

*CONVERGENCE COLLABORATIVE  
ON SOCIAL FACTORS OF HEALTH*

# Discovery Report



APRIL 2024

CONVERGENCE



# CONVERGENCE COLLABORATIVE ON SOCIAL FACTORS OF HEALTH

## About Convergence

Convergence is the leading organization bridging divides to solve critical issues through collaborative problem-solving across ideological, political, and cultural lines. Since 2009, Convergence has brought together leaders, doers, and experts – many who never thought they could talk to one another— to build trusting relationships, identify breakthrough solutions, and form unlikely alliances for constructive change on seemingly intractable issues. Our process is improving the lives of Americans and strengthening democracy for a more resilient and collaborative future.

For more information, visit [convergencepolicy.org](http://convergencepolicy.org)

This project was launched with generous support from and in collaboration with **CommonSpirit Health, the Episcopal Health Foundation, and Kaiser Permanente.**

## Contact

**Convergence Center for Policy Resolution**  
1775 Eye Street NW, Suite 1150-287  
Washington, DC 20006

(202) 830-2310  
ConvergencePolicy.org  
@ConvergenceCtr

CONVERGENCE



# TABLE OF CONTENTS

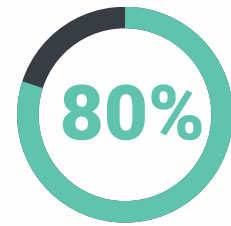
|            |   |      |
|------------|---|------|
| <b>01.</b> | <b>Introduction</b>                                     | 1    |
| <b>02.</b> | <b>What We Learned</b>                                  | 3    |
| <b>03.</b> | <b>Emerging Areas of Focus and Questions to Resolve</b> | 5-10 |
|            | Improving System Integration                            | 5    |
|            | Financing Approaches                                    | 6    |
|            | Expanding Data and Evaluations                          | 8    |
|            | Building the Workforce                                  | 10   |
| <b>04.</b> | <b>Next Steps</b>                                       | 10   |



In the United States, we are beginning to understand that **there is far more to good health than medical care. A person’s health condition is affected by many lifestyle and social conditions.** Indeed, some researchers suggest that housing conditions, available social services, nutrition, and other social factors account for as much as 80 percent of a person’s health status, with medical care responsible for only 20 percent. Many countries concentrate more on these social factors than we do in the U.S., while the American medical system has taken more of a “repair shop” function.

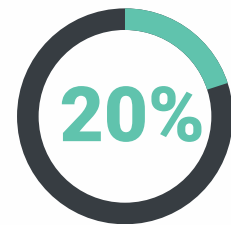
This is beginning to change. Increasingly, **health systems, housing organizations, social services groups, and levels of government are focusing on how to incorporate so-called “upstream” strategies to support individual, community, and public health.** With this shift in focus, it becomes clearer that existing policies influencing the financing, organization, and other features of our health system, as well as policies affecting the potential health role of social programs, reflect the more traditional medical intervention vision of our health system. **There is broad agreement that reforms are needed because the current structure of federal and state policies are not well aligned** with a strategy to foster collaboration by different sectors to improve community and individual health.

As organizations in healthcare and various social sectors consider more comprehensive, upstream approaches, they encounter various challenges. The financing and business models of most health systems, for example, do not easily adapt to a partnership role with other sectors. Public and private payment systems do not help. Even within the federal and state governments, close collaboration proves difficult for health departments and other departments, as does coordinating their budgets and programs. Vertical collaboration, from the federal level to local authorities, also remains problematic. Thus, despite the desire to do so, **it remains difficult to deploy public and private resources strategically across sectors to achieve health and other social goals, such as health equity.** For this frustrating policy environment to change, reforms affecting multiple sectors will be required.



Some researchers suggest that housing conditions, available social services, nutrition, and other social factors account for as much as 80 percent of a person’s health status.

