CIVICA

White paper

Social determinants of health and master data management

Helping patients and clients across healthcare and social services

It has long been established that social and environmental factors have a big impact on people's health.

Economically disadvantaged people – those who are poor or homeless, live in unsafe neighborhoods, or lack access to quality education – are more likely to get sick, be hospitalized, remain hospitalized longer, and be readmitted to the hospital within key quality measure timeframes.

Healthcare providers understand the human impact of these social determinants of health (SDOH). Social service providers, state and local governments and, to some degree, policy makers, have also recognized them. Yet a variety of barriers have slowed progress towards a model that gives service providers, from health to housing to transportation, an actionable "golden view" of their patients and clients — one that could help them provide better and more integrated services, at a lower cost.

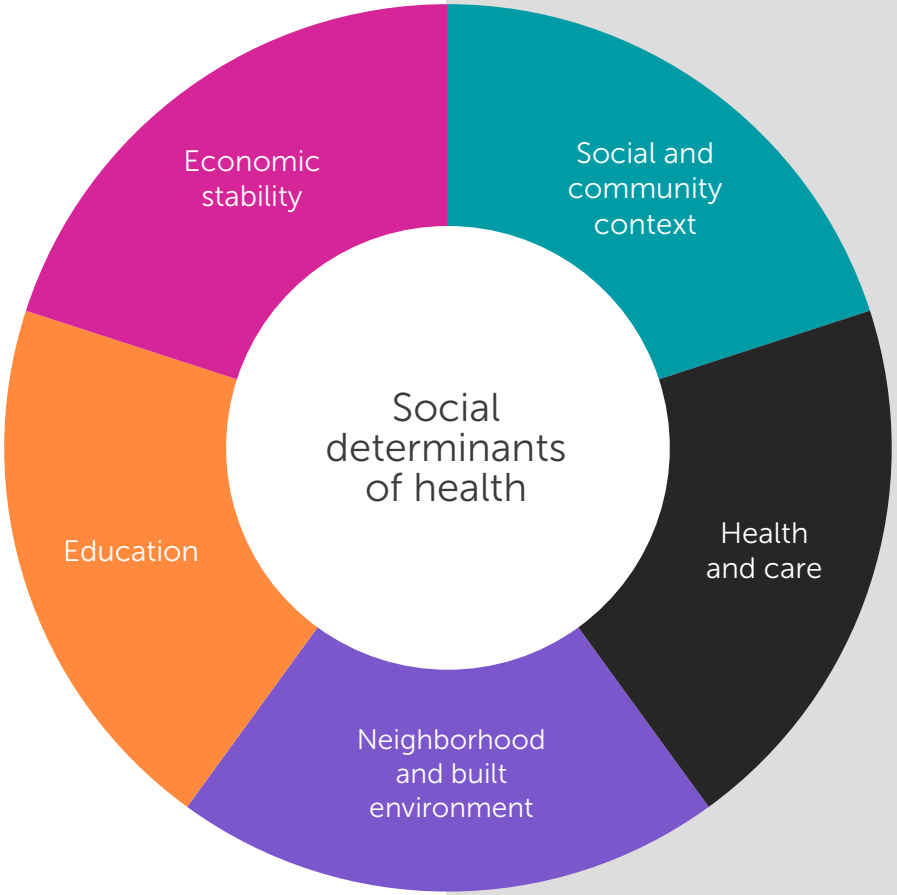
The five key areas of social determinants of health

And the need is there. Results of a year-long pilot reported in the Annals of Family Medicine gathered data on social determinants of health from three community-based clinics. The study, which tested the use of health record-based tools, showed that 97-99% of all patients had at least one documented SDOH need.

But a shift is taking place, as assorted service providers focus more sharply on efforts to stitch together a broader care continuum; one that includes a variety of social services and provides a golden view of the patient and client, one that gives service providers an accurate, holistic, and longitudinal view.

98%

of all patients have at least one documented SDOH need



Source: Healthypeople.gov

Industry steps in

Hospitals and health systems have begun efforts to connect with housing systems by supporting social programs and donating to housing development for homeless or disadvantaged populations.

Corporation for Supportive Housing (CSH) spokesman Robert Fiant told Healthcare Dive that the organization has been approached by several hospitals and health systems asking how they can become involved in supportive housing. In the same article, CSH estimated that healthcare systems have already invested between $75 million and $100 million in projects CSH supports.

With the rise of population-based risk contracts, payers and providers are also incented to address SDOH variables. Diagnostics tools, such as the PRAPARE assessment, a standardized protocol for evaluating a patient's SDOH, could allow providers to consistently collect data that could help mitigate health outcomes, and allow payers to help lower costs in risk contracts. Best in KLAS population health management (PHM) platform, i2i Population Health, is working with clients to integrate SDOH into their quality programs to improve community health outcomes.

With SDOH data, payers can better riskstratify contracts. Using traditional risk adjustment methods such as Hierarchical Condition Categories and Chronic Illness and Disability Payment System could show similar clinical risk for two populations, but outcomes might be vastly different for the population with greater social risks. The payer side of the industry has taken notice: Some eight in ten insurers are factoring social determinants of health into their member programs, according to the 8th annual Industry Pulse survey, taken in 2018. And in what may be a game-changer, the idea of bringing SDOH into healthcare is catching on at a federal level, which is something policy watchers and think tanks have been advocating for decades.

