HealthScape Advisors

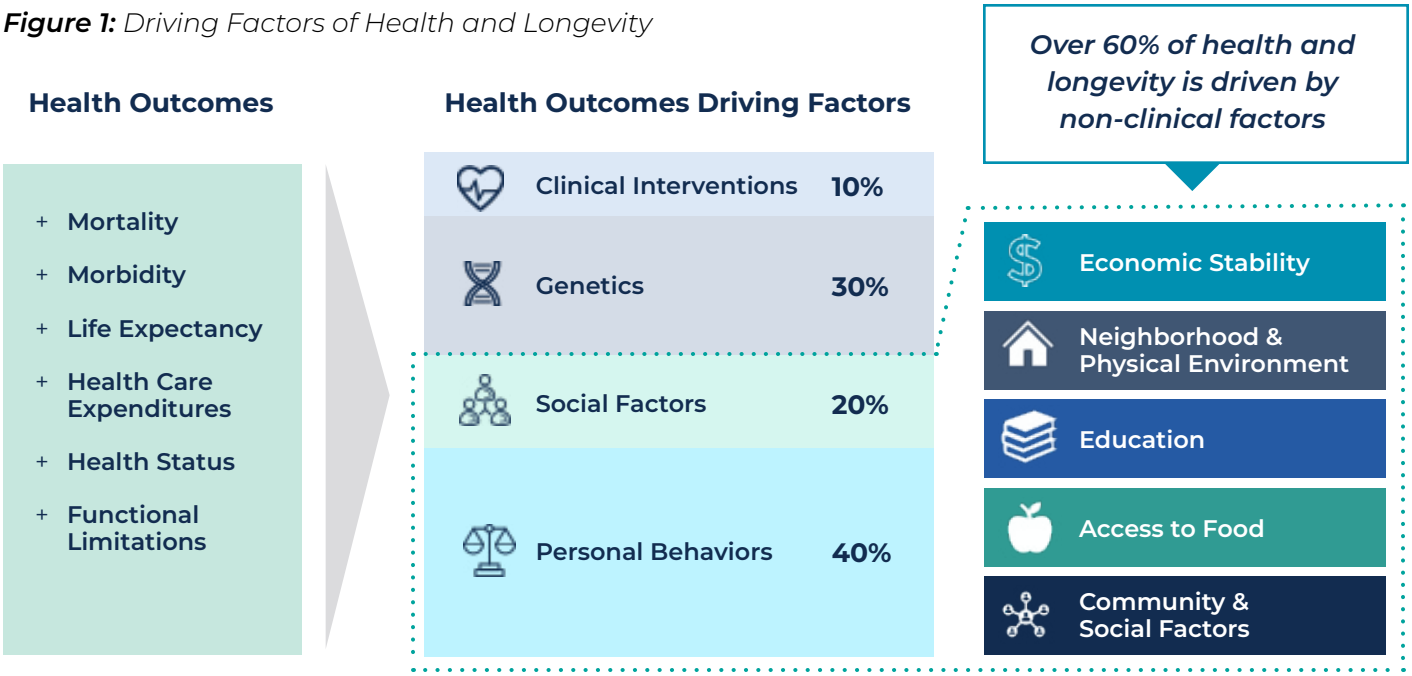
A CONVEY COMPANY

SOCIAL DETERMINANTS OF HEALTH:
DRIVING SUSTAINABLE HEALTHCARE VALUE AS A CONVENER

DEFINING CONVENER

Health starts in our homes, continues in our communities, and is largely impacted by our day-to-day choices and interactions. The interconnectedness of life demonstrates why providing holistic healthcare that delivers long term results is hindered by a primarily clinical approach. Instead, understanding how our health and wellness is influenced by how we live, work, play, and behave bears more importance than clinical and genetic factors. The concept of social determinants of health (SDOH), highlighted as a key trend in our recent **2020: Year of Integration** Executive Brief, evolved from an industry trend and buzzword to an area of significant focus for all healthcare stakeholders.

