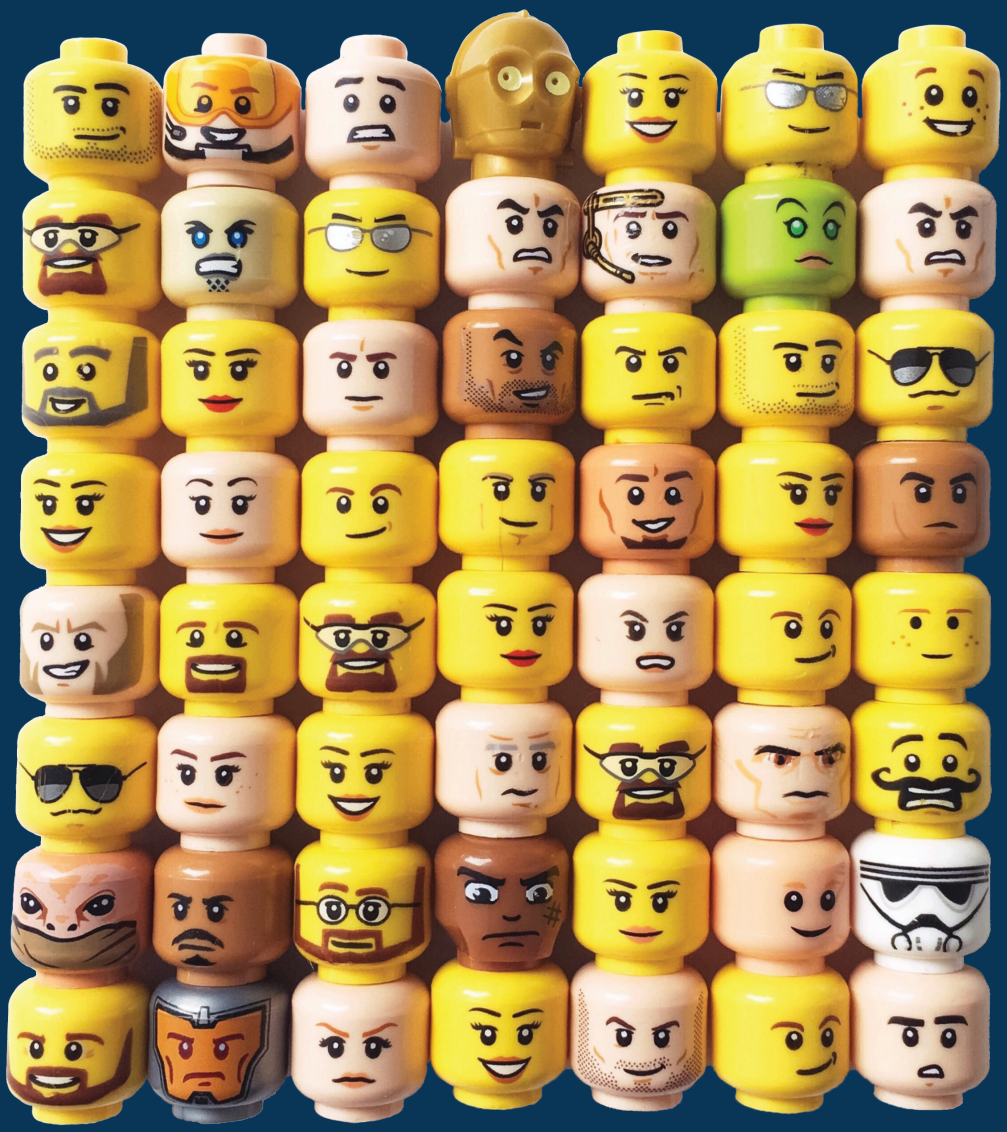
7 Strategies to Address Social Determinants of Health with Better Engagement



Icario™

Laying the Groundwork, Brick by Brick

Understanding social determinants of health (SDoH) among the Medicaid population has been a key strategy for improving overall health and well-being. Moving beyond one population, health plans can benefit from gleaning and applying evidence-based approaches in SDoH to support all individuals they support, be it Medicare-eligible members, state-funded plan members, individuals with disabilities, and commercially insured individuals and families.