National Academy of Medicine



Some researchers suggest that medical care is responsible for only 20 percent of a person’s health status.

National Academy of Medicine



To help address these challenges, Convergence interviewed dozens of key stakeholders and experts from different sectors, including healthcare, housing, social services, and nutrition, as well as government officials and organizations. **The purpose of these conversations was to improve the climate for collaboration in addressing upstream social factors influencing health**, by identifying areas of agreement and disagreement as a prelude to finding pathways to consensus on public policy reforms. Convergence’s role is as an honest broker for changemakers; **the Convergence team has no preconceived view of what policy reforms should be included in the consensus.**

**At the publication of this report, Convergence is convening a Collaborative of a diverse group of representative stakeholders and experts** through the summer of 2024, with the goal of finding consensus on a set of recommended policy changes. These federal and state actions will aim to create a significantly better policy environment for innovative collaborative efforts at all levels, to improve individual and public health.

This Discovery Report is based on early feedback in interviews and brainstorming sessions preceding the series of “get to yes” meetings. Rather than specific recommendations for policy reforms, this report does two important things. **First, it provides a brief overview of topics that were raised as key areas of focus by most stakeholders. Second, it lays out many of the questions that will need to be resolved to reach consensus.**

Convergence interviewed dozens of key stakeholders and experts from different sectors, including healthcare, housing, social services, and nutrition, as well as government officials and organizations.

In addition to specific concerns and ideas for reforms, the preliminary conversations highlighted important overarching themes that must be appreciated if consensus is to be reached. In particular:

**1 THERE ARE IMPORTANT DIFFERENCES IN TERMINOLOGY REFLECTING VIEWS OF THE PROCESS AND GOALS.**

**Different people and organizations currently use alternative terms to describe upstream social strategies to improve health.**

These terms often reflect different assessments of the connection between social factors and health, as well as different visions of the goals of collaboration. Some leaders see a strong causal connection between social factors and health and tend to favor the term “social determinants of health,” or SDOH. Others prefer social “drivers” or “dynamics” as less deterministic terms. Still others, including many experts in federal agencies, put the focus on the social conditions themselves and prefer “health-related social needs.” **In this Discovery Report, we use all these terms, with SDOH as the default** solely because SDOH is currently the most widely used term.

The goals and strategies shared by stakeholders also reflect other differences in emphasis. For some, the focus is on practical steps that would boost the effectiveness of the healthcare system by tackling specific upstream social factors. Some, however, see the objective as seeking major structural changes that might lead to broader social policy objectives, such as greater health equity. Many view the goal as creating healthier communities, not just improving individual health.



**SDOH**

stands for social determinants of health

or alternatively,

social “drivers” or “dynamics” as less deterministic terms.



## 2 NUMEROUS INITIATIVES ARE ALREADY IN MOTION.

Even with a current policy framework that often hampers efforts, **we found broad acknowledgment that considerable activity is underway in both the public and private sectors.**

For instance, several major health plans and hospital systems are investing in housing and non-medical services, partnering with transportation, nutrition, and other services, and exploring the impact on patient and public health. As payers, for instance, some for-profit and nonprofit health plans have established cross-sector community partnerships. Meanwhile, the government at all levels has been active in encouraging experimentation in multi-sector efforts to address health. For example, the federal government has provided more precise guidance on using social services [in lieu of medical interventions](#) under Medicaid, and the White House and federal agencies recently published a “[playbook](#)” and related [guidance](#) on addressing SDOH and health-related social needs. In addition, a wide range of states are making use of [Medicaid 1115 waiver requests](#) to experiment with combined medical and social services, including housing, to improve health outcomes for certain populations.

