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Population Health NEWS

# Catching Up With ….

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Jodi Smith is the Director of Consumer Journey for Welltok, Inc. Jodi is an accomplished researcher and published in multiple peer-reviewed journals on a variety of topics including readmission reduction strategies, care transitions, medication reconciliation, risk prediction and care in the home. She obtained her Master of Science in Nursing and Doctorate in Nursing at the University of Colorado and is Adult-Geriatric board certified. In addition to her experience as a Nurse Practitioner for Kaiser Permanente, Jodi was a health plan executive responsible for Hospital Operations and the Care Continuum.

***Population Health News**: What role do the Social Determinants of Health (SDOH) play in developing a population health strategy?*

**Ms. Smith:** Social Determinants of Health are becoming more widely acknowledged in the healthcare space as an important part of any provider or health plan's population health strategy. SDOH describes everything that happens with a person beyond the clinical setting and can drive as much as 70% of an individual's health status. A majority of Americans (68%) said they had at least one social determinant challenge, according to a survey by Waystar. These challenges can include financial security, food insecurity, transportation access and more. This is why it's important for healthcare stakeholders, whether they be provider or payer, to better understand where their consumers live, work and play. It also underscores the necessity of partnering with community resources to address specific needs at the local level. Better understanding of a patient's SDOH determinants can help providers keep patients on track managing chronic conditions and staying out of the emergency room or hospital.

One area in which social determinants can be addressed via community resources is in people's homes. The Bureau of Labor Statistics projects an enormous 41% growth in employment of home health aides and personal care aides from 2016 to 2026 which will be driven largely by the aging population. As a nurse practitioner who has provided medical care for thousands of Medicare and Medicaid beneficiaries, I feel strongly that being physically in a person's home provides an unparalleled view of how well (or not) that person is managing their health or illness.

***Population Health News**: What in your professional experience led you to see the importance of SDOH?*

**Ms. Smith:** Over the course of 15 years, I had a front-row perspective into the lives of the elderly, the sick and the economically disenfranchised. During these home visits, I was often able to identify the root cause of clinical outcomes, something that no blood test or EHR questionnaire could ever illuminate. Health systems and health plans would benefit immensely from incorporating house calls into their population health strategies specifically for their rising and high-risk segments. While there are few nation-wide universal community programs that incorporate this high-touch approach, many states, counties and cities do offer their own resources. For example, non-profits such as Meals-on-Wheels deliver cooked food to a patient's home after they are discharged. This is particularly valuable for patients who may be financially unstable and often make decisions between buying food or paying for their medicine.

Over the past few years, I've seen a more dedicated focus on localized programming and resources. Another example is Project Angel Heart, which delivers medically tailored meals to my hometown of Denver, Colorado. There are other community organizations that exist solely to aid the frail and sick in transportation, housing, food, economic support and daily living functions. Additionally, there is an increase in technology-enabled resources such as mobile applications for medication reminders and tracking, which can help connect individuals with the resources that will be most valuable to them.

At a more micro level, my home visit experiences showed me something that one cannot hear or see from the confines of a hospital or office setting: that understanding a patient's SDOH was often as (or more) important than the medical care I was providing. Many of my patients were clearly behind on their medical bills, not properly adhering to their medication regimen or had low health literacy. In order to make a difference, many providers like me had to extend far beyond their educational background

and medical training to fill patients' social gaps. Clinicians and systems must understand where food banks are in each zip code, how to find companies that transport wheelchairs and accept Medicaid, how to help patients identify the nearest grocery store that provides healthy choices, etc. Provider organizations should consider training staff on how to create these connections, removing silos to make it simpler for their staff – and thus their patients – to access and connect to existing resources. Aunt Bertha is an online resource that I recommended often for individuals to locate free or reduced cost services like medical care, transportation, food, job training and more in their community.

***Population Health News**: How can providers achieve this kind of support at scale?*

**Ms. Smith:** To achieve this type of personalized support at scale, payers and providers are starting to adopt a new type of health platform that connects consumers with community-based or other available resources like education and coaches. In order to identify who needs support and what type, the platform should include comprehensive SDOH data – not just clinical or retrospective claims data. This type of insight can provide a truly holistic view of a population down to the individual level, accurately and efficiently target those who require interventions, and identify who may be more or less receptive to aid.

Successful transformation of health outcomes influenced by social drivers requires not only predicting and assessing social needs but also securing resources to fill the identified gap(s). By proactively reaching out to at-risk individuals and making critical connections to community resources, population health managers have the potential to address social determinants and improve the lives and health of the populations they serve.