This eBook dives deep into SDoH, covering the following 3 topics:

- What social determinants of health are and why they can't be ignored
- Best practices to engage and address SDoH
- 7 proven strategies for health plans to adopt

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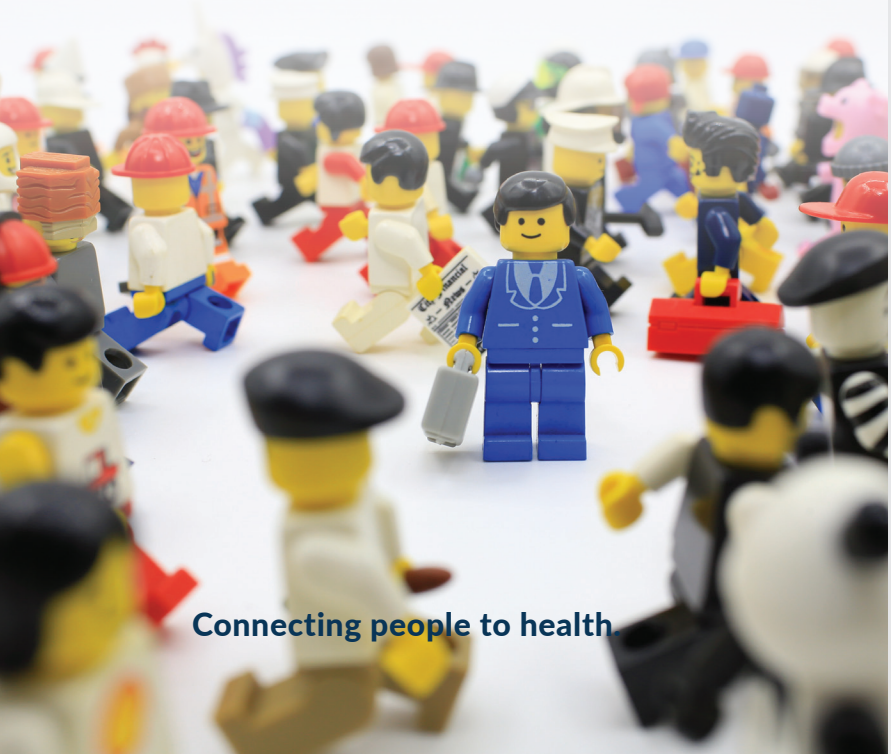
Social Determinants of Health—Why Now?

SDoH are not a new concept among healthcare leaders, but they are receiving increased attention in and outside the healthcare industry. Overall, there is an increased realization that SDoH are influencing behavior, causing significant disruption, and negatively impacting health outcomes, which can no longer be ignored.

Building a better understanding of member needs and the barriers they encounter will allow health plans to actionably address SDoH and impact the people that need the most help.



Approaching This Complex Subject

At the highest level, SDoH encompasses conditions that affect individuals at birth and throughout their daily lives that create social and physical environments that influence health. The determinants include:

- Biology and genetics
- Language and literacy
- Individual behavior
- Social environment
- Physical environment
- Health services, including access to medical care

These factors can have an enormous impact on health outcomes. For example, the use of the emergency room has been linked to homelessness.[1] Hospital admissions for individuals with diabetes have been associated with food insecurity.[2] **A combination of these factors also account for over a third of total deaths.**[3] A Milliman study reported that:

- The risk of having a health condition is highest among those with the lowest income
- Those with concerns about life necessities are two to three times more likely to report fair or poor health than those with little or no concern[4]

Organizations, such as health plans, are exploring and experimenting with SDoH methodologies. Plans can deploy various approaches, but one systematic approach that is particularly successful can be seen to the right.

This process creates an integrated closed-loop process, helps inform what is working for members, and enables efficient modification and augmentation to accommodate the member's need.

