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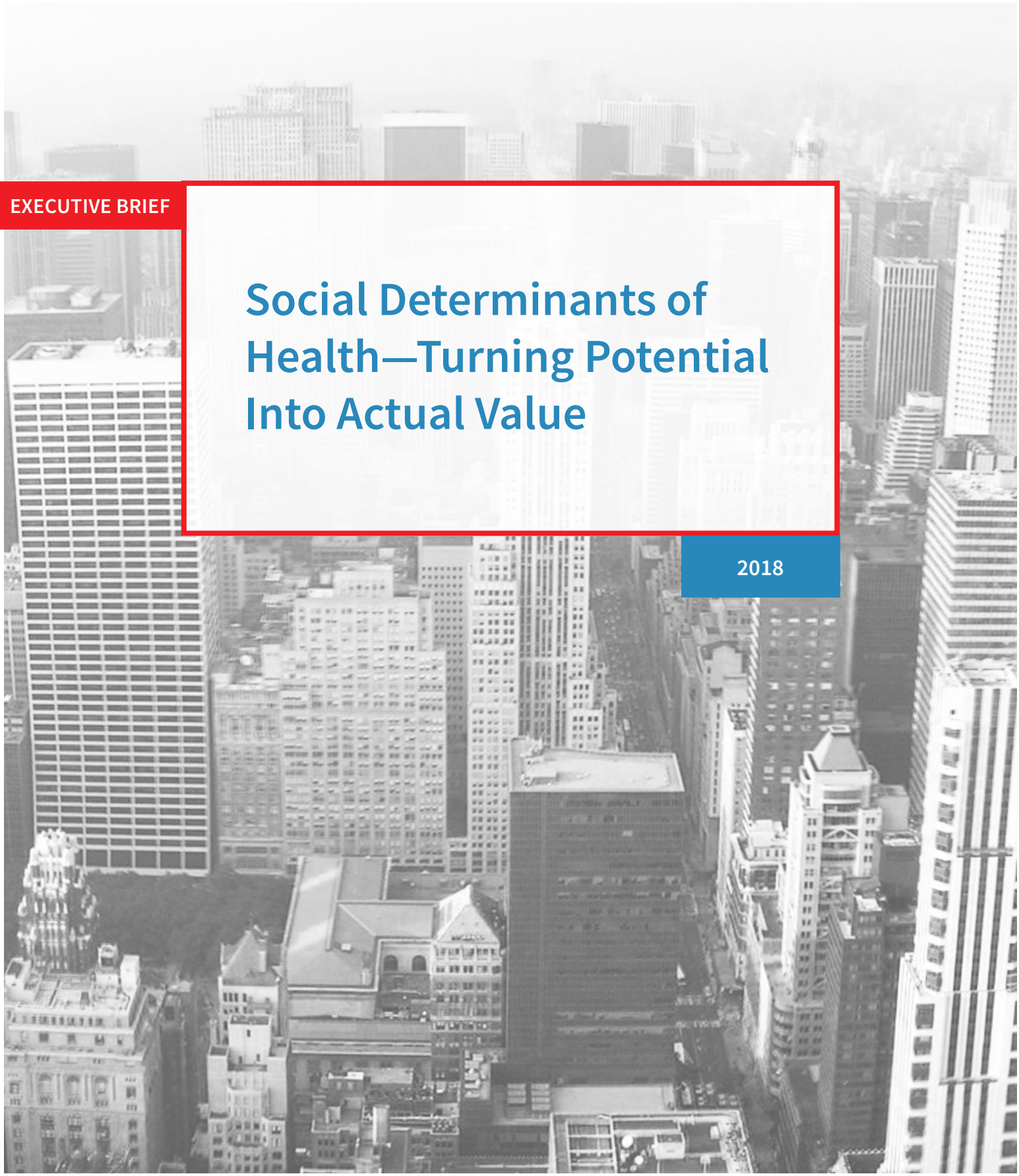


