Wright said he and his coauthors were surprised to see that in the weeknight sleep-restricted group, men slept more on the weekend than women. While both men and women slept longer on Friday night than they had at baseline, only men did on Saturday night. “What we do know as a general rule is that women are at a higher risk for insomnia than men,” he said.

The Upshot
“Sleep is pretty fundamental, and when we don’t get enough, it will disturb a lot of our physiology,” Wright said. “It’s kind of like smoking. The consequences are long term.”

And, he said, his study suggests that yoyo sleeping—trying to compensate on the weekends for too-little slumber during the week—is probably not going to prevent those long-term consequences and might even make them worse. ●

Note: Source references are available through embedded hyperlinks in the article text online.

The JAMA Forum
How an Expanded Vision of Managed Care Organizations Could Tackle Inequities

Stuart M. Butler, PhD

Are you a Pennsylvanian without a high school diploma? Then sign up with AmeriHealth Caritas for Medicaid and the plan will help you get your GED. Having trouble getting a job in Ohio? If you are enrolled in CareSource, the Life Services JobConnect in CareSource’s managed care organization (MCO) will arrange job coaching and other employment services at no cost.

These are not examples of corporate philanthropy. Rather, they reflect a growing recognition in the health care sector, especially among MCOs, that good health—and achieving lower medical costs—requires a focus on the nonmedical factors known as social determinants that affect health and well-being.

Incorporating Social Determinants
Why is this happening? For several related reasons. The primary impetus is that a growing body of research indicates that deficiencies in education, transportation, housing, food security and other factors contribute to health care costs, and also to health inequity in low-income and many minority communities. Thus, managed care plans like AmeriHealth and CareSource see addressing these social determinants as a way of reducing health costs and improving outcomes for many of their Medicaid enrollees.

Government action at all levels is accelerating this trend of health plans. In particular, many states are now building these nonmedical features into their Medicaid contracts and in their requests for Section 1115 waivers and Home and Community-Based Services waivers. (Such waivers provide federal approval for state pilots that promote the objectives of Medicaid but with new approaches.)

The federal government has helped significantly. One way it has done so is through its approach to waivers. Recent administrations have used 1115 waivers to permit states to allow Medicaid plans to incorporate nonmedical services. A 2018 waiver for North Carolina, for instance, lets the state use a certain amount of Medicaid funds to enable MCOs to pay for housing, food support, and transportation and provide services to combat violence and other forms of stress.

In addition, a major “final rule” for Medicaid MCOs, issued in 2016, gave Medicaid MCOs much greater encouragement to include nonmedical services. For instance, the rule permits alternative payment models that encourage MCOs to work with providers of nonmedical (primarily social) services—for example, by sharing the total savings achieved. While the Trump administration has proposed significant changes in these rules, it does not propose to modify this aspect of current standards.

In addition, new regulations and landmark health legislation enacted last year allows Medicare Advantage plans for the first time to include in their benefits package a range of nonclinical services that can enhance health. These include transportation to appointments, home-delivered meals, and even home modifications to enhance safety. With one-third of seniors enrolled in these managed care plans and as plans begin to adapt to these new opportunities, Medicare is joining Medicaid in seeking to achieve better health by breaking down the barriers between clinical care and a range of support services.

Over time, these developments and changes in policy could transform MCOs serving lower-income households and the
vulnerable elderly. MCOs could in effect become "well-being" anchor organizations, encouraging traditional medical centers and nonmedical organizations to work together to address a wide range of issues that are critical to both good health and socioeconomic improvement. And because health disparities in US health care and outcomes are so often attributable to such factors as unstable housing and inadequate transportation—and these problems are concentrated in certain communities—changing the role of MCOs could significantly reduce health inequities.

Some Challenges
The way ahead is not without challenges. There are barriers to MCOs and other health organizations adopting this role.

One challenge is data sharing. Improving an individual’s health through cooperation between sectors requires different sectors—such as schools, housing authorities, and physicians—to share information. There can be privacy concerns hampering this, but also interoperability glitches that need attention. For instance, UnitedHealthcare, with the Corporation for Supportive Housing and the Council of Large Public Housing Authorities, and with support from the Robert Wood Johnson Foundation, is undertaking a venture to improve the health of Medicaid beneficiaries in publicly assisted housing. A crucial first step has been to arrange formal data-sharing agreements, to allow matching of community and individual data. This will permit analyses of cross-sector data, helping interventions to be customized.

A broader data concern is gaps in what we know about the link between health and nonclinical factors. For instance, while there is generally strong research that addressing such areas as poor housing conditions, malnutrition, and severe family stress contributes to better health, there is conflicting evidence on the health impact of some interventions, such as permanent supportive housing. Thus, more research is needed to make a convincing case for including some nonclinical services.

Organizational culture can be another barrier. Some medical staff can be skeptical about the health value of nonclinical services. Even committed health organizations need to review their staffing, training, and contracting procedures and can encounter difficulties in building trust and smooth operating procedures when working with social service partners.

Government payment reforms are also still limited. True, by allowing more discretion over the range of services that can be included under the capped funding they receive for each beneficiary, MCOs do have a financial incentive to use the best mix of clinical and nonclinical services needed to improve an enrollee’s health. But unless Medicaid MCOs receive additional funding based on a state’s anticipated future government savings from potentially healthier, more successful enrollees, it is hard for these MCOs to redeploy current and over-stretched clinical dollars (North Carolina’s recent 1115 waiver includes such add-on funds for MCOs). Also, to measure the full potential impact of more flexible MCOs, calculations of those future savings should include nonmedical effects, such as reduced welfare costs.

Moreover, medical organizations that must bill Medicaid or other insurance on a fee-for-service basis don’t have the same flexibility to receive reimbursement for nonclinical services that Medicaid MCOs and Medicare Advantage plans now have. Even Federally Qualified Health Centers in low-income communities, which receive funding for "wraparound services," can find gaps in their ability to finance some nonclinical on-site services that would improve the health of their patients and reduce health inequity.

Improving the US health system requires many steps, of course. But an important one is to reimagine the role and scope of institutions within the system. Reimagining the business model for hospitals is needed and long overdue. But thanks to the growing understanding of social determinants of health, as well as government action creating incentives for MCOs to incorporate nonclinical services in their mix of covered benefits, the United States may well be on track to create a versatile new type of organization to help improve the well-being of more vulnerable households.

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Bench to Bedside
Noninvasive Ultrasound May Help Treat Inflammation and Other Conditions

Tracy Hampton, PhD

Two separate studies suggest that ultrasound stimulation may be an alternative to the use of implantable devices for treating conditions that respond to neuromodulation, including arthritis and hyperglycemia.

Previous research has shown that nerve stimulation with implanted electrodes can benefit patients with inflammation, diabetes, gastrointestinal disorders, and other conditions that manifest outside the central nervous system. For managing chronic inflammatory diseases, this option was proposed after the discovery nearly 2 decades ago that peripheral nerves communicate with and can alter the activity of the immune system.

This communication, which occurs through the so-called cholinergic anti-