One state Medicaid director noted, "I don't know that piecemealing some of this is going to help. If a hospital says they're going to do screening for food insecurity and then makes a referral for food insecurity, that's a good thing. That's a great step in the right direction, but it doesn't get into a holistic view of a person's needs."[5]

A Change Healthcare Study found that **80% of payers believe that addressing the SDoH of their beneficiaries is a crucial way to improve their population's health.**[6]

The following details 7 health engagement strategies for health plans to consider as they apply SDoH to increase positive health outcomes for their members.

80%

of payers believe that addressing the SDoH of their beneficiaries is a crucial way to improve their population's health.

Process to Address SDoH

IDENTIFYING

patients who are likely to have multiple health and social needs.

SCREENING

patients for SDoH needs and determining appropriate organizations, such as insurers or community-based services, have the resources and knowledge to address specific needs.

CONNECTING

patients with organizations to help address their health-related social needs.

FOLLOWING

up to ensure patients complete SDoH intervention or activity.

TRACKING

outcomes of patients receiving community-based services.

STRATEGY #1

Data

An individual's ZIP code is a stronger predictor of an individual's overall health more so than other factors such as race and genetics.

Use All Available Data

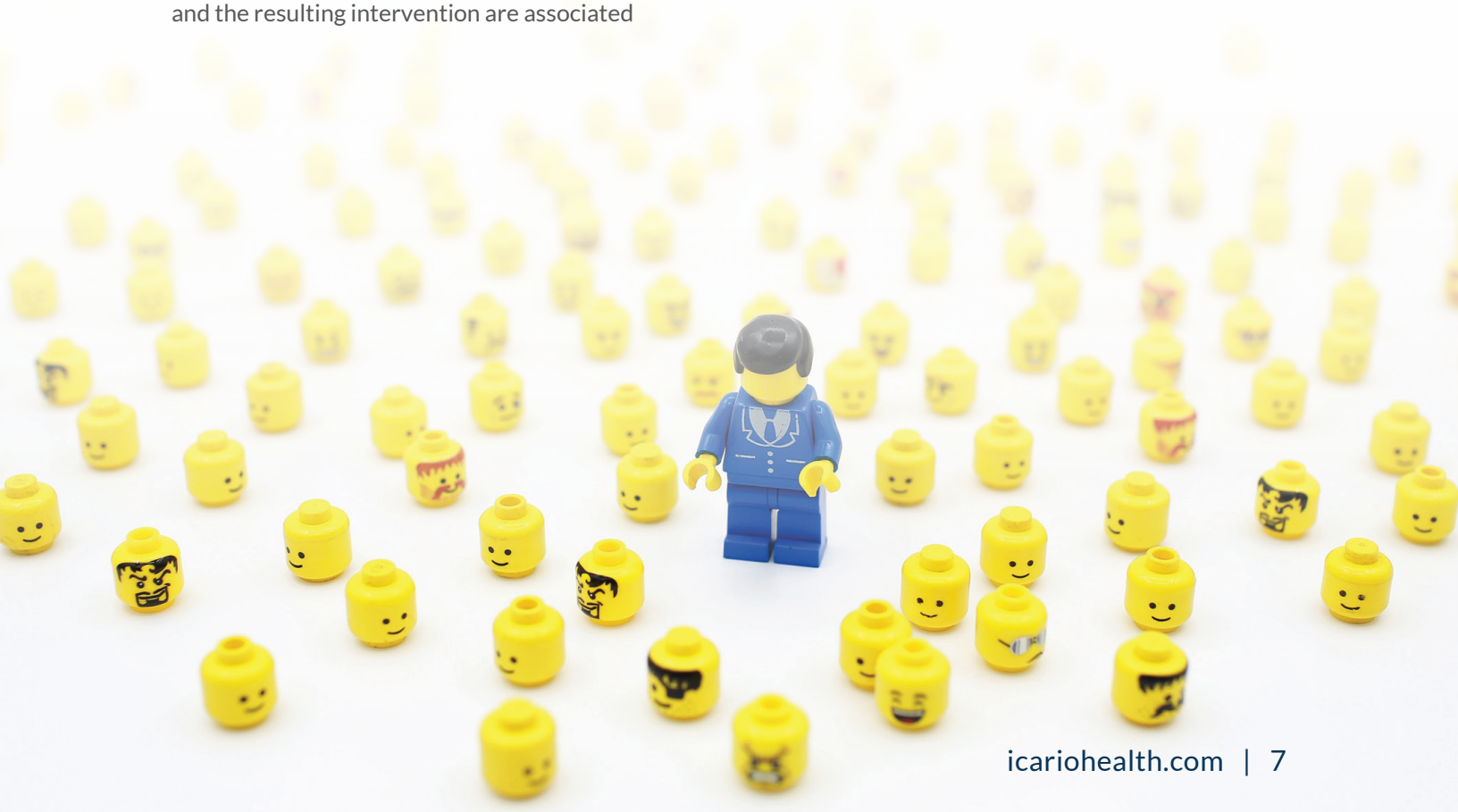
It's difficult to champion a strategy without data to support the scope of the problem and appropriate resources. In addition to claims and enrollee data, plans can leverage publicly available data sources to discern the viability of particular solutions within a given geography or ZIP code.