> SDOH has a profound impact on patients and their ability to receive the right care at the right time. Capturing SDOH data at the point of care is the most opportune time to collect the right data."
>
> Justin L. Neece
> President and CEO,
> i2i Population Health

Social determinants of health in the US

567,715 People who experienced at least one night of homelessness in 2020

12.3% People living below the poverty level

12.7% People 25+ without a high school degree

25% Lower income patients who missed or rescheduled appointments because of lack of transportation

Sources: U.S. Department of Housing and Urban Development U.S Census Bureau Journal of Community Health

In 2016, CMS launched a five-year, multi-site national effort called the "Accountable Health Communities Model." According to CMS, the model "will support local communities to address the health-related social needs of Medicare and Medicaid beneficiaries by bridging the gap between clinical and community service providers.... By addressing critical drivers of poor health and high healthcare costs, the model aims to reduce avoidable health care utilization, impact the cost of health care, and improve health and quality of care for Medicare and Medicaid beneficiaries."

The $157 million project will support its 31 participating organizations as they screen for SDOH metrics such as transportation, housing and utility needs, food insecurity, and risk of interpersonal violence. The model then pinpoints high-risk beneficiaries and links them to community services in an attempt to address their health-related social needs.

U.S. Secretary of Health and Human Services Secretary Alex Azar, speaking at a November 2018 symposium, said the administration is thinking seriously about the role social determinants play in health care and social services.

"We are deeply interested in this question and thinking about how to improve health and human services through greater integration has been a priority throughout all of our work," Azar said. He also suggested the possibility that CMS may be able to give organizations more flexibility, so that they might pay a beneficiary's rent if their housing situation was unstable, or give diabetics access to affordable, nutritious food.

Breaking down barriers

One way to help hospitals address social determinants of health is to be sure that patient records include that crucial information.

Civica's Master Data Management (MDM) cloud solution can offer that complete view, allowing health care providers to see the whole context of a patient's circumstances, including their physical and social environments and their financial and housing situation.

Data is pooled from multiple data points or electronic medical records to offer the most complete picture possible. The provider knows about past medical problems as well as income status, safe housing, and access to food. They are aware if their patient has a high-risk occupation, such as working in an industrial environment with exposure to asbestos, that may predispose them to certain medical conditions. They can then recommend more frequent screening exams.

And patients have a higher level of trust because they feel their provider knows their situation and cares about their health. If a provider recommends a certain screening test because they know about a patient's occupational hazards based on access to this type of data, the patient feels cared for and it is easier to establish trust and promote compliance with recommendations – ultimately leading to better outcomes.

When patients engage with healthcare providers early, a provider may be able to predict and prevent a hospitalization or disease state. If a patient's family member has Type II diabetes, the provider may take steps to help prevent the patient and other family members from going down the same path. Providers may recommend earlier screening tests and make a referral to a dietician to encourage lifestyle changes that may help prevent the disease altogether.

That, in turn, saves costs and improves outcomes. If providers know how many patients in their profile have a certain chronic medical condition, take a certain medication, or need transportation to appointments, they can aggregate this data and determine the most effective treatment plan or suggest a screening test that may prevent a hospitalization, and reduce overall costs.

1million

patient records reduced to 80k through duplicate matching and merging for Verinovum

"The good news is, the tools to help support supplying this 'golden view' of people, on a holistic and longitudinal basis, are increasingly sophisticated and able to handle views across providers in a secure yet accessible manner."

Chris Owen, Divisional Managing, Director Digital and Data Solutions

Intervention with MDM

Civica's MDM can also help track details to help more effectively change behavior. For example, motivations for a low-income smoker to quit smoking might be quite different from that of a high-earning smoker.

And knowing communication preferences such as language and preferred mode of communication can help bolster trust and understanding between patient and provider. A recent Patchwise Labs report noted that though only about 4% of health systems and managed care organizations have invested in SDOH referral platforms, representing an $88-92 million market, that figure is expected to grow to 12-15% by 2023.

As SDOH and person-centered data become a consistent feature in the future of healthcare, it's clear that using an MDM solution will help maximize revenue, foster better population health, and allow service providers to act early and effectively in helping individual patients and clients.

4%

of health systems and managed care organizations have invested in SDOH referral platforms

"Well-managed data can be a huge asset to your organization and the people you serve. If you're not managing it correctly, then by default it's a liability because you don't know what you're dealing with. By managing your information, you can gain insights and turn the data into an asset."

An-Chan Phung, Chief Innovation Officer
Civica

Create a complete, accurate and sharable customer view with Civica MultiVue

To find out more and book a demonstration
email **sales@civicaus.com**

Cert No. 663
ISO 9001, ISO 27001, ISO 22301, ISO 14001,
OHSAS 18001, ISO 20000

INVESTORS IN PEOPLE™
We invest in people Gold

CIVICA

civica.com

sales@civcaus.com

linkedin.com/company/civica-us

/CivicaUS

@civicaMDM