Figure 1: *Driving Factors of Health and Longevity*

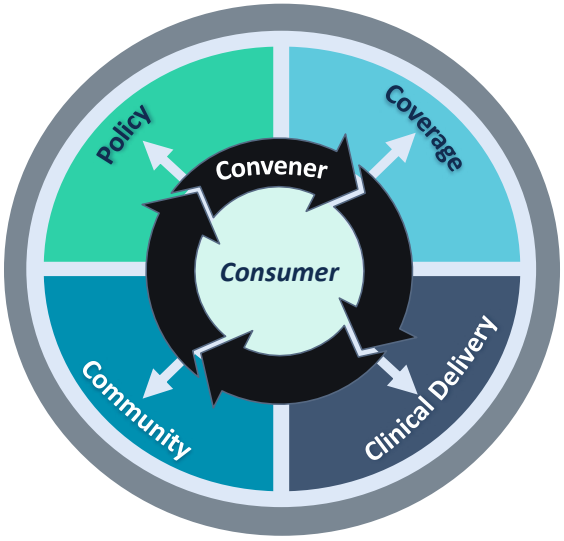


Sources: Kaiser Family Foundation, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, May 2018

Although there are numerous ad hoc solutions making strides toward addressing social barriers, the missing link for sustained success is a convener—an entity that serves as the primary coordinator to unite all the individual efforts of health plans, clinical delivery, community and policy stakeholders in a holistic way. The healthcare ecosystem is the proverbial "the whole is greater than the sum of its parts" and the convener is the thread that stitches together the disparate SDOH players under a shared value proposition to deliver long-term sustainable costs and improved health outcomes. By aligning incentives and outcomes, conveners are responsible for coordinating and integrating coverage, policy, clinical delivery, and community-based resources for a member-centric approach:

Figure 2: *Member-Centric Approach of a Convener*

The figure below depicts the role of a convener helping coordinate and align roles toward a common consumer centric model across coverage, policy, clinical, and community resources.



	Description	Convener Value Proposition
●	**Coverage** Health plans or other entities supporting affordability and access to care.	+ Determines **optimal coverage option** based on assessment of holistic member needs + **Reduces health costs** through a coordinated approach to care
●	**Clinical Delivery** Health systems or other entities providing "traditional" direct healthcare services to patients	+ **Supports fee-for-value arrangements and steerage opportunities to lower cost settings** + Provides health plan, community, and policy resources to **support patient care away from the clinic**
●	**Community** Community-based organizations, institutions, and initiatives, excluding traditional health care service settings and primarily government-funded institutions	+ **Improves community health** and wellness + **Provides participants and funding** for programs sponsored by large organizations with greater access to capital
●	**Policy** Any local to federal government entity that influences policies tied to the physical, mental, or behavioral health of a consumer. Programs / initiatives are directly supported by government funding	+ **Improves population health** + Ensures **greater return on funding dollars** by supporting members holistically + Provides opportunity to **integrate with local programs**

Many organizations could play the role of a convener, and this role may vary by community. Payers, health systems, public health systems, and potentially large endowed community-based organizations are all options based on the local market. We believe that health plans are uniquely positioned to assume the convener role and drive alignment across policy, coverage, community, and clinical delivery. Health plans provide the greatest number of touchpoints with the entities above, as well as the capital and long-term value proposition to effectively act as a convener and achieve successful and profitable SDOH programs. Health plans are further ahead in advancements in data and analytics, cost management strategies, consumer engagement, and value-based care models to drive alignment as a convener in the future.

THE VALUE OF A CONVENER

While health plans have demonstrated value creation by deploying social programs, a truly scalable model that drives sustainable cost reduction has not been proven. Figure 3 highlights examples of point solutions that address specific social needs. Based on point-to-point solutions and market-based solutions as seen below, we believe conveners can sustainably drive 5% of medical cost savings by aligning appropriate parties to comprehensively address social determinant factors and truly improve community health. Health plans with larger Medicaid and Medicare populations can demonstrate the greatest return on investment; however, we see opportunities across lines of business for group and individual members.

