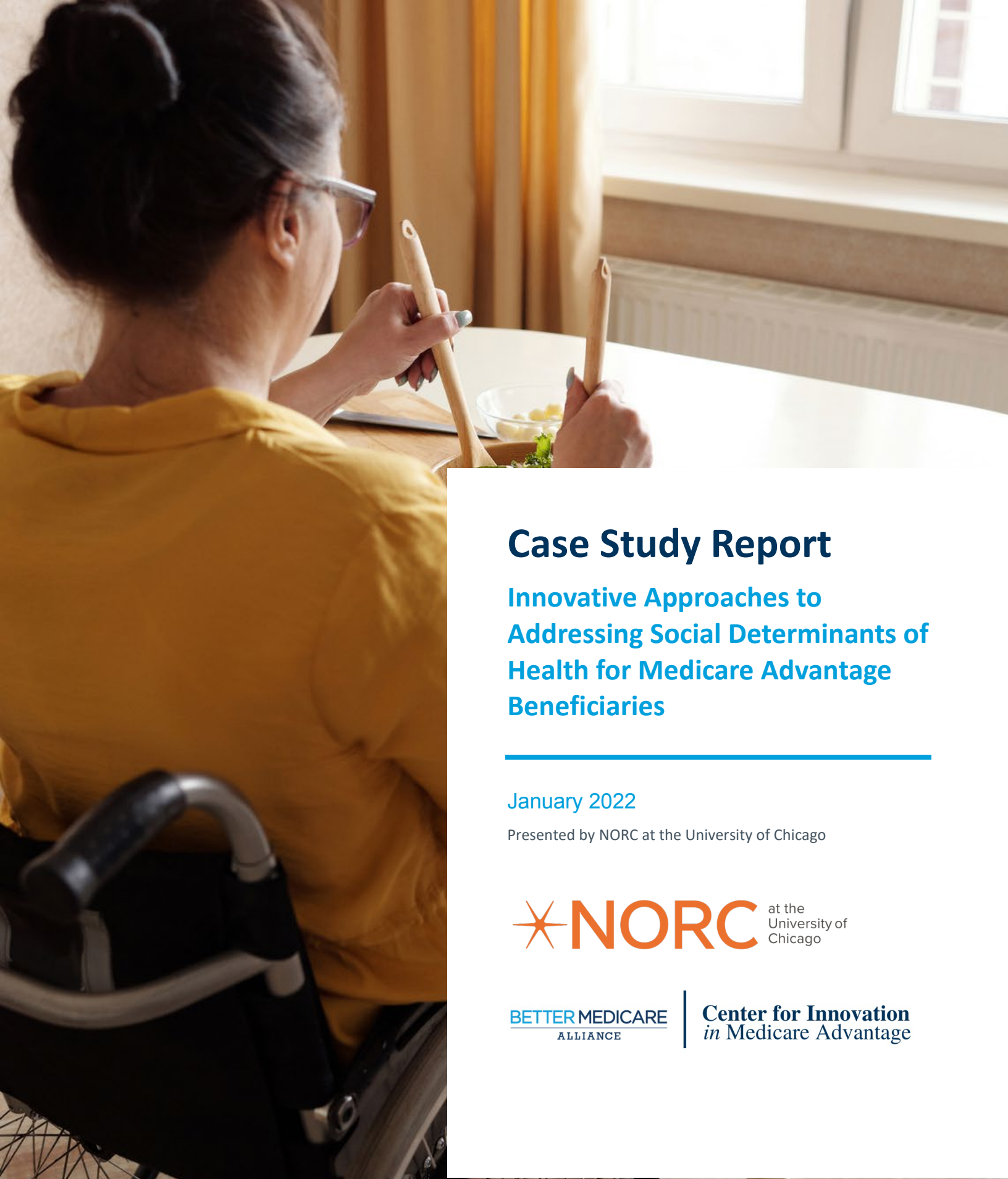

Case Study Report

Innovative Approaches to Addressing Social Determinants of Health for Medicare Advantage Beneficiaries

