Healthcare Leadership Network
of the Delaware Valley

Bold Steps Forward

Effectively Incorporating SDOH Into Your Health System

by Melissa Fox

Ever since the 1978 landmark Whitehall Study demonstrated the relationship between socioeconomic status and health outcomes, it has been abundantly and consistently clear that addressing social needs should be a critical component of any impactful health offering. The Social Determinants of Health (SDOH) refers to conditions in which people are born, grow, live work and age, and these complex elements contribute to 80% of the factors which affect healthy outcomes, as well as inflating healthcare costs.

A 2000 study examining the number of deaths in the U.S. attributable to social determinants estimated that 423,000 deaths were attributable to poverty, 245,000 were related to low educational status, 162,000 to low socioeconomic support, and 119,000 to income equality.[1] Overall, addressing SDOH as part of an integrated care strategy is a smart approach from both a financial and purely human perspective.

Then, why aren't more physician practices, hospitals and health systems effectively incorporating processes to fully address the social determinants?

Amanda Kimmel, MSW is the Assistant Vice President for Population Health at Jefferson Health in New Jersey, where she oversees clinical integration, Transitions of Care and healthcare innovation. "Long-term funding for community benefits has been a tremendous historical challenge," Kimmel said. "Policy shifts at the local, state and federal level are necessary to fund community benefits and other incentives that promote improved population health outcomes."

Kimmel's finding is consistent with current statistics. A recent survey of 300 hospitals and health systems conducted by The Deloitte Center for Health Statistics revealed that though almost 90% of survey respondents were screening for social needs, the follow-up to those needs tended to be ad hoc or inconsistent. The screening was also limited to very specific populations including inpatient or high-utilizer populations, so there did not tend to be a broad community-based strategy. Most importantly, 72% of respondents confirmed they did not have the resources to address all of the appropriate populations, and that finding sustainable funding to address social determinants was a significant challenge.

The disconnect between appropriate funding mechanisms and the importance of social factors in healthcare creates significant barriers to implementation. However, these challenges also present opportunities for innovative community partnerships which will not only strengthen the network of care, but also improve short and long-term health outcomes for patients. There

are state innovation models[2], ACO's and even Accountable Health Communities, which serve as excellent templates for frameworks to help address social determinants within the context of healthcare.

Technology can also be used to help further the aims of population-based care. "Technology solutions like Aunt Bertha and NowPow can be implemented in physician practices and integrated in the electronic health record to connect patients to community benefits," Kimmel said. "If local community and social service organization also use these solutions, then the referral loop can be closed. These solutions enable users to know if patients have visited the community resources they were referred to. From an interoperability standpoint, both the referring providers and the community organization must be on the same platform in order to close the loop."

Sometimes health systems can partner with other community providers which have the existing infrastructure to address the social determinants more efficiently. One example would be a Federally Qualified Health Center, such as the one overseen by Dinetta Armstrong of Public Health Management Corporation in Philadelphia. Armstrong is the Managing Director of the Specialized Health Services division which includes a network of several FQHC sites. "The mission of Federally Qualified Health Centers (FQHCs) is to be a safety net for marginalized and vulnerable populations," Armstrong said. "FQHCs are in a unique position to address social determinants of health because we realize that attention to these areas are key to improving health outcomes for the population that we serve. At PHMC, we integrated an SDOH screener into the workflow at our health centers. As a result, we are better able to serve our patients by assessing their needs, creating a care plan based on those needs and following up and linking patients to appropriate resources. FQHCs must remain committed to caring for the underserved and that requires that we not ignore the social conditions that impact these individuals' health on a daily basis."

These and other examples demonstrate the great potential which exists for creating partnerships and collaborations to help achieve truly integrated care models.

It is clear that the stakes are high related to the need for incorporating sustainable approaches which address SDOH. Patients' needs are more complex than ever, social factors affecting our communities continue to grow, and health outcomes continue to suffer. By understanding the needs of the communities being served, identifying the social factors affecting care, and either incorporating resources or partnering with other providers to effectively address patients' needs, hospitals and health systems can create sustainable systems of integrated care which include SDOH as a truly actionable component.

[1]Estimated deaths attributable to social factors in the United States.
Galea S, Tracy M, Hoggatt KJ, Dimaggio C, Karpati A
Am J Public Health. 2011 Aug; 101(8):1456-65.

[2]Hester, J. A., J. Auerbach, D. I. Chang, S. Magnan, and J. A. Monroe. 2015. *Opportunity knocks again for population health: Round two in state innovation models.* Discussion Paper, Institute of Medicine, Washington, DC. https://nam.edu/perspectives-2015-opportunity-knocks-again-for-population-health-round-two-in-state-innovation-models/ (accessed June 8, 2017).