Figure 3: *SDOH Examples*

WELLCARE HEALTH PLANS

Factor: Economic Stability

Launched WellCare Works to connect Kentucky Medicaid members to employment opportunities, including job preparedness & placement

WellCare's Community Connections links members with community-based public assistance programs

10%

Overall reduction in medical cost for those connected to their MCO (WellCare)

AMERIHEALTH

Factor: Access to Food

Amerihealth started a "food as medicine" initiative and partnered with Community-Based Organizations to improve access to nutritious meals

AmeriHealth also provides vouchers to farmers markets, meal delivery services, and in-home food

30%

Reduced inpatient admissions

10%

Decrease in emergency department visits

CAREMORE HEALTH

Factor: Neighborhood & Physical Environment

Anthem's CareMore Health partnered with Lyft to provide transportation benefits to Medicare Advantage members in multiple states

Partnered with lyft

39%

Average ride cost reduction

45%

Lowered wait times

FLORIDA BLUE

Factor: Community and Social Factors

Partnered with Miami-based community group, Papa, to connect older adults to college-age students who serve as companions and aides for running errands to help address social isolation issues

Partnered with papa

Savings N/A – new program as of 2020

CARESOURCE

Factor: Education

Utilize Life Services program and JobConnect platform to provide direct member coaching and access to job and education opportunities

Provided funds to launch a digital preschool for low-income children

50%

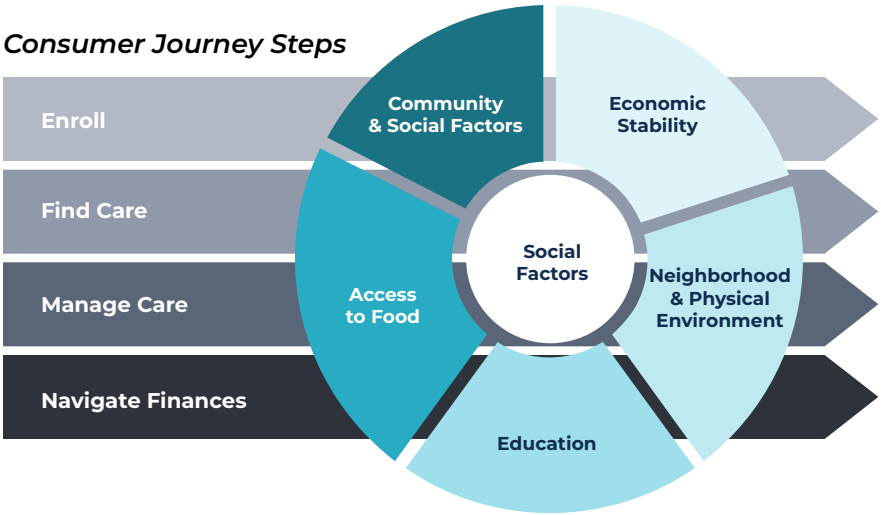
Cut early childhood education costs for participating members

HOW TO DRIVE VALUE

Today, only one or two entities collaborate to address a singular need within their communities. This fragmented narrow focus serves a singular value proposition rather than provide a broad community-based care approach.

To drive long-term value, the understanding of unique consumer needs and the differences across markets will require a convener to create tailored programs at the intersection of a consumer journey point and market dynamics.

Figure 4: *Consumer Journey & Market Based Approach*



Implications

- **Understand consumer journey steps:** Remove traditional payer centric functional barriers and deliver capabilities to meet consumer needs at their steps in the journey
- **Identify unique market level social attributes:** Each local market has unique micro needs for social barrier requiring payers to understand each local market's dynamics in a more nuanced way
- **Develop localized strategies for support:** Every local market requires a customized approach based on the unique social needs and consumer attributes

The payer, acting as a convener, holds unique insights into market demands and member needs regarding social determinants. These insights will be critical in developing adaptable and fluid approaches to addressing SDOH factors that often vary between regions, creating unique market profiles across the country. For example, the needs of members in urban, suburban and rural markets will vary based on different demographics and social barriers.