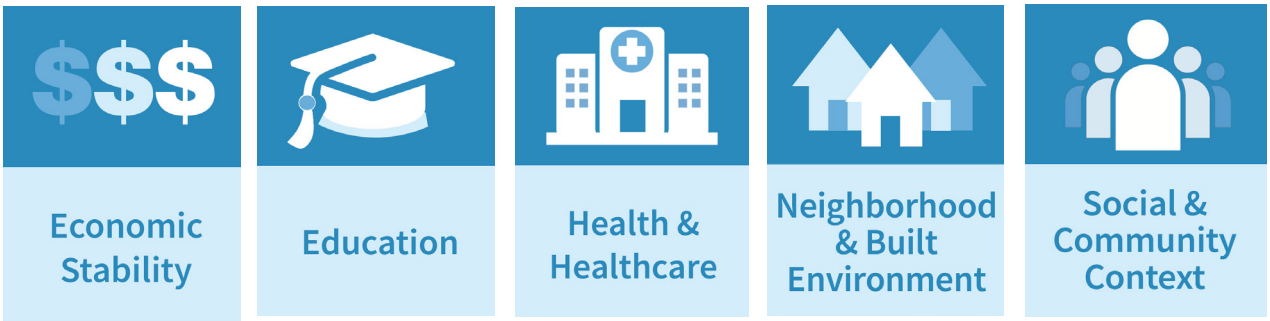
EXECUTIVE BRIEF

# Social Determinants of Health—Turning Potential Into Actual Value

2018

# SOCIAL DETERMINANTS OF HEALTH

Up until somewhat recently, socioeconomic data wasn't part of the conversation on how best to improve health outcomes. Where people live, learn, work and play – commonly known as social determinants of health (SDOH), are today, considered essential factors for gaining a more complete picture of members – revealing how members' daily lives impact their mental and physical health. The Centers for Disease Control and Prevention (CDC) considers these five categories[1] for overall SDOH:




An audience of over 650 healthcare payers and providers joined LexisNexis Risk Solutions Health Care executives for an insightful webinar that examined what is needed to deliver success with social determinants of health and how SDOH innovation can impact quality goals while simultaneously reducing costs and improving overall member experience. The speakers debunked several of the myths associated with social determinants of health, including a myth where many consider that socioeconomic data is just more noise in an already data-overloaded world, versus the truth from a County Health Rankings study that finds medical care determines only 20% of overall health - while social, economic and environmental factors determine 50% of overall health.[2]

## Top 5 myths about social determinants of health:

### Myth 1

MYTH: SDOH data is just more noise in an already data-overloaded world.

TRUTH: Medical care determines only 20% of overall health - while social, economic and environmental factors determine 50% of overall health.

### Myth 2

MYTH: All data regarding a person's lifestyle, environment, situation and behaviors relates to their social determinants of health.

TRUTH: While the data may be useful in some capacity, not all data on a person is a social determinant of health.

**Myth 3**

MYTH: Examining only individual socioeconomic attributes about a person will allow you to make accurate predictions about a member's overall health risk.

TRUTH: Focusing in on individual attributes, rather than the combined picture, can be misleading.

**Myth 4**

MYTH: Aggregated data at the zip code or census level can be used to personalize care for a member.

TRUTH: For personalizing care, individual level data is necessary to explore the combined impact of socioeconomic data.

