EXECUTIVES FOR HEALTH INNOVATION

INCORPORATING SDoH INTO COMMUNITY HEALTH PROGRAMS

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INTRODUCTION

Over the last decade, researchers have identified how social determinants of health (SDoH) impact vulnerable communities. Social determinants of health are the nonmedical factors that influence health outcomes. It's generally agreed that SDoH factors can be broken into five categories: education access, quality healthcare, strong neighborhood and built-environment, economic stability, and social and community context. SDoH data provides an additional layer of valuable information to help clinicians and public health experts better understand their populations. Community Health Programs (CHPs) are continuing to incorporate elements of SDoH into their work serving patients.

Collecting and properly using population data is the foundation to a successful and sustainable community program. One of the most difficult elements of community health programs is analyzing data to identify people who need services. Many vulnerable populations do not regularly visit doctors' offices or sign up for preventive care programs. SDoH data can be invaluable for identifying at-risk individuals and targeting care. More robust data improves targeted outreach to engage the individuals who can most benefit from community programs. With improved targeting of services, community programs can thrive, expand and truly scale.

Recently, Executives for Health Innovation (EHI) spoke with experts in SDoH and Community Health Programs to explore the use of SDoH in CHPs. Many of these groups are incorporating EHI's Principles for Ethical Use of SDoH. This paper provides an overview of the important elements of incorporating SDoH into a community health strategy. An example of an Organizational Maturity Model (OMM) is also provided to assess the use of SDoH in a community health program's growth and potential for sustained progress.

PRINCIPLES FOR ETHICAL USE OF SDoH

To appropriately utilize SDoH data and positively impact patients, CHPs must take precautions when collecting patient health and environmental data. When patients share their data, they are entrusting that it will be protected and leveraged by their care team to identify barriers to care and enhance their health outcome. Beyond the directed efforts organizational leadership employs to ensure data is collected properly and consistently, a CHP's workforce must also be trained to make ethical decisions regarding patient's SDoH data.

In 2019, Executives for Health Innovation (EHI), with support from LexisNexis® Risk Solutions released the Guiding Principles for Ethical Use of Social Determinants of Health Data, which proposed recommendations for the ethical use of SDoH data by healthcare organizations. The Guiding Principles helped inform the development and optimization of SDoH interventions and services. The Guiding Principles focused on five principles, which were recently updated to include:

1. Coordinate Care
2. Recognize Risk Through Analytics
3. Map Needs to Resources
4. Determine Best Fit
5. Assess Impact

The Guiding Principles help CHPs understand the appropriate ways to incorporate data into care when working with vulnerable communities. Similarly, it is important for CHPs to identify specific barriers to care as well.

IMPORTANCE OF SDoH IN IDENTIFYING BARRIERS TO CARE

Understanding barriers to care is critical to addressing health outcomes in vulnerable communities. Without a true understanding of SDoH factors, CHPs have little hope of addressing the causes for gaps in care. It has been well documented that SDoH factors often interfere with an individual's access to care.

Up to 80% of health outcomes can be traced back to the conditions of a patient's environment. (source) An ASPE HHS report states that "socioeconomic factors such as poverty, employment and education have the largest impact on health outcomes" (source). Studies find that US adults face both affordability and non-financial barriers to care: 18% and 21% respectively. (source) Lack of employment is shown to lead to much higher diagnoses for "stress-related illnesses such as high blood pressure, stroke, heart attack, heart disease and arthritis." (source) On top of that, an individual's level of education is linked to disparities in employment because it "affects the type of work people do, the working conditions they experience, and the income they earn." (source) In addition, Individuals with less education are "more likely to have jobs that are physically demanding or include exposure to toxins." (source)

While these statistics don't highlight every aspect of health inequality, it showcases that barriers to care and negative health outcomes aren't always directly connected to medical care.

Without understanding the challenges that patients face acquiring quality care, gaps in health equity will only grow. For example, people without public transportation may be unable to travel to a doctor's office. Similarly, individuals unable to take time off from work may fail to regularly see their healthcare practitioner. Both examples demonstrate a lack of access due to an SDoH – not a medical reason. Many barriers of care in vulnerable communities are due to similar SDoH factors. Therefore, a study of an organization's population should focus on barriers to care, such as those outlined below.