January 2022

Presented by NORC at the University of Chicago

NORC at the University of Chicago

BETTER MEDICARE ALLIANCE | Center for Innovation *in* Medicare Advantage

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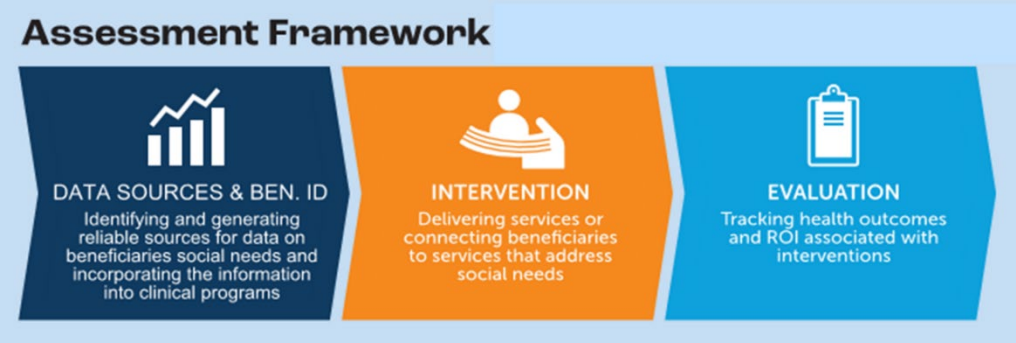
Introduction

In recent years, the U.S. health care industry has recognized that unmet needs in an individual's social and physical environment can significantly affect health outcomes and contribute to continued inequities. Unfortunately, traditional patient interactions with the health care system do not produce the data needed to identify and address these health-related social needs, and government payment programs have been slow to incentivize investment in both data capture and non-medical service provision. However, many health plans, including Medicare Advantage (MA) plans, have taken initial steps to incorporate Social Determinants of Health (SDOH) data into their care management programs. Additionally, recent regulatory changes and guidance from The Centers for Medicare & Medicaid Services (CMS) have allowed for more flexibility to use Supplemental Benefits for the Chronically Ill (SSBCI) ("supplemental benefits") to meet social needs.

The heightened focus of Medicare Advantage organizations on SDOH reflects a broader trend both within the health care and non-health sectors. The Department of Health and Human Services (HHS) has positioned addressing SDOH as one of the five overarching goals of its Healthy People 2030 campaign, grouping social determinants into five separate domains (Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context) and establishing measurable objectives and working groups targeted at many specific issues within each domain.

This analysis is the second in a series of reports[1] by NORC at the University of Chicago for Better Medicare Alliance's Center for Innovation in Medicare Advantage, using research and expert interviews to identify leading practices among its Allies and key stakeholders in incorporating SDOH data into care management and developing interventions to improve health outcomes and health equity. NORC leveraged the information collected through interviews with 12 organizations to create this case study report.