## 3 THE CURRENT EVIDENCE LACKS DETAIL.

Designing strategies to address non-medical factors in health is still relatively new, and while evaluations and associated research studies are expanding rapidly **there are significant gaps in the currently available research needed to shape policy.** For example, there is good evidence that housing conditions and good nutrition are strongly related to better health, although even there the evidence on specific interventions is often limited. Fortunately, [SIREN](#) and other research centers are collecting research and undertaking new analyses, so this problem will diminish over time. But the gaps in the evidence on effectiveness of approaches causes many stakeholders to stress the importance of well-evaluated federal and state pilots and fostering well-documented local experimentation.



## EMERGING AREAS OF FOCUS AND QUESTIONS TO RESOLVE

Convergence found that certain broad areas were frequently cited by stakeholders and experts as offering opportunities for consensus on policy improvements. Within these promising areas there was typically some agreement on the importance of certain sub-issues. However, there was not always initial agreement on how to address these, and therefore several questions need to be resolved to reach consensus in various areas of policy.



### Improving System Integration

---

Most stakeholders and experts see cross-sector collaboration to address upstream factors influencing health as not just fostering specific partnerships at various levels, but requiring an updated vision of how different sectors can be better integrated and a strategy that reflects that vision.

#### **Improving Collaboration:**

Improved collaboration across sectors and between levels of private and public organizations is viewed as essential for effective SDOH strategies. **Inadequate collaboration is widely believed to be a major impediment. The Convergence team heard that achieving collaboration requires system integration rather than case-by-case solutions.** Trying to solve problems systemically raises important questions that need to be answered.

- Question:** To what degree would the problem be solved through greater clarity and guidance from the state and federal government officials on what local government and community-based organizations (CBOs) can do under current law? What procedures and responsibilities would be most effective to provide clarity and guidance to states and communities on what they can and cannot do under laws and regulations?
- Question:** The federal government has recently unveiled a set of proposed actions to improve interdepartmental collaboration at the federal level and it has also issued guidance for states and local organizations on how to incorporate social services within Medicaid and other programs. How can the federal government, as well as states and local authorities, better coordinate such information and promote greater coordination across departments and programs?
- Question:** Does the federal government and/or the states need to create and fund special bodies to better coordinate programs and offices to advance local SDOH initiatives (perhaps modeled on state Children's Cabinets)?

## Supporting Partnerships:

All over the country, health systems and health plans are reaching out into their communities, forming partnerships with CBOs with the aim of assuring that individuals with health-related social needs receive the combination of medical and social services they require. These efforts have sparked a robust discussion of how best to organize and support such partnerships. Part of that discussion centers on the role of intermediary institutions that could assist and coordinate activities and funding for local CBOs. These institutions are typically referred to as “**community care hubs**” and “backbone organizations.”

**Question:** Could modifications to federal nonprofit hospital community benefit requirements encourage more investment in creative local collaboration, and should such investments become a requirement? Could adjustments to the obligations of financial institutions under the Community Reinvestment Act obligations lead to more joint finance-health SDOH ventures?

**Question:** How can the federal government, and states, help develop and support community hubs acting as intermediaries? Should regulations at some level of government specify the skills and functions of community hubs as a condition of providing them with funding?

**Question:** Are there local institutions (e.g., housing associations, Area Agencies on Aging, schools, community health clinics etc.) that could function as community hubs in some communities? What limits them from undertaking this role today, and could there be an adequate level of regulation and oversight of such institutions without constraining their creativity and flexibility?

**Question:** To what extent can public health agencies play a key role in identifying SDOH concerns and working with community hubs to organize and deliver services?



## Financing Approaches

Funding concerns were featured prominently during the Convergence interviews and brainstorming sessions. Experts and stakeholders generally agreed that current payment systems and program funding are not well aligned with encouraging cross-sector strategies to improve health. It is difficult to braid or blend money from different programs, for instance, and departments at the national and state levels often do not collaborate closely in making funding decisions. That said, the government at all levels has been taking steps to facilitate greater cross-sector collaboration, including through the Medicaid 1115 waiver process and improved guidance on using grant and program funds.