TRACKING THE POLICY LANDSCAPE

Recently, federal legislators and regulators have begun to address the importance of social determinants in health. While the 118th Congress is still working to develop and introduce SDoH legislation, looking back at the 117th Congress can predict what may be in the pipeline.

- S. 509/ H.R. 6072: Leveraging Integrated Networks in Communities (LINC) to Address Social Needs Act. This bill as introduced would "assist states in establishing statewide or regional public-private partnerships to better coordinate health care and social services, leveraging local expertise and technology to overcome longstanding challenges in linking people to health, food, housing, child development, job training, and transportation supports and services." (source)

- H.R. 2503: Social Determinants Accelerator Act of 2021. This bipartisan act was written to address ways to "help states and communities devise strategies to better leverage existing programs and authorities to improve the health and well-being of those participating in Medicaid." (source)

In addition to the federal government, regulators are beginning to make efforts to close the health equity gap, too. The Department of Health and Human Services, for example, has "committed to addressing inequities and advancing equity through assessing and changing policies, programs, and processes across the Department." They're also working to "shift the culture, resources, approaches to institutionalize and sustain a focus on equity over time." (source)

The Centers for Medicare and Medicaid Services (CMS) recently released a Framework for Health Equity. The Framework "provides a strong foundation for [their] work as a leader and trusted partner dedicated to advancing health equity, expanding coverage, and improving health outcomes" by "strengthening [their] infrastructure for assessment, creating synergies across the healthcare system to drive structural change, and identifying and working together to eliminate barriers to CMS-supported benefits, services, and coverage for individuals and communities who are underserved or disadvantaged and those who support them." (source)

Leadership within HHS has developed an Equity Action Plan, which highlights components of policy and programmatic decision-making to help advance equity in healthcare. On top of this actionable plan, the HHS Strategic Plan for FY 2022-2026 includes five strategic goals. Importantly for SDoH, Strategic Goal 1 is to "protect and strengthen equitable access to high quality and affordable healthcare." Though each objective within this Goal is crucial to the entire Strategic Plan's success, an example of an opportunity for significant change to community-based healthcare is Strategic Objective 1.3: "Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health." (source)

For a while, providers were frequently seeing affordability barriers when treating their patient's wholistically. While they often wished to address SDoH issues as a part of a patient's care plan, payers were unlikely to cover the cost of these services, making it unrealistic. However, due to updated guidelines in 2018 of the ICD-10-CM (the system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the US (source) led to a more widespread utilization of Z-codes by clinicians to capture data on the social needs of their patient population. This helps identify "non-medical factors that may influence a patient's health status." (source) As CMS is the largest payer in the U.S., their announcement to reimburse SDoH-related Z-codes and their wide-spread influence of coverage has led to real social policy change.

A MATURITY MODEL FOR ASSESSING SDoH PROGRAMS

Assessing the growth of CHPs is critical so that programs can be refined and improved. Organizational maturity models can help communities assess program progression. Serving as a guide, public health experts and policymakers can better understand their work to date, as well as where to focus future resources. One maturity model, developed by LexisNexis Risk Solutions (LNRS) Organizational Maturity Model (shown in figure 1 below), provides four different stages of development.