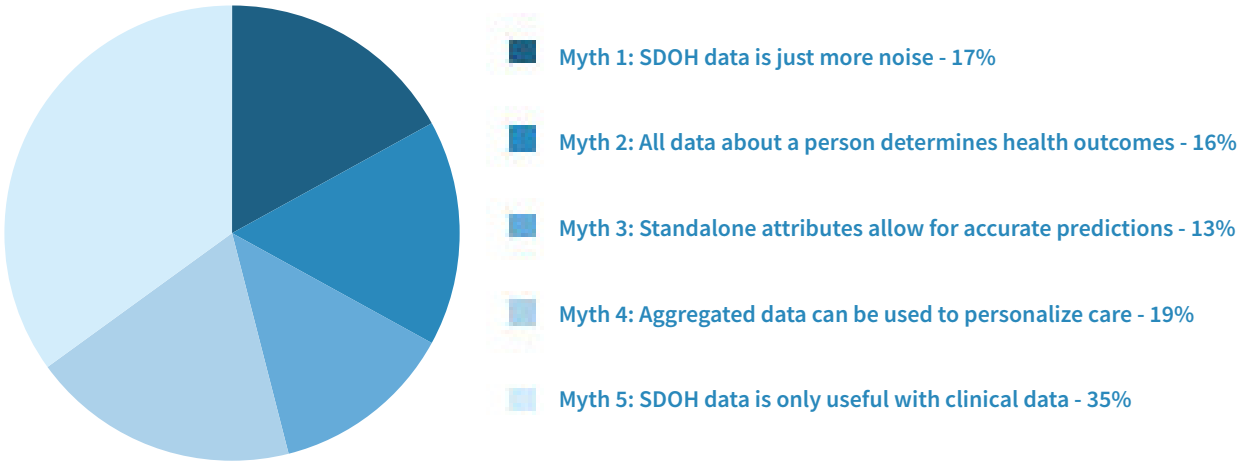
**Myth 5**

MYTH: Socioeconomic data is only useful in combination with clinical data.

TRUTH: Socioeconomic data is valuable with or without clinical data.

The webinar audience was polled for their thoughts on which of the five myths about social determinants of health was the most surprising. Over a third of the audience indicated that myth #5, socioeconomic data is only useful in combination with clinical data, was the most surprising:

## Polling Question: Which myth about SDOH was the most surprising to you?



## SOCIAL DETERMINANTS OF HEALTH

Below are examples of SDOH categories that correlate to outcomes. When understood, providers and care managers are able to personalize care plans so patients have an opportunity to realize optimal outcomes.


### Economic Stability

- Address stability
- Assets
- Income
- Professional licenses
- Liens
- Bankruptcies

### Education

- Level
- Quality
- Area of study

### Health & Healthcare

- Proximity to healthcare
- Proximity to primary care

### Neighborhood & Built Environment

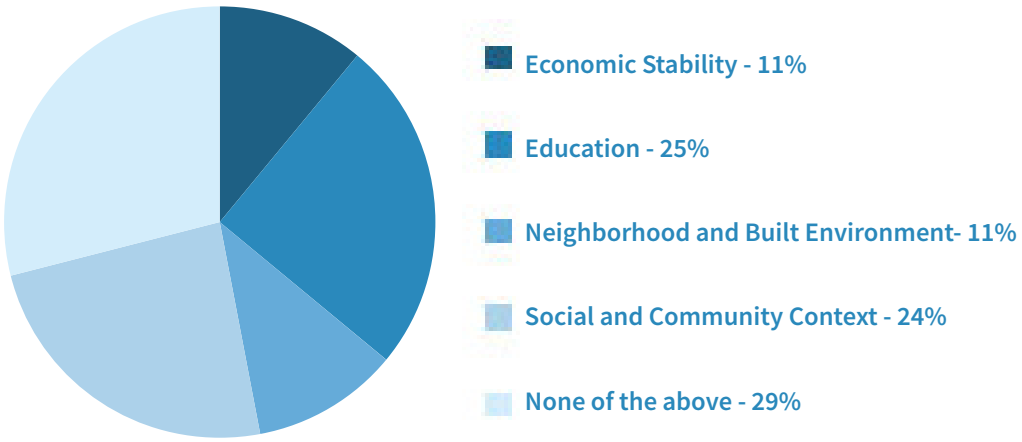
- Household demographics
- Housing types
- Crime index
- Income index

### Social & Community Context

- Accidents
- Crimes
- Weapons and sporting licenses
- Voter registration
- Relatives/associates

Following a brief discussion on the sources of applicable social determinants of health data, the audience was asked a second polling question:

## Which of the following social determinants of health would be easiest for your organization to address based on current care programs?



