Helion Bulletin
Issue 6

Moving Toward Health Equity by Addressing Social Determinants of Health

Health care organizations nationwide are focusing efforts on achieving health equity — giving all people the chance to achieve their full health potential. It's a lofty goal that entails helping both patients and communities overcome social determinants of health (SDOH), the economic and social conditions that influence differences in health status.

Addressing SDOH is vital in improving patient outcomes and reducing health differences within the community. For health care organizations, taking steps to improve population health will also eventually lead to lower health care costs.

What are social determinants of health?
According to the U.S. Department of Health and Human Services (HHS), SDOH are "the conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." Put simply, if someone doesn't have access to basic needs such as healthy food, regular paychecks, or transportation to health appointments, that person's health may suffer. And these scenarios are not the only social determinants affecting communities.

HHS groups SDOH into five domains (areas): economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

Some specific social determinants may include:

- Child care access
- Employment
- Financial strain
- Food insecurity
- Health literacy
- Housing stability
- Safety
- Social connections
- Transportation

For providers, the framework for addressing SDOH aligns with the idea of value-based care: taking proactive and individualized measures leads to better patient outcomes and lower care costs.

Highmark Health's approach to addressing social determinants of health
Highmark Health is working to address social determinants of health within its own network and community under the leadership of Nebeyou Abebe, senior vice president, Social

Determinants of Health. The biggest challenge, according to Abebe, is conveying the massive impact that SDOH have on our patients' health.

"Research shows that 80% of health and well-being is driven by SDOH. Only 20% is driven by health care," he says. "Until we identify and address social risks within our member and patient population, we won't truly achieve performance and quality measures or bend the cost curve."

To address SDOH, Abebe and his team continue to develop their strategy, which includes:

Empowering providers to assess patients for social determinants
To meet the social needs of patients, providers need to be aware of the risks each patient faces, adjust clinical care to address those needs, and connect patients with community resources. Highmark Health helps providers with these tasks by offering complimentary tools that include:

- **Universal SDOH assessment:** This assessment surveys patients about the social needs and risks they may be facing. It includes core questions centered around nine domains of SDOH.
- **Community support platform:** Once providers identify a patient's social determinants, they can search the Community Support Platform, powered by Aunt Bertha, for local services specific to the patient's needs. Some agencies on the platform allow providers to conduct a direct referral.

  Highmark Health and Allegheny Health Network (AHN) introduced the SDOH tools about a year ago and continue to receive a positive response. According to Abebe, the Highmark Community Support Platform and AHN Community Support have recorded more than 100,000 searches. "The top searches were within the domains of health literacy, food, housing, transportation, and social isolation," he says. "Providers are performing assessments and making connections to relevant resources, and it's very promising."

Engaging with community partners to improve health equity
To address social determinants of health within a community, the Highmark Health team partners with community benefit organizations (CBOs). The partnership helps resolve the needs identified by the Universal SDOH Assessments.

"We work creatively with our CBO partners, whether it's the business community or local philanthropy," Abebe says. "Together, we devise evidence-based strategies we know will move the needle with respect to population health. Our goal is to help advance the work they do in their respective communities."

Implementing the strategy for SDOH in post-acute care

The next step for Highmark Health is working with Helion to address SDOH with post-acute care (PAC) providers. According to Kevin Knaus, LCSW, CCM, Helion's senior clinical program manager, they will be piloting the SDOH strategy (including the Universal SDOH Assessment and Community Support Platform) in five Allegheny County nursing homes.

As part of the planning, Helion is developing SDOH training for network providers and network performance managers. "It's important for PAC providers to understand SDOH and its impact on patient outcomes," Knaus says. "Addressing SDOH directly relates to health care costs and providing good patient care. After we collect information on the most frequently requested services, we'll see where the gaps are so we can address needs on a community level."

Knaus expects to have all PAC providers and facilities utilizing the Universal SDOH Assessment and Community Support Platform within the next few years. "Our goal is to get everyone the care and support they need," he says. "In the end, it will reduce readmissions and help us decrease costs."

Preparing for a future focused on addressing SDOH

The belief that health equity plays an integral role in health care is not new. But moving toward health equity by addressing SDOH is a direction that is gaining steam.

Centers for Medicare & Medicaid Services (CMS) now offers value-based programs that have evolved to include social risk. Large foundations are also coming aboard, offering grants for the development of programs related to SDOH. This past May, the Richard King Mellon Foundation awarded Highmark Health a $5 million grant to create and deploy personalized health support programs and increased access to such services.

"The focus on social risk is here to stay," Abebe says. "All of Highmark Health's SDOH initiatives will better position us as SDOH mandates and expectations increase over time. And hopefully our findings while implementing these initiatives will help advance this work for everyone."

To learn more about Highmark Health's SDOH initiative, contact Nebeyou Abebe, senior vice president, Social Determinants of Health: Nebeyou.Abebe@highmarkhealth.org. For more information about how Helion plans to implement the SDOH strategy with PAC providers, contact Kevin Knaus, LCSW, CCM, Helion's senior clinical program manager: Kevin.Knaus@helionhealthcare.com.

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