

Health Begins Where Children Live, Learn, and Play: Advancing Health Equity

The implementation of the Affordable Care Act (ACA) in California, coupled with state legislation that extended Medicaid coverage to undocumented children, has resulted in nearly every child in the Golden State having healthcare coverage. However, quality health care coverage, while vital to ensuring the health and development of a child, is only part of a much bigger picture.

Health begins where children live, learn and play—long before they get ill or have to visit their doctor or dentist for a scheduled check-up. Social determinants such as affordable housing, economic security, safe neighborhoods, and access to adequate and healthy foods affect a child’s health on a daily basis. Addressing these social determinants of health (SDOH) can improve long-term health outcomes for children, as well as help reduce long-term costs for both families and states.

For decades, different players in the healthcare system—including the federal government, states, managed care plans, providers, foundations, and advocates—have turned their attention to addressing SDOH, both at the individual and population levels. As a result, they have explored and promoted a number of innovative models and strategies addressing different facets of the SDOH paradigm. However, one of the main challenges has been limited attention on the child population because children are generally healthy and have lower health care costs than adults.



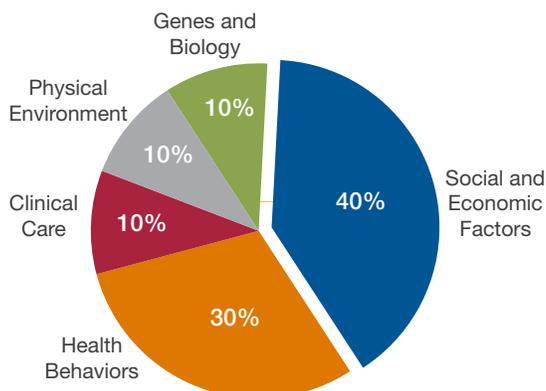
The Children’s Partnership (TCP) has produced this report in order to provide a brief overview of SDOH, examine how they affect our state’s most vulnerable children, and explore several promising approaches in addressing SDOH as a long-term investment to promote children’s well-being. In doing so, we hope to highlight opportunities that policymakers and health advocates will be able to support in order to advance children’s health equity.

Social Determinants and Children

Social determinants of health (SDOH) are the social, economic, environmental, and other factors that impact individual and family health and well-being. Food, nutrition, income, housing, safe neighborhoods, clean air and water, wellness and exercise, mental and behavioral health services and supports (including substance abuse treatment), education, child care, transportation, and family and social networks—all of these are factors that impact life-long health more significantly than direct medical care.¹

These social determinants affect an individual at all stages of life, but the effects are particularly significant to the health and ongoing development of children. Children are relatively healthy compared to adults, having fewer chronic diseases.

Figure 1. The Determinants of Health



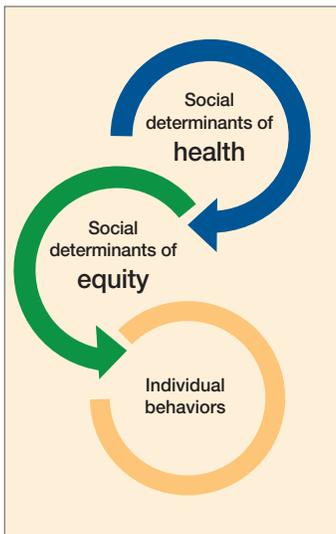
Source: “Advancing Health Equity in Minnesota: Report to the Legislature,” February 2014.

However, children are also vulnerable to a wide range of factors that can disrupt their ongoing physical and mental development at key stages, which lay the foundation of health and well-being for future years. Researchers have noted that children should be differentiated from adults by the “4Ds”—development, dependency, differences in epidemiology, and demographics—all of which magnify the effects of any one social determinant.² A 2016 joint report from the New York-based Schuyler Center for Analysis and Advocacy and the United Hospital Fund emphasizes this connection between a child’s health and the elements in the home and community:

When a child is repeatedly exposed to food and housing insecurities, personal abuse or neglect, and/or a disruptive household environment, this can have a particularly detrimental effect on child health. Exposure to adverse social determinants of health has a cumulative effect upon children. This impact shows up initially in poor health and educational outcomes, but the full impact of negative early childhood events may not show up until adulthood.³

Ensuring a child grows up healthy requires not just ensuring access to healthcare, but a larger, more comprehensive strategy that provides solutions to the social determinants in a child’s life.

