LexisNexis® RISK SOLUTIONS

Health Care

EXECUTIVE BRIEF

Social Determinants of Health: Lessons from 2018

2019

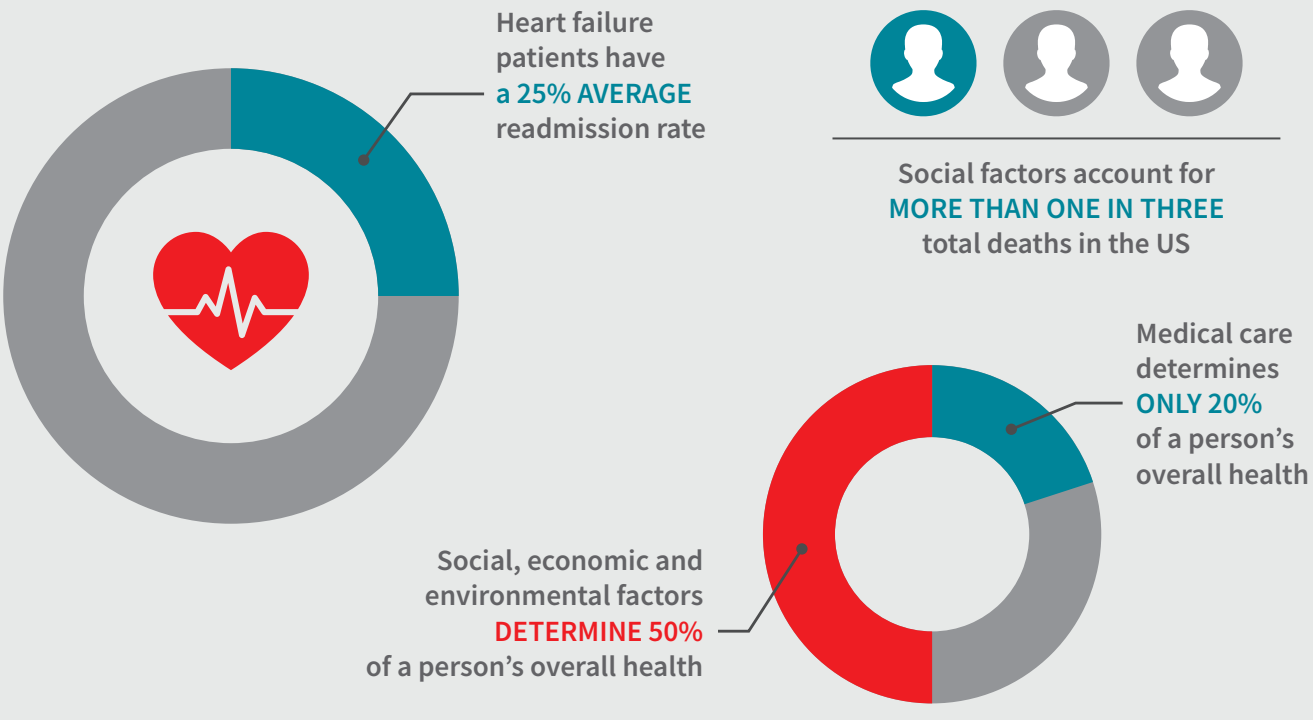
Insights from LexisNexis® Risk Solutions

Social determinants of health (SDOH) were in the spotlight in 2018 as stakeholders across the industry recognized the value and patient benefits of addressing these non-clinical health influencers. They are a significant factor in achieving the best possible health outcomes and should be used to tailor care management and planning. Health plans and providers can take a variety of steps to use this data to improve their care management strategies and better serve their patients.

Identifying Patient Needs

Four patients of the same age and gender are all discharged from the hospital following treatment for heart failure. With a 25% average readmission rate for heart failure patients, we know statistically that at least one of them will wind up back in the hospital. Which one is it likely to be and what can be done to prevent that from happening?

