WORKBOOK

Executing an Integrated Approach to Social Determinants of Health for Short- and Long-term Value

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Social determinants of health (SDOH) can account for as high as **80% of clinical health outcomes, research shows**.[1] By now, it's clear to payers and providers that SDOH must be addressed to improve patient outcomes and deliver high-quality, value-based care.

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What is still not widely understood? How to effectively solve SDOH challenges for members. Awareness is one thing. Identifying members who need help is another. Being able to connect those members with needed resources at every step of the healthcare journey should be the standard we're aiming for.

Organizations that are successfully addressing SDOH are using a truly integrated approach. In fact, in a recent webinar from Becker's Natosha Anderson, Associate VP, Population Health, Blue Cross Blue Shield of North Carolina, spoke about the critical role of leveraging an integrative approach that includes SDOH, among other elements, to properly connect the dots for members.

"Our healthcare system and processes are very complex. And it's not only when you are in the hospital. It means working with your physicians, outpatient, outpatient surgeries, inpatient medications, specialties, population health, and social determinants of health. And it's really identifying, as best we can, members who have gaps in care, and need help and need the assistance of a team-based program to help them improve their health or to help them coordinate care, which is really important.

It's coordination of care to help members. And it's difficult because there are so many different people that participate in this space. When you think about it. Pharmacists, doctors, dietitians, social workers, community health workers, nurses, physicians, there's just a lot of people trying to help members and sometimes that's just not all connected."

Natosha Anderson
Former Associate VP, Population Health, Blue Cross Blue Shield of North Carolina
Industry Roundtable: The State of Care Management & Value-based Care, 2024

[1] *Ogilvie, J. (2021 December 27). Social Determinants of Health 101 for Health Care: Five Plus Five. National Academy of Medicine.* [https://nam.edu/social-determinants-of-health-101- for-health-care-five-plus-five/](https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/)

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Rather than being a standalone initiative, SDOH treatment should be woven into the fabric of an organization's health equity and care management/coordination programs. As Anderson explains, for organizations focused on care management, a coordinated approach that includes each setting across the continuum is paramount to closing gaps, addressing needs, and empowering health plan members (members) to understand and participate in their health.

To help payers and providers better approach SDOH, we've created this workbook. This work is designed to function as an exploratory guide for payers on how to integrate SDOH management within their programs, as well as to educate providers on the importance of SDOH within the overall care continuum and the integrative approach payers may leverage. In this workbook, you'll find practical advice, real-world examples, and interactive exercises to help you:

- ✓ Understand the model to apply for SDOH
- ✓ Learn how to proactively identify SDOH challenges and needs
- ✓ Leverage SDOH-related data and resources to close critical care gaps
- ✓ Eliminate barriers to healthcare adherence to help drive better health outcomes
- ✓ Create an approach that helps address SDOH to improve members' health and empower more independent self-management in the long term

But before we dive into the guide, let's quickly look at why this approach is so important.

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THE IMPORTANCE OF SDOH

Understand the New Model of SDOH Management

SDOH needs certainly are related to access to food, shelter in a safe environment, transportation, healthcare services, social companionship, behavioral and mental health services, financial resources, and other major human needs.

But SDOH also is about smaller components of those needs. Cooking utensils to be able to prepare nutritious meals. A mattress for a comfortable night's rest. Reading glasses to clearly see the fine print on medication. Well-fitting sneakers to safely walk for exercise. Lacking essentials like these can negatively impact a member's ability to actively participate in supporting their own health.

When speaking with Bonnie Boyle, RN, Complex Care Manager at Innovation Care Partners (ICP), recently about ICP's Complex Care Team, she emphasized why it was important to consider SDOH at every level of care and setting.

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"A lot of times, it can seem like a little thing or a small fix, but it makes a huge impact. Some members I have helped can't take care of themselves because they're caring for a spouse, or they're lacking a bed, or need help getting into a bath, don't have kitchen utensils, or are struggling to care for their basic needs. And so ICP created our Complex Care Team to be able to step in at any time throughout a patient's journey, identify the need, and then provide additional education or a piece of equipment (wheelchair, mattress, etc.), help communicate and coordinate with the patient's doctor for home health orders, guide the care coordination team, or help identify and address health-related issues and other care gaps that are inhibiting the patient's progress. SDOH is always on, and a key element for our team in keeping members out of the hospital and moving forward along their health journey."