Experts and stakeholders generally agreed that **current payment systems and program funding are not well aligned with encouraging cross-sector strategies to improve health.**



### **Determining Funding:**

Advocates of SDOH strategies often call for large upfront investments in non-clinical social services influencing health, such as housing or food assistance, and in the “infrastructure” of collaboration, to achieve downstream health gains. Infrastructure refers to data-sharing and referral systems, creating community hubs, and other elements often described as connective tissue. Calls for large upfront investments raise questions about the appropriate sources of funding – including who should be responsible for funding particular elements. Today, potential sources of both public and private finance approaches often encounter “wrong pockets” disincentives. Wrong pockets refer to situations in which one sector or department primarily benefits from collaboration, but another sector or department would be the main funder (for example, a housing authority paying for bathroom improvements that lead to fewer falls, resulting in lower Medicare costs). Addressing these issues raises several questions.

**Question:** To what extent do significant gains from collaborative strategies depend on a substantial increase in public funding for housing, social services, and other services? Without such an expansion, could there be significant improvements through different uses of existing funds, such as Congress defining SDOH interventions as appropriate medical services expenses for the calculation of health plans’ “medical loss ratio” under the Affordable Care Act? Might there also be more collaboration if states clarified how grants may be used to address SDOH (similar to recent changes to the federal Uniform Guidance on the administration of grants and other federal funds to states and other entities)?

**Question:** To what extent should SDOH services and infrastructure be viewed as “public goods,” implying at least a degree of public financing? And to the extent that collaborative ventures provide private benefits, such as reduced costs for managed care organizations, does that imply a private sector financial responsibility?

**Question:** Is the “medicalization” of social services a significant concern in designing SDOH approaches where health systems and hospitals play a central role in the design and leadership?

### **Optimizing Resources:**

Agreement on how the investment obligations for SDOH strategies should be distributed still leaves questions regarding how the optimal financial resources can be raised and what public policies would create the best environment to encourage investment.

**Question:** Does private investment have a significant role in financing the infrastructure of SDOH approaches, perhaps through pay-for-success models such as social impact bonds?

**Question:** To what extent would “co-opetition” and other joint private funding approaches by health systems lead to an increased level of private financing for local community hub infrastructure? More generally, could health system investment in backbone organizations and community hubs, as well as housing and other services, become a key feature of the basic business model of health systems rather than being seen as mainly a secondary and philanthropic activity?

**Question:** What budget process reforms would help federal and state governments ameliorate wrong pocket disincentives for collaborative financing?

**Question:** What policy improvements would encourage more braiding and blending of program funds to improve community and individual health?





## Expanding Data and Evaluations

Issues associated with data collection, data sharing, and evaluation were also featured prominently in the preliminary discussions. Improving the collection and use of data is widely viewed as a critical element in fostering collaboration to advance SDOH approaches. Good data is also essential for evaluating the effectiveness of strategies and local initiatives.

Improving the collection and use of data is widely viewed as a critical element in fostering collaboration to advance SDOH approaches.

### Optimizing Data Collection:

Data collection and sharing is critical for screening and successful referrals. And, improved data and cost-benefit tools are important for measuring the broader multi-sector impacts of an SDOH investment. The stakeholders and experts raised several needs and challenges to these desired outcomes.

**Question:** Smaller CBOs generally lack the capacity to collect, analyze, and report data. How can we improve the capacity of CBOs to collect and manage data? Should states clarify their grants administration policies, as the federal government has, to make it easier to use money for data capacity building?

**Question:** To what extent do HIPAA and FERPA privacy rules discourage data sharing and collaboration? Are changes in federal and state rules necessary, or would better guidance for local organizations be sufficient?

**Question:** Health systems, communities, states, and other institutions and levels of government have experimented with different data sharing and referral models. Some health systems contract exclusively with a data/referral intermediary, which then contracts with individual social service providers and CBOs. In other cases, a data/referral intermediary connects multiple plans and CBOs. Which models best achieve the needs of health systems, and the needs of community hubs and other service sectors, and what policy steps would encourage the expansion and replication of successful models?

