Applying Social Determinants to Improve Care Coordination

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In today's era of value-based care, providers must focus more than ever on ensuring that patients get the care they need, when they need it, across the entire care continuum, including in non-traditional health care settings. This is important not only as it relates to patient outcomes, but also to providers' bottom lines.

However, when patients lack access to basic care-centric needs like proper housing, food, transportation, and a support system, they're unable to get the right type of care at the right time. These patients in turn frequently have higher rates of ER visits, hospital readmissions, more chronic diseases requiring ongoing care, and limited access to follow-up care.

This is why providers must increasingly pay attention to the conditions in the places where their patients live, learn, work, and play, as these conditions often affect patients' health risks and outcomes – what's called social determinants of health (SDOH). In this article, we highlight the specific care coordination activities which providers should focus on when factoring in SDOH.

Why SDOH Matters

According to CMS Medicaid data analyzed by Waystar, SDOH contributed to 50 percent of readmissions; those with

"transportation access risk" had an average of 41 percent excess days in the hospital; those with "home instability risk" were 32 percent more likely to exceed average hospitalization time.

As new regulatory programs require increased provider accountability for quality, costs and outcomes across a comprehensive array of health care services, a shift in the health care industry is taking place. Specifically, providers are realizing that in order to effectively impact patient care, they must first help patients address their most basic needs. As a result, providers are increasingly partnering with community resources to ensure that patients get the care they need, even when they're not within a provider's facility or direct purview.

Five SDOH Practices to Consider

In conjunction with payers and community-based organizations, providers should consider acting upon some or all of the following five care coordination-related ways of positively impacting SDOH:

1. **Leverage data to identify at-risk patients** – Administer a SDOH self-assessment to patients which asks them to answer a set of questions aimed at determining their level of risk. The SDOH survey results, combined with a range of data sources including claims data, and community-level data, should be leveraged by the health care provider to identify potential at-risk populations and individuals. Artificial intelligence tools can be used to digest large amounts of data and hone in on patterns and key social determinants relevant to a given patient. An individual's specific social determinants will help determine the relevant coordination required to keep that patient healthy and meet his/her basic needs.
2. **Provide accessible preventative care** – Provide patients with access to shuttle services and ride-share programs so that they are able to get to their medical appointments. Telehealth visits make it easier for people in rural areas, lacking transportation, or with busy schedules to access care where they are. Telehealth visits, which have increased exponentially over the past five years, capitalize on the fact that 96 percent of the population in the United States now has a cellphone. Lastly, provide more care options for at home and at community locations, such as community centers, churches, grocery stores, and mobile units. These make it possible to connect with at-risk patients before they arrive in the ED.
3. **Develop a high quality referral network** – Networks of high-quality clinical and social services providers offer patients wraparound services to meet their basic needs and help keep them healthier. Health systems and community agencies can help patients understand what government benefits they qualify for and complete the necessary paperwork to obtain available resources. Connecting patients to resources outside of their doctor's office can help keep patients fed, housed, and out of the emergency room.
4. **Facilitate communication with an integrated technology platform** – Develop an integrated system allowing for real-time communication that is accessible by all parties including the health system, community-based organizations, and patients. Health systems are partnering with tech companies to develop solutions that offer direct communication, track outcomes, create dashboards, enable direct

referrals, and are easy to use on a mobile device.

5. **Manage care coordination and provide support** – Case management can be the greatest opportunity to improve patients' health literacy, provide accountability, and serve as an ongoing resource and advocate for patients. Research has shown that integrated case management significantly improves mental and physical wellbeing. Many patients negatively impacted by their SDOH need an ongoing and consistent support network to navigate social and health needs.

Conclusion

Organizations looking to improve their value-based care and reimbursement are analyzing SDOH to understand their greatest opportunities. By starting with small, pilot care coordination programs targeting SDOH, you can improve others' confidence in the impact of such programs and demonstrate opportunities for larger, longer-term efforts.