Traditional analytic modeling approaches depend on clinical and claims data. While important sources of information, they present all four patients as almost identical. However, when the patients' social determinants of health are considered, the picture becomes clearer. Factoring in information like a patient's address stability, financial health, education, support system, and transportation situation gives care providers a new lens through which they can identify not only who most needs additional help but also what kind of assistance they need—from meal delivery to medication assistance.



Social Determinants Explained

With social factors accounting for more than one in three total deaths in the US annually, SDOH received considerable attention in 2018.[1-5] Analysis of coverage reveals that, while the industry clearly sees value in investing in social determinants data, there's still a tremendous need for education and alignment among providers and payers to make meaningful use of the data.

Here's what we know:

Care managers can't afford to ignore socioeconomic data. Studies have demonstrated that medical care determines only 20% of a person's overall health, while social, economic and environmental factors determine 50%.[6] Socioeconomic data is a vital force for health care risk prediction and can help providers and payers allocate the appropriate resources to achieve better health outcomes.

Aggregated data at the ZIP code or census level is too broad. While high-level data may be useful for market expansion and resource allocation, it's not specific enough for risk stratification or for designing personalized care management programs. Instead, hundreds of patient-level data points must be considered, and they must come from an extensive variety of sources, including public records, credit information and consumer data.

Not all data points are useful as SDOH. To be useful, a data point must be clinically validated to correlate with a health outcome, such as medication adherence or hospital readmission. For example, medication adherence has been shown to drop sharply when a patient's closest relative or associate lives greater than 25 miles away. To date, the LexisNexis data science team has clinically validated over 400 social attributes that correlate to specific health outcomes.

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Making it Actionable

The process of assimilating data and presenting it as actionable information to care management teams can be summarized in three steps:

Step 1: Predictive models are used to identify individuals who face barriers to improving or maintaining their health.

Step 2: These models generate risk scores that predict the individuals who are at greatest risk for negative outcomes, as well as the severity of that risk.

Step 3: Care management teams are provided with insights that will assist with how to approach individuals based on their relative risk and their specific social-determinant needs. Care managers can then align resources to remove barriers to achieving optimal health outcomes for their patients.

Applied to care management, the hundreds of SDOH data points fall into categories such as address stability, financial health, social isolation, education and health literacy that can be used to create actionable care plans for patients. When alerted that patients are challenged in any of those areas, care managers can tailor outreach efforts to address those needs.

