

## Availability & sufficiency of social determinants of health data

Written by Connance | October 20, 2017

**As the industry moves toward value-based reimbursement models, providers are looking for ways to lower medical risk and improve outcomes, while reducing costs.**

The focus until recently has been on clinical factors such as vital signs, physical health, and medication adherence. However, new data suggests a patient's social factors may more accurately predict care outcomes. These factors, known as Social Determinants of Health (SDoH), include such things as where people are born, live, and work. Research from organizations such as the CDC and the Robert Wood Johnson Foundation find that 75-80% of health outcomes are directly related to SDoH, leaving just 20% for clinical factors. A recent study by Connance supports those findings. It found joint replacement patients with high-risk social factors were 20 times more likely to be readmitted as were those with lower level risk, regardless of their clinical factors. A separate analysis found that high-risk SDoH patients were 65% more likely to miss appointments. Clearly, these surveys demonstrate there is significant correlation between social determinants of health with the quality of care outcomes.

**Who has access to the data, and what do we do with it?**

To determine the current state of accessibility to SDoH data, Connance created the Connance 2017 Clinical Survey, which collected data from 175 healthcare professionals working in inpatient settings across the U.S. The survey focused primarily on case managers, social workers, and clinical executives. The results found 95% of respondents have access to some type of sociodemographic factors on their patients, such as race, language, religion, location, and income. Unfortunately, 90% said the level and completeness of that information was insufficient for use in a meaningful way. More than half agreed that having more insight into the information would be extremely valuable to them in their daily work.

One way to gain added insight is with "person-specific" factors, which go beyond just groups of people. An example would be a patient without transportation who lives in an area that lacks transportation options. With this type of information, patients can be matched to resources and programs that can eliminate barriers to appropriate care. In fact, 92% of respondents rated transportation access as one of most useful socio-demographic factors in

assessing a patient's health risk; without transportation, patients lack the ability to travel to ongoing appointments or fill prescriptions. Alcohol abuse, financial stability, access to food, and the risk of homelessness were also ranked as top factors in assessing a patient's health.

**The right information, in the right place, at the right time**

Providence Health and Services in Oregon has been exploring the best ways to bring SDoH to the point of care. Ann Kirby, Executive Director Care Management, and Shelly Yoder, Program Manager of Community Engagement, say the process has been challenging. Their first challenge was determining what types of information to collect, who should collect it, and at what point in the care workflow it should be collected. To be most impactful, they believe data would need to be gathered pre-hospitalization. The majority of survey respondents agree; 68% said having SDoH information prior to a patient's arrival would be most beneficial, and 58% said collecting it at admission is too late to be fully impactful. Eighty-two percent of respondents said having access to the right person-specific data at the right time would increase their ability to stratify patients based on risk or need, enabling them to focus first on patients with the highest risk.

## SDoH in action

Another challenge Providence has faced is overcoming a patient's hesitance to share sensitive information such as financial status, living situations, and relationships. Pressuring patients for this highly personal information can add to the stress already created by needing a medical procedure. Adding to the challenge was that many admissions staff didn't feel comfortable asking questions for which they had no solutions or resources to offer. Kirby and Yoder needed a way to easily communicate what resources were available. They created the "CRD referral card," a checklist of available services that can be provided by a Community Resource Desk (CRD), which is staffed by a co-located social service organization. Now that admissions staff has the ability to ask questions and provide referrals for services, patients can get the help they need to overcome social obstacles to better health, which results in more impactful care plan development.

As an additional step, Providence is working to enable their electronic medical record to capture and flag SDoH information so referrals can be made directly from the EMR to the Community Resource Desk. Data can be aggregated to provide a picture of which patients are being helped and which services they're receiving. They are also using this information to collaborate with a community partner on transitions out of the hospital for patients whose SDoH indicate they are at risk.

## Elements for success

The results of the Connance 2017 Clinical Survey clearly indicate clinicians understand the need to integrate social determinants of health into a patient's care plan strategy. They believe the ability to identify these factors as early as possible – preferably before admission or an acute episode – would enable them to proactively engage patients before these factors negatively impact their health status.

### **As Providence has found, success requires the following elements:**

- Ask the types of questions so that the data is as specific to the individual as possible
- Focus on factors identified as most impactful (i.e. transportation, alcohol use, financial status)
- Collect information as early in the patient relationship as possible
- Integrate data collection into the care team's existing workflow
- Use data aggregation to flag patients with high-risk factors for proactive intervention
- Leverage SDoH to collaborate with community organizations for transitions of care

While the Connance survey focused on acute care clinicians, there is value in using SDoH data across the entire care continuum. Having the right data at the right time, available at the right place to the right person, can lower medical risk,

improve outcomes, and reduce the cost curbed for all.

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