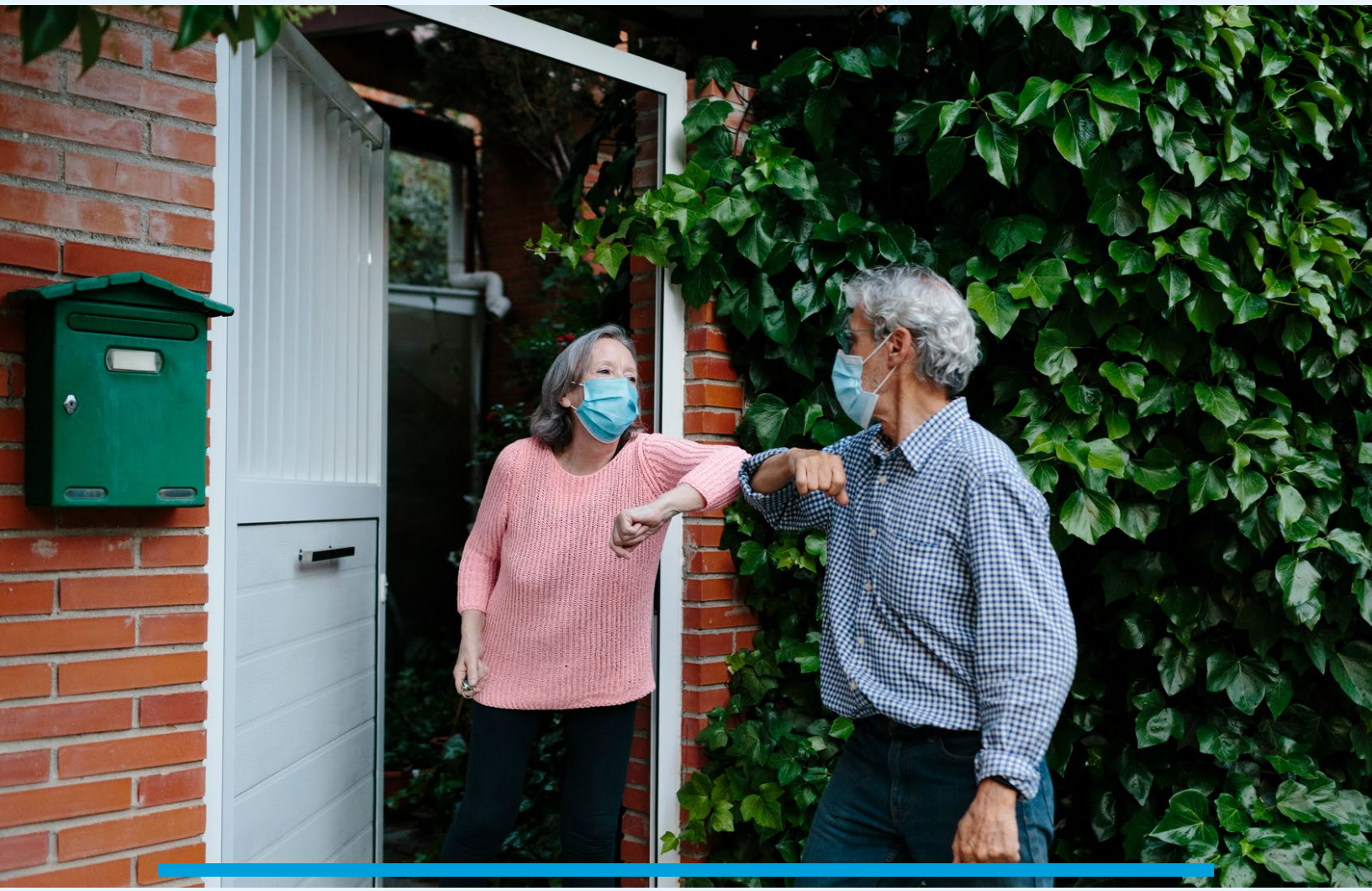
Each case study highlights programs implemented by a variety of health plans, provider groups, community-based organizations, and technology companies and provides instructive examples for policymakers and industry stakeholders looking to expand access to innovative programs to meet beneficiaries' social needs. Based on the findings in the first series of this report, the health plan and partner activities are grouped into three domains: Data Sources and Beneficiary Identification, Intervention, and Evaluation. The data sources and beneficiary identification domain is described as the ability and act of transmitting information about beneficiaries' social needs between health plans, providers, and CBOs to understand beneficiary SDOH needs. In response to these

[1] https://bettermedicarealliance.org/news/report-shows-dramatic-increase-in-medicare-advantage-activity-to-address-social-determinants-of-health-but-barriers-remain/

identified needs are interventions; the intervention domain is described as action taken by health plans, providers, and their partner organizations to address areas of SDOH needs. The outcome, efficacy, and feasibility of these interventions is determined in the last stage, evaluation. The evaluation domain is defined as the tracking of the health outcomes and ROI associated with employed interventions.

Each case study illustrates a best practice and solution that falls within the assessment framework described above. The case studies below are organized by topic and provide examples of how organizations can collaborate across industries and stakeholders to improve SDOH in their communities. These insights contribute to important discussions among policymakers as they seek to integrate lessons learned from the COVID-19 response and assess how to best address the needs of an increasingly diverse Medicare population.

Case Studies



Data Sources and Beneficiary Identification

Best Practice:

Using Data Analytics to Identify and Alleviate Friction in SDOH Program Referral and Capture Processes

Case Study:

Healthify (Technology Company)

Healthify, recently acquired by WellSky, the largest acute, post-acute, and community care technology and services provider, builds the infrastructure which enables payer and provider organizations to improve health equity and outcomes. The Healthify platform identifies social needs, finds local services, enables bi-directional referrals, and coordinates care with an accountable network of community-based organizations (CBOs). Furthermore, Healthify's platform integrates into health plan and provider clinical systems, alleviating significant friction between electronic health records (EHR) systems. Healthify's clients, such as payers, providers, accountable care organizations (ACOs), and government entities, use the Healthify platform to send referrals to community organizations to address non-clinical needs of vulnerable populations. Referrals for non-clinical needs include access to food, housing, and transportation.