Figure 5: *Market Archetype Overview*

SDoH Market Dynamics

Economic Stability:
Employment, Income, Expenses, Debt, Medical Bills

Neighborhood and Physical Environment:
Housing, Transportation, Safety, Parks, Playgrounds, Walkability

Education:
Literacy, Language, Early Childhood Education, Vocational Training, Higher Education

Food:
Hunger, Access to Healthy Options

Community and Social Factors:
Social Integration, Support Systems, Community Engagement, Discrimination, Stress

Health Care System:
Health Coverage, Provider Availability, Provider Linguistic and Cultural Competency, Quality of Care

Illustrative Local Markets

Urban Community – Providence, Rhode Island

Market Attributes
- Urban area with a **significant education gap** and a significant **low income population**
- Public transportation and healthy food options readily available
- Large **Spanish and Portuguese** speaking populations
- Several **large hospital systems** as well as local, regional and national payers

Suburban Community – Pasco County, Florida

Market Attributes
- Suburban area ~30 miles northwest of Tampa with **average travel time to work >30 min.**
- **Large uninsured population** – 15% of the population under age 65
- Rental housing is expensive but **over 70% of people own their own home**
- **One large health system** and several regional medical centers
- **Florida Blue – large non-Medicaid market share,** Medicaid dominated by large nationals

Rural Community – Ellsworth, Kansas

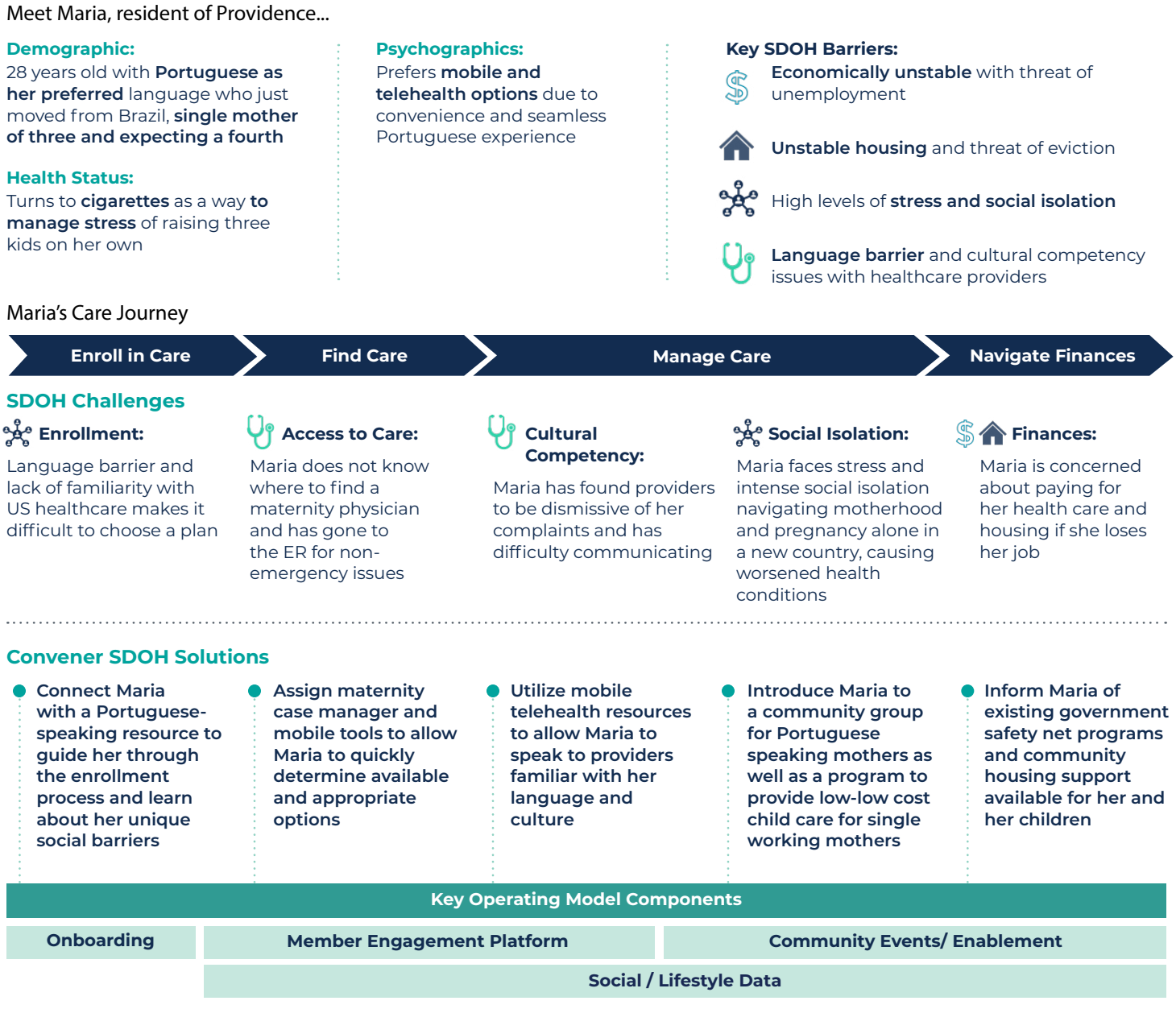
Market Attributes
- **Rural area** with rather **limited participation in labor force** (~50% of population age 16+)
- Large population of individuals **age 65+**
- One in four homes **lack internet access**
- **One hospital system** that includes four rural health clinics
- Blues plans dominate commercial markets while large nationals dominate government markets

