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Leveraging Social Determinants of Health

A Practical Roadmap

A combination of technological advancements and increasing clinical evidence has created a clearer understanding of how much the environment in which people are born, grow, live, work and age impacts their health. An environmental approach, rather than a clinical approach, provides the greatest opportunity to improve the health of the world's population.[6]

- According to the Kaiser Family Foundation, medical care alone impacts only about 10 percent of an individual's health while 60 percent of health outcomes are tied to Social Determinants of Health (SDoH), or the social and physical factors affecting our lives.[1]
- Conditions in the places where people live, learn, work and play affect a wide range of health risks and outcomes.[2]
- Behavioral factors account for 40 percent of all deaths in the United States.[3]
- Differences in health are striking in communities with poor SDoH, such as unstable housing, low income, unsafe neighborhoods or substandard education.[4,5]

More recently, government agencies and commercial health insurers in the U.S. have been factoring SDoH into their operations:

- CMS is currently testing the Accountable Health Communities Model which brings clinical and community-based organizations together to address patients' health-related social needs, in an effort to improve outcomes and reduce costs.
- CMS has given payers with Medicare Advantage plans greater discretion in determining supplemental benefits that address SDoH.
- The U.S. Department of Health and Human Services has been renamed the Department of Health and Social Welfare, an acknowledgment of its integration of SDoH with traditional medical care for determining reimbursement of services provided by hospitals.
- Medicaid Managed Care Organizations have begun addressing a range of social determinants in their payment models, as well as home-based community service programs and coordination of care. In 2017, 19 states required Medicaid plans to assess social needs and provide referrals.
- According to the 8th Annual Industry Pulse Report (2018), commissioned by the U.S. HealthCare Executive Group, "more than 80 percent of health plans are already taking steps to promote value-based healthcare by addressing the social needs of their members."[7]

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The Transformation of SDoH from Concept to Real World

Many factors have coalesced to bring SDoH into the here and now. Among them are the compelling statistics cited above as well as the pursuit of health care's Triple Aim: (1) improving the patient experience, both in terms of quality and satisfaction; (2) improving the health of all population segments; and (3) reducing the per capita cost of health care.[8]

The cost factor is especially relevant in this country because the U.S. health care system is the most costly in the world. Estimates from National Healthcare Expenditure Projections[9] say U.S. health care costs will grow to nearly 20 percent of the country's total gross domestic product by 2020. There is mounting pressure from all directions to bring costs down and improve quality and overall experience at the same time.

Addressing SDoH can be a daunting and complex task, but health care providers are accepting the challenge and making incredible strides, according to Dr. Tamara Cull, Senior Vice President of Aveus, the consulting division of Medecision, an integrated health solutions and services company that helps payers and providers find their best path forward.

Dr. Cull says, "Research has finally caught up to what health care teams have known all along – a person's social health is often more important than their medical health. For years, care managers and social workers have tried to address the SDoH issues presenting during a medical encounter knowing that if these issues were left unresolved these patients would return to seek more medical care to solve their complex social needs."

Teams are now publishing outcomes that reflect decreased costs, decreased readmission rates, decreased ED visits, and decreased readmission penalties as a result of focusing on removing social determinant barriers to care. The most successful programs have built a harmonized delivery model that closes both social and medical services gaps for patients and families. The results are gaining the attention of CMS and other payers who are now putting reimbursement policies in place to help teams address SDoH factors.

Going from Potential to Performance: a Practical Roadmap

The key question regarding SDoH is not when, but how. "The broad market has begun investing in it," says Tony Glebe, Medecision VP Channel Development/Partner Solutions. "Early adopters are seeing results. But this is complex work. It's different than traditional medical care work. A lot of people don't know how to do it – and they don't know how to develop different strategies around it."

Of course, strategies will need to vary from organization to organization, but one universal place to start is the first of five important steps to consider, according to Ted Jones, Medecision VP of Government Engagement. "Whether you are a state Medicaid agency or a commercial health plan, the first thing to do is look at the data you already have."

1. Look at the data you already have.

You may already have some of the data you will need to gain a more holistic view of your patients rather than a view based exclusively on conditions and costs. At the least, you will understand what data you have and what you still need to acquire.

