

## Tackling Social Determinants of Health

Jennifer Covich Bordenick Chief Executive Officer eHealth Initiative & Foundation



### eHI's Mission

To serve as the industry leader in **convening executives** and multi-stakeholder groups to **identify best practices** that **transform healthcare** through the use of technology and innovation





### eHI Leadership Council

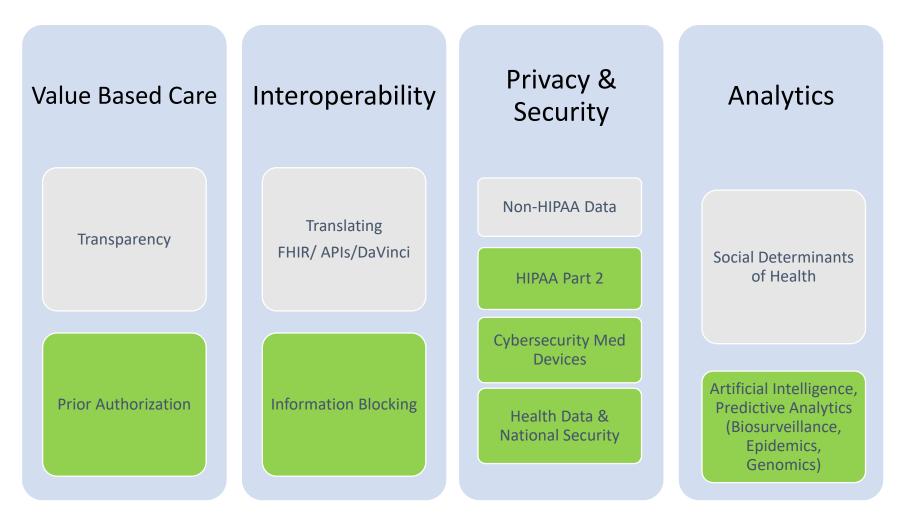








### **Current Areas of Focus**





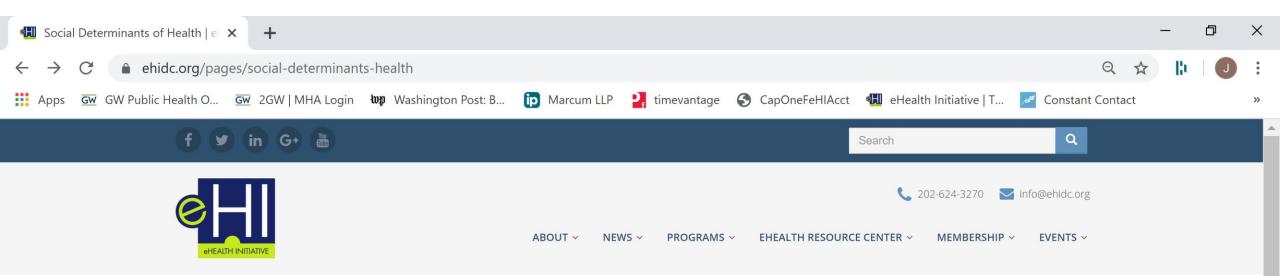
# eHealth Resource Center

- Best Practices
- Reports
- Surveys