The Social Determinants of Health vs. Social Determinants of Equity



In order to better identify the effects of various social determinants, researchers have identified social determinants of equity—social and political structures that are responsible for distributing both resources and adversity based on race, immigration status, sexual orientation, gender identity, and/or other elements of population identity.⁴ Certain children are at higher risk for poverty, homelessness, and malnutrition because of their race/ethnicity or their immigration status. For instance, a 2017 publication by the Children’s Defense Fund reports:

- Nationwide, children of immigrant families made up an estimated 30 percent of all low-income children. In terms of household income, the median income for immigrant families with children was found to be 20 percent less than that for U.S.-born families.
- Black and Latino households with food-insecure children were two times more prevalent than White households with food-insecure children.⁵
- In California, the numbers paint a similar picture. Children of color are disproportionately poor, with 30 percent of the state’s Black children and 27 percent Latino children at the poverty level.⁶

	Definition	Examples
Social Determinants of Health	The social, economic, political, and environmental conditions in which people are born, grow, work, live, and age.	<ul style="list-style-type: none"> • Individual resources: An individual’s occupation, income, level of education, and wealth. • Neighborhood or community resources: The quality of housing available; the range of available food choices; the level of public safety; the availability of transportation; the accessibility of parks and recreation; and the level of political influence. • Hazards and toxic exposures: pesticides, lead, or reservoirs of infection that can differ by place, occupation, or group membership. • Opportunity structures: quality schools, meaningful jobs, and equal justice.
Social Determinants of Equity	Structural factors that determine how different groups of people experience the social determinants of health.	<ul style="list-style-type: none"> • Racism • Sexism • Homophobia • Anti-immigration

Addressing Social Determinants

Although there has been significant research linking social determinants to children's health and well-being, there are more limited SDOH-oriented initiatives that specifically target children. One of the primary reasons for this has to do with costs—children's coverage is relatively inexpensive compared to that of adults, with the latter typically being a higher-need, higher-cost population. In California, for instance, children make up between 50-60 percent of Medi-Cal enrollees, yet the cost of their care makes up 19 percent of total Medi-Cal costs.⁷ In addition to the lack of incentives related to cost reduction, researchers have pointed out the challenges associated with proving that SDOH interventions for children can effectively reduce the long-term costs of healthcare, since quality outcomes take longer to appear. As a result, innovations for children's healthcare becomes a lower priority for states and the federal government.⁸ But, there are a number of promising initiatives incorporating SDOH-centric ideas and activities that may be utilized in improving children's health outcomes.

► **Creating SDOH-Centric Communities.** Recognizing the importance of addressing social factors in order to improve health outcomes, the Centers for Medicare & Medicaid Services (CMS) established the Accountable Health Communities Model program under the rubric of the Center for Medicare and Medicaid Innovation (CMMI). Focusing on individuals enrolled in Medicare and Medicaid, the five-year program takes a place-based approach by focusing on projects across the U.S. that are expected to address health-related social needs by improving the linkages between clinics and the community, with the goals of improving health outcomes and reducing costs.⁹ The model is also expected to raise Medicaid and Medicare beneficiaries' awareness of community-based services, making it more likely they will access community services to receive assistance in times of need or crisis. As part of this initiative, CMS also developed a screening tool to evaluate the impact of different entities in addressing health-related social needs to improve health. The 10-question screening tool addresses housing instability, food insecurity, transportation needs, utility needs, and interpersonal safety.¹⁰

California is pursuing its own path towards accountable health communities. In 2014, the state leveraged support from a CMS State Innovation Model (SIM) design grant towards the completion of the State Healthcare Innovation Plan, which included among its initiatives the development of Accountable Communities for Health (ACH).¹¹ A second SIM design grant, coupled with private funding, enabled a small group of healthcare stakeholders to create the