These sources may include information from credit agencies and census data to define the scope of homelessness or economic status, transportation agency information, law information records, and average education level. **An individual's ZIP code is a stronger predictor of an individual's overall health more so than other factors such as race and genetics.**[7]

Moreover, plans can draw critical SDoH data from health assessments. Collecting this data and the resulting intervention are associated with statistically significant declines in the total cost of care for individuals with identified needs. Individuals with two or three social needs can see an approximate savings of $1,000 per year.[8]

States such as New Hampshire, Virginia, and Washington are even going so far as to define the social domains that need to be addressed through screenings. North Carolina has developed a standardized social determinants screening tool for plans to use.[9]

Some states are requiring plans and providers to complete health assessments to earn a portion of available financial incentives and withholds.[10] CMS has also tied Star Ratings to completion of the health assessment for the Special Needs Population.[11]



In addition, hospitals and health systems can now capture SDoH data through ICD-10 categories Z55-Z65,[12] which identify persons with potential health hazards related to socioeconomic and psychosocial circumstances. These codes cover a wide range of social, economic environment, and interpersonal issues, including:

Z55
Problems related to education and literacy
Illiteracy, schooling unavailable, underachievement in a school, educational maladjustment and discord with teachers and classmates.

Z56
Problems related to employment and unemployment
Unemployment, change of job, threat of job loss, stressful work schedule, discord with boss and workmates, uncongenial work environment, sexual harassment on the job, and military deployment status.

Z57
Occupational exposure to risk factors
Occupational exposure to noise, radiation, dust, environmental tobacco smoke, toxic agents in agriculture, toxic agents in other industries, extreme temperature, and vibration.

Z59
Problems related to housing and the economic circumstances
Homelessness, inadequate housing, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, lack of adequate food and safe drinking water, extreme poverty, low income, insufficient social insurance and welfare support.

Z60
Problems related to housing and economic circumstances
Adjustment to life-cycle transitions, living alone, acculturation difficulty, social exclusion and rejection, target of adverse discrimination and persecution.

Z62
Problems related to upbringing
Inadequate parental supervision and control, parental overprotection, upbringing away from parents, child in welfare custody, institutional upbringing, hostility towards and scapegoating of child, inappropriate excessive parental pressure, personal history of neglect in childhood, z62.819 Personal history of unspecified abuse in childhood, Parent-child conflict, and sibling rivalry.

Z63
Other problems related to primary support group, including family circumstances
Absence of family member, disappearance and death of family member, disruption of family by separation and divorce, dependent relative needing care at home, stressful life events affecting family and household, stress on family due to return of family member from military deployment, alcoholism and drug addiction in family.