Sources: U.S. Census Bureau QuickFacts; BestPlaces; BCBS National Health Index; Becker's Healthcare

By viewing unique member needs through the lens of local market dynamics, conveners can create targeted SDOH programs with the greatest impact. In the example below, a convener leverages its understanding of the unique member needs and local market to create a value-driven engagement model.

The role of a convener varies significantly by market, but the personalization and understanding of local dynamics remains the same. In an urban market like Providence, a convener must address an ethnically diverse population with lower levels of financial security; a convener in a rural market such as Ellsworth, Kansas, grapples with convenient and timely access to basic necessities (e.g., healthcare, fresh food, fitness facilities). Additionally, a convener in suburban markets such as Pasco County, Florida, must examine barriers stemming from long work commutes and a high crime rates. In each market, a convener must consider systemic challenges in developing SDOH solutions. For example, linguistic and cultural barriers are focal areas for a predominantly non-English speaking market like Providence, whereas social isolation is the critical focus in a rural market such as Ellsworth.

Figure 6: *Urban Convener Example*

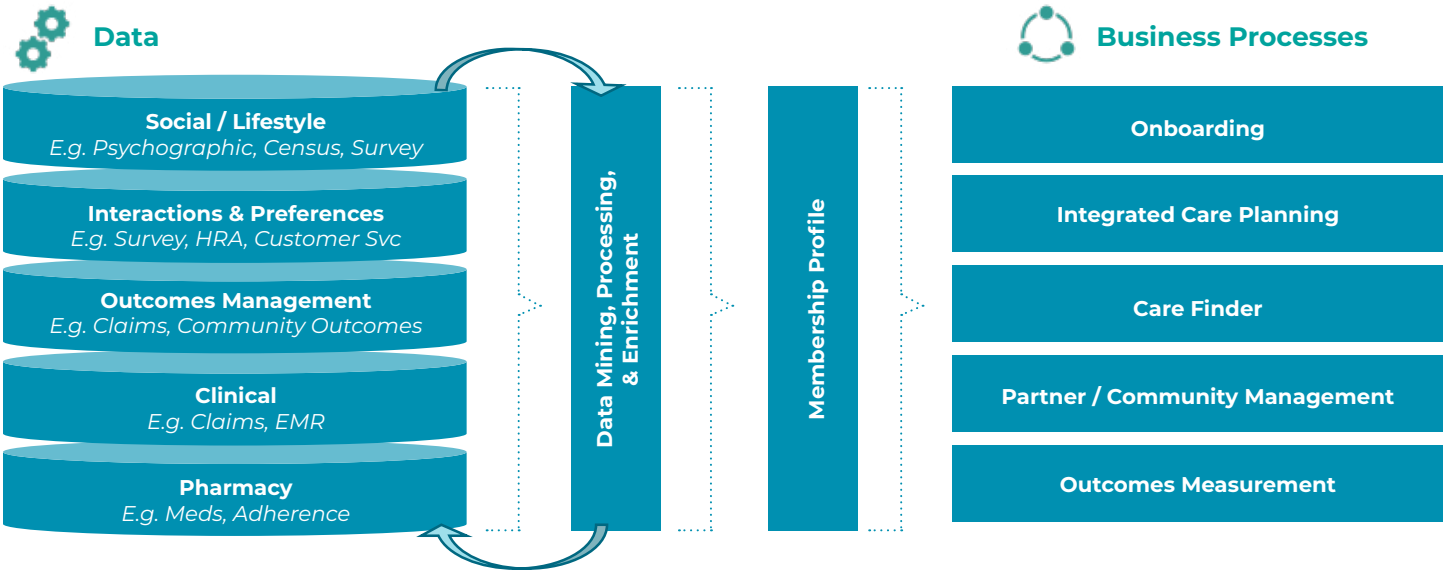


CONVENER CAPABILITY IMPLICATIONS

Paramount to becoming a convener, health plans must develop a coherent strategy addressing investments across people, process, technology and data analytics.

These investments reflect the drivers behind successful implementation of an integrated approach to SDOH that health plans are primed to lead.

Figure 7: *Integrated Health Plan Convener Operating Model*



People

Integrated Care Team & Partners

Healthcare Professionals

Behavioral Health Workers

Customer Service

Members

Care Givers

Community & Non-profit Support

Healthy Living Coaches

Social and Community Workers

Leadership & Business Enablement

Accountable VP-Level Social Lead

Business Enablement

Integrated Member Engagement Teams

Technology Processes

Member Stratification

Integrated Member Engagement Engine / Platform

Social Service Connectivity

Digital Tools & Enablement

Advanced Analytics

Data

Health plans will need to transcend historical approaches to member data (e.g., enrollment, claims) to adopt a more predictive and comprehensive model that addresses gaps in social and preference factors.

1. **Social / lifestyle:** increase access to census, financial, local public health, psychographic, and consumer lifestyle data for a nuanced understanding of a population's social behavior and lifestyle
