Activate Care

Welcome to the **Era** of **SDOH Care**.

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Welcome to the **Era** of **SDOH Care**.

Social needs have long been an important concern in the healthcare space, but only in the past five years have they exploded as a full-fledged trend. The trend isn't going away anytime soon. In fact, we at Activate Care believe that our industry is now five years into a 20-year business cycle – what we call the Era of SDOH Care. Healthcare industry stakeholders and their partners in social services who are looking to improve community health outcomes and reduce total cost of care need to understand what SDOH care means today in order to successfully navigate it.

01.

What influences health today?

The concept of SDOH has long been part of public health practice. Public health practitioners have referenced and consistently used the World Health Organization (WHO) definition of SDOH: the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems.

Our collective understanding of the social determinants of health (SDOH) continues to make headway. We now recognize SDOH as vitally essential components of health and well-being. This way of thinking is increasingly incorporated into care coordination strategies because SDOH is often the barrier that interferes with our ability to achieve our best level of health. Healthcare organizations are now seeking ways to "close the loop" with community-based organizations that are best positioned to address these social needs.

When thinking about social determinants of health, it is important to use the right terminology and to think about the concept holistically, with credit to the Milbank Foundation for helping to distinguish these terms:

- **Social needs:** The circumstances of people's daily lives, such as living and working conditions, and access to money to buy food, clothes, and other basic resources.

- **Social risk factors:** The adverse social conditions associated with poor health, such as food insecurity and housing instability.

- **Social determinants of health:** The circumstances in which people are born, grow, work, live, and age, and the broader set of forces and systems shaping the conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems.

02.

Why is SDOH such a hot topic right now?

Go to any industry event or conference, and you will likely agree that there is perhaps no topic that is more trendy in healthcare today than SDOH. Given the evidence that social determinants impact our health more than the healthcare services we receive, it only makes sense that it would eventually become a hot topic, especially given

the intersectionality between the social determinants of health and the goals of value-based care.

Even though the topic has gained newfound attention among healthcare thought leaders, the social determinants of health have always been present in our communities and still represent a crucial indicator of the health of communities. Today, however, SDOH care is manifesting in new and different ways than in the past, driven by the demands of increasingly aggressive value-based contracts and state and federal policy mandates. Only now are healthcare organizations recognizing SDOH as an important part of competitive strategy for providers, payers, and social services partners.

03.

What is SDOH Care?

SDOH care can be defined as:

The organized provision of care and services to address an individual's complex health and social needs, often delivered in the context of community- and population-level programs that are designed to address social risk factors and, ultimately, the social determinants of health.

There are five core operational components of SDOH care that are organized accordingly:

1. ***Assessment & Screening***
   Capturing individual and family social, financial, medical, and other needs, in addition to patient/family preferences and goals of care.

2. ***Commuity Resource Directory***
   Assembly, maintenance, and curation of social services organizations and providers.

3. ***Referral Management***
   Overarching closed-loop referral process, from healthcare to social services and vice versa, as well as social services to other social services.

4. ***Community Coordination***
   Care planning and project management in coordination with all community and clinical partners.

5. ***Reporting & Analytics***
   Data capture and reporting for referral, service coordination, utilization, trends, and invoicing.

Sizing up the **SDOH Care Marketplace.**

The SDOH Care marketplace is comprised of a wide-ranging amalgam of services and economic sectors that collectively represent $6,270,000,000,000 – that's six trillion, 270 billion dollars, or 33% of US GDP. The trend to incorporate SDOH care programs into the vast health and human services industry has the potential to radically transform the US economy, our job market, and the health of the nation.

In 2018, for the first time in history, the healthcare industry surpassed the manufacturing and retail sectors to become the largest source of jobs in America. There has been a 20-percent growth in health care sector jobs since 2008, while the average rate across the economy was only 3 percent. According to the Bureau of Labor Statistics, health care jobs are expected to grow at a rate of 18 percent from 2016 to 2026, again, much faster than the rate of the rest of the economy. The importance of the healthcare industry to local and state economies across the country cannot be overstated.

In terms of spending, the latest official figures from the US Department of Health & Human Services show that healthcare spending grew 3.9 percent in 2017, reaching $3.5 trillion or $10,739 per person. As a share of the nation's Gross Domestic Product, health spending accounted for 17.9 percent.