According to Healthify CoFounder and CEO Manik Bhat, "Healthify's SDOH infrastructure centers around a framework we've developed, which we refer to as the social needs funnel. In it, we **focus on four critical points of friction in the journey to address a community's SDOH needs**. At each point of the journey, Healthify has built a scalable solution."

To start, Healthify executes a population health analysis to identify individuals with social needs, the impactable cost, and medical management opportunities for social service interventions. Healthify's analytics team captures individual, household, and neighborhood data to create a complete picture of the SDOH needs in a specific population. The data is normalized and used to develop predictive models that help organizations focus on the most impactful SDOH interventions and populations. To address SDOH in the community, Healthify designs accountable networks of CBOs that meet the specific social needs of particular populations. To develop effective networks, Healthify analyzes the social service landscape in each community and develops relationships with convening organizations and CBOs.

Integration across different plan and provider EHRs is a pain point between plans, providers, and health technology companies. Logging into a separate platform can represent a burden for health plan care managers and providers with established IT systems and workflows. To address this friction, the Healthify team is working with WellSky to further advance its closed-loop referral technology through integration with health plan care management

software and provider EHRs. Bhat noted that Healthify has executed such integrations into software programs from several leading care management and EHR vendors.

Furthermore, Healthify partners with organizations to capture baseline data on key outcome measures, such as emergency department utilization. The data is analyzed throughout the process to determine the ROI associated with addressing the social drivers of health.

"It's been a core tenant of our company: what doesn't get integrated, doesn't get used," said Bhat. "On the plan side we integrated with care management… we call it 'fully immersive integration,' meaning Healthify basically lives in the care management system. [The system uses] single sign-on, where they log into one system, then they'll log into ours at the same time… [It] really depends on each EHR and the instance of the health system."

— Manik Bhat,
Healthify CoFounder and Chief Executive Officer

Best Practice:

Integrating SDOH Data into the Clinical Data Ecosystem

Case Study:

Humana (Health Plan)

Humana, Inc. is a health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. Serving over 4.8 million beneficiaries nationwide in individual and group products, Humana is one of the largest Medicare Advantage plans in the nation. The company has developed an **advanced data ecosystem to support its efforts to understand and address beneficiary social needs and prioritize outreach**. They do so by incorporating data from a variety of internal and external sources into individual risk models for high-impact SDOH such as food and social isolation. Additionally, Humana has created an overall social risk index that feeds into its main clinical risk model. The company derives social risk data from a wide array of sources, which the Population Health Strategy team describes as "3 C's": Company data, Community data, and Consumer data.

- **Company data** includes clinical and non-clinical information generated from beneficiary interactions and provider encounters. Humana has several methods for collecting such information, including health risk assessments, wellness programs, home care programs, telephonic care management, multidisciplinary care teams including nurses and social workers, and large-scale beneficiary surveys. Humana uses validated screening tools like the Hunger Vital Sign and the UCLA Loneliness Scale.[2]
- **Community data** includes geographic-level data sets such as the Robert Wood Johnson Foundation (RWJF) County Health Rankings, the Centers for Disease Control and Prevention (CDC) 500 Cities Project, the U.S. Census, and U.S. Department of Agriculture food desert data. Humana has built a tool called *zoom in*™ which allows the company to layer the data and focus down to a block-by-block level and create heat-mapping pockets of risk. The tool also produces neighborhood stress scores based on indicators like poverty or vehicle access rates. Angela Hagan, PhD, Associate Director of Population Health Strategy at Humana, explained the importance of being able to drill down beyond the city- or county-level data that often appears in research. "I live in Louisville, Jefferson County, which is well over 20 miles end-to-end, right at 400 square miles. If you go a mile apart, the drivers are different." While such geospatial data can be useful to inform predictive algorithms, the company prefers member-specific data whenever possible. "Even at the granular geospatial level there's still an imprecision… the best practice and gold standard is still individual-level data," reports Hagan.