Z64
Problems related to certain psychosocial circumstances
Unwanted pregnancy, multiparity, and discord with counselors.

Z65
Problems related to other psychosocial circumstances
Conviction in civil and criminal proceedings without imprisonment and other incarceration, release from prison, other legal circumstances, victim of crime and terrorism, and exposure to disaster, war and other hostilities.

STRATEGY #2

Prioritization

Health plans need to identify the specific unmet needs or social factors to pair that individual with precisely the right resources.

Prioritize the Population

Post data collection, plans need to determine the best way to operationalize a SDoH strategy. It is inefficient to apply resources across an entire population. Some of the resources are inapplicable or irrelevant to certain segments. Consequently, plans need to develop a segmentation strategy that takes into account social needs to assign resources.

Expanding on segmentation, plans need to identify the specific unmet needs or social factors to pair that individual with precisely the right resources. Without this in place, member doubt can develop around the benefit of accessing further services and programs.

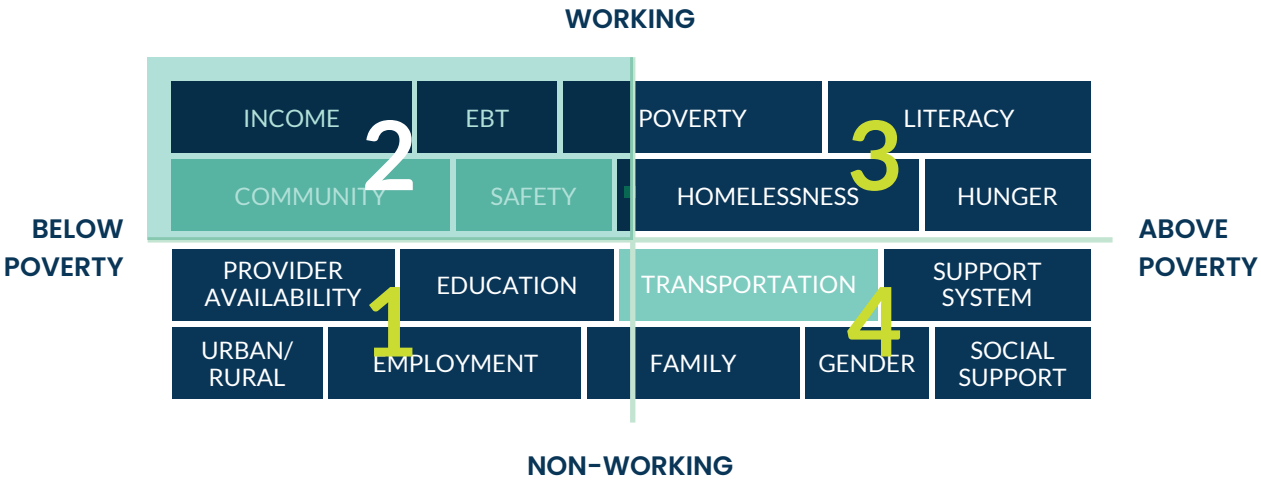
Layer SDoH Factors

For example, for a member like Rosie whose income is below the Federal poverty level and who is unemployed, relevant social factors may include education level, literacy aptitude, and hunger. As a result, resources need to target these specific areas. Less relevant factors may entail a lack of social system support, debt, or safety protections, so a plan should consider foregoing these types of support structures.

COMMUNITY

SAFETY

TRANSPORTATION



STRATEGY #3

Individualize

On paper, two individuals may look identical. But when social factors are layered in, they likely have very different needs and risks.

Meet the Need

Two individuals may look identical when reviewing claims data. When social factors are layered, two individuals with the same conditions and comorbidities may have very different needs and risks. The following is an example of stark differences occurring in a risk profile when conducting a SDoH analysis.[13]

SDoH Factors

When the analysis layers SDoH factors, the two individuals are very different.