Meanwhile, the latest data from the Healthcare Payment Learning & Action Network – which collects the largest and most comprehensive measurement data of this kind – indicate the percentage of health care payments tied to value-based models of care has increased at a steady pace from 23% over a two-year span. The data show that there is sustained, positive momentum in the effort to shift health care payments from traditional fee-for-service into value-based payments. This shift towards value-based payments that incentivize prevention and outcomes rather than service delivery alone has enabled new approaches to addressing upstream, health-related social factors.

Categorizing **SDOH Care Interventions.**

The US Department of Health and Human Services has identified five key areas of social determinants of health. These key areas represent opportunities for health and social care to collaborate. SDOH care interventions may fall into any one or multiple of these key areas and may be designed to address one or more of the underlying factors shown here.

Social Determinant of Health	*Examples of Underlying Factors*
• Economic stability	• Employment • Food insecurity • Housing insecurity • Poverty
• Education	• Early childhood education • Enrollment in higher education • High school graduation • Language and literacy
• Social and community context	• Civic participation • Discrimination • Incarceration • Social cohesion • Community collaboration
• Health and healthcare	• Access to healthcare • Access to primary care • Health literacy
• Neighborhood and built environment	• Access to healthy food and water • Crime and violence • Environmental conditions • Quality of housing

How consumers respond to **SDOH Care Interventions**.

Social determinants of health affect everyone, but effectively addressing them requires participation from the patient. Since it's not traditional to ask a patient about their social, economic, and physical environment, it can be hard to get people to open up about such things and get the answers needed to determine health in this area. According to a survey by SIREN, 83% of primary care and 75% of emergency department respondents thought social needs screening was very or somewhat appropriate, and 66% of primary care and 62% of emergency department respondents were very or somewhat comfortable with screening information being in their health record.

Community health programs that have been created to assist with housing, food, and transportation have shown to reduce costs in hospitals. However, it's essential to consider the patients' perspective on SDOH and what types of experiences they value. It will change based on the community and the person, but that's why SDOH are so unique and essential to health.

In an initiative that funded screening in eight pediatric clinics, parents were initially surprised at the non-medical questions, but would eventually understand and answer. People are generally comfortable with SDOH information being collected and stored in their health record, but efforts to engage patients on these issues can often fall short. The reasons for this can range from failing to ask the right questions in the right way, to not recording data accurately. And, while there is a greater understanding of the importance of SDOH with care providers, consumers generally don't have adequate knowledge of what SDOH are and why they play a role in healthcare. Care providers must articulate the right questions in the right way with a sufficient explanation of the inquiry.

Technology plays a helpful role in adequately storing SDOH data so that information is analyzed and appropriately leveraged in care delivery. What experiences are consumers interested in, and how can they facilitate a useful SDOH screening? In the SIREN study, patients answered SDOH-related questions. The results showed that patients generally appreciate these SDOH questions and are willing to answer them, especially if they trust that the provider cares and is willing to take action to arrange help if necessary.

> *"I think it's important for it to be in the chart because our medical providers then can consider the entire person and not just the symptoms that are coming in..."*

More negative responses revolved around the distaste for information about an individual's personal life being written down and the possibility of that information being shared with the wrong people. The more often SDOH data is projected as what it is – essential healthcare data – then we as patients will more often understand and appreciate these efforts.

SDOH Care Maturity Model.

How can services that address social needs be integrated into clinical care? What kind of infrastructure will be needed to facilitate that integration? To begin answering these questions, the National Academies of Sciences, Engineering, and Medicine assembled an expert committee to examine the potential for integrating social care services into the delivery of health care with the ultimate goal of achieving better and more equitable health outcomes. The resulting report, Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health, identifies and assesses current and emerging approaches and recommends ways to expand and optimize social care interventions in healthcare settings. The report was released on September 25, 2019.

According to the report, there are five complementary activities that can facilitate the success of SDOH care models: awareness, adjustment, assistance, alignment, and advocacy. While all of these activities will ultimately benefit patients, adjustment and assistance focus on improving care delivery provided specifically to individual patients based on information about their social needs. Alignment and advocacy relate to roles that the healthcare sector can play in influencing and investing in social care resources at the community level. All of these delivery and community-level activities are informed by efforts that increase awareness of individual or community-level social needs in a health care system's geographic region or for its attributed population.