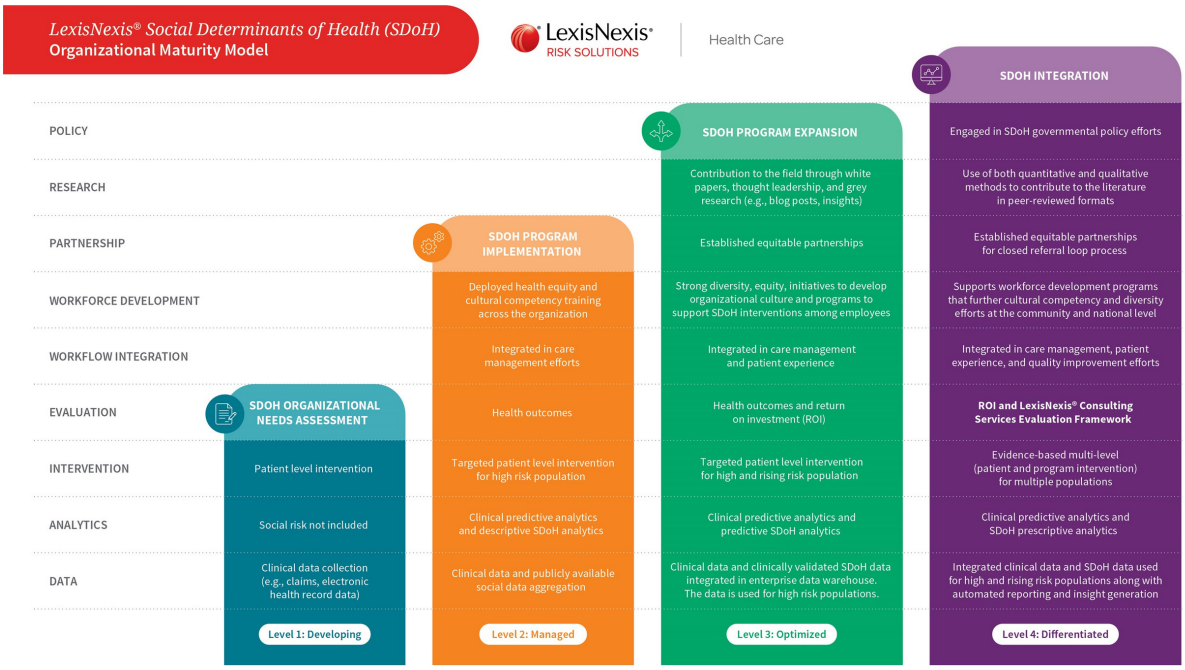

Figure 1

Figure 1 is broken down into four different stages. Along the side of the table shown in Figure 1, are key additions to an organization's program as they develop.

- **Stage 1: Developing** - SDoH Organizational Needs Assessment
- **Stage 2: Managed** - SDoH Program Implementation
- **Stage 3: Optimized** - SDoH Program Expansion
- **Stage 4: Differentiated** - SDoH Integration

Maturity models are tools that will guide an organization's program towards success, but it takes time and patience to ensure that a solid foundation is built before progressive sustainability is an option. Organizational leaders should commit to assessing their efforts against each stage of the Organizational Maturity Model. Ideally, each stage builds upon each other, however, programs may achieve elements of latter stages without completing the prior stage. For example, you could begin to establish community partnerships prior to developing predictive analytics.

"[When assessing your program,] you have to [ensure that it has] all five 'rights'… this means getting the right information, in front of the right person, at the right time, in the right way and for the right reason." - Andrea Green, MBA, RN, Director - Provider Strategy, LexisNexis Risk Solutions.

Most companies that look to improve their program through an organizational maturity model have already begun a community program. It is likely programs may have staff hired, rules and processes running and population data collected – and they might feel ready to start Stage 2 (program implementation) and dive into addressing health equity. However, experts suggest that it is important to fully assess your efforts at each stage.

COMMON CHALLENGES

Many CHPs struggle with program implementation (Stage 2). They may inadvertently miss important processes that will create problems almost immediately. For example, workforce development, engagement and education are critical to a well-performing program. If the workforce doesn't understand why they are adding extra steps and tools into their already crammed workflow, it's difficult to maintain a program's foundation.

> "Your frontline staff should be well versed in health equity, cultural competency, and diversity and inclusion, otherwise the foundation under that house is more fragile and may not be stable or even sustainable." - Andrea Green, MBA, RN, Director - Provider Strategy, LexisNexis Risk Solutions.

If staff aren't educated on the intent or goals for program outcomes, for example, this can cause problems in data collection and analysis which in turn lead to irregularities in SDoH interventions and overall equity efforts. To ensure an organization becomes a true industry leader in research and other outcomes, staff must be well-versed in health equity, cultural competency, and diversity and inclusion. Otherwise, these irregularities can cause a breakdown in program organization.

There are many tools to help build diversity and inclusion culture into your organization. For example, the American Hospital Association's Dashboard for Health Equity, Diversity & Inclusion Measures for Hospitals and Health Systems, can be a great place to start the development of high-standard staff training. (Source)

(Source: ifdhe.aha.org)

Organizations that are slow to change or skip steps during foundation development (Stage 1) may have challenges maintaining positive health outcomes, ensuring cost savings, and managing care plans for patients with chronic conditions. Many successful CHPs understand that patients want to been seen and treated as whole people. For example, community health organizations in Boston, MA are partnering with Fresh Connect, a "tech-enabled food prescription program that empowers people with the money and flexibility to buy the foods they need to be healthy." (Source)

Some payer organizations are working to cover their patient populations in a more wholistic way. Examples include Humana's Healthy Options Allowances, and UnitedHealthcare's Healthy Food Benefits.