California Accountable Communities for Health Initiative (CACHI), with the goal of transforming the health of entire communities.¹² CACHI currently supports the work of 15 ACH initiatives across the state—including communities in Sacramento, Boyle Heights, Riverside County, and Imperial County—that are committed to building enduring infrastructures that address a variety of health issues, such as cardiovascular disease, asthma, community violence, and trauma. One CACHI-supported community in Long Beach is focusing on developing an ACH specifically for children. Entitled *All Children Thrive*, the goal of the initiative is to enable local communities, across the country, to create more resilient ecosystems of child health, development, and well-being. The network seeks to change human development services and systems in order to optimize child and family outcomes.¹³ In Long Beach, the initiative is currently working towards creating a community environment that supports positive development in children ages zero to eight.¹⁴ The City of Long Beach Department of Health & Human Services is leading a team of community partners and other City departments in addressing social determinants of health, by utilizing an equity lens, community engagement, and partnerships that support collective impact.¹⁵



In addition to state-funded initiatives, communities are also engaging in a variety of models to address the comprehensive needs of children and families. Addressing the social determinants requires engagement of many sectors and the health setting can serve as a key hub of connection. One such model is the Medical-Legal Partnership, which recognizes the potential for legal services to help health care providers respond to the social needs identified in the health setting.¹⁶ Growing recognition for the value of such partnerships is made clear through the endorsement of national provider organizations, such

as the American Medical Association Board of Trustees, the American Academy of Pediatrics, and the American Bar Association, as well as support by federal programs with both the federal Department of Veterans Affairs and the federal Health Resources and Services Administration (HRSA) encouraging such partnerships. In California, the Peninsula Family Advocacy Program (FAP) in Santa Clara County is one such example of a Medical-Legal Partnership between the Legal Aid Society of San Mateo County, Lucile Packard Children's Hospital Stanford, Stanford Health Care Emergency Department, Gardner Packard Children's Health Center, Ravenswood Family Health Center, and the Prenatal Clinic at San Mateo Medical Center. The Partnership allows for free, accessible legal services for patients and families, while also making available training opportunities for providers and collaboration on policy issues. connect patients to available services.

Similar efforts to address a continuum of services for families include state programs like Healthy Start, which provided grants for services and activities such as health, dental, and vision care; mental health counseling; family support and parenting education; academic support; health education; safety education and violence prevention; youth development; employment preparation; and others. Although Healthy Start was discontinued due to state fiscal constraints, the results of the program were impressive. Schools that received Healthy Start grants saw substantial improvements in students' reading and scores, as well as reduced absenteeism and detentions.¹⁷ As a result of its effectiveness in improving health and learning outcomes for children, supporters of the program, such as the California Children's Health Coverage Coalition, continue to advocate for its revival.¹⁸

- ▶ **Identifying Social Determinants at an Early Age.** One of the more promising opportunities for SDOH-centered activities specifically for children comes in the form of The American Academy of Pediatrics' Bright Futures, a national health promotion and prevention initiative. As part of its evidence-based guidance for preventive care screenings and well-child visits, Bright Futures offers a recommended schedule for specific screenings, immunizations, and procedures. These guidelines can serve as a model for states that need to establish their own periodicity schedules for its Medicaid child-centered services in Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).¹⁹ In 2014, California updated its EPSDT program's screening requirements such that it now requires the use of the Bright Futures Periodicity Schedule.²⁰

During an update to the Bright Futures program in 2017, one particularly important improvement was made. As part of the psychosocial/behavioral screenings for children, the revised guidelines now recommend that health providers conduct a family-centered assessment that includes various social determinants of health, including child social-emotional health and caregiver depression.²¹ As a result, for California and other states that have adopted Bright Futures as part of its EPSDT program, it is important to follow through on at least two important actions. First, states must ensure that EPSDT educational and outreach resources (as well as policy and provider manuals) are revised to incorporate this change in its screening practices. Second, states must develop methods of integrating oversight and reporting on the new provisions in their quality strategies.²² As these practices evolve, monitoring provider engagement is critical to ensuring they are supported with the resources, knowledge, and connections to make the necessary referrals for children and families.



