From Value to Cost Effectiveness of Health

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Many hospitals and health systems have a mission of improving health, and in some cases, improving lives. But, in reality, they typically focus on improving health*care*. What are the implications of that distinction and why does it matter?

Key Board Takeaways

- Board members should reframe healthcare as one factor—not the largest one—that contributes to health.
- Hospitals and health systems can draw on six organizational capabilities to expand the healthcare organization's role in improving health for their patients and communities.
- By asking targeted questions, board members can engage in productive conversations about options for expanding their organization's reach and ability to fulfill its mission.

Healthcare Is Just One Element of Achieving a Mission of Improving Health

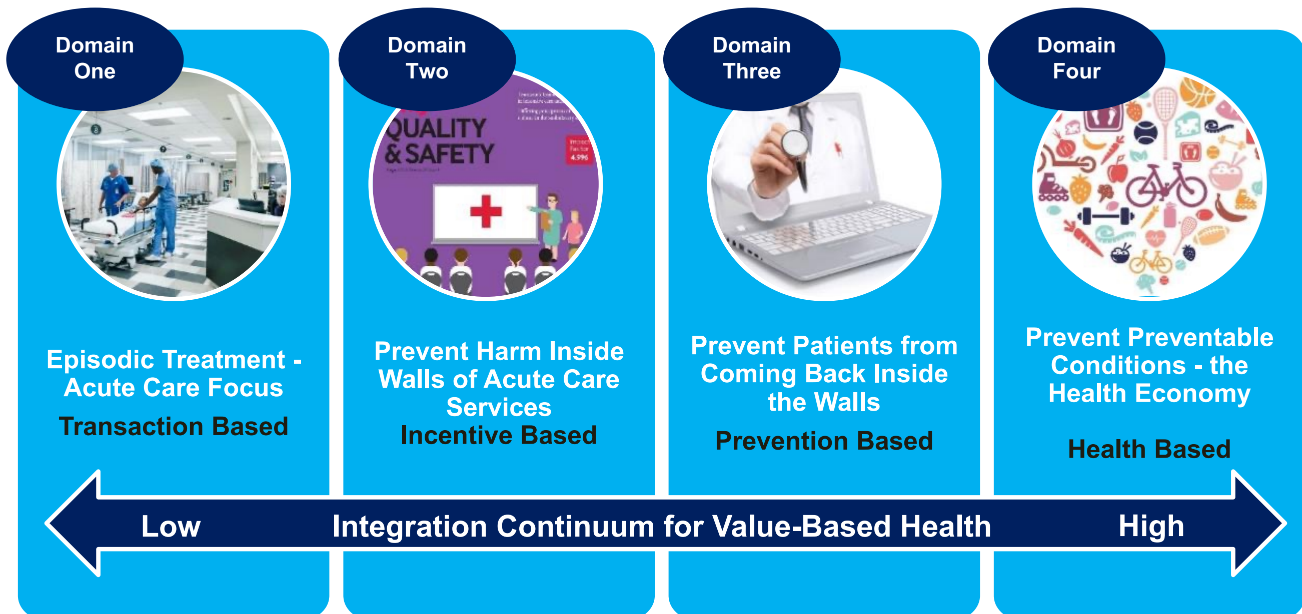
Among the many definitions of health, the World Health Organization's definition stands out for its clarity: "Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." The single biggest contributor to health, at 60 percent, are social determinants of health (SDOH), which encompass all conditions in the environments where people are born, live, learn, work, play, worship, and age. The other two contributors to health, genetics and healthcare, each account for 20 percent.

As a society, we are spending most of our health-related dollars on health*care,* not on SDOH and behavioral factors, despite their larger impact on health. Most healthcare dollars are spent on treating chronic conditions—even though many are linked to SDOH. Here are a few examples of the links between SDOH and expensive chronic conditions:

- **Diabetes**: Adults who experience food and nutrition insecurity are two to three times more likely to have diabetes than those who don't.[1] Diabetes is the most expensive chronic condition in America, with $1 out of every $4 in healthcare costs spent on caring for people with this condition.[2]
- **Cardiovascular disease**: Biologic pathways have been identified that link multiple SDOH associated with low socioeconomic status (i.e., unsafe housing, neighborhood violence, limited access to healthcare, and early childhood adversity) with chronic inflammation, which in turn is linked with cardiovascular disease.[3] Total spending on cardiovascular disease care in the U.S. in 2016 was $320.1 billion.[4]
- **Asthma**: Some 40 percent of asthma episodes—representing $5 billion in preventable medical costs annually—are caused by preventable triggers in the home, including hazards like mold and dust mites.[5]

