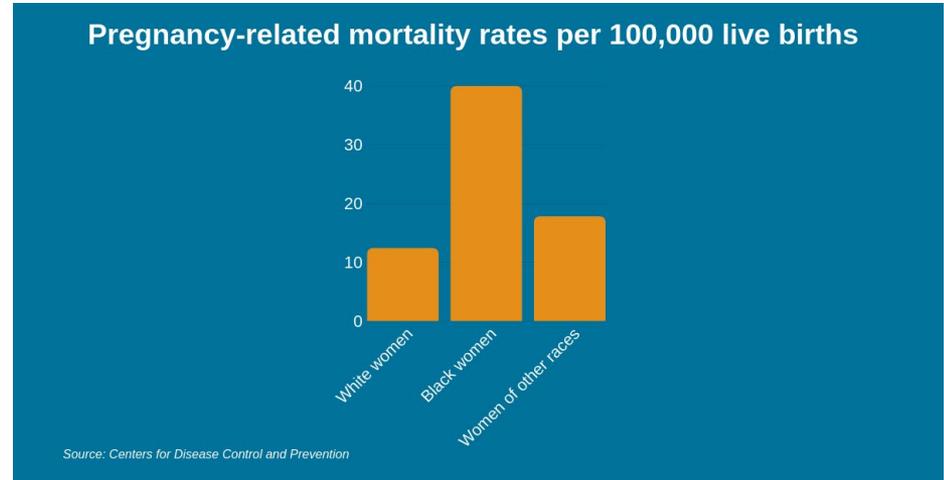
Understanding root causes involves systematic epidemiological studies and qualitative data on lived experiences

# What does the data say? US Population

Exhibit 1: The US far outspends all other countries

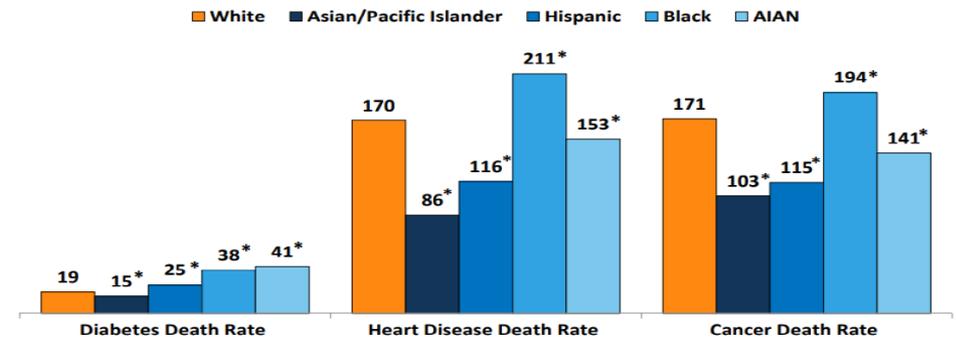


Source: Organization for Economic Cooperation and Development. *Health expenditure per capita*. Paris, OECD; 2019.



Source: Chetty R, Stepner M, Abraham S. *JAMA*. April 26,2016; 315(16):1750-1766.

## Age-Adjusted Death Rates per 100,000 for Selected Diseases by Race/Ethnicity, 2014



Source: Artiga S, Foutz J, Cornachione E, Garfield R. Key Facts on Health and Health Care by Race and Ethnicity. Kaiser Family Foundation. June 2016.

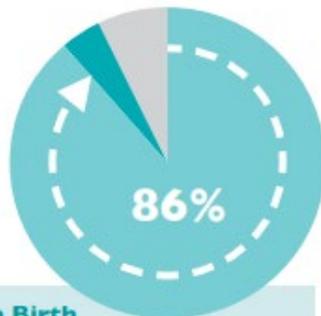
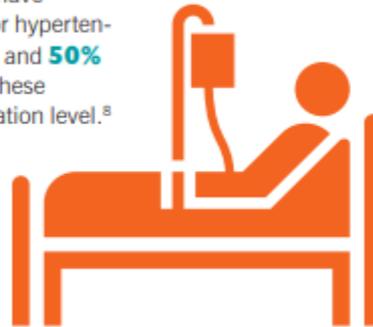
# What does the data say? SF Community

## San Francisco Community Health Needs Assessment 2019

### Preventable Hospitalizations and Emergency Room Visits

While preventable hospitalizations for most causes have decreased over time, preventable hospitalizations for hypertension and diabetes have respectively increased **45%** and **50%** between 2011 and 2016 — potentially indicating these conditions are not being well managed at the population level.<sup>8</sup>

Preventable hospitalizations and ER visits are significantly higher among Black/African Americans and Pacific Islanders compared to all other ethnicities in San Francisco.<sup>9</sup>



### Full-Term Birth

Full term birth more likely for Whites (**93%**) than Black/African Americans (**86%**).<sup>2</sup>



### Food insecurity among pregnant women in San Francisco<sup>1</sup>

**26.5%** among Latinx women

**19.5%** among Black/African American women

**6.6%** among Asian and Pacific Islander women

Almost no White women in San Francisco report food insecurity during pregnancy.