Bonnie Boyle
Complex Care Manager (RN)

Boyle's example is a perfect illustration of why SDOH cannot be a stand-alone initiative for payers. Solving SDOH requires an **integrated approach that prioritizes SDOH throughout the continuum of care**. It ensures that if these needs – big or small – pop up at any point in a member's healthcare journey, they can be flagged and immediately addressed to prevent treatment from being derailed.

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A PRACTICAL GUIDE TO APPROACHING SDOH

An Integrative SDOH Approach

In the next few sections, we'll go through what an integrative approach looks like for SDOH. In each section, you'll find practical data and insights, interactive questions to ask yourself and your team, and then real-world examples and advice from leading healthcare organizations around the country.

1. Identify Members in Need of SDOH Support

Discovering health-related social barriers lays the foundation for SDOH management. That means knowing the right questions to ask and when to ask them. It also means identifying members' needs at the right times. That's right – *times, not time*.

SDOH challenges can present at any stage of the care continuum and negatively impact care management or coordination efforts, medication and treatment adherence, and care plan execution. Checking in with members on SDOH needs is not a one-time effort!

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DISCUSSION ACTIVITY

Do you believe you are effectively identifying SDOH challenges and members in need?

If so, list the ways you believe your team is achieving this. If not, list ideas for improvement, then discuss them with your team.

Asking the Right Questions

Identifying SDOH needs starts with asking the right questions. SDOH screenings should assess factors including the following (but can also address more depending on your population's unique needs):

- ✓ Housing stability
- ✓ Physical safety
- ✓ Food insecurity
- ✓ Transportation
- ✓ Legal needs
- ✓ Clothing
- ✓ Employment
- ✓ Language
- ✓ Health literacy
- ✓ Mental & behavioral health
- ✓ Environmental safety
- ✓ Economic stability
- ✓ Social support *(i.e., does the individual have family, friends, neighbors, or others in the community to rely on for companionship and help when needed?)*

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Ideally, you'll drill down further to identify details of members' needs. Community Care of North Carolina (CCNC), whose population is a mix of Medicaid and commercially insured individuals, takes this approach.

"So we've learned over the years, it's not as much about compliance, not about why are they not taking that medication, but instead you really have to look at their environment. We have requirements from the state, but even before that, we've always assessed SDOH beyond the medical view and tried to ask the right questions. The ones that help you look at those environmental barriers to see why a member can't pick up their medication, or get to an appointment.

For our population, it's often low income, access, transportation, food insecurity, and language that are the top barriers. And when we're able to identify these and assess the SDOH around them, our teams and the individual's healthcare providers are finally able to understand that maybe it's a decision between food and medication, and this person is not able to even prioritize their health because of that."

Avera White
RN, MSN, CCM, Executive Director of Diversity, Equity, Access and Inclusion (DEA&I) at Community Care of North Carolina

The way CCNC properly identifies these needs is via SDOH screenings where these questions are put forth for members to answer. From these questions, White explained, it's possible for CCNC to then educate a member on the community resources available to them and how to access them, as well as to understand and manage any existing chronic conditions. It's also helpful from a clinical perspective to help build trust with a member and better enable the member to move beyond the SDOH barriers they're facing, and get into their provider, and move forward within the care management program.

Two of the tools CCNC uses include the Camberwell Assessment of Need (CAN) and the Community Health Workers (CHWS) assessment. CAN is a standardized, comprehensive, multi-perspective family of questionnaires that assesses the overall health and social needs of adults across 22 domains of life. This includes issues related to physical health, psychological distress, relationships, and more.

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The CHWS assessment is used to help identify the five major domains of food, housing, utilities, transportation, and interpersonal violence, as well as a few others, helping to paint a better picture of social and environmental concerns.

Assessments like CAN are ideal for identifying SDOH needs and challenges. They include specific questions, rating systems, and easy-to-understand explanations that enable a care manager to capture an individual's personal situation and barriers in a way that provides the framework for resolution.

Page 1 of the 2nd edition Camberwell Assessment of Need – Clinical (CAN-C) is shown below to provide an example. This page illustrates how to screen for issues around housing. You can learn more about CAN assessment variants and CAN in general at www.researchintorecovery.com/measures/can/.

1 Accommodation

What kind of place do you live in?
What sort of place is it?

Assessments: Service user rating | Staff rating

Does the person lack a current place to stay?

Rating	Meaning	Example
N	No problem	Person does have an adequate home (even if in hospital currently)
M	No/minor problem due to help given	Person is living in sheltered accommodation or hostel
U	Current serious problem	Person is homeless, precariously housed, or home lacks basic facilities such as water and electricity
?	Not known/prefer not to say	

If rated N or ? go to next page

How much help with accommodation does the person receive from friends or relatives?