From a societal perspective, it doesn't make economic sense to treat chronic conditions downstream rather than addressing SDOH upstream. Although our payment system is still designed to pay for treating downstream health conditions, not social determinants, that approach is neither cost effective nor sustainable in the long run. It won't yield

Exhibit 1: Four Domains of Integration toward Achieving Value-Based Health



1 Centers for Disease Control and Prevention, "Food and Nutrition Insecurity and Diabetes: Understanding the Connection."
2 Centers for Disease Control and Prevention, "The Health and Economic Benefits of Diabetes Interventions."
3 Tiffany M. Powell-Wiley, et al., "Social Determinants of Cardiovascular Disease," *Circulation Research,* American Heart Association, March 4, 2022.
4 Maxwell Birger, et al., "Spending on Cardiovascular Disease and Cardiovascular Risk Factors in the United States: 1996 to 2016," *Circulation Research,* American Heart Association, July 27, 2021.
5 Sarah Beth Barnett and Tursynbek Nurmagambetov, "Costs of Asthma in the United States: 2002–2007," *Journal of Allergy and Clinical Immunology,* January 2011.

the improvements in patient outcomes and value that care purchasers increasingly expect and deserve.

Healthcare finance leaders recognize that cost effectiveness is a weak spot for hospitals and health systems. Nearly 80 percent of CFOs surveyed for HFMA's "Healthcare 2030" series considered cost effectiveness as an area where healthcare organizations are highly vulnerable to disruption.[6] Forward-looking hospitals and health systems that are ready, willing, and able to consider strategies other than "running out the clock" on fee-for-service payment are considering how they can expand beyond their traditional healthcare domain into the realm of SDOH.

A Roadmap for Navigating New Domains in Service of Mission

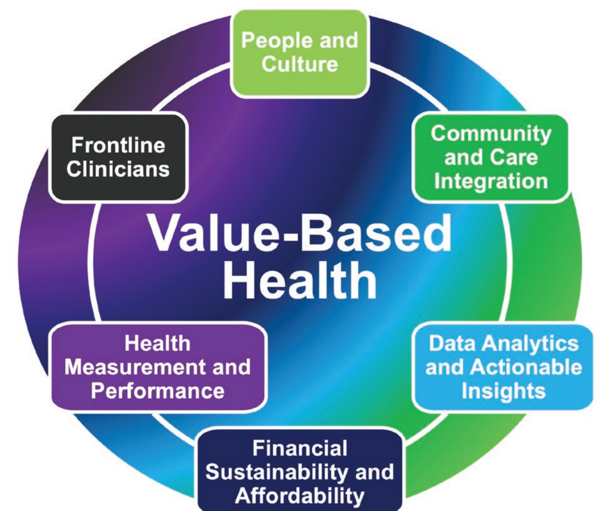
Where do hospitals and health systems begin, when it comes to expanding from healthcare into SDOH in service of their mission of improving health? Hospitals have traditionally focused on care provided within hospital walls, as depicted by domains one and two in **Exhibit 1**, episodic care and preventing harm within the acute care facility. More recently, spurred by financial penalties associated with hospital readmissions, hospitals have engaged in limited efforts to prevent readmissions, represented by domain three. Addressing SDOH, represented by domain four, necessitates adopting a mindset that may be summarized by the catchphrase, "preventing preventable conditions," i.e., reducing the disease burden of chronic conditions by addressing the underlying SDOH that contribute to them.

HFMA has identified six organizational capabilities that are necessary for moving down the continuum of value-based health toward domain four, the health-based domain. As shown in **Exhibit 2**, these capabilities include people and culture, community and care integration, data analytics and actionable insights, financial sustainability and affordability, health measurement and performance, and frontline clinicians. These capabilities build on the capabilities for value that we developed in our research on improving healthcare value in 2012.[7] Hospitals and health systems can draw on these capabilities to serve individual patients, who are already in a hospital or health system's patient population, and to take actions that address SDOH at the broader community level.

At the individual patient level, hospitals and health systems typically start by screening patients for unmet SDOH needs and then make appropriate referrals, either to programs or interventions within the system, when available, or to community-based programs. Ideally, patients are followed to determine and document referral outcomes.

