Want to Survive the Coronavirus Pandemic? Invest in the Social Determinants of Health

Michael Menconi*

Keywords: Medicaid, New York, bioethics, social determinants of health, DSRIP

INTRODUCTION

Local, state, and federal governments are currently responding to the immediate healthcare infrastructure demands created by the COVID-19 crisis. In New York City, these responses have included erecting makeshift field hospitals in Central Park, converting the Javits Convention Center into a 1,000-bed field hospital, and sailing the 1,000-bed USNS Comfort to Pier 88 in Manhattan. Such unprecedented efforts have required assistance from the New York Army National Guard, the United States Army Corps of Engineers, and the U.S. Navy. Simultaneously, government-enacted social distancing measures have been implemented to "flatten the curve." The predominant consensus among experts is that the combined strategies of widespread social distancing and isolation in conjunction with unprecedented health infrastructure expansion is the only way to avoid reaching a crisis point within the U.S. healthcare system—a disastrous scenario in which hospitals become unable to manage the exponential influx of patients. The situation is most dire in New York City, as the number of confirmed COVID-19 cases approaches 165,000.

ANALYSIS

In the background, however, an obscure evidence-based healthcare delivery program designed to serve New York's most vulnerable populations may be the most effective weapon in addressing resource shortfalls. In fact, this policy has the potential to mitigate the ongoing overflow of New York City's emergency rooms, intensive care units, and inpatient units, potentially saving countless lives while simultaneously streamlining the massive public health response. This policy is known as the Delivery System Reform Incentive Payment Program (DSRIP), which derives from the current New York State Medicaid expansion program.

DSRIP—a groundbreaking and award-winning Medicaid redesign initiative—was implemented in 2015 after Governor Andrew Cuomo signed a deal with the federal government that allowed $8 billion federal Medicaid dollars to directly address the social

* Michael Menconi is pursuing his MS in Bioethics and MPH at Columbia University.

determinants of health (SDH). One of the resulting initiatives, the supportive housing program, has served over 13,000 high-acuity Medicaid patients to date. The most recent evaluation of the program demonstrated a 40 percent reduction in hospital days and a 26 percent reduction in emergency room visits. Accomplishing this, however, was no simple feat. After patients are temporarily placed in supportive housing, they are assigned a primary care provider and then integrated into a network of social services that include food assistance (subsidies), mental health counseling, and a plethora of other services designed to treat social and clinical ailments simultaneously.

Many of the program's beneficiaries suffer from multiple comorbidities including substance abuse and mental health disorders, as well as HIV/AIDS and other chronic conditions. In the event they contract COVID-19, these individuals are at high risk of severe complications, including death. Consequently, SDH-inspired initiatives like the supportive housing program not only protect vulnerable Medicaid populations from institutional exposure to COVID-19 by keeping thousands out of hospitals and clinics during the pandemic, such programs also alleviate strain on an already overwhelmed NYC healthcare infrastructure.

With over 5 million Medicaid enrollees in New York State—over 3 million of whom reside in one of the five boroughs of New York City—this level of reduction in healthcare service utilization has the potential to save countless lives during the onslaught of a global pandemic. If SDH-inspired programs were scaled to meet the entire New York State Medicaid population, hospitals would be left infinitely more prepared to withstand the surge of emergency room visits and hospitalizations. Recently, frontline clinicians have raised alarms about the suspicious decrease in heart attacks and strokes showing up in emergency rooms—many experts suggest this may be the unfortunate result of reluctance by the public to seek care in an overwhelmed healthcare system. Such significant declines in healthcare utilization will also decrease personal protective equipment (PPE) use. This is critical in the context of the current national shortage.

Social scientists have long asserted that the key to ameliorating health inequities lies in addressing socioenvironmental factors such as housing insecurity, food insecurity, and inadequate healthcare access. These factors—dictated by race, ethnicity, and socioeconomic status— inevitably lead to health disparities evidenced by the disproportionate burden of chronic disease suffered by the Medicaid population. As early as the mid-90's, sociologists have postulated that access to flexible resources such as money, knowledge, and social capital dictate our health outcomes. This is known as the fundamental cause theory. We have long possessed the intellectual and conceptual tools necessary to identify factors that contribute to systemic health disparities. Disparities continuously overburden the healthcare system. When New York City becomes an epicenter of a global pandemic, this burden thrusts the city's healthcare infrastructure closer to its breaking point. DSRIP remains one of the few available strategies capable of avoiding such catastrophe.

Tragically, barriers to the implementation of such socially conscious policies persist. Most healthcare institutions operate with razor-thin margins. Many fail to profit at all, only taking in enough revenue to pay their workforce. For example, the New York Presbyterian Hospital, one of the top-five academic hospitals in the country and one of the nation's largest, reported only a 2.8% profit margin in 2018. While SDH-informed initiatives stemming from DSRIP have proven cost effective in the long term, healthcare institutions are responsible for creating and implementing the infrastructure required of these programs, in addition to covering up-front costs. The most expensive and resource-intensive intervention in the DSRIP program was the creation of health homes. These are not physical spaces like those employed in the aforementioned supportive housing program, but rather highly integrated resource networks that provide social services, housing and food services (subsidies), and healthcare management for high-risk members of the Medicaid population.

CONCLUSION

As long as the institutional cost savings of addressing social determinants of health are only realized longitudinally, revenue-conscious C-suite executives will continue to supplant humanity with corporate interests, thus avoiding implementing many of DSRIP's most efficacious interventions. Both federal and state governments must bear some of the up-front cost of these programs by increasing the flow of Medicaid dollars to DSRIP, thus incentivizing healthcare institutions to provide the program's infrastructure. The results, while not immediate, will indisputably improve health outcomes for New York City's most vulnerable populations while simultaneously increasing preparedness for the next global public health crisis.