2. **Interactions & preferences:** build a holistic view of members' communication preferences (e.g., digital vs. mail, language preferences) for various stakeholders, including their caregivers and providers, to enable successful two-way communication
3. **Outcome management:** create well-defined metrics to measure outcomes and gather data to demonstrate the success of SDOH programs; build a close-looped management system to refine community approach
4. **Clinical:** develop a clinical profile based on genomic data, claims data and EHR information
5. **Pharmacy & ancillary:** integrate with clinical data to understand the pharmaceutical and behavioral attributes of members

Market example:

Humana completed a Comprehensive Social Needs Survey Channel Test for over 100,000 members which helped identify financial strain, housing insecurity, and transportation access issues. Humana reviewed data sources across social needs assessments, EHRs, encounter data, census, and CMS and made a strategic enterprise investment in data management and governance to leverage this data to better address the social needs of its population.

Processes

Health plan investment in business capabilities and processes will unite policy, clinical delivery, and community-based resources to deliver effective SDOH programs:

1. **Onboarding:** create differentiated processes to educate and align members with community resources and virtual health to help achieve health and wellness goals
2. **Integrated care planning:** re-define care planning to account for behavioral and social data points that are accessible across entities and include a holistic view of care gaps
3. **Care finder:** direct consumers to find the right care through benefit design, transparency of community resources, and tailored recommendations through advocacy solutions
4. **Partner and community management:** invest in processes and support roles to manage clinical, community, and policy partner organizations and focus on the ability to rapidly mobilize partnerships that incentivize mutually beneficial outcomes
5. **Outcomes measurement:** define community health-based KPIs and supporting processes to measure program effectiveness for continuous refinement

Market example:

Accolade, a customer advocacy company serving employers, develops a personalized integrated care plan for all members. As part of this critical process, Accolade leverages social and behavioral data from its members and employer geographies to build a robust member profile. A personalized care plan is critical for member engagement as they sell to employers with a wide variety of socio-economic status employees.