[2] https://populationhealth.humana.com/wp-content/uploads/2020/12/GCHK7Y4EN-Loneliness-Social-Isolation-Physician-Quick-Guide-2.pdf

- **Consumer data** helps Humana fill in gaps in individual-level SDOH information, including demographic information (e.g., family composition and homeownership) and lifestyle factors (e.g., consumer spending). Humana obtains consumer data from vendors such as KBM Group, which maintains the AmeriLINK Consumer Database.

Incorporating all these data into a single environment presents considerable challenges but is key to maximizing utility in predictive modeling. "We've had a mature clinical data set for a long period of time—the health record. We have medical claims-based data, pharmacy, labs, and Electronic Health Records (EHR). … But social determinants and social needs are really new spaces, from a data perspective," reports Dr. Andrew Renda, Vice President of Bold Goal and Population Health Strategy.

"We work with our Digital Health and Analytics team and the Data Governance Office as we're doing these screenings, or importing data sets, to make sure that we standardize, certify, and integrate them into our larger data ecosystem. That allows us to do more advanced Artificial Intelligence (AI) analytics, and to build platforms, and tools and trackers."

—Dr. Andrew Renda,
Vice President of Bold Goal and Population Health Strategy

Best Practice:

Partnering with Providers to Share SDOH Data

Case Study:

UnitedHealthcare (Health Plan)

UnitedHealthcare ("UHC") is the nation's largest provider of Medicare Advantage plans, with over 6.3 million beneficiaries nationwide. UHC has been a leader in advancing the use of International Classification of Diseases, Tenth Revision (ICD-10) "Z codes," a set of codes that can be attached to medical encounters identifying non-medical factors influencing health status. Z codes are provided for occasions when circumstances other than a disease, injury, or external cause classifiable to categories. A subset of these codes, Z55-Z65, are focused on factors related to SDOH. Widespread use of Z codes could facilitate SDOH data sharing between providers and health plans, giving health plans more up-to-date information about beneficiary social needs and triggering referrals for social services such as those provided through Medicare Advantage supplemental benefits.

ICD Code	Description[3]
Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

UHC has partnered with the American Medical Association (AMA) to propose 23 new Z codes related to SDOH not covered under the original set of codes. These newly proposed codes include issues such as food insecurity, transportation, home safety, ability to afford medication, ability to afford utilities, and caregiver needs.[4] UHC representatives are now working to implement updated codes with the Gravity Project, an initiative sponsored by University of California at San Francisco's Social Interventions Research and Evaluation Network (SIREN) that aims

[3] https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf
[4] Robeznieks, A. "New ICD-10 codes will help physicians tackle social barriers to care." American Medical Association Blog, 2019.

to develop standards to harmonize the exchange of SDOH data across the health care and social service sectors. According to the latest guidance from the CDC, the upcoming October 2021 ICD-10 release will include many new codes to support proposed SDOH gaps.[5]

UHC is also working to implement existing Z codes and integrate social service support within its provider networks. While a CMS study demonstrated relatively low use of Z codes within the Traditional Fee-for-Service (FFS) Medicare population during the initial years of availability, UHC has worked closely with provider partners to encourage greater adoption across all lines of business with spillover effects on Medicare FFS.[6] Company officials credit **two primary factors in achieving increased use of Z codes: the development of specific training programs and the incorporation of Z codes into meaningful plan-provider partnerships**. "We created and provided a trauma-informed curriculum with a variety of different large health systems from around the country, training them on hot spotting, using evidence-based screening (i.e., Adverse Childhood Experiences or "ACEs"), Z codes, the impact beyond just monetary, and then thinking about next-gen strategy when it came to health disparities and delivering data-driven, empathic, social service integration into their health system. We did that in partnership with our Health Executive Administration Council," said Cyrus

> **"The trainings are key, the partnerships are key. In the work we did addressing social determinants of health and health equity with focus on housing and health, for example, we identified a critical need of a particular health system like Maricopa Integrated Health System in Arizona; we helped them to better understand the population of people experiencing homelessness being served within their health system and came to the table with a solution. We had [housing] units available and community health workers with wraparound trauma informed supports, so we could go to their leadership team with some sophisticated analysis and support."**
>
> **— Cyrus Batheja,**
> **National Vice President of Enterprise Transformation and Strategic Solutions**