- Policy Briefings
- Comment Letters

#### **Thousands of Resources**







#### Social Determinants of Health

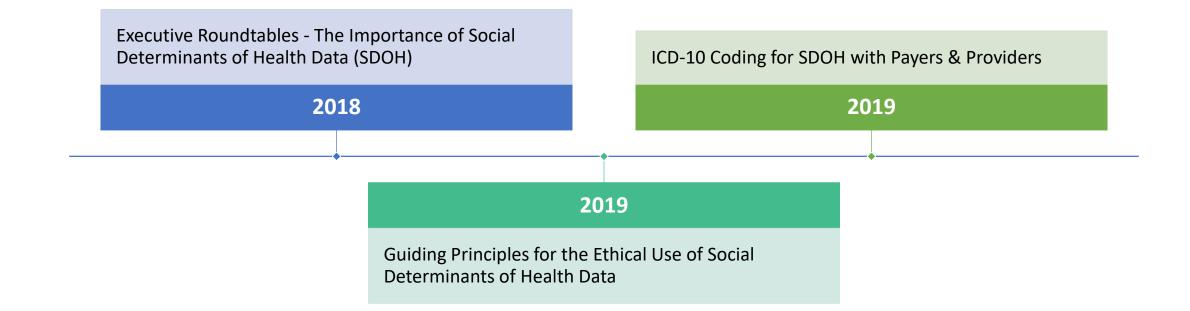


#### What are Social Determinants of Health (SDOH)?

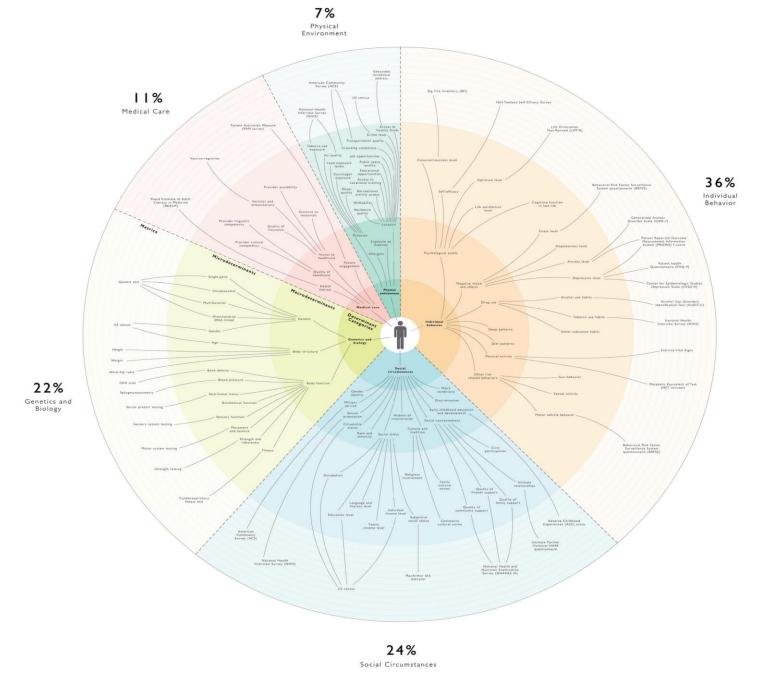
Health encompasses many facets of our lives and is more than physical well-being. Health begins in our homes, neighborhoods, schools, communities, and workplaces and is influenced by a number of factors. According to the World Health Organization, "social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels."