People

Conveners require accountable roles dedicated to community and social needs as well as a specialized workforce that engages members in their health outcomes:

1. **Integrated care team and partners:** invest in clinical and non-clinical resources responsible for developing integrated care plans that account for SDOH factors
2. **Social and community enablement:** invest in social and community workers to collaborate with community resources
3. **Dedicated leadership and business support:** conveners must establish leadership roles dedicated to SDOH and community / social support teams to signify the importance of SDOH across the enterprise and establish accountability for SDOH KPIs

Market example:

SCAN Health Plan, a California-based Medicare Advantage plan, utilizes well-trained care managers with customer service experience to help dually enrolled members navigate their benefits. Additionally, SCAN launched a program to integrate social workers and community health workers into the care team to help support physicians in addressing SDOH. The efforts adopted by SCAN Health Plan illustrate the intersection between members, providers, and community organizations. The health plan sits at the middle of this intersection, capable of coordinating and driving efforts through meaningful investment in human capital.

Technology

Investment in advanced data management and integration removes silos and enables advanced workflows that augment member engagement and administration of SDOH programs.

1. **Member Stratification:** develop new member stratification models that shift from a primarily claims-based model to a socially and behavioral focused model to better predict future costs and interventions
2. **Integrated customer relationship management (CRM):** development of a next generation CRM platform that provides an integrated view of members' preferences, interactions, and history across clinical and customer service needs
3. **Social service connectivity:** development of a new model to prioritize social services above traditional network providers in a way that understands the local market supply and member needs
4. **Digital tools and enablement:** investment in digital transparency tools that promote social services as well as EMR integration to support social barrier interventions are required to create value as a convener
5. **Advanced analytics:** investment in predictive analytics that identify member engagement opportunities based on learning mechanisms of social barrier reduction

Market example:

Unite Us, a care coordination, software developer, provides a digital platform to handle external referrals between community organizations and providers as well as tracking patients' outcomes and care journey. The focus Unite Us places on connecting organizations across silos and enabling seamless coordination provides a model for conveners to follow.

CONCLUSION

The current COVID-19 pandemic amplifies the need for a convener to address social barriers for access to care and the impact of non-clinical factors on health care access, quality, and outcomes. The ability to socially distance safely, find safe and healthy food sources, and access transportation are highly influenced by social status and the consequences of inequality. As of early April 2020, African Americans made up ~50% of COVID-19 cases in Chicago and ~70% of deaths, but represent only 30% of the total population. COVID-19 is highlighting the outcomes of social disparities. The underlying causes for these disparate outcomes are driven from social and behavioral factors. As health plans and providers seek to alleviate the short and long-term challenges of COVID-19, they should begin building programs designed to remove social barriers.

Ultimately, delivering effective SDOH programs require a convener across community organizations, clinical resources, policy-makers, and health plan coverages to obtain a holistic view of an individual's clinical and social / behavioral factors which impact health outcomes. Payers are best positioned to play the role of convener due to their broad access to key stakeholders (community organizations, clinical and policymakers), investment capital, and member touchpoints. To develop an effective SDOH strategy, we recommend building toward a convener role through the following steps:

- Build a coherent strategy that connects social mission with capability investments specific to local markets and member needs
- Identify and empower dedicated leadership and support roles to signify the importance of a concerted effort for SDOH and help coordinate cross-functional stakeholder needs
- Develop a data strategy that builds on existing assets and creates a roadmap toward a member profile that includes demographic, clinical, and social factors
- Create a member engagement strategy that leverages a broad set of opportunities to interact with a member based on their personalized needs
- Pilot social and community programs with measurable results
- Identify the right capabilities to deliver and what to build, buy, or partner
- Enhance digital and virtual health strategies to support social and community needs

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HEALTHSCAPE CAN HELP.

An effective SDOH program is key to driving long-term value as a health plan. From insight to execution, HealthScape works with plans to address social determinants and barriers.

Contact Jesse Owdom for more information.