[5] https://www.cdc.gov/nchs/icd/icd10cm.htm
[6] https://www.cms.gov/files/document/cms-omh-january2020-zcode-data-highlightpdf.pdf

Best Practice:

Tailoring SDOH Interventions and Care Management across Risk Tiers

Case Study:

SCAN Health Plan®

SCAN Health Plan® ("SCAN") is a non-profit MA plan serving over 220,000 Medicare beneficiaries across California, many of whom are dually eligible for Medicare and Medicaid benefits. SCAN offers the only Fully Integrated Dual-Eligible Special Needs Plan (FIDE-SNP) in California within Los Angeles, San Bernardino, and Riverside counties. SCAN's FIDE-SNP covers all Medicare and Medicaid benefits, including long-term services and supports (LTSS), under one entity.

SCAN is a leader among health plans in addressing social risk factors, with roots as both a social service organization and a participant in the Social Health Maintenance Organization (SHMO) demonstration program. The SHMO demonstration was an early effort to integrate health care and social services sponsored by the Health Care Financing Administration in the 1980s and 1990s. Today, SCAN provides home and community-based services (HCBS) to older California Medicaid beneficiaries through a waiver program, as well as additional community-based medical management and education services.

SCAN Health Plan **completes HRAs for over 80% of FIDE-SNP beneficiaries, close to 80% of Chronic Conditions Special Needs Plans (C-SNP) beneficiaries, and 35% of non-SNP beneficiaries**. Under the FIDE-SNP model of care, health plans must attempt to complete HRAs for beneficiaries. SCAN incorporates questions related to SDOH, such as the ability to perform activities of daily living, in its HRA. This information is combined with Artificial Intelligence (AI) and predictive models and is included into the clinical risk stratification program.

SCAN assigns beneficiaries to care management tiers based on the results of its HRA screening tools. This includes assigning beneficiaries to a specific peer-to-peer intervention, based on social needs and common geriatric conditions such as falls. They also use AI to predict beneficiaries who may be at risk for preventable hospitalizations and/or be likely to need LTSS.

In the first, lowest-risk tier, beneficiaries with identified social needs are referred to resources. Some of these resources are delivered through supplemental benefits. Examples of benefits delivered include transportation, caregiver support, and food benefits, which are targeted to beneficiaries with chronic conditions in all plans, but especially those enrolled in SCAN's FIDE-SNP and C-SNP.

In the second tier, beneficiaries are enrolled in a peer support model called "Member2Member," in which they are matched with other SCAN beneficiaries (who are also SCAN employees) with similar health and demographic backgrounds and trained to provide one-on-one support. The peer model helps beneficiaries address issues that they may not feel comfortable discussing with the plan or their medical providers.

"We recognized there are topics, such as mental health, urinary incontinence, and physical activity, that our beneficiaries were not necessarily going to bring up to their doctors," said Eve Gelb, Senior Vice President of Member and Community Health. SCAN is currently in the process of developing a peer model for beneficiaries with mental health conditions.

> **"We are continuously learning how valuable and effective peers can be. As we encounter new things that we want to manage, like social isolation, we look to see if peer support can help. Of course, we found that the peer connection is successful for mitigating loneliness, so we added peers to the Member2Member program to work with older adults who are socially isolated."**
>
> **— Eve Gelb,**
> **Senior Vice President of Member and Community Health**

In the third tier, each beneficiary is assigned a care navigator. This tier includes all beneficiaries enrolled in the FIDE-SNP, as it is part of SCAN's D-SNP (Dual Eligible Special Needs Plans) Model of Care, as well as other beneficiaries at elevated risk based on medical and social needs. "The care navigator is the one who onboards the individuals, using the annual HRA as the mechanism to engage with the member, connecting them to community resources. We direct people as much as we can to community resources, food banks, and other programs that could be beneficial to them," said Gelb.

Finally, members in the fourth—and highest-risk—tier need complex care management. This includes telephonic and in-person engagement from nurses, social workers, and community health workers who engage the beneficiary to meet social needs and connect them to wraparound social services.