Rating	Meaning	Example
0	None	
1	Low help	Occasionally supplied with few pieces of furniture
2	Moderate help	Substantial help with improving accommodation, such as redecoration of flat
3	High help	Living with relative because own accommodation is unsatisfactory
?	Not known/prefer not to say	

How much help with accommodation does the person *receive* from local services?

How much help with accommodation does the person *need* from local services?

Rating	Meaning	Example
0	None	
1	Low help	Minor decoration, address of housing agency
2	Moderate help	Major improvements, referral to housing agency
3	High help	Being rehoused, living in group home or hostel
?	Not known/prefer not to say	

Service user's view of support needed from services

Action(s)	By whom	Review date

(Camberwell Assessment of Need – Clinical (CAN-C)

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As another illustration of some of the key questions to ask members to identify critical SDOH needs, consider these SDOH screening questions from the North Carolina Department of Health and Human Services (NCDHHS).

Food

- Within the past 12 months, did you worry that your food would run out before you got money to buy more?
- Within the past 12 months, did the food you bought just not last and you didn't have money to get more?

Transportation

- Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?

Housing/ Utilities

- Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?
- Are you worried about losing your housing?
- Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?

Interpersonal Safety

- Do you feel physically or emotionally unsafe where you currently live?
- Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?
- Within the past 12 months, have you been humiliated or emotionally abused by anyone?

Optional: Immediate Need

- Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, and you are afraid you will get hurt if you go home today.
- Would you like help with any of the needs that you have identified?

(Source: NCDHHS. Healthy Opportunities: SDOH Screening Questions. https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions, accessed May 16, 2024.)

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BRAINSTORM ACTIVITY

What domains did you identify as critical for your population?

Brainstorm some SDOH questions that you feel are most relevant to your population(s) and then try to identify the themes that emerge.

Screening and Assessment Tools

After defining what questions need to be asked, the next step is determining how to ask them. The easiest way to do this is by using screening and assessment tools.

Standardized assessments are key within a coordinated care approach because **tailoring questions to specific needs across the continuum** is critical to properly identifying and addressing SDOH challenges. **If standardized assessments are utilized, it's easier for healthcare providers and payers to coordinate and align on a person's specific needs and how to best address them.**

Moreover, assessments like the ones CCNC leverage (including CAN), can be utilized to help develop and inform how a care management team should approach an individual. For example, in HELIOS assessment responses can be captured and then parsed within the platform to use within workflows that automatically flag SDOH risks and challenges a care team may need to address, help auto-assign tasks to care managers to reach out to members, auto-populate referrals, and elevate higher-risk members to the front of a care manager's caseload.

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Here are some other widely used SDOH screening tools in addition to CAN to consider:

Social Needs Screening

These tools can be used by family physicians and their practice teams to screen their members for social determinants of health, identify community-based resources to help them and work with members to develop an action plan that encompasses social needs.

Accountable Health Communities Health-Related Social Needs Screening Tool

This tool assesses health-related social needs across five core domains (living situation, food, transportation, utilities, and safety) and eight supplemental domains (financial strain, employment, family and community support, education, physical activity, substance use, mental health, and disabilities).

WE CARE Survey (Boston Medical Center)

This survey is designed to identify unmet social needs in pediatric members' families by self-report and determine whether parents would like assistance with any of their unmet needs.

PRAPARE Screening Tool

This resource is designed to help healthcare professionals better understand and act on individuals' SDOH. It includes an action toolkit to help users leverage data to improve health equity at the individual, community, and systems levels.

In-person or Virtual Follow-up Is Key

Virtual or in-person follow-ups are another important element of identifying SDOH. Some SDOH challenges can be more challenging to identify than others and may require visual identification. A member may be hesitant to talk about their circumstances, or the issue may be something within the home or not covered by a standard screening. Sometimes, the issue is something that needs to be observed in person. *For example, what if a member lacks kitchen utensils or a proper bed.*

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Consider the approach used by Innovation Care Partners (ICP) with their Complex Care Team, when performing super visits to identify barriers and how assessments and in-person visits pair up to help ICP better support high-risk and complex members and keep or get the patient back to a more independent level of care.

REAL-WORLD EXAMPLE

"When I start working with members, I go into HELIOS first thing," said Complex Care Manager, Bonnie Boyle, RN. "Everyone has their own assessments and tools for different settings - acute, post-acute, etc. - so we really rely on reviewing those assessment results, documentation, care setting notes, and more in the member's profile in HELIOS to see what's going on. For example, when I follow a patient, I look first for what our Acute Care Managers are saying, and if the patient has gone to post-acute, then I follow up with what the post-acute team is saying and then review what the care coordinators are documenting, so I can easily gather from each angle what's going on and where I need to step in next. Then we'll execute the next steps, which is often a super visit with a patient. These visits can take place anywhere, anytime, and the goal is to get a better picture of what gaps or obstacles are keeping this patient from getting healthy or are causing their condition to worsen or to be readmitted to a hospital."

