Social Determinants of Health: Using Consumer Insights to Move from Why to How

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The social, economic and physical environment in which a person lives is widely recognized as influencing their overall health and well-being. Moreover, COVID-19 exposed how these factors create devastating health equity gaps within communities and health systems. Across the U.S., healthcare organizations are more aware than ever of the need to address systemic biases inside their own systems to better serve their patients and communities.

> Addressing SDOH is about leveraging consumer data and technology to shift from traditional care models to ones that support a complete health strategy.

As healthcare evolves, addressing social determinants of health, or the nonmedical factors that impact one's ultimate health, will continue to drive a host of evolving policies, initiatives, partnerships and technology across public and commercial domains of the healthcare industry.

The Centers for Disease Control and Prevention (CDC) supports a menu of programs, research and assessment tools aimed at addressing SDOH. The Centers for Medicare & Medicaid Services (CMS) continues to push the criticality of addressing SDOH to lower the cost of care and improve health outcomes in a value-based healthcare environment. The organization recently released its road map for states to accelerate the design and use of social determinants programs.

Kaiser Permanente and United Healthcare are among the major payors making significant investments in SDOH programs, and the pressure on providers to ramp up SDOH initiatives has only increased since the start of the pandemic.

While the adoption of value-based payment models has been slower than predicted, risk-based initiatives are not going away, requiring organizations to think strategically about whom they partner with outside the walls of their facility. The collective impact of such alliances may ultimately hold the biggest return on investment as organizations seek to create healthier communities.

Consumer and Population Insights

SDOH-related programs will continue to be diverse in approach and size, but what has become consistent is healthcare leaders' understanding that patient and consumer data will play a role in how they deliver better health outcomes.

For providers, the complexity of social health drivers paired with a varying list of organizational priorities makes it hard to know where to focus. Determining the who and what of SDOH programs begins with a data-driven understanding of an organization's consumers.

Organizations just beginning to leverage SDOH data should start small and strategically by capturing and addressing needs such as transportation and home support risks as part of inpatient discharge planning. Leaders can also look to a known high-risk segment such as the diabetic population and begin examining underlying factors from medication adherence to food insecurity to housing that might be impacting that group.

Food security and housing quality, two environmental aspects of SDOH known to have a strong link to health, are common areas of focus for healthcare organizations. For example, Montefiore Health System in the Bronx boasts a 300% return on investment (ROI) on its housing assistance program. Atrium Health and its partners committed $10 million to help address affordable housing issues, and provider-sponsored food assistance programs are emerging across the U.S.

Understanding market-specific consumer population issues, including prevalent environmental social factors, is also leading many health systems to focus on increased access to behavioral health services, mobile clinic offerings and virtual telehealth offerings as part of their overall growth strategies. Shifting an organization's mindset regarding consumer insights, including SDOH data, can inform the way organizations generate network expansion and create services aligned to consumer preferences and needs.

Strive for Collective Impact

No organization should initiate new programs to address SDOH without first evaluating its community for potential partnerships. Collective impact, or solving complex problems through cooperative, cross-sector collaboration, should be the goal.

For example, ProMedica, a non-profit healthcare system based in Ohio, co-founded a coalition expressly dedicated to addressing social determinants threatening the health of their population. NCH Healthcare System in Southwest Florida reported significant ROI after adopting the Blue Zones Community approach, which unites workplaces, schools, grocery stores, faith-based organizations and others toward the goal of improving the health and well-being of a community.

As value-based care moves from the exception to the rule, clinical outcomes and an organization's subsequent financial success hinges on partnerships and solutions designed for collective impact. Eventually, more healthcare providers may develop shared savings agreements with outside organizations to ensure everyone is invested in a program's goals and outcomes.

Tech Is Foundational to Addressing SDOH

For many years, effective low-tech strategies such as community health workers, community needs assessments and questionnaires have been staples for organizations seeking to address consumers' needs beyond medical treatment.

Today, organizations are tapping into technology enabled solutions for analyzing consumer vulnerability to high-risk social determinants, linking to available social programs and improving patient activation.

Tools such as Carrot Health provide patients pecific insights into social determinant risks and predictive analytics to help clinical teams make real-time

decisions about patients' needs for housing, transportation, food or other factors contributing to their health outcomes. Companies such as Insignia Health and GetWellNetwork provide tools to facilitate health education, patient activation and improved self-management.

Electronic health record (EHR) platforms have rapidly advanced their functionality to address SDOH with enhanced data collection, predictive insights and other population health capabilities. Provider health systems will have to prioritize the use and interoperability of SDOH data as part of their overall data management strategies.

Ultimately, addressing SDOH is about leveraging consumer data and technology to shift from traditional care models to ones that support a complete health strategy.

Key Takeaways

To advance SDOH efforts, organizations must:

Think differently.

Consider how well you truly understand the needs of your patient populations and the role that SDOH programs will play in helping your organization close health equity gaps in your community.

Plan differently.

Develop SDOH initiatives with collective impact in mind; focus on the community and technology partnerships that are foundational for any organization seeking to address consumers' needs beyond medical treatment.

Act differently.

Combine social determinants of health with other consumer insights to develop customized, holistic healthcare plans, grow your network and improve clinical outcomes.

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