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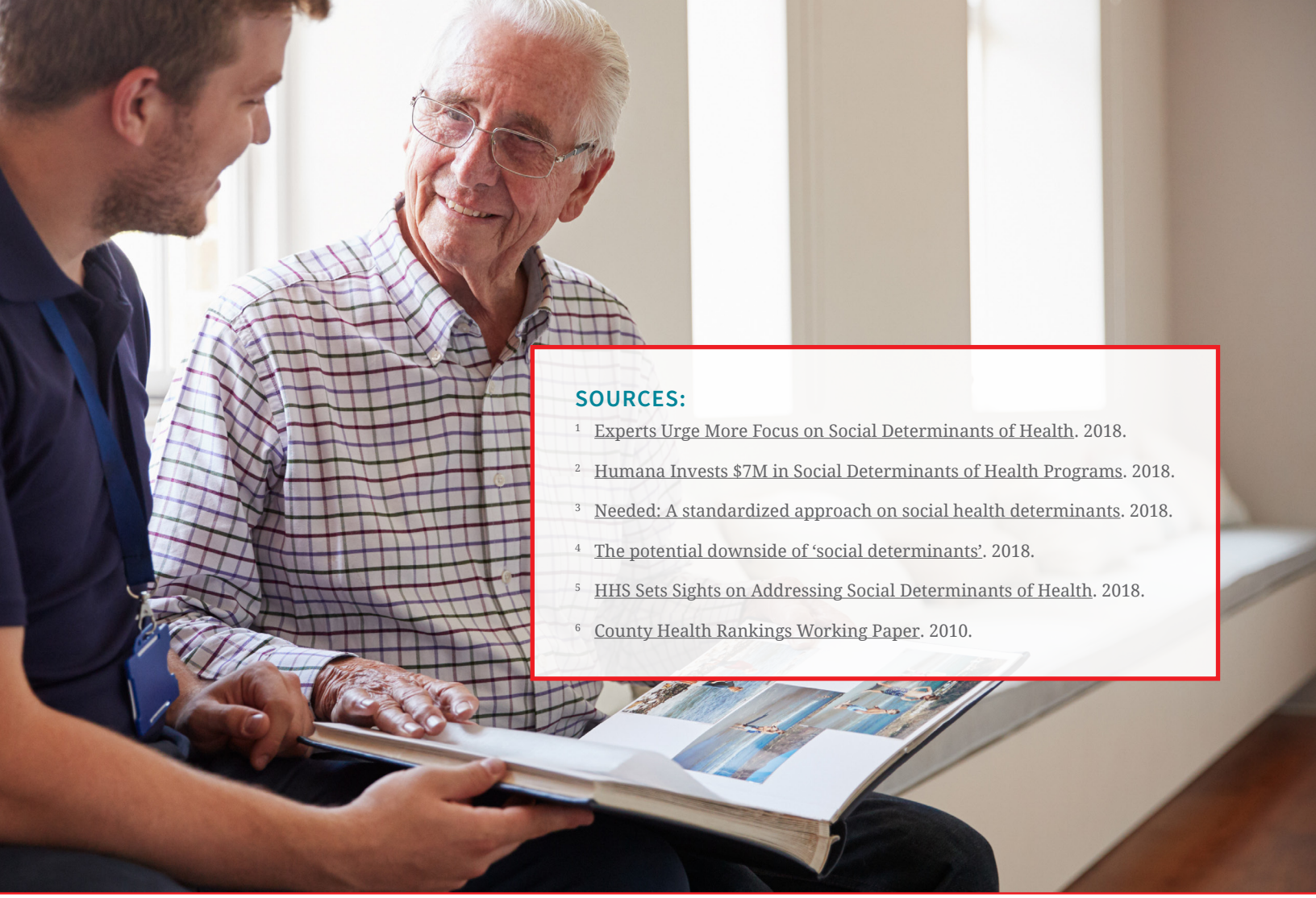
Addressing Patient Needs

Returning to the four heart failure patients who are all the same age and gender, how will their care managers respond to the insights provided by SDOH data? For Tony, whose significant income decrease and frequent changes in residence put him at a 78% risk for readmission, care managers can coordinate financial or housing assistance. Alex, at 52% risk of readmission, may need transportation or medication delivery because he lives in a community that lacks public transportation and he doesn't own a car. Chris lives with a relative who is over the age of 80, so his care manager will want to explore whether care-provider assistance is needed to mitigate his 35% readmission risk. Finally, Greg, at 10% readmission risk and with no significant socioeconomic challenges, can be managed with the established best-practice treatment options for someone of his age and medical condition.

This personalized approach allows care managers to intervene before complications develop or worsen, and the risk scores ensure that organizational resources are deployed where they are needed most. As the industry continues the shift toward value-based care, use of SDOH data enables tailored, prioritized outreach efforts that address not just the medical condition but the whole person.



SOURCES:

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3. Needed: A standardized approach on social health determinants. 2018.
4. The potential downside of 'social determinants'. 2018.
5. HHS Sets Sights on Addressing Social Determinants of Health. 2018.
6. County Health Rankings Working Paper. 2010.

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Our healthcare solutions combine proprietary analytics, science and technology with the industry's leading sources of provider, member, claims and public records information to improve cost savings, health outcomes, data quality, compliance and exposure to fraud, waste and abuse.