Sometimes, Boyle notes super visits involve going to the PCP office and meeting with the patient's care coordinator and the physician. Other times visits take place in a post-acute facility, a skilled nursing facility, a recovery house, a halfway house, or even a specific street by a restaurant. The goal she notes is to begin the process and then step in wherever a need is identified. The team may provide additional education or a piece of equipment (wheelchair, mattress, etc.), help communicate and coordinate with the patient's doctor for home health orders, guide the care coordination team, or help identify and address health-related issues and other care gaps that are inhibiting the patient's progress.

"Wherever the patient is who needs me, I go, and whatever they need we are going to work on getting it for them," Boyle says. " We're going to consistently follow up until they're on the path they need to be. If a patient needs a food box, we have the care coordinator go out and get it. For our homeless populations, communication and tracking where they are is a big barrier, so sometimes it's about tracking this patient down, equipping them with a cell phone, and working with them on how to stay in touch so we can properly support them. Other members I have helped can't take care of themselves because they're caring for a spouse, or they're lacking a bed, or need help getting into a bath, or caring for basic needs. A lot of times, it can seem like a little thing or a small fix, but it makes a huge impact."

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What if a patient is too far away or an in-person visit isn't viable with your current care management staff? If having a care manager physically present in the patient's home isn't possible, virtual follow-up can be an effective substitute. Care managers not only can have a face-to-face conversation, but they can also ask members to flip their screens, allowing them to check for environmental hazards, safety needs (e.g., handrails), and other possible issues.

ANALYSIS ACTIVITY

Do your staff conduct in-person or virtual follow-ups?

If so, analyze the relative pros and cons of each for the past year. If not, list the steps needed to implement this approach and what potential challenges you foresee to execute either.

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2. Integrate SDOH Management into Your Care Management Program

After screenings have identified members who have SDOH-related challenges, it's time to take action to connect them with resources and services. Again, SDOH can be a need that arises multiple times at any stage of a member's care journey, so the way you incorporate SDOH needs to account for that.

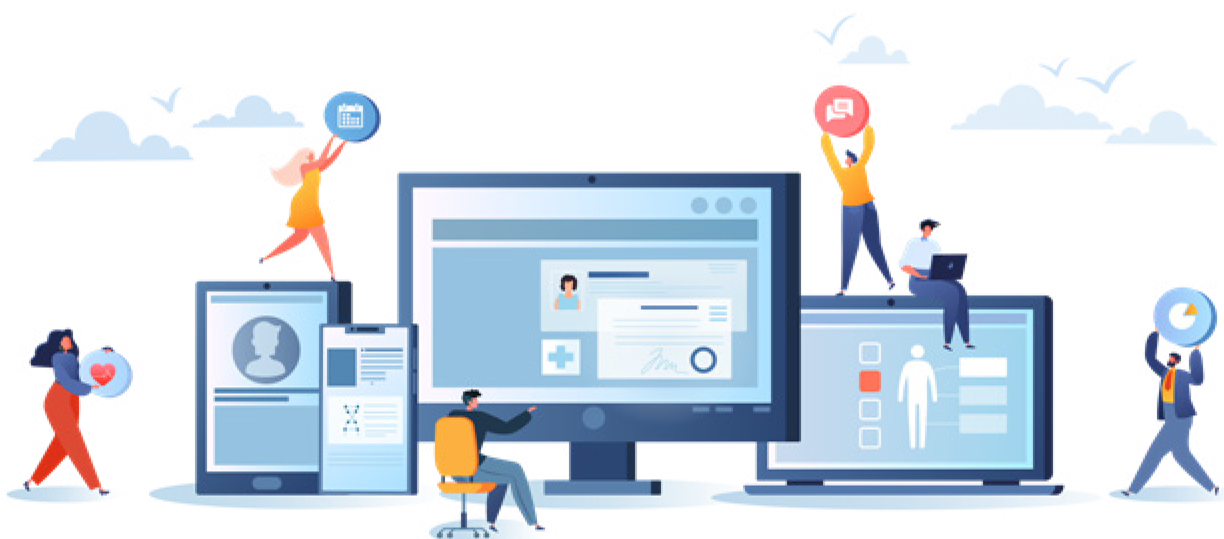
The solution is to fully integrate SDOH as a basic part of your CM/Coordination program. The old approach of considering SDOH to be a stand-alone effort limits your visibility into evolving SDOH needs over time. In reality, SDOH is directly connected to every facet of care and ultimately influences whether a care plan succeeds. As member's circumstances change over time, their SDOH challenges may as well. **If SDOH is approached in only one part of the care continuum, the risk is high that SDOH may become an issue again later on.**

But when SDOH is considered continually, it's easier to ensure members don't slip through the cracks. Below are ways to integrate SDOH into your care model.