"Five A's" of Mature SDOH Care Organizations

1. ***Awareness activities***
   Identify the social risks and assets of defined patients and populations.

2. ***Adjustment activities***
   Alter clinical care to accommodate identified social barriers.

3. ***Assistance activities***
   Reduce social risk by connecting patients with social care resources.

4. ***Alignment activities***
   Enable health care systems to understand their communities' existing social care assets, facilitate synergies, and invest in and deploy them to impact health outcomes positively.

5. ***Advocacy activities***
   Bring together as partners health care and social care organizations to promote policies that facilitate the creation and redeployment of resources to address health and social needs.

Best Practices for **SDOH Care Stakeholders.**

01.

AETNA

Kathe Fox, PhD | VP Informatics

"Our engagement with Activate Care proves that enhanced member engagement supports successful outcomes for all parties involved."

How to mitigate risk and improve care for your most costly members:

In New York City, the International Alliance of Theatrical Stage Employees (IATSE) Local One represents 6,000 entertainment workers who construct, install, maintain, and operate the lighting, sound equipment, scenery, and special effects for Broadway, Radio City Music Hall, Madison Square Garden, and the many television studio sets at CBS, NBC, PBS, and FOX.

Local One members do it all: lights, sound, video, scenery, rigging, and special effects. Their work is physically demanding. Their shifts include long and odd hours. Due to the nature of this work, Aetna knows these members are often hard to reach and difficult to engage. In fact, the engagement rate for Aetna's disease management programs was less than 5% among this population.

In order to make an impact on engagement and utilization, Aetna knew they needed to change how they communicated with members. With a modest amount of effort from the right clinical resources using the right technology, the IATSE community could stay healthier and avoid unnecessary hospitalizations.

Aetna hired a nurse as an on-site Healthcare Coordinator responsible for helping their members navigate the healthcare system – especially those members with chronic conditions and complicated medical situations. Next, they deployed Activate Care with Aetna data feeds and gave the nurse access. Member engagement skyrocketed from 5-15% to 70-80% – resulting in cost savings of $1.4M in under two years.

MARIN COUNTY HEALTH AND HUMAN SERVICES

Ken Shapiro, MSW | Director, Whole Person Care

> *Marin County believes Whole Person Care improves health outcomes in our community while reducing the costs of care. We're able to achieve this by integrating the expertise of care providers across healthcare, public health, social services, and behavioral health, along with other county departments and community providers. Activate Care serves as our collective collaboration hub.*

How to break down barriers for those most in need:

Across the state of California, 25 programs in local communities are focusing on providing better coordination of medical care, behavioral health, and social services for Medicaid members who live with complex health conditions. These people are often homeless, and some have been recently released from prison or jail; many use the emergency department as their first point of care. These innovative SDOH care programs, known as "Whole Person Care" programs, provide social services that wrap around Medicaid benefits in order to improve health and social outcomes, and save money.

According to the California Health Care Foundation:

> *The WPC pilot involves a diverse array of stakeholders, services, and data found within the participating entities, and the needs of the program's target populations are great. Integrating care across sectors is no easy task. The breadth and depth of new partnerships and systemic changes required to truly integrate services across the continuum of care can be dauntingly complex.*

In Marin County, a broad range of stakeholders are committed to the model, including the County's departments of Behavioral Health and Recovery Services, Epidemiology, Social Services, Adult Protective Services, Emergency Medical Services (EMS), and Criminal Justice, and many community agencies encompassing healthcare, behavioral health, and social services across the community. In 2017, there were 1,117 individuals experiencing homelessness. With this model of care in place, 30% of members in the program moved from homeless to housed, which is one-third of their chronic homeless population.

03.

NORTH COAST HEALTH IMPROVEMENT & INFORMATION NETWORK (NCHIIN)

Martin Love | Chief Executive Officer

"Building relationships and trust are fundamental, and it takes time. Social services are not healthcare in a different color; their use cases and supporting IT infrastructure must be co-designed."