Interventions

Best Practice:

Expanding Supplemental Benefits through Strategic Vendor Partnerships

Case Study:

SummaCare (Health Plan)

Sponsored by the health system Summa Health, SummaCare is a non-profit health plan based in Akron, Ohio with nearly 23,000 Medicare Advantage beneficiaries. SummaCare's Medicare Advantage plan has received high marks from CMS, recently earning an overall rating of 4.0 Stars. SummaCare is exclusively focused on its home market of northern Ohio, and many of its early SDOH efforts resulted from its deep roots in the community, including its relationships with the local Area Agency on Aging (AAA) and county health departments.

With new supplemental benefits authority to offer non-primarily health-related benefits, SummaCare once again **leveraged its knowledge of local needs and turned to a deep strategic partnership to develop its approach**. "When we added the transportation benefit back in 2019, we were talking with our care managers on needs that they were seeing, and there were some pretty heartbreaking stories of people who couldn't get to the doctor's office for a multitude of reasons—they didn't have a ride or they needed help getting to the car," said Kerri Towsley, Manager of Product Development and Market Intelligence. "When we added our transportation benefit, it's not just a ride share. We have four different levels in our transportation benefit depending on the need. We have the ride share, we have a sedan service. If somebody just needs help walking to the car and putting their walker in the trunk, we have that. Then we also offer a wheelchair and stretcher ambulance to get our beneficiaries to the doctor's office. And we offer the benefit in one-way trips because with the ride share portion of it, sometimes we know that beneficiaries can get one way but they don't have family to sit with them through the visit and take them back, so they can get most out of their visits using the one-way trips."

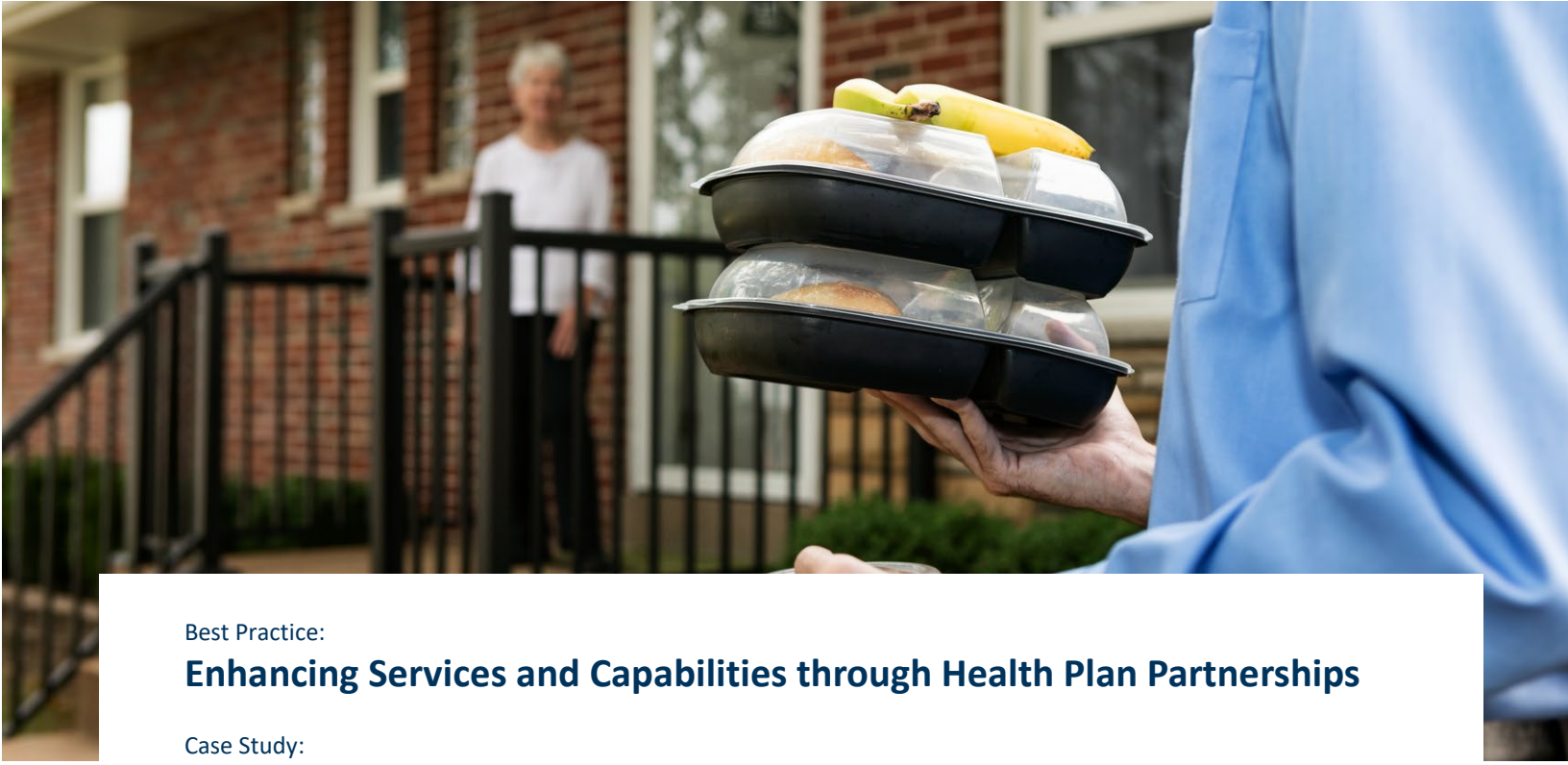
Anne Armao, Vice President of Member Experience and Product Development, noted that the selection of the transportation vendor was not made at random, "We were able to identify a vendor with whom we had great success in other areas like durable medical equipment and diabetes supplies and they said, 'We could help you

