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
Rationale: Health is much more than Health Care

<table>
<thead>
<tr>
<th>Study</th>
<th>Health Care</th>
<th>Health Behaviors</th>
<th>Other Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bunker et al (1995)</td>
<td>(43%)</td>
<td></td>
<td>(57%)</td>
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<tr>
<td></td>
<td></td>
<td>(40%)</td>
<td>(45%)</td>
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<td></td>
<td>(25%)</td>
<td>(15%)</td>
<td>(50%)</td>
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<td></td>
<td>(20%)</td>
<td>(30%)</td>
<td>(10%)</td>
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Source: County Health Rankings and The King’s Fund
What are the Social Determinants of Health?

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

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
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</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
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<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
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<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Social integration</td>
<td></td>
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<td>Parks</td>
<td>Vocational training</td>
<td>Support systems</td>
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<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td>Community engagement</td>
<td></td>
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<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
<td>Discrimination</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Zip code / geography</td>
<td></td>
<td>Stress</td>
<td></td>
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</tbody>
</table>

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Figure 1: Causes of Excess Costs Due to Health Disparities

**Affordability**

- Excess Cost (higher health care costs)

**Quality**

- Excess Burden (higher disease prevalence)

**SDOH**

- Quality (did not receive good care)
- Access (could not get care)
- Attitudes and Beliefs (did not believe care would help)
- Literacy (did not understand need for care)
- Ability (did not pay for/travel to care)

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 outsends all other countries


Pregnancy-related mortality rates per 100,000 live births

Source: Centers for Disease Control and Prevention

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

**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.8

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

**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.7

**Median Income**

In San Francisco, there is significant inequality in household income between races.9

- White household median income is over **$111 k**
- Black/African American household median income is **$28 k**

**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.9

**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.10,12

Low-birth weight is highest among low-income mothers.13

**Food insecurity among pregnant women in San Francisco**

- **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.

**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%**).6
What does the data say? SFHSS Membership

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

<table>
<thead>
<tr>
<th>SFHSS Benefit Eligible Members</th>
<th>Members²</th>
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<tbody>
<tr>
<td>Area Deprivation Decile¹</td>
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</tr>
<tr>
<td>1</td>
<td>23,975</td>
</tr>
<tr>
<td>2</td>
<td>31,760</td>
</tr>
<tr>
<td>3</td>
<td>27,097</td>
</tr>
<tr>
<td>4</td>
<td>12,195</td>
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<tr>
<td>6</td>
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<td>7</td>
<td>3,612</td>
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<tr>
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<td>9</td>
<td>2,543</td>
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<tr>
<td>10</td>
<td>3,073</td>
</tr>
<tr>
<td>Unknown</td>
<td>16,689</td>
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</tbody>
</table>

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

¹ Area deprivation deciles displayed are an in-state California comparison only. These scores are created using 17 indicators from the ACS 2011-2013.
² Members eligibility snapshot 3/1/2020

Neighborhood Atlas® is a registered trademark of the University of Wisconsin
SFHSS Sphere of Influence

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?
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.