At the community level, a typology has been proposed that establishes three categories of hospital and health system actions to address SDOH: 1) leveraging business operations for community economic development, through hiring from or investing in local historically marginalized communities; 2) improving availability of local social services by providing support to external agencies or providing services directly to the community; and 3) advancing systems and policy change by supporting and engaging in multi-sector coalitions and advocacy.[8]

Exhibit 2: Organizational Capabilities for Moving down the Continuum of Value-Based Health



Assessing Options for Addressing SDOH

Using this typology in conjunction with HFMA's six organizational capabilities for achieving value-based health, **Exhibit 3** on page 3 offers suggested discussion questions for board members to engage in productive conversations about the organization's potential roles in addressing SDOH. Such discussions may uncover opportunities for extending the health system's reach and leveraging or building organizational capabilities.

Closing Thoughts

In the short term, addressing SDOH can be a heavy lift. Rural hospitals, critical access hospitals, and safety-net hospitals, in particular, are screening patients for unmet SDOH needs but have fewer programs in place than other types of health systems do, even though SDOH needs for their patient populations are often higher. Limited financial resources, workforce constraints, limited community resources and institutional partnerships, and lack of incentives are among the obstacles they face.[9]

It may be helpful to take the long view when it comes to SDOH initiatives. Improving lives and achieving cost-effective health is a just cause, a goal that people who work in all areas of health and healthcare can believe in and rally around. Finding the fortitude for a long-term endeavor like this may require redefining both success and return on investment. The organizational capabilities for achieving value-based health provide a road map for getting from healthcare to health. It's up to each of us to summon the courage to follow it.

The Governance Institute thanks Joseph J. Fifer, FHFMA, CPA, President and CEO, Healthcare Financial Management Association, for contributing this article. He can be reached at jfifer@hfma.org.

6 Paul Barr, "CFOs Concerned About Hospital Service Lines, but Some Embrace the Coming Disruption," Healthcare Financial Management Association, October 1, 2021.
7 Healthcare Financial Management Association, *The Healthcare Value Sourcebook*, 2015.
8 Matilda Allen, et al., "Community-Level Actions on the Social Determinants of Health: A Typology for Hospitals," *Health Affairs Forefront,* October 11, 2022.
9 Jose Figueroa, et al., "Assessment of Strategies Used in U.S. Hospitals to Address Social Needs During the COVID-19 Pandemic," *JAMA Health Forum,* October 21, 2022.

Exhibit 3: Discussion Questions for Assessing SDOH Options

Action	Organizational capabilities	Discussion questions
Individual patient level		
Screening for unmet SDOH needs	Data analytics and actionable insights People and culture Frontline clinicians	• Are we screening patients for SDOH? • Which SDOH are included? • How was the SDOH list generated? To what extent are community members/groups involved in this process? • Are SDOH screening results charted and communicated to the primary care provider? • How can we support primary care providers in recognizing and addressing SDOH needs? • How can/should we factor SDOH needs into our financial assistance policy?
Internal referrals for SDOH	Data analytics and actionable insights Community and care integration Frontline clinicians Health measurement and performance	• To what extent are social service referrals being made internally when unmet SDOH needs are identified? • How is information about internal SDOH resources/services developed and disseminated to frontline clinicians? • What action (if any) is taken when we don't have the internal resources to address a patient's SDOH needs? • How are we closing the loop with regard to referral outcomes?
External referrals for SDOH	Data analytics and actionable insights Community and care integration Frontline clinicians Health measurement and performance	• To what extent are social service referrals being made externally when unmet SDOH needs are identified and cannot be met internally? • How is information about community SDOH resources developed and disseminated to frontline clinicians? • What action (if any) is taken when there are no known resources to address a patient's SDOH needs? • How are we closing the loop with regard to referral outcomes, internally and externally?
All actions in support of meeting SDOH needs for individual patients	Financial sustainability and affordability	• What opportunities do we have for engaging in risk sharing at a higher level (e.g., through participation in value-based payment models or launching/ramping up a provider-sponsored health plan)? • How can we develop or expand partnerships with payers that would include payment for SDOH?
Community level		
Leveraging business operations for community economic development	People and culture Financial sustainability and affordability	• What opportunities exist in our community for place-based impact investing (e.g., renovating and housing support functions in underutilized buildings in the community)? • What opportunities exist for developing or partnering with others to develop training programs for health careers? (Consider projected areas of staffing shortages in your organization.)
Improving availability of local social services	Community and care integration Data analytics and actionable insights Financial sustainability and affordability	• Considering both internal and external sources, and applying information from our community needs assessment, what gaps do we know about in local social services that are important in our community? • What opportunities exist for strengthening formal or informal collaborations with external groups or agencies?
Advancing systems and policy change	Financial sustainability and affordability	How can we better leverage opportunities for alignment with other groups that share our concerns regarding SDOH?