v

## eHI's Support of SDOH 2018-2020





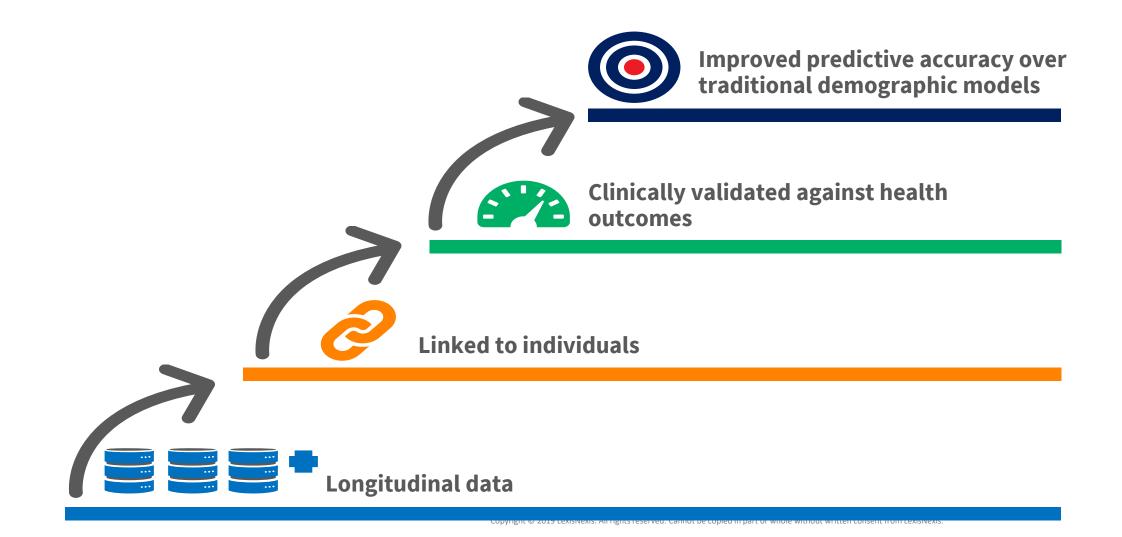




www.ehidc.org

#### determinantsofhealth.org

#### The logic behind optimizing SDOH data





#### The evolution of SDOH approaches



1st Generation

**Effort:** County or zip code level "community" insights **Problem:** Wide variance in social factors at the community level





Effort: Patient-level data not specifically designed for healthcare from non-clinical vendors
 Problem: Data dumps that typically address only one category of SDOH, frequently with little correlation to health risk





A source of data that addresses multiple categories of SDOH and can Next Generation deliver increased lift over existing models while decreasing time to value

Copyright © 2019 LexisNexis. All rights reserved. Cannot be copied in part or whole without written consent from LexisNexis.





# 2019 Guiding Principles for Appropriate Use of Social Determinants

A Collaborative Project

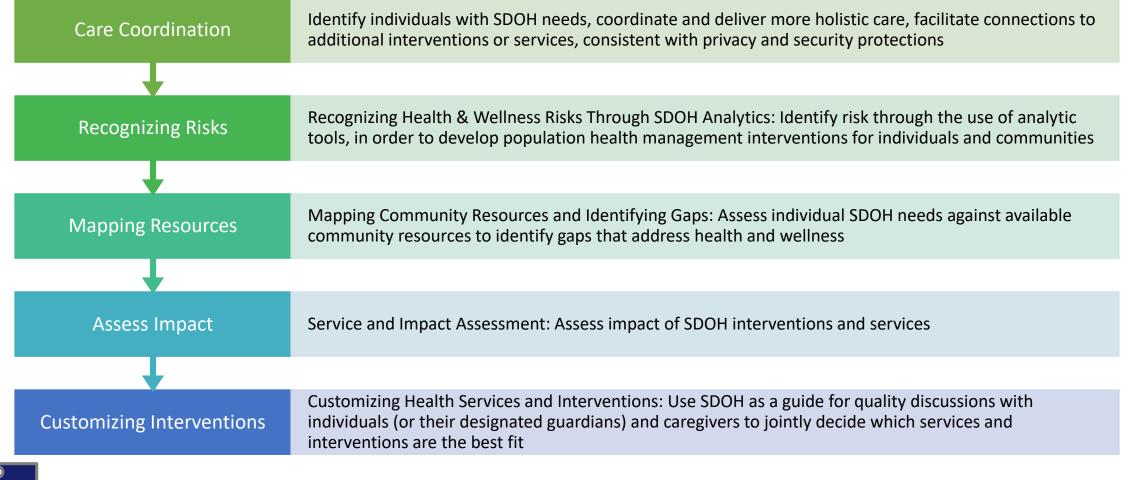
### **Participants**

- AHIMA
- AHIP
- Allscripts
- Amazon Web Services
- American Cancer Society
- American College of Cardiology
- American College of Physicians
- American College of Radiology
- Anthem/ HealthCore
- athenahealth
- BDO
- Care Compass Network
- CareSource
- Cerner
- Change Healthcare
- CHRISTUS Health
- Cognizant
- CRISP
- eHealth Initiative

- EHNAC
- Epstein Becker & Green
- Google Cloud at Google
- GWU
- HL7
- Hogan Lovells
- Inovalon
- InterSystems
- Johnson & Johnson
- LexisNexis
- LifeWIRE Corp
- Manatt Health
- Marshfield Clinic Health System
- Mayo Clinic Foundation
- MedAllies
- MGMA
- National Alliance of Healthcare Purchaser Coalitions
- NextGen Healthcare
- Noridian Healthcare Solutions