Position SDOH to Span the Entire Continuum

SDOH is everyone's responsibility. All care team members on the provider side and payer side should have a voice in SDOH, asking questions and sharing information to foster a **collaborative approach.**

Use assessments, screenings, check-in visits, and other member-facing interactions to help keep track of SDOH challenges and resolution efforts, as well as to stay aware and get ahead of potential environmental or social shifts that could impede care.
Make SDOH part of the workflow. Create automated tasks and routine check-in reminders. Prompt



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teams to ask questions about health barriers just as you would ask for a member's name, address, and clinical health needs.

Make sure SDOH-related data is captured and incorporated across your care management platform and integrated systems to keep teams informed about needs and resolution progress.
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REAL-WORLD EXAMPLE

Success Story: How NC IncK Is Elevating SDOH Management

North Carolina Integrated Care for Kids (NC IncK) designed a care model to integrate social needs and services to support more holistic care. NC IncK talked about their approach as part of a webinar in the fall of 2022, Better Care Delivery Starts with an SDOH Ecosystem Webinar. Here are a few tactics they shared that helped make the program a success:

- Staff use data at every step to determine and address SDOH. Once a need is identified, they perform a targeted assessment. They also rely on close listening to uncover individual family concerns and needs.
- Care teams are brought together to meet needs as they come up, with documentation on SDOH interventions to promote alignment among the team.
- Establishing a long-term, trusted relationship with the family is the ultimate goal, with check-ins at least quarterly to build a year-long model of support.

Use Motivational Interviewing During Check-Ins

Another good tactic to incorporate is **motivational interviewing**. Motivational interviewing is a goal-oriented style of communication that provides a compassionate framework for engaging with people. It's a valuable tactic to help care managers drill down into specific SDOH needs, build trust, and motivate individuals to want to make change.

Here are examples of motivational interviewing style questions to ask:

- ✓ What do you see as your biggest hurdle to becoming healthier?
- ✓ Why is it important to you to improve your condition and feel better?
- ✓ Where would you like to start?

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Connect Members with Needed Resources + Tools

Of course, getting the members the help they need to address SDOH is critical. The goal is to solve members' needs as they arise and intervene before they interfere with treatment. There are various avenues of support to explore, but two you can look to use within a care management program easily are:

1. **Social Care Technology Solutions.** Unite Us and findhelp, which operate on a social care referral network platform to connect members to needed services in their community, are two examples. *See more from Unite Us below.*

2. **Community partners.** Establishing relationships with local organizations that provide social care services is crucial. Care managers should be provided with updated access to these resources so they can reach out on a member's behalf as soon as a need arises.

   It's important to build partnerships and relationships with organizations that provide services related to things like housing, food assistance, substance abuse, transportation, and even childcare and eldercare services.

3. **Education tools.** Many studies uphold the positive correlation between patient education and improved adherence, self-management, engagement, and outcomes. Equip care managers with educational tools in care management platforms such as the following that they can pass along to members:

   - Digital resources from industry leaders like Healthwise/WebMD that provide disease- and condition-specific information tailored to different learning styles
   - Medication instructions
   - Nutrition education
   - Exercise program instructions
   - Home medical equipment instructions
   - Pre-op and post-op information for any upcoming procedures

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Explore the Programs in Your Community

Again, it's crucial for care managers to be aware of available resources and to easily access them for members. Chances are, you've already established relationships with some community-based organizations. That information should be kept updated and at the fingertips of care management/ coordination staff.

Ideally, you have a relationship with community-based organizations that include:

- ✓ Food banks and pantries
- ✓ Housing assistance agencies providing rental assistance and affordable housing programs
- ✓ Community health centers that provide affordable or free services to underserved populations
- ✓ Childcare and early childhood development centers
- ✓ Legal aid organizations
- ✓ Education and literacy programs
- ✓ Transportation services, including ride-sharing programs, public transit, and volunteer drivers
- ✓ Substance abuse treatment centers
- ✓ Mental and behavioral health services centers

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RESEARCH ACTIVITY

Complete the below with your team to explore the programs you may already be connected with, where gaps exist, and/or what new avenues you'd like to explore.