- ▶ **Leveraging Medicaid Systems.** Furthering opportunities to address social determinants of health was the increased access to preventive health services under Medicaid made possible by the ACA. The issuance of Medicaid regulations in 2013 provided additional flexibility regarding the types of preventive services eligible for reimbursement.²³ Prior to the ACA and this regulation, states could only cover preventive services that were provided directly by a licensed practitioner. However, the 2013 regulations newly permitted states to reimburse for preventive services recommended by a physician or other licensed practitioner, within the scope of their practice under state law. The change, which requires states to submit a Medicaid State Plan Amendment (SPA) to CMS, provides an opportunity to incorporate a diverse spectrum of health professionals who have a better understanding of the experiences and socioeconomic realities of the communities that they serve, and who, as

a result, can better address specific social determinants through their services. Research has shown that health professionals such as home visitors and community health workers play a vital role in addressing SDOH through services such as outreach and engagement; education, coaching, and informal counseling; social support; care coordination; and basic screenings and assessments.²⁴ In California, the Regional Asthma Management and Prevention program (RAMP) is seeking support for a state budget proposal to fund such a preventive services option for Medi-Cal asthma patients. If a doctor suspects a patient's asthma is triggered by in-home air quality factors, they can prescribe (and Medi-Cal will pay for) a certified community worker trained in asthma prevention education and in-home air assessment to work with the family, including visiting the family's home to assess whether and what type of asthmatic triggers exist and what can be done to remedy the situation.

A number of states are also exploring the potential of their own Medicaid healthcare systems in deploying various SDOH strategies. Colorado, for instance, has developed an Accountable Care Collaborative that connects beneficiaries to health care providers as well as social and community services. Other states such as New York and Massachusetts are exploring funding strategies, either as incentives to improve health outcomes for children entering kindergarten, or as an additional resource to provide extra care for patients who are at higher risk for poor health outcomes due to environmental factors.²⁵

One state, Oregon, is adopting a variety of these strategies by leveraging its coordinated care organizations (CCOs). Initiated in 2012, these locally-governed networks provide all Medicaid enrollees with physical health services, as well as behavioral health and dental care.²⁶ In 2017, Oregon Governor Kate Brown asked the Oregon Health Policy Board (OHPB) to focus on social determinants of health and equity as it considered the future of the state's CCOs. As part of its CCO 2.0 Work Plan, the state is exploring various policy options related to SDOH, including:

- The prioritization of SDOH in Oregon's next Medicaid 1115 Waiver, with the potential inclusion of increased incentives for CCOs to spend on health-related services;
- The establishment of an Oregon Health Authority workgroup focused on coordinating and expanding SDOH work connected with health system transformation;
- The development of a set of recommendations on how to best utilize Community Health Workers, Personal Health Navigators, and other designated Traditional Health Workers;²⁷ and

- The development of new SDOH-related metrics as incentive metrics: food insecurity screening and health-related factors of kindergarten readiness.²⁸

In addition to these activities, Oregon is also working towards developing sustainable funding for SDOH activities. In 2018, the Oregon Legislature passed legislation that requires CCOs spend earnings above a specified threshold on services designed to address health disparities and social determinants of health.²⁹

California is also looking at its own Medicaid system as a means of employing SDOH strategies. In its current Medicaid 1115 Waiver Renewal—entitled Medi-Cal 2020—the state included the need to address social determinants of health and improve health care equity as one of its five core goals. As a result, 1115 Waiver activities include Whole-Person Care pilot projects, which require the identification of community resources for patients at risk of cancer, obesity or heart disease, in order to receive not just targeted services, but other community preventive resources as well, including those that address social determinants of health.³⁰ Specific to children, Medi-Cal 2020 is just beginning to explore the potential of SDOH-centric activities in improving oral health outcomes through several dental pilot programs. For example, the Inland Empire-based dental pilot highlights the role of a community-based workforce in addressing poverty and geography as social determinants of health for children. To that end, the pilot seeks to prioritize children of low-income families for home visitors and community health workers to support in the delivery of oral health education and preventive services and communities.³¹

A number of California's Medi-Cal managed care plans are also addressing social determinants in other ways. Mounting healthcare costs associated with an increase in chronic diseases have led many plans to move ahead of the spending curve by working to improve the overall health of their members. As population health management becomes more important to reducing expenses on the provider side, plans are taking a similar approach to preventive, proactive engagement by making significant investments in improving SDOH, either by providing support to public safety net providers and community-based organizations, or through other strategies intended to improve referral to resources. The activities of two health plans, California Health & Wellness, and L.A. Care, are profiled (see Box). TCP is slated to complete a fuller survey of health plans' activities related to SDOH and children in late 2018.