### Heart Disease

Heart Disease impacts Black/African

Americans at younger ages. Rates of heart disease related hospitalizations among Black/African Americans in their 40s and 50s **are comparable to those seen in other races/ethnicities over 75 years of age.**<sup>7</sup>

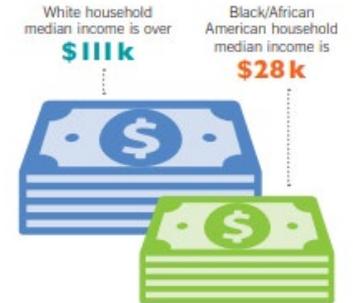
### Nutrition



Black/African American and Latinx SFUSD students are 2–3 times more likely to consume fast food (**64%**, **73%**), or soda (**44%**, **36%**) at least weekly, as compared to White students (fast food (**35%**) and soda (**17%**)).<sup>6</sup>

### Median Income

In San Francisco, there is significant inequality in household income between races.<sup>3</sup>



### Income Inequality and Health

**San Francisco has the highest income inequality in California.**

The wealthiest 5% of households in SF earn 16 times more than the poorest 20% of households.<sup>9</sup>

**Low income impacts lifetime health, beginning with pregnancy and birth.**

Lower-income children in San Francisco experience higher rates of asthma, hospitalization, obesity, and dental caries.<sup>10-12</sup>

Low-birth weight is highest among low-income mothers.<sup>13</sup>

# What does the data say? SFHSS Membership

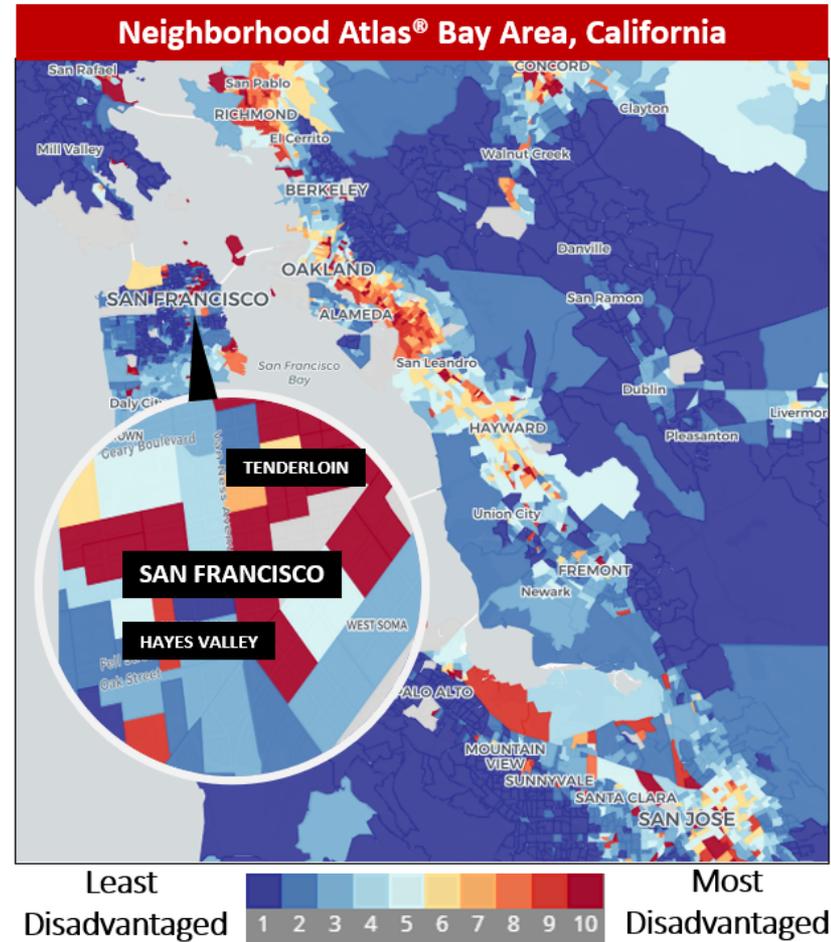
Area deprivation looks at domains of employment, housing, education, income, & family structure.

Our members living in a disadvantaged neighborhood are more likely to have:

- Higher rates of chronic conditions
- Increased utilization of health services
- Lower life expectancy

SFHSS Benefit Eligible Members	
Area Deprivation Decile <sup>1</sup>	Members <sup>2</sup>
1	23,975
2	31,760
3	27,097
4	12,195
5	7,841
6	4,575
7	3,612
8	3,931
9	2,543
10	3,073
Unknown	16,689

<sup>1</sup> Area deprivation deciles displayed are an in-state California comparison only. These scores are created using 17 indicators from the ACS 2011-2015  
<sup>2</sup> Members eligibility snapshot 3/1/2020



# SFHSS Sphere of Influence

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
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## Guiding questions for inquiry:

How can SFHSS work with health plan, City, and vendor partners to identify & address social determinants?

Where does SFHSS already interact with SDOH through data analytics, finance communications, member services and wellbeing?

Member Services: Benefits Navigation

Contracts & Finance: Value-based Payment Models & Aligning Performance Goals

Enterprise Systems and Analytics: Monitor Quality of Care Indicators by Plan, Race, job....

Communications & Well-Being: Education & Awareness on Mental Health, Healthy Eating...

Well-Being: Diabetes Prevention Programs...

## Conclusion & Next Steps

- Quality, whole person health is more than traditional health care
- Key stakeholder (providers, insurers, purchasers, philanthropy, government, non-profit) interests are converging to develop innovative and evidenced based practices to address SDOH
- SFHSS has initiated a comprehensive measurement plan to identify actionable data and support partnership with Health Plans to establish a focused, effective and operational framework to address health disparities.
- Provide periodic updates to the HSB regarding priorities and actionable data plan.
- Racial equity is City-wide priority and important lens (amongst others: e.g. gender identity, job type, etc.) to examine SDOH and health outcomes.