LARRY

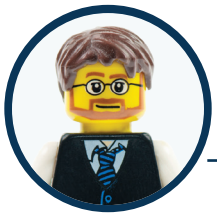
HEALTH & HEALTHCARE
No PAR PCPs / Hospitals within 40 miles

ECONOMIC STABILITY
Average income <$25k

EDUCATION
High school education

SOCIAL & COMMUNITY CONTEXT
Lives alone

NEIGHBORHOOD & BUILT ENVIRONMENT
High crime



BILL

HEALTH & HEALTHCARE
PAR PCPs / Hospitals within 10 miles

ECONOMIC STABILITY
Average income >$150k

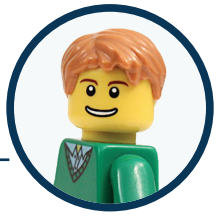
EDUCATION
4-year degree

SOCIAL & COMMUNITY CONTEXT
Lives with spouse and relatives within 10 miles

NEIGHBORHOOD & BUILT ENVIRONMENT
Safe neighborhood

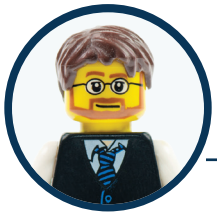
The Real Story of Larry & Bill

The actual risks for each individual are disparate, creating a segmentation and resource investment roadmap. While relevance is critical, it is also important to determine which communication mode is best suited for the member. Some members respond well to calls during the day and others do not. For some, communicating digitally is also an option. However, instrumental to success is appreciating the need for unique member experiences. This step involves precise execution on personalizing communication channels and choosing the best time of day and day of week when engaging members around health actions.



LARRY

Larry has **significantly more risk** than claims only-based analytics tell us



BILL

Bill has **significantly less risk** than claims only-based analytics tell us

SEVERE RISK	HIGH RISK	CHRONIC CARE PROGRAM	LOW RISK
Arrange for alternative living	Weekly phone call	Health risk assessment	Monthly postcard
In-home services	House visit	Monthly nurse call	Wireless invitation
Financial services	Healthcare visits		

STRATEGY #4

Connection

A closed-loop and integrated process will result in a better understanding of gaps and intervention effectiveness.

Connecting people to health.

Connect the Dots

One of the most effective data collection methods involves a closed-loop and integrated process. The result will give the plan a better understanding of gaps and intervention effectiveness of subsequent program needs. This methodology can also include information on the efficacy of the contracted social service organization.

Program results are also important to state governments for a continued understanding and magnitude of social and economic issues. If possible, and consistent with other industry trends, functional outcome data may also be available to analyze behavior.

This category of data is rarely collected from plans since it cannot be captured through claims information. Knowledge regarding returning to work patterns or eating three meals a day provides additional tangible insight into members' health.

For a deeper look into which solutions are most effective and how to collect relevant data, Icario's behavioral research team spent time talking with health plan members in their homes to understand the unique barriers they face. From these interviews, we took away these 6 key insights to help health plans understand and address SDoH more effectively.

STRATEGY #5

Partnerships

Bring social services, community health workers, and other interdisciplinary teams together to engage members.

Connecting people to health.

Create or Partner with Existing Social Programs

Plans are using several different resources or activities to execute on this strategy, such as linking members to social services, community health workers, or other interdisciplinary teams to engage members.

For example, Health Partners Plans, an insurer and provider, has offered home-delivered meals tailored to their beneficiaries' health conditions and dietary needs, resulting in the following:[14]

28%
Reduction in Hospital Admissions

7%
Reduction in ER Visits

26%
Of Diabetic Participants Decreased HbA1c Levels

CareSource, a health plan, provided enrollees with no-cost services for professional development and employment. Of their 392 participants, emergency room visits decreased by 15.5% and there were substantial differences in utilization before and after the program. Pharmacy claims increased by 37%; however, that increase may be an indicator that this population achieved greater medication adherence, which ultimately may lower healthcare costs.[15]

STRATEGY #6

Goverment

State governments are analyzing emerging trends and applying best practices to best address social determinants of health.

Connecting people to health.