1. List community-based organizations you're already partnering with:

2. Brainstorm additional community-based organizations to explore partnerships with:

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3. Leverage a Comprehensive Platform to Address and Track SDOH Needs and Outcomes for Members

In the current healthcare landscape, effectively addressing Health-Related Social Needs (HRSNs) is crucial for enhancing patient outcomes and achieving value-based care. Both payers and providers should consider using a comprehensive solution for managing SDOH needs and outcomes that integrates with their care management platform (such as HELIOS).

This ensures patients and members receive comprehensive care that not only covers medical but also social needs, aiming to address issues as they emerge and prevent them from affecting treatment. To truly cater to their members' needs, payers need to closely monitor social care outcomes by analyzing SDOH data.

Utilizing an SDOH solution within or alongside a care management platform like HELIOS enables faster, more accurate identification of trends and service gaps, revealing how to improve social care services. This analysis is key to developing targeted strategies, allocating resources effectively, and ultimately boosting the health and well-being of both individuals and the community at large.

Closing the Loop with Intuitive Workflows & Tools for Seamless Coordination and Communication

Effective management of SDOH requires that all parties involved in a person's healthcare coordinate and communicate flawlessly. To achieve this, a comprehensive platform like HELIOS may be used as a central hub for member health information and an SDOH solution like Unite Us may be used to enable closed-loop referrals, securely track and monitor progress, and facilitate the sharing of information among caregivers.

Additionally, integrated communication tools can help simplify and streamline communications between providers, organizations, and care teams. For example, HELIOS has chat features, and

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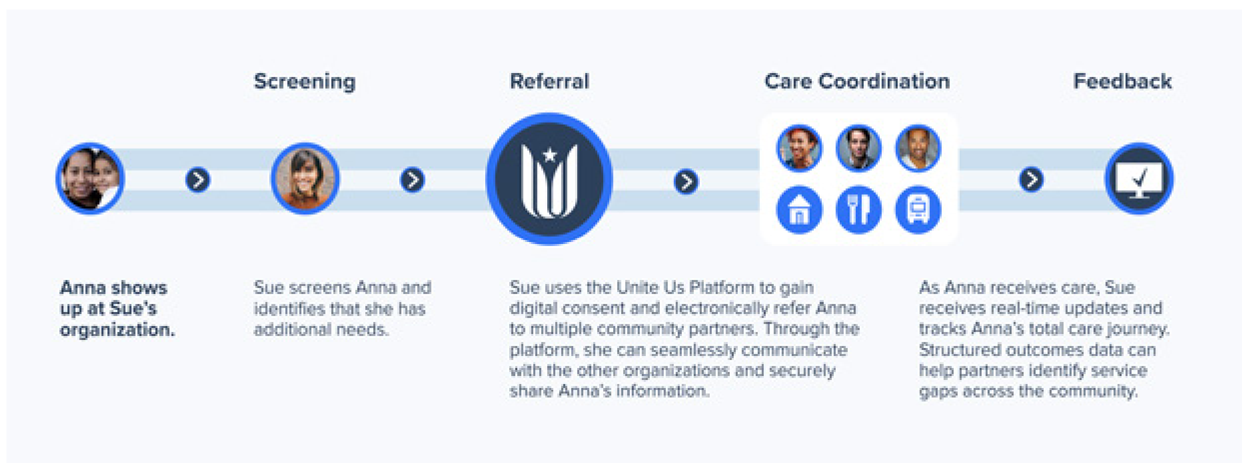
HIPAA-compliant text, messaging and video-conferencing capabilities, and Unite Us has a HIPAA-compliant, real-time chat feature that ensures that providers can immediately connect with other organizations to arrange necessary social services. This can help guarantee that healthcare providers, health plans, and community-based organizations are in sync and collaboratively striving towards shared objectives. Ultimately, enhanced coordination through the use of an SDOH solution leads to more effective care delivery and improved outcomes for patients.

See below for an example of how this can come to life via the workflow, showcasing from Unite Us.



Tailored Insights and Resource Recommendations

A comprehensive platform provides a unified view of each member's health, integrating both clinical data and social determinants. By considering factors such as housing, food security, transportation, and social support, healthcare organizations and Health Plans can better manage and improve overall health outcomes.