Profile: California Health & Wellness

California Health & Wellness is a for-profit Medi-Cal managed care plan that operates as a subsidiary of Centene Corporation. The plan serves Medi-Cal beneficiaries in Imperial County and a number of rural regions, including Alpine, Butte, Nevada, and Sierra.³² The plan works to address SDOH in a number of ways. One strategy focuses on community and strategic giving focused on addressing various social determinants. For instance, the Plan has provided capacity building funding to local community-based agencies to develop resource and referral databases, as well as to school-based initiatives focused on mental health and resiliency building among children and adolescents, such as an anti-bullying project and an anti-social isolation project.

In addition to strategic giving, California Health & Wellness also employs a number of programmatic strategies for addressing SDOH. For instance, the plan is piloting an Emergency Department (ED) diversion program whereby a core team—consisting of a community health worker, a nurse case manager, and a social worker—provide home visiting and intensive care coordination to identify and address SDOH among members who are identified via claims data as high ED utilizers. Based on the Camden Coalition of Health Care Providers' COACH model, the team builds relationships with the patients and examines the factors that are most important to them (faith, employment, rent, housing, etc.).³³ The team then works with the patients in these areas to equip them with the tools they need to take charge of their health and well-being and sustain behaviors that keep them out of the ED and moving toward their health, social, and professional goals. They hope to be able to use the model to assist families in crisis.

California Health & Wellness also relies on community health workers to identify and address health plan members' needs beyond medical care, such as food or long-term services and supports, and to assist members with referrals to social services programs. The plan also utilizes Aunt Bertha (www.auntbertha.com), an online interactive tool that searches for local community services for case management purposes. Case managers can create a member folder, including specific community sources, and build it into a member's care plan.³⁴

In 2016, California Health and Wellness's parent company, Centene, further expanded its services in California by merging with Health Net, Inc., one of the largest health plans in California. The plan is the commercial option for Medi-Cal Managed care enrollees in a number of counties, including Los Angeles, Sacramento, Tulare, and San Diego. In recent years, Health Net has been recognized for its work in addressing SDOH. For instance, its Postpartum Project for African-American women in the Antelope Valley works to improve postpartum visit rates by addressing the barriers around timely access to care and providing transportation to appointments for parents and children. Health Net also established a Health Equity Advisory workgroup and implemented a disparity-reduction model that involves the community, provider, member, and system-level touch points.³⁵



Profile: L.A. Care Health Plan

Established over 20 years ago, L.A. Care is the largest publicly-operated health plan in the country, providing health coverage for vulnerable and low-income residents and communities in Los Angeles County.³⁶ It is one of the sixteen local, non-profit, publicly-governed health plans that together serve over 7.5 million (or 70 percent of) Medi-Cal beneficiaries in the state.

Similar to California Health & Wellness, L.A. Care also engages in community and strategic giving focused on addressing SDOH. In 2000, L.A. Care established its Community Health Investment Fund, which supports not just community clinics seeking to expand access to medical care for low-income families and individuals, but also local organizations and initiatives that address a variety of social determinants that impact the lives of L.A. County individuals and families. Since the fund was created, it has provided support to more than 400 projects. In 2017, of CHIF's \$10 million grant budget, approximately \$6 million went directly to programs and services addressing a variety of social determinants, including homelessness, income and food assistance, immigration, violence prevention, and alcohol and drug dependency.

L.A. Care is also exploring how SDOH can be directly integrated into care for children. For instance, in an updated asthma toolkit for its providers, L.A. Care encourages the development of a comprehensive asthma treatment plan that addresses social determinants of health, such as exposure to asthma triggers found in substandard housing and deteriorating schools, as well as chronic stress resulting from community violence.³⁷ Researchers have noted that the development of SDOH-related practices specific to asthma can serve as a test model of how to incorporate social determinants of health into public policy for other chronic conditions impacting children.³⁸

In a similar fashion, L.A. Care has also worked to educate its providers on the effects of socioeconomic factors on a patient, and the importance of tailoring diagnoses and therapies in this context. For instance, in a 2014 newsletter to its providers, L.A. Care notes that physicians can take a more active role in improving the health of vulnerable and low-income populations, and provides a list of recommended activities, including: providing additional outreach and assistance for vulnerable groups; supporting access to healthy food programs such as CalFresh and WIC; and providing referrals for public assistance and housing through local and state government programs.³⁹