- Ohio Health
- Orion Health
- Point-of-care Partners
- PricewaterhouseCoopers LLP
- Providence St Joseph's
- Salesforce
- Solera Health
- Sonora Quest Laboratories/Lab Sciences of AZ
- Strategic Interests, LLC
- The University of Chicago Medicine
- Updox
- Validic
- Verato
- Well Doc, Inc.
- Wellmark
- Zipnosis, Inc

#### Guiding Principles for Appropriate Use of Social Determinants



#### **Care Coordination**



Identify individuals with SDOH needs, coordinate and deliver more holistic care, and facilitate connections to additional interventions or services, consistent with privacy and security protections

- Better care management and personalized care
- Provides meaningful insights into circumstances that directly affect the health and well-being of individuals
  - Food security, transportation, employment, and housing, offers
- With the right patient data, providers, community health workers, and other key stakeholders can create personal care plans that combine both medical and SDOH needs, ensuring patients have what they need to successfully follow their care plans.
- SDOH data should be collected, maintained, used and disclosed in accordance with privacy and security protections.





#### Recognizing Risk Through SDOH Analytics



Identify risk through the use of analytic tools, in order to develop population health management interventions for individuals and communities

- By leveraging their SDOH data, a healthcare stakeholder may be able to predict if an individual is at an increased risk of a certain adverse health outcome, such as being readmitted to the hospital or not adhering to a medication regimen and coordinate the appropriate action.
- In preparing a predictive model, it is important that data used in algorithms ensure accuracy and relevance related to use cases.
- Important that choices made about modeling and analyzing data elements are free from bias. Standardization may be a means to help eliminate potential bias and discrimination.





# Mapping Community Resources and Identifying Gaps



#### Assess individual SDOH needs against available community resources, to identify gaps that address health and wellness

- SDOH data positions healthcare and community stakeholders to be able to map existing resources in the populations they serve.
- This data can be used to identify resource gaps so new programs and interventions can be developed to adequately address population-level care obstacles.





# Service and Impact Assessment

#### Assess impact of SDOH interventions and services

- Stakeholders should measure and monitor SDOH interventions and their correlations to better health outcomes, specifically whether the intervention positively impacts the SDOH needs and related health outcomes.
- There should be standard processes in place for tracking referral outcomes. These processes are needed to coordinate between social service organizations and healthcare stakeholders in order to evaluate and track results and make any necessary adjustment to the interventions.





#### Customizing Health Services and Interventions

Use SDOH as a guide for quality discussions with individuals, or their designated guardians, and caregivers to jointly decide which services and interventions are the best fit

- It is important to involve potentially impacted individuals in the discussion when SDOH is being used to improve their care.
- This includes educating individuals on how their SDOH impact their health, reviewing interventions and services available to help, and jointly agreeing on next steps.





# ICD-10 Coding for Social Determinants of Health

#### Collaborators

- Aetna
- American Health Information Management Association (AHIMA)
- American Hospital Association (AHA)
- eHealth Initiative
- Higmark Health
- Humana
- Kaiser Permanente
- Missouri Hospital Association
- National Committee for Quality Assurance (NCQA)
- OptumCare
- UnitedHealthcare
- UnitedHealth Group
- URAC





## What is it?

eHealth Initiative and UnitedHealthcare's (UHC) National Strategic Partnerships Division convened a collaborative meeting of leaders from payer organizations and other stakeholder groups to address the use of ICD-10-CM codes for capturing SDOH data. This meeting marked a significant milestone in the shift to value-based care. Despite the competitive nature of healthcare, the private sector is working together to address factors pertinent to patient care and well-being in a sustainable, scalable manner.



#### Resources Related to Project

- ICD-10-CM Coding for SDOH project
  summary
- <u>eHI Explains ICD-10-CM Coding for</u> <u>Social Determinants of Health</u>
- <u>Coder Tool Transforming health care:</u> <u>Why including SDOH codes on claims is</u> <u>critical</u>
- <u>Provider Tool Using SDOH coding to</u> <u>transform health outcomes are</u> <u>available for use</u>



### Today's Agenda

