Ample evidence suggests that health outcomes are affected as much by factors outside the walls of the health care system as within. Unmet social needs are increasingly understood to contribute to persistently inequitable health outcomes across racial and socioeconomic groups. There is thus understandable enthusiasm about the opportunity to use health care resources in more flexible and responsive ways to improve health outcomes—and contain health care spending1—by identifying and addressing social needs.

For example, it is possible that providing healthy food to insurance enrollees with diabetes might improve their health outcomes and lower spending on hospital and emergency department visits. Both public and private insurance programs are experimenting with offering a broader array of services to address health-related social needs, such as food insecurity, housing instability, challenges with transportation and utility payments, and experiences of violence.2

Adding flexibility to programs that aim to improve health outcomes and reduce disparities, allowing them to break down silos and address interlocking population needs, holds a great deal of promise. However, that flexibility ought to come with accountability for assessing effectiveness in improving health outcomes, particularly given that resources for public insurance programs are scarce, and private insurance premiums are increasingly unaffordable for many individuals and families. Programs need to be assessed based on how effective they are in achieving those goals in absolute terms, but also relative to alternative uses of the resources, such as other programs or cash assistance.

Although there is need for innovation in addressing health-related social needs, evidence of whether current approaches improve health outcomes can be murky. Furthermore, even when evidence is available, it is not always integrated into policy or implementation decisions. One of the challenges of generating such evidence is the usual challenge of discerning the causal effects of program participation when programs target specific populations and participation is voluntary. For example, people taking up an insurance benefit of healthy food delivery might be more likely to live in places with environmental hazards and thus experience worse health outcomes than nonparticipants—or they might be more attuned to the importance of a healthy diet and exercise and thus experience better health outcomes than nonparticipants. It is therefore crucial to evaluate programs addressing health-related social needs with methods that take these confounding factors into account to yield insights into the effect of the program itself—such as through randomized controlled experiments or rigorous quasiexperimental approaches.3-5 Another reason evidence is hard to come by is that many opportunities to evaluate programs are lost when program decisions are made without thought to facilitating and implementing rigorous evaluations.

Many programs that sound promising do not bear up to such scrutiny. For example, an important randomized controlled evaluation of the Camden "hotspotting" program in Camden, New Jersey, which aimed to divert frequent users of hospital emergency departments through intensive social services,6 found that—contrary to prior perceptions—the program did not appreciably reduce readmissions. This is an example of an intensive intervention focused on specific populations believed to be particularly likely to benefit. Targeting such high-cost, high-touch interventions is important to ensure that they are practical and cost-effective, but identifying which people would be most likely to benefit is often more challenging than expected. For example, it might be highly
effective to stave off 1 expensive hospitalization by a particular patient with diabetes by providing that patient with healthy food if a program knew exactly who to target, but it would not be an effective and sustainable use of health insurance funds to provide many thousands of patients with healthy food for years to stave off 1 hospital admission.

Thus, rigorous assessment is needed to gauge both the effectiveness and affordability of innovative programs, and program leaders who are willing to partner on such evaluations play a vital role in advancing public policy. Having good evidence is crucial, and integration of the results from rigorous scientific studies into policy and programmatic decision-making is just as critical.7

The Nurse Family Partnership (NFP) is a flagship program aiming to improve maternal and child outcomes for first-time parents through regular home visits by specially trained nurses during the mother’s pregnancy and through the child’s first 2 years. The program has been a leader in deploying rigorous evaluation. Studies dating back to the 1970s have supported its beneficial effects for mothers, infants, and families—including reductions in maternal hypertension and preterm birth for some groups.8,9

The NFP once again supported innovative delivery and assessment by partnering with the state of South Carolina to deliver NFP services to Medicaid enrollees starting in 2016—the first time the services had been offered through public insurance using a “pay for success” model that tied future funding to achieving benchmark outcomes. This approach provided an opportunity to evaluate the effectiveness of NFP in a modern context—in which patient needs, demographics, health care delivery, and the broader environment have evolved considerably since the program’s inception and prior evaluations. In a randomized clinical trial that we helped to lead10 as part of the Medicaid waiver that authorized the program, we found that the NFP did not have detectable effects on birth outcomes, such as the prevalence of low birthweight, preterm birth, or perinatal mortality. This was true both overall and for the prespecified subgroups believed to be most likely to benefit.

Studies of this population to assess the effects of the NFP on a much wider array of longer-term outcomes are continuing, so this is far from the last word on this program. But the findings highlight the value of ongoing assessment of programs in an ever-changing environment. More importantly, innovative models that tie flexibility in public programs (such as having Medicaid deliver home-visiting services not typically covered by the program) to rigorous assessment of effects on the ultimate goals (improved maternal and child health and overall family well-being) offer a promising way to address the complex causes of health disparities with a more flexible set of tools. The fact that this particular program did not achieve the first set of outcome targets is disappointing. But it helps pave the way for greater flexibility and innovation in service delivery by ensuring that policy makers will gain information they need for allocating resources to programs that achieve valued policy goals.

ARTICLE INFORMATION
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Corresponding Author: Katherine Baicker, PhD, Harris School of Public Policy, University of Chicago, 1307 E 60th St, Chicago, IL 60637 (kbaicker@uchicago.edu).
Author Affiliations: Harris School of Public Policy, University of Chicago, Chicago, Illinois (Baicker); Department of Global Health and Population, Harvard T.H. Chan School of Public Health, Boston, Massachusetts (McConnell).
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REFERENCES