Real-time tracking and reporting capabilities are crucial for managing SDOH effectively. A comprehensive platform allows payers and providers to monitor the status of social care referrals and interventions continuously. This real-time data provides actionable insights into the effectiveness of services and helps identify any gaps in care. By understanding which interventions are working and which are not, healthcare organizations can refine their strategies and allocate resources more efficiently.

Providers and health plans should be looking for a solution that tracks:

- Referral status
- Top sending and receiving organizations
- % of programs receiving referrals
- Patient/member demographics
- Top service types requested *(e.g., food, housing, transportation)*

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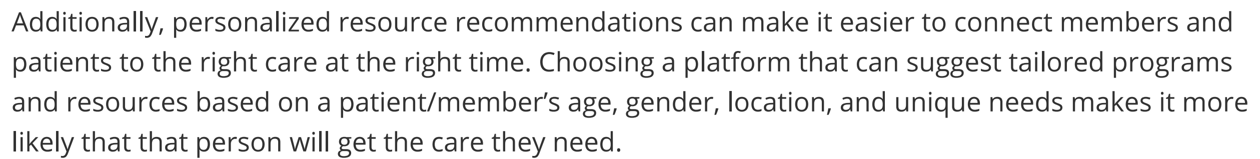

Additionally, personalized resource recommendations can make it easier to connect members and patients to the right care at the right time. Choosing a platform that can suggest tailored programs and resources based on a patient/member's age, gender, location, and unique needs makes it more likely that that person will get the care they need.

Social Care Revenue Cycle Management

Another consideration for an SDOH solution to use alongside your care management platform is an SDOH solution with a scalable payment solution that ensures that community-based organizations (CBOs) are reimbursed for the services they deliver. This functionality is essential for sustaining the network of social care providers and enables health plans to track funding and align social care reimbursement programs with healthcare billing to scale social care reimbursement and protect against fraud, waste, and abuse to maintain program integrity. By integrating payments into the platform, CBOs can receive timely and accurate reimbursement, which supports their ability to continue providing vital services. This financial support encourages more CBOs to participate in the network, expanding the range of services available to members and enhancing the overall effectiveness of SDOH interventions.

Data-Driven Insights

Finally, when thinking about how to address social needs at scale, a proactive approach is better than a reactive approach. How can providers and health plans leverage technology tools to take a more proactive approach to social care?

That's where data-driven insights can come into play. Together with a closed-loop referral system and a robust referral network, such insights can help providers and health plans design proactive interventions and address social needs upstream.

Data-driven insights and dashboards can help you:

- ✓ Identify members with social needs in your population and how to best reach them
- ✓ Enroll members into care using an optimized engagement and intervention strategy
- ✓ Serve members through a curated network
- ✓ Measure network and organization-level activity, health disparities, community impact, and success
- ✓ Invest in services and programs

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4. Building an Action Plan to Better Address SDOH within Your Populations

Now that we've walked through identifying, addressing, and integrating SDOH, it's time to take all that information and start to build an action plan that fits your care model and population needs.

To start that, you'll need the right tools in place and interventions outlined.

Choosing the Right Tools and Features to Help Address SDOH

Technology plays a crucial role in helping organizations manage SDOH. A care management platform that collects and aggregates SDOH data makes it easier to identify members and populations at risk and keeps the entire care team looped in regarding progress.

Consider the following four technical elements as part of your foundation for SDOH:

1. **Evaluate your platform and decide if additional integrations or a new platform may be needed to support:**
    - Capture and processing of SDOH data from assessments, screenings, and other sources
    - Auto-generation of alerts and tasks to notify the care manager when to take action on SDOH needs
    - Integration with partner organizations to create referrals to Community-Based Organizations (CBOs) to support needs
    - Closed-loop reporting capabilities
    - SDOH customized assessments, Care Gaps, and Care Plan
    - Configurable workflows and rules to incorporate assessment responses and metrics
    - Real-time multi-dimensional risk stratification

2. **Digital education resources such as those from Healthwise.**

    These can boost health literacy regarding diseases and conditions as well as help patients stay on track with their own care plans and health goals.

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3. **In-platform telehealth and video conferencing tools.**
   When in-person meetings aren't possible, care managers can maintain the invaluable back-and-forth of a live conversation, which is critical to relationship-building.

4. **In-platform SMS and email.**
   Digital communication tools can help facilitate convenient ongoing contact and exchange of resources between care teams and even care managers and members.

BEST PRACTICE TIP

Using a holistic medical management platform that tracks SDOH data helps keep everyone informed of member needs, interventions, and progress. This is critical to achieving a truly integrated, collaborative approach to SDOH management.

THINK & DISCUSS

How does your organization ensure that all care team members are in the loop regarding members' SDOH challenges?