Starting the Conversation and Implementation

It can be difficult to know where to start; most organizations have started to build a foundation for their program, so none of the organizations, before using a maturity model, will be at the same starting line. Each community organization has their individual factors to consider; the variety of staffing, budget, resources, and population ensures that there is no one single way to start.

An evaluation of the program and its potential must be completed by leadership and staff; this will guide the initial organizational decisions. This evaluation must be an honest examination of the organization's factors and facets. It's paramount that every step be taken and every process completed; even the smallest brick will be important to the program's foundation.

Decision makers should be given an overview of the model's expected return on investment (ROI). As with any big changes within a large organization, this investment will need to be budgeted for in advance, and it helps to review the beneficial outcomes. As evidence of an organization's individual maturity model, ROI will be difficult to produce before use. Research into other successful community programs will be beneficial to the conversation.

Use cases are a great way to develop an ROI analysis and qualitative measures. They can inspire qualitative assessments that may be implemented in an organization. During this research, it's important to pay attention to similarities in a use case's population and other factors. This ensures that ROI analyses are truly predictive of an individual program. While no analysis can be entirely sure, controlling for factors like budget, patient population makeup, staff size and program age will be defining to overall outcomes.

USE CASE

Community Health Innovations for Sinai Urban Health Institute (SUHI)

SUHI's community population is historically marginalized, overburdened and under resourced. Community Health Innovations for Sinai Urban Health Institute (SUHI) is the community-engaged research arm of Sinai Health System in Chicago. They deal with a multitude of challenging issues such as chronic disease, violence, structural racism and many other social challenges. To best care for this population, SUHI's community health workers (CHW) "engage the community in every step" [of the program's development].

"To improve health equity among the populations, we serve…[our team] goes outside of the hospital walls. [This allows us to] really engage the Community every step of the way, to really understand and provide context to the health equity data that our organization and others collect. [It also] harnesses the Community's [own] assets and really prioritize needs, based on the input of the Community." Stacy Ignoffo, Executive Director of Community Health Innovations, Sinai Urban Health Institute (SUHI).

SUHI has been able to expand their CHW program to better, and more thoroughly, serve their population. SUHI's CHW teams are often individuals who have a close understanding of the communities they serve. Some CHW have shared experiences with others inside the community, but SUHI also works diligently to ensure that all CHW are "trained intensively in core skills including cultural competency, motivational interviewing, conducting home visits, and working with healthcare providers to navigate a complex system."

The SUHI CHW program is expanding their work into many important areas, including community referrals and addressing the social needs of patients once they've been discharged. But without a strong foundation, and thoroughly trained staff, SUHI's program would crumble as it grew. The tools and assessment skills CHW's learn help deter irregularities in data collection through competency training and a concerted effort to understand their community -- and with this basic foundation, they are able to truly help their community [in the best way they can.] To learn more about SUHI's mission for achieving health equity within their patient population, and their Community Health Workers, go to sinaichicago.org.

CONCLUSION

In the end, it all comes down to efforts made by organizational leadership to 'do it right.' With the negative health outcomes facing vulnerable populations, it is understandable why CHPs want to quickly jump into action delivering interventions and services. However, CHPs should take time to assess their progress in developing their program. Without a foundation built on targeting at-risk individuals, community health programs can waste valuable resources and become ineffective. While the time and effort put into the implementation may be slow and potentially financially challenging, the research shows just how beneficial guidance and measurement can be in the long run. Strong programs that continue to produce positive health outcomes within vulnerable communities are the backbone to meaningful change within the entire healthcare industry. All patients, in all communities, deserve to be cared for meticulously and holistically – and by providers who 'do it right'.

About Executives for Health Innovation

Executives for Health Innovation (EHI) is a catalyst for healthcare transformation, convening diverse leaders from across the industry to unlock opportunities for collaborative innovation. EHI, along with its coalition of members, focuses on education, thought leadership, and advocacy. We believe that innovation and diverse perspectives power the transformation of healthcare. Our members are working toward consumer-centered health that is lower cost, higher quality, and more accessible for all populations. www.ehidc.org

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EHI thanks LexisNexis Risk Solutions for their generous support of this report and their continued support of our organization's work in realizing a society where everyone has a fair and just opportunity to be as healthy as possible.

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