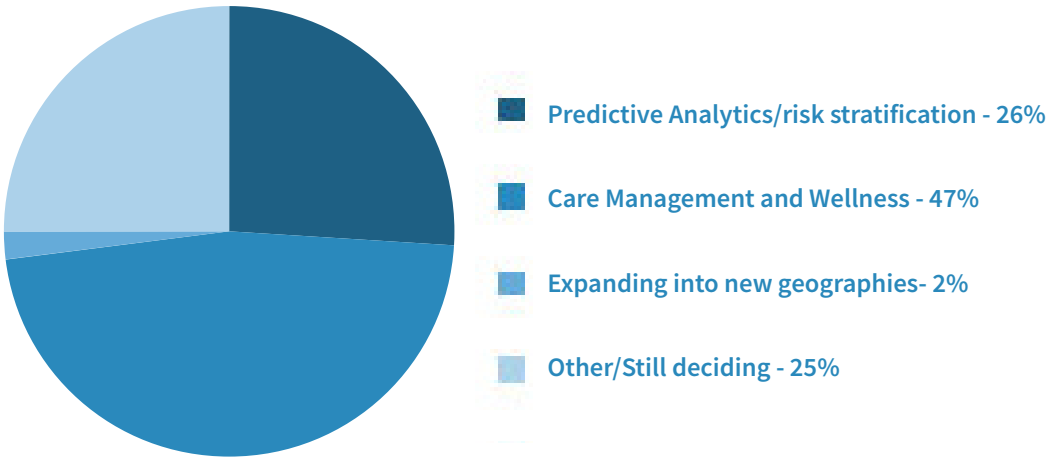

Education is one of the top responses from the audience. More and more healthcare organizations are doing education in the community around health preventive programs, and social and community programs in terms of support groups are fairly common now as well. Many healthcare entities are still trying to figure out how to integrate social determinants of health data into workflows.

An interesting perspective on using social determinants of health to create value can be gleaned from a comparison of two health plan members, Larry and Bill, both with similar age, location and health risk, which based on analytics of claims and enrollment data alone, would lead to the same intervention program. However, adding in social determinants of health tells a very different story. Whereas Larry lives alone, in a high crime neighborhood unfit for outdoor exercise, with no post high school education and with no providers or hospitals within 40 miles, Bill lives with his spouse in a safe neighborhood, holds a post-graduate degree and has providers and hospitals within 10 miles. In this scenario, Larry has significantly more risk than insights gleaned from claims only based analytics would have revealed.

Innovation tools are used to best align low risk (Bill in the scenario above) versus severe risk (Larry in the scenario above). Examples of low risk interventions include wellness program invitations whereas severe risk patients may need help arranging alternative living arrangements, in-home services, Medicaid, or other financial services. Next generation SDOH tools enable healthcare organizations to better identify high risk members and address the SDOH obstacles they face so they can achieve better health outcomes.

The final audience polling question asked:

## Where will/did your organization first integrate SDOH into the workflow?




Almost half of the audience is or will be integrating social determinants of health into their care management and wellness programs. Social determinants of health can be introduced in many ways into an organization to help along the entire member journey.

The key take-away from the discussion, by using social determinants of health data, payers can more accurately surface members that require action and provide better care management by incorporating social determinants of health information. Along with improved health outcomes for members, social determinants of health data helps health care organizations to reduce expenses, lower medical loss ratios and retain members.

[1] https://www.cdc.gov/socialdeterminants/index.htm

[2] Bridget C. Booske et al, "Different Perspectives for Assigning Weights to Determinants of Health," http://www.countyhealthrankings.org/sites/default/files/

To watch the full one hour webinar, visit: https://youtu.be/Z2r0Bxui1z8
For more information, call 866.396.7703 or visit risk.lexisnexis.com/healthcare

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