► **Improving Horizontal Integration Between Social Programs.** One of the major goals in developing SDOH initiatives is improved integration between health and non-health services. The National Quality Forum coined the phrase SDOH-Targeted Healthcare to refer to activities that connect individuals to non-health services that can address SDOH, such as Temporary Assistance of Needy Families (TANF), Head Start, and homelessness assistance programs.⁴⁰

In a similar fashion, states like California are working towards this goal with the integration of health programs and human services programs, often referred to as horizontal integration. Under this strategy, Medicaid-enrollee data could be linked with enrollee data from another program such as Women, Infant & Children (WIC) or the Supplemental Nutrition Assistance Program (SNAP) to identify dually eligible individuals that are eligible but not enrolled. As of early 2017, at least 21 states had integrated at least one non-health program—such as SNAP, TANF, or child care—into their Medicaid eligibility system. In early 2018, the California Legislature introduced AB 2579 (Burke), a new bill that would facilitate express enrollment of WIC enrollees into Medi-Cal. According to the California WIC Association administrative data, 90,000 children enrolled in WIC are not enrolled in Medi-Cal (although they are eligible). Optimally, with greater data sharing and coordination between programs, Medi-Cal enrollees also could be easily connected and enrolled into other social services programs like SNAP or WIC.

► **Exploring Payment and Delivery System Reform.** In addition to exploring the aforementioned strategies and efforts related to SDOH, the overall context of the state and federal payment and delivery system cannot be ignored. The CMS Medicaid managed care rule, updated in 2016, includes several delivery and payment reforms intended to increase access to interventions addressing SDOH, such as expanded care coordination, coverage of non-medical services, alternative payment models, and home and community-based services.⁴¹

Payment reform is intended to incentivize improved health outcomes over the volume of health care services being delivered. But in order for payment reform to work

effectively in a managed care setting, it must be specifically designed for the managed care context, as opposed to a fee-for-service one. Given that the overwhelming majority of the state's children (approximately 5 million) are currently in Medi-Cal managed care, California should address payment reform through this context. It is important to establish capitated payment rates from the state to the managed care organization that are calculated in a way that incentivizes plans to invest in strategies that improve social determinants of health and thus health outcomes. In addition, the state could explore shared savings strategies, whereby health plans can invest in new approaches, such as investments in community SDOH strategies, and can share in any resulting health care savings.



To address SDOH at the provider level, payments must also follow SDOH activities, rewarding improved care and improved health outcomes, such as value-based purchasing (VBP) payment reforms. However, because pediatric care has a longer-term payoff for children’s health, payment models traditionally undervalue pediatric care in current fee-for-service rates. As a result, existing value-based purchasing structures cannot be transplanted into the context of children-centric care, as those structures are developed with health outcomes for adults in mind. Because most of children’s health care is inexpensive and primarily focused on well-child care, the value in VBP strategies for children should emphasize the quality of care as opposed to the payment or cost efficiency.⁴² Payments from managed care plans to the providers must reward improved care outcomes, via value-based purchasing payment reforms, at the provider level that address SDOH.⁴³

In its present form, California’s capitated payment system for Medi-Cal managed care does not promote the integration of SDOH activities. Under the current rules, Medi-Cal managed care plans cannot typically utilize capitated payment funds for non-medical services vital to addressing SDOH. Further, under existing conditions, a managed care plan that saves money by lowering health care spending by addressing SDOH will effectively lose that money. When the state calculates the plan’s capitated rate for the year following the savings, those rates are reduced based on the amounts saved in the previous year). As a result, there is a perverse incentive—a fundamental flaw in the way the state contracts with Medi-Cal managed care plans.⁴⁵

The 2016 CMS Medicaid managed care rule for the first time gives states the flexibility to dictate how health plans pay providers. For instance, California can require Medi-Cal managed care plans to pay providers based on outcomes and population health metrics.⁴⁶ The Children’s Partnership is currently laying the foundation of its activities in these areas. We are currently working with plans, providers, and California’s Department of Healthcare Services (DHCS), to explore policy options for incentivizing plans and providers to invest in and implement tools and strategies that address SDOH and realize health savings for managed care organizations and California, and, in turn improve health outcomes and well-being for California’s children.