In the early days of SDoH, when teams were assessing the social or environmental needs a patient had, they asked them questions and wrote down their answers on a spreadsheet. Analytics, artificial intelligence and machine logic were not around. But technology has come a long way. Today, there is no longer a need to use spreadsheets to try and manage a population of thousands. Invest in a data strategy – including your current data – that reveals SDoH gaps and helps teams close those gaps efficiently and effectively.

2. Consider acquiring third-party data.

Without the benefit of personal assessments, third-party data is another route to take to learn more about the social factors impacting members and patients. For example, transportation data can be acquired from DMV records. Income data can be provided by credit bureaus, like Experian. There are also aggregators, like LexisNexis, who gather all kinds of data from different sources and pull it together into a comprehensive, but still granular, view. There are even companies that specialize in tapping into those data sources, to generate insights specific to relevant SDoH.

In the absence of being able to directly ask questions of members/patients, this third party data may be the next best source for learning, as an example, who might be having difficulty finding transportation to appointments.

3. Create a personal assessment model for your population.

This is the ideal way to gather social, cultural and environmental data about high-risk individuals and groups within your organization. In fact, these comprehensive assessments may reveal more about a person's true risk level than the traditional medical definitions of "high-risk." They do, however, require a different kind of assessment. There are several integrated solutions providers in the health care space that can help a payer or provider create a configurable assessments platform for gathering and applying SDoH. Next-generation care management tools, such as the one utilized at Medecision, create a holistic view of any members in need of assistance, taking into consideration both social and medical gaps in care. From there, these tools have the ability to shape a comprehensive care plan; and ultimately, to allow teams to make "real time" referrals to address those gaps and track efforts to close them.

4. Create a network of community-based organizations and providers that are willing to partner on a cross-sector approach to SDoH.population.

Not even the biggest health system in the world can, on its own, address the challenges presented by SDoH. It takes a village. Every payer will need to engage the power of partnerships and communities to accomplish this. Building and maintaining a directory of community-based organizations – and defining who they are and how they can help high-risk patients – should be a priority.

According to Dr. Cull, "People are reaching across the aisles in different ways than I've ever seen in my 30-year career – which is exciting." Community-based organizations partnering with health systems and health plans to surround one patient who has SDoH needs are becoming more and more common. In addition, we are seeing health systems and health plans play a more active role in their communities, helping to build community gardens, distribute food and housing vouchers, and a wide range of other support resources to members in need. One impressive example: Montefiore Health System in New York City is working with a community-based organization to provide housing and respite care beds for homeless patients and has reaped a 300 percent return on its investment.[10]

In a growing number of cases, where health systems infuse traditional care with SDoH, outcomes have improved and expenditures have decreased.[11-14]

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5. Look for technology tools that can positively impact a population's risks.

Just as social media connects groups of people, technology can help connect members/patients with their care circle. One example from Medecision: Aerial InCircle. This "contemporary care engagement" application houses a real-time, longitudinal personal health record which is shared by a caregiver with selected members of a patient's care circle. With a few clicks, a caregiver can turn to this connected community for help at any time.

For example, if a mom has questions about potential reactions her child may have to a new medication, she can use the secure messaging feature to bring the child's care manager, health system nurse and school nurse into the conversation. Through InCircle, these clinicians have access to the child's personal health record, so they can respond with patient-specific advice. The health system nurse could tell the mom what type of side effects warrant further attention. The school nurse could then monitor for these issues when she encounters the child at school. This type of engagement has the potential to empower the mom to better manage her child's health. Without such engagement, and with her anxiety mounting, many moms head to the emergency room.

Closing all gaps in care, not just clinical gaps.

Healthcare providers got into healthcare because they wanted to improve the overall health of people, not just their medical conditions. Today, SDoH models enable providers to do that work. These models have the potential to lead to the most significant improvements in health outcomes we have seen to date, along with decreased costs and increased patient and provider satisfaction – simultaneously.

People and their health are at the heart of everything we do. As an integrated health solutions company with over three decades of experience, we partner with risk-bearing organizations to manage 50 million+ members within our HITRUST CSF®-certified Aerial™ offering.

But, it's not enough to deliver technology. We are driven to create real solutions that solve real problems with the goal of improving the care and outcomes of everyone involved. Let us show you how.

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