Leverage the State

With the increased focus on SDoH, state governments are analyzing emerging trends and applying best practices. Plans can leverage these findings, which can help them systemize efforts to connect members to social support and create a strong integration into primary care. These strategies are also broadening to populations with difficult social issues that may not have been historically categorized as a SDoH.

For example, incarceration can be considered a SDoH for individuals and communities. It can have lasting, detrimental effects on individual health, economic opportunity, educational achievement, family unity, and community viability.

States are developing "front–end" programs (e.g., drug treatment courts to prevent incarceration) and comprehensive healthcare services during incarceration. They also link people to healthcare services after their incarceration to improve health and well-being.[16]

For a summary of various state initiatives and requirements read Icario's The Impact of Social Determinants of Health Guide.

STRATEGY #7

Innovation

States are using regulatory levers to build networks and innovate in the SDoH space.

Connecting people to health.

Champion Innovation

States are using regulatory levers to build networks and innovate. For example, 1115 waivers have allowed states to establish requirements and incentives for developing and implementing unique ideas to address SDoH. States are also requiring an increased level of data interoperability since it becomes difficult to execute strategies without sharing and exchanging health information.[17]

Historical quality and financial performance frameworks, such as pay-for-performance, performance improvement plans, quality improvement programs, and capitation withholds are being extended to organizations implementing SDoH programs.[18]

Similar to the 1115 waivers, plans can leverage the existing regulatory environment to make these programs more innovative and financially viable. States are increasing the number of non-traditional services that a plan can include and covered by its medical loss ratio (MLR) side of the ledger.[19]

The state determines that these alternative services or settings are medically appropriate and a cost-effective substitute for the covered service or setting under the plan. An example could be providing prenatal visits in-home for maternal health purposes. These benefits count towards capitation rate-setting.

Plans may also provide value-added services. These are voluntary extra services and programs unrelated to the Medicaid benefit such as nutrition class and peer support.[20]

CMS significantly expanded a plan's ability to provide supplemental benefits (referred to Special Supplemental Benefits to the Chronically Ill (SSBCI)) that can address SDoH. Examples of these benefits include transportation for non-medical needs, home meals beyond the current allowed limit, food and produce, pest control, indoor air quality equipment and services, and other benefits to address social need.[21]

ADDRESSABLE Strategies

To successfully execute on a SDoH strategy, plans should consider the following approach:

STRATEGY #1

Use all available data. Even a lack of data, in some cases, is data. For example, if an individual is referred to different social service resources, this movement is a data point.

STRATEGY #2

Prioritize the population. The populations requiring social determinant support can be large. As a result, it is critical to have a methodology to prioritize the population. This also helps ensure that the approach matches individual needs.

STRATEGY #3

Meet the need. Different levers exist to match the need and resources to assess an individual accurately and personalize a support program.

STRATEGY #4

Connect the dots. Ensure there is a single point of engagement to understand all the drivers and inputs into assessing health.

STRATEGY #5

Create or partner with existing social programs. Plans should understand relevant social services organizations that can successfully address various needs. This involves knowing the organization's engagement strategies, success, and population mix.

STRATEGY #6

Leverage the state. Plans should leverage state data, financing mechanisms, and regulatory flexibility to support program implementation and operations.

STRATEGY #7

Champion innovation. Some of the best programs have been the result of trial and error. States offer waivers to support new approaches.

Final Takeaway

There continues to be an ever-expanding number of resources covering SDoH. While resource availability is critical, the most central tenant is measurable success. Without that, SDoH programs will face viability challenges and cancellations. So, as organizations continue to push to advance this space, special attention should be placed on bringing the SDoH approaches and results full-circle continuing to challenge and evolve member support.

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[19] 42 CFR § 438.3(e)(2)(2016).

[20] 42 CFR § 438.3(e)(1)(2016).

[21] Icario SDoH PAPER

Icario

Powering over 100 million connections with people, Icario is the leading health action platform that unites whole person data, behavioral science, and digital-first omnichannel pathways to personally connect everyone to health.

Our mission is to move people to do things that are good for them.

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