How to connect diverse sectors for community collaboration:

NCHIIN is a California non-profit providing both health information exchange and health improvement in Humboldt County. Working with Activate Care, NCHIIN has brought to their county a cloud-based HIPAA-compliant hub for community coordination around complex client cases.

In Humboldt County, CA, individuals who are high utilizers of healthcare are likely to be high utilizers of multiple systems across the county (including law enforcement, social services, education and, justice systems). Martin Love and the NCHIIN team are working across organizations and bridging silos to collaborate and share data across sectors.

Bolstering these emerging efforts is essential to comprehensively supporting high utilizer clients across multiple systems of care, and avoiding high-cost, repeat encounters, as well as poor outcomes for some of Humboldt County's most vulnerable residents.

04.

EAST BOSTON SOCIAL CENTERS

Justin Pasquariello | Executive Director

"Communities across Massachusetts are developing and deploying new integrated program and service models to meet the needs of their communities. We are developing a collective impact approach with our community partners toward a vision of ensuring all children enter kindergarten ready to learn, joyful, and thriving – and their families have the resources they need to support this."

How to make joy a priority in health and social services:

Joy matters. The only way to build a more joyful world is to focus on building more joyful communities. While there are many self-help books and booming industries promoting individual pathways to joy, some research suggests joy has been declining in the US in recent years. This is because joy is not a solo sport.

East Boston Social Centers programs foster strong relationships for people of all ages, allow volunteers and participants to engage with their purpose, support physical fitness, and are rooted in fun as a fundamental element.

Further, their role as a community gathering place enables them to support these roots of joy locally – with specifically tailored community events. The East Boston Social Centers is leading a movement to make East Boston the world's most joyful place—and in so doing, to demonstrate a replicable model for change.

US DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mark Vafiades | Senior Advisor, ONC

"As a country, we need to get community information exchange into and connected to the electronic health record."

How to make interoperability happen across health and human services:

The goals of the Office of the National Coordinator (ONC) are three-fold:

1. Increase innovation and competition by giving patients and their health care providers safe and secure access to health information and to new tools, allowing for more choice in care and treatment.

2. Reduce burden and advance interoperability through the use of United States Core Data for Interoperability (USCDI) standard, new API requirements, and EHI export capabilities for the purposes of switching health IT or to provide patients their electronic health information.

3. Promote patient access through a provision requiring that patients can electronically access all of their electronic health information (structured and/or unstructured) at no cost.

Core to achieving these goals is recognizing that much of the population interfaces with community services in addition to medical services. This includes behavioral health services, group home facilities, shelters, prisons and jails, emergency services, and other sectors of social services. The next step for data interoperability is to get this data integrated into the health system, to make it valuable for care teams and strengthen connections across sectors.

06.

OPEN REFERRAL

Greg Bloom | Chief Organizing Officer

"It often doesn't matter how clever or well-designed a new technology is – if it can't easily work with other technologies (and other organizations and people), then it may not accomplish much good at all."

How to mobilize communities for collective action around interoperability:

Every community faces a similar challenge: there are many different kinds of health, human, and social services that are available to people in need, yet no one way that information about them is produced and shared. Instead, many organizations collect and structure community resource directory data in different ways – yielding redundant, fragmented silos.

As a result, it's hard to 'see' the safety net. Many people never discover services that could help improve their lives. Service providers spend precious time verifying data rather than helping people. And without access to this information, decision-makers struggle to evaluate program effectiveness and health outcomes. This yields underperforming systems that fail people and communities in tragic ways.

Open Referral develops data standards and open source tools that make it easier to share, find, and use information about health, human, and social services. By standards, we mean common ways of doing things. In the case of data standards, that means an agreed-upon set of terms and relationships that define and structure information so that it can be readily transferred between systems. With such common agreements, it can become even easier to leverage existing resources and technology and to develop and adopt new technologies at lower cost and broader possible use.

07.

CAMDEN COALITION

Kelly Craig | Chief Strategy & Information Officer

"Ensure that you can hold true to your model so that every individual you serve receives whole-person care rooted in authentic healing relationships."

08.

CAMDEN COALITION

Victor Murray | Director, Field Building and Resources

"You have to be upfront and transparent about your organization's boundaries and limitations. These will inevitably impact your stakeholder relationships. So what is the vision for your community's collective impact? What would the ideal system or workflow look like that best meets the community's needs? It never hurts to begin by taking a step back and doing this foundational assessment honestly."

