Social Determinants: The Next Phase of Value-Based Innovation

UNDERSTANDING AND INFLUENCING KEY PREDICTORS OF HEALTH OUTCOMES

Presented by RAM Technologies, Inc.
INTRODUCTION

At first glance, the social determinants of health (SDOH) seem beyond the purview of healthcare providers and payers, but it has become increasingly clear that these factors are important to health outcomes, and they must be addressed if stakeholders are to improve the health of vulnerable populations. Identifying SDOH, integrating data into health records and models, and using that information to guide interventions are the keys to improving health and bending the cost curve, but barriers such as data and stakeholder silos remain. Payers, with repositories of claims and demographic data as well as advanced analytic capabilities, are strongly positioned to forge partnerships with healthcare providers and community groups to surmount these barriers, address SDOH and unlock value in healthcare.

NATIONAL AND REGIONAL STAKEHOLDERS TARGET THE SDOH

SDOH are central to the CDC’s Healthy People 2020 initiative – a list of 1,200 objectives in 42 categories meant to improve public health nationwide. Meanwhile, coalitions are forming across the nation to address SDOH. The Camden Coalition of Healthcare Providers’ citywide care management system, Harlem Children’s Zone Project, the Colorado Health Foundation’s Healthy Places initiative and the Healthy Food Financing Initiative are among the efforts developed to pursue neighborhood-level interventions by targeting poverty, physical activity, nutrition and more.

Payers are also getting involved. Through the Center for Medicare and Medicaid Innovation’s State Innovation Models Initiative, health plans are working with states on population health improvement models that include a social determinants component. Other Medicaid payment and delivery reforms also encourage organizations to consider and address SDOH, and in some cases, Medicaid reimburses for housing.
**TECHNOLOGY CAN HELP INTEGRATE SDOH INTO CARE**

**PATIENT-LEVEL INSIGHTS**

SDOH cannot be adequately addressed until they are identified and quantified. Because SDOH vary between and within patient populations, interventions must be personalized based on reliable data capture, sharing and analysis.

**GENERALLY, THE SOCIAL DETERMINANTS OF HEALTH ARE THE CONDITIONS IN WHICH PEOPLE ARE BORN, GROW, WORK, LIVE AND AGE. THEY INCLUDE:**

**LIFESTYLE FACTORS**
- tobacco use
- illicit drug use
- diet
- exercise
- isolation

**ENVIRONMENTAL FACTORS**
- pollution
- noise

**SOCIOECONOMIC FACTORS**
- financial stress
- education level
- housing quality
- access to transportation
- access to healthful food
- access to recreation
- neighborhood safety

The basic electronic health record (EHR) is a foundation, but to be useful for developing and evaluating targeted interventions, the EHR must be expanded to include new types of data. Sources include patient questionnaires, activity trackers and other medical devices, as well as demographic data. In addition, data silos must be brought down to allow data to flow freely to where it can be most effective. For example, payers already house key demographic information, and when they share it with providers, clinicians gain a more robust understanding of patients and may go on to collect additional data.

The result is a more informative EHR that when analyzed yields insights for addressing SDOH at the patient, community and population levels. Indeed, HHS “envision a future where clinicians in a multi-payer environment obtain actionable, reliable, and comprehensive feedback data regardless of who pays for their patients’ care.”
COMMUNITY-LEVEL INSIGHTS

Geographic information systems can be used to identify communities and neighborhoods with high rates of poverty and unemployment, low education levels, exposure to pollution, a lack of transportation, food deserts and other factors that contribute to poor health. Mapping and analyzing data enables the development of a community health needs assessment to guide interventions. The CDC offers resources for completing such an assessment.

POPULATION-LEVEL INSIGHTS

Payer claims data also holds clues to SDOH. For example, cardiovascular disease and depression may be linked to stress caused by insecure housing; environmental factors contribute to asthma; obesity and diabetes may be tied to poor access to healthful food; and transportation problems may result in missed appointments. Claims analyses tease out these and other associations that might otherwise be missed. Payers that share this and other data with clinicians and other partners arm them with the insights needed to truly make a difference.

STANDARDIZATION IS KEY

Clinical SDOH assessment tools have come to the market, but the field lacks standards, guidance and best practices for multi-sector data sharing and systematically capturing, documenting and prioritizing SDOH. Various efforts are underway to fill the gaps, and some stakeholders have introduced tools for measuring SDOH. In addition, the National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association and the Institute for Alternative Futures have joined forces to implement, test and promote a standardized risk assessment protocol to assess and address patients’ social determinants of health.
HOW PAYERS ARE LEADING THE WAY \[1,4,5,12-15\]

In addition to data sharing and analytics, payers are strongly positioned to take SDOH to the next level in other ways — indirectly through provider and patient incentives and directly through philanthropy.

Value-based insurance design is one framework for encouraging providers to collect and use SDOH data, and many payers have already launched pilot programs in this area. Identifying SDOH allows health plans to not only waive cost-sharing for key services but also to cover food as medicine and provide housing and transportation assistance, for example.

Major health plans also continue to leverage partnerships with community organizations to identify and address SDOH. These payers are investing directly or through community groups in interventions that improve housing, transportation, employment, nutrition, education and health behaviors in the patient populations they serve, and in at least one case, adopting a “whole patient” perspective for high-cost, high-need patients that accounts for social determinants. In addition, Association for Community Affiliated Plans members are testing myriad programs and initiatives to improve housing, economic stability, education and food security in the patient populations they serve.

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LOOKING TO THE FUTURE 2,4,16

The transition to value-based care is well underway, but continued progress is needed to optimize healthcare and outcomes if stakeholders are to build a more sustainable system. Research has shown that SDOH are at least as important to patient outcomes as medical care itself, and for Medicare, Medicaid and dual-eligible populations, SDOH are particularly important. As value-based care places new emphasis on prevention and outcomes, stakeholders have realized they must find a way to account for SDOH, and many have pursued efforts to influence social determinants as a result. This is the next phase of value-based care.

To effectively identify and influence SDOH, data silos must be eliminated, partnerships formed and tools for integrating SDOH interventions into clinical care must be developed. These efforts will require stakeholder support, investment, incentives and new ways of thinking about healthcare. Payers have the perspective, resources and tools to ensure SDOH are fully recognized and addressed as an integral component of healthcare.

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References


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