**Question:** Are there cost-benefit tools available, or under development, that could adequately measure the multi-sector social returns on investment (SROI) to enable private and public budget managers to devise procedures to “share value” associated with SDOH collaborations?

## Refining Government-Sponsored Experimentation:

Continuous experimentation and evaluation is critical to discovering better techniques to achieve policy objectives. This is happening in a variety of ways to address health-related social needs that impact health outcomes. These changes include state initiatives to create [health enterprise zones](#) that provide regulatory relief and incentives for health investments in underserved areas, federal expansion of non-clinical benefits available under Medicare Advantage plans, and federal-state partnerships to include certain food and social services and housing assistance in recent Medicaid 1115 state waivers. Making wider use of government-sponsored experimentation in this way, with careful evaluation, could accelerate our understanding of SDOH techniques and encourage further innovation.

➤ **Question:** What major lessons have we learned from existing government-sponsored experimentation?

➤ **Question:** What types of pilots should the federal government launch?

➤ **Question:** What 1115 waivers should states propose, or the federal government invite, to assess the potential of SDOH approaches? Is the 1115 waiver authority and the ability of the federal government to launch pilots sufficient, or are statutory/administrative changes needed?





## Building the Workforce

A frequent refrain among Convergence stakeholders and experts has been that achieving cross-sector and cross-departmental collaboration “is not really anyone’s job.” In some cases, they refer to the absence of a person or department with the appropriate function – and authority – to coordinate activities and budgets across sectors. In other situations, they express concern that individuals and departments may be tasked with coordination, but lack the training, authority, and resources to carry out that task. Meanwhile, at the federal and state level, there have been a variety of initiatives to coordinate departmental activities that focus on improving health.

### Establishing the Workforce:

Coordination of multisector services is required at all levels, from assembling services for individuals at the community level to budget and program coordination at the state and federal levels. Requiring coordination of multisector services at all levels raises questions about where responsibilities should lie and what training is needed at the local level.

**Question:** Are there particular professionals at the community level, such as community health workers, social service workers, or perhaps a new professional category, who should be designated as cross-sector coordinators in CBOs, community hubs, and local government? How should they be trained, licensed, and paid for this role?

**Question:** What major changes in curricula at professional schools and in licensing requirements would produce more workers with the skills needed to coordinate services across sectors?

**Question:** In addition to the experiences of community hubs and other backbone organizations in identifying key workers at the local level, what does experience suggest are the best models and designated lead officials at the federal and state level?

### Supporting Critical Staff:

To support workers tasked with coordinating a range of different organizations and services, pay systems and program funding must provide appropriate compensation and resources.

**Question:** What are the most important changes required in Medicaid, housing services, and other federal and state programs to ensure that money is available to build the workforce needed for initiatives?

**Question:** What major changes in the health industry and health insurance payments are required to ensure that the health sector makes more use of skilled workers to link medical services with social services delivered by other sectors?

## NEXT STEPS

As a result of the interviews and conversations that raised these issues and questions, Convergence has assembled a Collaborative of stakeholders and experts from various sectors, including health, housing, social services, and nutrition. Starting with the themes and questions in this Discovery Report, the Collaborative is exploring how administrative actions and legislative reforms could create a much better policy environment for local partnerships to address SDOH. The Collaborative will seek consensus on a set of recommendations and expects to issue a report in the Fall.



# Contact Us

**Convergence Center for Policy Resolution**

1775 Eye Street NW, Suite 1150-287  
Washington, DC 20006

(202) 830-2310  
[ConvergencePolicy.org](http://ConvergencePolicy.org)  
[@ConvergenceCtr](https://twitter.com/ConvergenceCtr)



**CONVERGENCE**