The Camden Coalition of Healthcare Providers is a multidisciplinary nonprofit working to improve care for people with complex needs in Camden, NJ, and across the country. The Coalition works to advance the field of complex care by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health.

How to disrupt the cycle of social vulnerability in the lives of patients:

When the Camden Coalition identifies a candidate for its care management services, many patients say yes and enroll immediately. For any number of personal reasons, some patients decline. For those who do enroll, they may "fall out" of the program at any point in time. Based on their experience over the last 18 years, the Coalition knows that if they retain records of all these encounters and conversations with each and every patient, they can prevent that patient from having to re-tell their story, relive their trauma, and re-start a relationship with Coalition staff. Retaining data over time helps Camden stay true to their model of authentic healing relationships.

Camden County, NJ, is the #1 most vulnerable county in the state, according to state health rankings. The Coalition's care management programs are working with extremely vulnerable populations. Naturally, it takes a long time to build trust at the individual and community levels. By retaining an authentic healing relationship with each patient over many years, Coalition staff can direct their energies not just to meeting immediate needs but also to helping patients plan for brighter futures.

Boston Medical Center is New England's largest safety-net healthcare provider and a national leader in creating innovative, upstream solutions to health disparities.

09.

BOSTON MEDICAL CENTER

Megan Sandel, MD | Associate Director, GROW Clinic

"While addressing housing isn't medical work, it's an innovation we need to be part of, just as much as a new technology or type of pill. We see our role in the ecosystem as partnering with other sectors."

10.

BOSTON MEDICAL CENTER

Laurie Douglass, MD | Director of Pediatric Epilepsy

"With Activate Care, our patients will leave the hospital with an enhanced virtual medical home that can be shared with other family members, developmental or behavioral specialists, teachers, and during emergency room visits to better coordinate care."

BOSTON MEDICAL CENTER

Jack Maypole, MD | Complex Care Pediatrician

> *"The number of children with complex, long-term medical needs is growing, and many of these children require care and attention 24-7, so it's important that we continue our team-based care approach with help from Activate Care's tools, all of which leads to improved care, more time at home and in school, less time in the ER or hospital, less family stress, and overall savings in health care costs."*

How to address structural barriers to good health in vulnerable communities, starting in childhood:

About one in 25 children born in the United States experience medical complexity. The population of these children is increasing at a rate of about 5 percent annually – outpacing the population growth rate of children as a whole – in part due to more babies surviving challenges such as premature birth and low birth weight, and improved treatment for conditions such as cystic fibrosis, congenital heart disease, and neurological conditions. Nationally, these children account for roughly 30% of pediatric health costs – $100 billion annually – comprising 55% of all pediatric inpatient and 85% of all pediatric 30-day readmission costs.

Epilepsy can be one such complex condition affecting children and families. Additionally, children facing health disparities often have a high risk of unrecognized seizures and epilepsy. A screening of 900 children at ten years of age showed that a third had not been previously reported to have epilepsy. Nearly seventy-five percent of those with unrecognized epilepsy, or approximately 225 children, came from low-income and/or single-parent families. The need to travel to a metropolitan area for a diagnosis or specialty care, like that required by epilepsy, can place an inordinate burden on patients and families, especially patients with disabilities and those of limited means.

Families who are behind on rent are also at risk of fair or poor health, developmental delays, and are below average in length/height, a marker for under-nutrition. Between the years of 2010-2014, 32% of families with young children interviewed by Children's HealthWatch in the Pediatric Emergency Department at Boston Medical Center were behind on rent during the previous year and 7% of families moved more than twice in the previous year. Previous research links multiple housing moves with increased risks of fair or poor child health and developmental delay.

Across all of these complex health and social challenges, Boston Medical Center has united forces across departments and across Boston's local health and social sectors, to rise to each challenge with comprehensive, evidence-based interventions. Activate Care has helped Boston Medical Center achieve tremendous results in SDOH care:

- *Dramatic improvements in patient and family quality of life, and reductions in utilization*
- *Demonstrable success in improving health outcomes through supportive housing services*
- *Expanded access to specialty care via innovative telemedicine applications delivered by Activate Care*