Data for Good: The Case for Operationalizing Social Determinants of Health into Clinical Models

Healthcare leaders have increasingly recognized the value of social determinants of health (SDOH) data in improving care management and predictive models.

Knowing the circumstances in which individuals live, work, and play can help providers boost medication adherence, reduce hospital readmissions, and enhance engagement among all patient populations.

While healthcare organizations understand the important influence of non-clinical factors on overall health, many still struggle to leverage this data for tangible results.

"Most health systems and health plans have teams dedicated to outreach and coordination with the population itself. So why aren't we making a bigger impact?" Vertical Solutions Senior Director Rich Morino said in a recent PatientEngagementHIT webcast.

"It's estimated that quality of care impacts only 20 percent of an individual's overall health outcomes and genetics impacts another 20 percent," he continued. "That means 60 percent of health outcomes are based on social, economic, and behavioral decisions. Providers can deliver excellent care, but if the patient is discharged to a home where they're socially isolated, lack transportation, and have low health literacy, the odds are quite high that they'll return to the hospital."

To deliver optimal care, enhance patient engagement, and improve overall health, providers will need to leverage and address social determinants of health. Morino and LexisNexis Risk Solutions Health Care Senior Director of Market Planning Erin Benson provided strategies and best practices for integrating this data into clinical practice and using it to boost outcomes.

Using social determinants data for care improvement, coordination

To begin to understand and address a patient's health status, providers must get to the root causes of poor outcomes, which will require organizations to combine individuals' clinical and social data.

"Early efforts to combine social determinants of health data into clinical models focused on potential risk. While that's certainly a good outcome of including social determinants of health data into your predictive models, current efforts are highlighting why someone might be at risk, which is even more impactful," said Morino.

"Understanding why someone is at risk is crucial to the success of any social determinants of health effort. Currently, quality departments are either combining socioeconomic data with their clinical data to predict who is at risk and then choosing the select data to inform care management practices or using pre-built scores based only on social determinants of health information that provide insight into why someone is classified as high-risk."

Once leaders understand the why, the next step is to translate this information into concrete actionable and valuable information to help patients.

"The question is, how do we turn all this insight into better care for patients? More and more often, the answer lies in the mantra, 'think globally but act locally,'" said Morino.

"Thinking globally means identifying which conditions are prevalent in your population and where. Form a multi-year strategy to decide which conditions you can align with the social service and when. But in the short run, focus on members who already have a social service in their community that can address a specific barrier to their health, such as someone with a high risk of readmission who has no access to transportation."

Finding business use cases for social determinants of health

Once organizations turn SDOH data into meaningful insights and solutions for patients, they can translate this information into beneficial financial results. In a value-based care environment,

that often means preventing adverse health consequences, according to Benson.

"When we talk about using social determinants of health data in the clinical workflow, we mean using it to predict who's likely to need help and what help they're likely to need. With this information, we can proactively address these needs before a negative health outcome occurs, like a readmission," she said.

"This data can also help with creating programs or forming community partnerships to get those patients the help they need before they end up getting readmitted."

Reducing readmissions is critical for health systems to avoid financial penalties, as this metric impacts quality measures under HEDIS, MACRA, and other value-based care incentive programs, Benson noted. Assessing social determinants of patients can help organizations identify and address issues leading to readmissions.

"Within one sample patient population, we saw that from patients with a medium to high risk of being readmitted to the hospital, about 1,200 had phone access challenges and about 350 had address stability challenges," she said.

"If you knew those needs existed within your population and you knew that addressing their phone and address stability needs could help prevent those readmissions, wouldn't it make sense to help those individuals find housing or reliable access to a phone?"

Once healthcare leaders understand the barriers, they must work to overcome them in order to reap the benefits, Benson stated.

"One study evaluated the impact that providing medical respite housing to people experiencing homelessness in New Haven, Connecticut, had on readmission rates. The hospital system was able to reduce readmission rates for homeless patients by six to 14 percent over three years, with an estimated savings of $12,000 per patient across all Medicaid claims in the year following this study," she said.

"This clearly shows that if you start to address social determinants, there is value to be achieved as well as helping patients."

While the benefits of leveraging SDOH information are now well-known to healthcare professionals, many organizations still struggle to identify a starting point, Benson said.

"There are so many options when it comes to addressing social determinants that it can be hard to figure out where to start. We suggest starting with clinically validated social determinants of health data to evaluate the needs of the population on an individual level so that you can make some key decisions about which health outcomes to address and what types of programs to use," she said.

Although it can be intimidating to start an SDOH initiative in any organization, the critical first step to improving outcomes and care delivery is focusing on manageable goals and programs.

"In all cases, the most important thing is to begin," Benson concluded.

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