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Evaluate the Right SDOH Interventions

Evaluating the effectiveness of SDOH interventions is the other essential part of properly integrating and executing SDOH management. The right interventions can iterate and improve your approach.

Here are some ways to assess progress and evolve interventions over time:

- ✓ Develop dashboards with metrics specific to your organization to help determine the impact on member outcomes and healthcare utilization.
- ✓ Gauge internal buy-in: what percentage of stakeholders are participating in SDOH efforts?
- ✓ Survey members for feedback. For example, a healthcare organization that matched seniors with companions solicited member feedback through the partnering organizations, and respondents reported dramatically lower levels of loneliness.
- ✓ Evaluate the volume of SDOH-related challenges, trends in SDOH domains, and what % of each are being addressed proactively
- ✓ Evaluate changes in health outcomes for members with identified SDOH needs
- ✓ Routinely meet as a team to discuss SDOH trends within your population, challenges to intervention or resolution, and other process-related concerns
- ✓ Collaborate with partner organizations to track:
    - When a provider initiates a referral
    - How many referrals are made
    - When a member utilizes services
    - How long until services are completed

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Creating Greater Health Equity

Helping all members bridge gaps created by SDOH is crucial to health equity and outcomes. We hope these tools and insights serve as a springboard on your journey to improving health outcomes by reducing barriers to health and incorporating SDOH across your entire care model.

KEY TAKEAWAYS

- ✓ SDOH encompasses broad and small needs, such as accessing food and having the equipment to prepare it.
- ✓ An integrated approach that makes SDOH part of the ecosystem of care is necessary to ensure the efficacy of treatment and improve member outcomes.
- ✓ Determine the best screening tools and assessments to use for your care populations.
- ✓ Asking members questions about their social needs should become part of the clinical workflow.
- ✓ Determine tailored questions to ask your members that can drill down to specific needs.
- ✓ Partner with community-based organizations that can bridge gaps for members with SDOH challenges.
- ✓ Select technology to assist with SDOH data management and facilitate seamless connection with partner organizations.
- ✓ Education is a key aspect of addressing SDOH challenges. Equip care managers with resources on diseases, conditions, procedures, medication instructions, nutrition, exercise, and other topics that can boost health literacy for members.
- ✓ Evaluate SDOH interventions and set goals for improvement.

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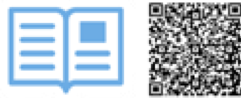
At VirtualHealth, we believe SDOH and health equity are integral to value-based care. Part of our founding mission was to connect members with the vital community resources needed to bridge SDOH gaps. VirtualHealth is proud of the work our clients are doing to elevate health equity and address SDOH within their communities, and honored to be part of that effort. We hope this resource will help other payers and healthcare plans move forward in delivering whole-person care to their populations.

Next steps: Explore these helpful resources for SDOH

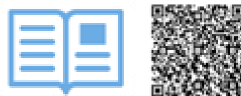
UniteUs | uniteus.com
Specialized software that identifies social needs in communities, manages enrollment of individuals in services, and leverages meaningful outcomes data and analytics to further drive community investment.

FindHelp | findhelp.org
An online repository of community-based resources to bridge gaps related to housing, food, transportation, and more, searchable by location.

Healthwise | healthwise.org
Digital health education resources designed for all types of learners spanning common conditions, procedures, and acute and chronic diseases. Ranked #1 in Patient Education by the 2024 Best in KLAS Report.



White Paper | Navigating Social Determinants: A Population Health Perspective (VirtualHealth)
Learn how Community Care of North Carolina partnered with a transportation services provider to reduce inpatient admissions and realize cost savings.



White Paper | Personalized Value-Based Care: Effective Multi-Generational Care Management Strategies (VirtualHealth)
earn tailored approaches to deliver value-based care that addresses SDOH needs for each generation.

Webinar | Better Care Delivery Starts with an SDOH Ecosystem (VirtualHealth)
Get expert insight on how to create a closed-loop SDOH ecosystem and expand access for greater health equity while delivering better outcomes.

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VirtualHealth is a mission-driven company seeking to make healthcare more proactive through technology. VirtualHealth simplifies value-based care management for healthcare's largest, most innovative payers with our cloud-based platform, HELIOS®.

HELIOS is the country's leading enterprise technology for care management, disease management, utilization management, and population health management. We are proud to provide a solution that's available to fit organizations of different sizes and population needs, and helps to eliminate data silos, streamline processes, reduce IT resource usage, and support whole-person, value-based care across generations.

For more information, visit www.virtualhealth.com.

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