Improving health through more than clinical care

Providing impactful, quality care involves many factors, and providers are increasingly finding that clinical care is just one piece.

Social determinants of health (SDoH) can determine much of our long-term well-being, with factors ranging from economic stability and community, to education and access to transportation. And when used to support decisions on patient care, these factors can together play a big role not only in keeping patients healthy and out of hospitals, but also in determining how successful clinical care is when it's needed.

OTHER FACTORS INCLUDE BIOLOGY AND GENETICS, INDIVIDUAL BEHAVIOR, SOCIAL AND PHYSICAL ENVIRONMENT, AND GOVERNMENT POLICY.[2]

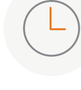
SEVERAL RESEARCH EFFORTS ESTIMATE THAT MEDICAL CARE ACCOUNTS FOR ONLY ABOUT **10%** OF HEALTH OUTCOMES.[1]

Supporting sustainable behavioral change in patients

9 YEARS

THE GAP IN LIFE EXPECTANCY BETWEEN THOSE WITHOUT A HIGH SCHOOL DIPLOMA AND THOSE WITH A COLLEGE DEGREE.[3]

The Optum® Care Coordination Platform care plan templates integrate problems, goals and tasks to positively influence a patient's social and economic conditions and address key concerns related to:

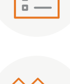


Delayed health care

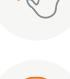
Financial issues

Health beliefs or cultural beliefs

Health literacy



Personal responsibilities



Physical challenges

Psychological challenges

Transportation issues

The importance of social intervention

When providing care, medical interventions alone can often be ineffective. Let's take, for example, a diabetes patient who is also homeless. It will do the provider little good to lecture the patient on the importance of taking their diabetes medication when they're struggling to find a safe place to sleep every night. The provider first needs to connect the patient with housing resources in the community, then work to address their diabetes.

To most appropriately provide care, providers need a patient-centric view at the point of care that can TAKE INTO ACCOUNT DIFFERENT SOCIAL AND COMMUNITY FACTORS, IDENTIFY POTENTIAL RISKS AND HELP PATIENTS FIND THE RESOURCES THEY NEED to thrive in their community.

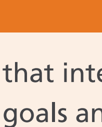
78% OF PROVIDER EXECUTIVES REPORT THAT THEY LACK THE DATA TO IDENTIFY PATIENTS' SOCIAL NEEDS.[4]

Bringing social and clinical care together seamlessly

Tools like the Optum Care Coordination Platform can help providers and care managers provide necessary clinical care while integrating SDoH, census and clinical information to provide more impactful, well-rounded care. The workflow tool arms providers and care managers with:

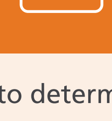
POINT-OF-CARE ASSESSMENTS

to screen for and evaluate a patient's economic and social conditions, which might influence their access to high-quality care — and trigger suggestions on interventions, resources and community referrals to address any barriers.



CARE PLAN TEMPLATES

that integrate problems, goals and tasks to create patient-centered care plans that address a patient's social needs and improve health in ways that can be sustained over time.



REPORTING TOOLS

to determine common needs in the community and help care coordinators make better data-based decisions like how and where to implement change to drive better performance and provide evidence-based care.

Learn how the Optum Care Coordination Platform can support your organization's efforts at:

Connect with us:

1-800-765-6705 | discover@optum.com

Sources:

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3. Advisory Board. Population Health Advisor. Social Determinants of Health 101. June 2019.
4. PwC Health Research Institute. Clinician Survey, 2017.

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