Value-Based Purchasing

The goal of value-based purchasing is to maintain or improve quality while decreasing cost. These payment strategies intend to change provider incentives to focus on outcomes and efficiency. Increasing value for kids should come from better outcomes because there are comparatively few opportunities to save money in children’s health care. Children have different health care and psychosocial needs than adults, especially in early childhood. Also, children account for a small proportion of Medicaid costs. Moreover, most value-based payment efforts focus on one-year savings, but many childhood prevention efforts have long-term returns that don’t necessarily accrue to the health care system and instead impact other systems (e.g. education, and justice). It is essential to identify, monitor, and report on the appropriate child health outcome and performance measures in VBP strategies. For example, VBP measures could encourage integration of behavioral health, oral health, and social determinants of health services into primary care.

Source: Schuyler Center for Analysis and Advocacy ⁴⁴



Conclusion

The role of social determinants of health in shaping the health and development of California's children cannot be overemphasized. With the growing recognition of the potential of SDOH, innovative strategies are appearing at all levels. At the federal level, recent Medicaid Managed Care regulations include the option to expand covered services to include non-medical services and care coordination, as well as promote VBP and other payment and delivery system reforms. At the state level, horizontal integration efforts to streamline eligibility and enrollment and well-child initiatives to strengthen connections between and among health and social safety net programs are growing. And at the local level, new and enhanced partnerships between health plans and community-based social service organizations are emerging, as well as large community philanthropy investments by health plans.⁴⁷

Another important issue in incorporating SDOH strategies into healthcare is the specific role of any one social determinant in affecting the health of a child. For instance, immigration status is a relatively recent consideration as a social determinant, yet its full effect cannot be underestimated.⁴⁸ This is especially evident today, with immigrant families being vulnerable, not just to the increase in detention and deportation activities, but to ongoing efforts to curtail access to essential health and social services programs:

- A 2017 TCP survey of healthcare providers regarding immigrant families found that an estimated two-thirds of providers observed an increase in families' concerns about enrolling in Medi-Cal, CalFresh, WIC, or other public programs. Even worse, nearly 40% stated that immigrant families have increasingly expressed interest in dis-enrolling in Medi-Cal, CalFresh, WIC, or other public programs.⁴⁹
- In February 2018, the Department of Homeland Security (DHS) drafted a proposed rule that would further expand the public charge determinations to include WIC, health insurance subsidies under the Affordable Care Act, Medicaid benefits, SNAP, the Children's Health Insurance Program (CHIP), Section 8 housing vouchers, and Head Start education programs.⁵⁰ As of this writing, the proposed rule has not yet been made public. If the rule is approved, utilization of these programs would be considered as a negative factor by DHS and could be used to deny an immigrant legal status.⁵¹ However the news is already having an effect, as families are reportedly dropping out of public nutrition programs.⁵²

California has made great strides in increasing health coverage for children. But to truly improve health outcomes for all children, we must look at the bigger picture of where children live, play, and learn. This report has profiled a number of promising initiatives that policymakers and health advocates can further explore as we move towards systems that address social determinants of health that affect not just high-cost populations, but also our most vulnerable children. Investments in this area will not only yield benefits in terms of improved health and education outcomes for these individuals as children, but also for long-term results in economic security and wellbeing as adults.

► Questions to Consider:

As we consider potential improvements that promote the integration of SDOH strategies into the state's healthcare system, a number of questions must be considered:

- How can health advocates and other stakeholders work with managed care plans to invest more in social determinants of health and equity activities that target children, and hold them accountable for these investments?
- How do we ensure improved provider cultural competency, language accessibility, and a diversified workforce that reflects the population served in order to address social determinants of equity such as racism?
- What improvements in data collection, monitoring, and reporting on key measures can we make to increase our understanding of social determinants of health and equity initiatives and disparities?
- What needs to be done in order to update the Medi-Cal managed care rate-setting process such that it incentivizes the adoption of SDOH strategies to improve health outcomes and reduce the growth of health care spending?

Endnotes

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The Children’s Partnership is a non-profit, advocacy organization that works to improve the lives of children where they live, learn, and play. Since 1993 we have worked to advance the health and wellbeing of underserved children in California and in the country, through meaningful community partnerships, forward-thinking research, and community-informed policy.

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