with transportation too.' So, we made it so simple with one number, and we don't have restrictions where a ride reservation has to be made 24 hours in advance, and we also don't have restrictions on mileage." SummaCare used the vendor to provide additional supplemental benefits, including home safety, acupuncture, massage therapy, and durable medical equipment. The vendor also provides hearing aid benefits for SummaCare beneficiaries.

With the success of the transportation benefit, SummaCare looked for ways to provide even more services. "I guess the best way to describe it is, we've built a relationship and they're interested in innovation as much as we are; we found them to be so service-oriented. We continue to find ways to address these social determinants of health or other needs and it's one [telephone] number."

— Anne Armao,
Vice President of Member Experience and Product Development

Towsley described the collaborative partnership that SummaCare has developed with the vendor, "We do more brainstorming and giving them our big ideas, but they do come to us when they have ideas that they would like to run past us… And they've been able to provide a solution or actions for solutions for anything we've asked so far. We send them eligibility data because each of our health plans offers a different benefit and certain levels. We might have a $250 max for home safety on one plan and $150 on another. When a member calls in, they are checking their benefit, they're making sure that they have the doctor's order if it's required and then they're providing the service and we get monthly reports back on utilization."



Best Practice:

Enhancing Services and Capabilities through Health Plan Partnerships

Case Study:

Meals on Wheels America (Community-Based Organization)

Meals on Wheels America is the national leadership organization supporting more than 5,000 community-based senior nutrition programs throughout the nation. Meals on Wheels serves nearly every corner of the country, with staff and volunteers delivering meals, providing companionship, and checking in to ensure seniors remain safe in their homes.

> **"If someone has a certain score on the UCLA scale, they're eligible for an additional service which is a once-a-week friendly visitor service for 13 weeks, where we match a volunteer to that Humana member who goes out and spends time with that person, plays cards, chats, looks at photos… the hope is that the benefit will be long enough that there'll be a relationship that's borne out of that that will live beyond."**
>
> **— Lucy Theilheimer,**
> **Meals on Wheels America Chief Strategy and Impact Officer**

The focus on addressing senior nutrition and social isolation makes Meals on Wheels an ideal partner for Medicare Advantage plans. In describing local Meals on Wheels program affiliates, Meals on Wheels America Chief Strategy and Impact Officer Lucy Theilheimer remarked "Local Meals on Wheels programs are in the social determinants business, they've been in the social determinants business since the movement began basically. Because it's all about addressing those factors in their home environment, in their communities that can get in their way, and keep them from living a quality life in their communities." Meals on Wheels affiliates partner with Medicare Advantage plans in locations across the country, with health plans most often leveraging their core meal delivery service to assist beneficiaries recently discharged from a hospital or post-acute setting. Some health plans are even looking to expand the set of services for which they contract with Meals on Wheels.

In addition to expanded services, partnerships with some Medicare Advantage plans and other health care organizations are prompting Meals on Wheels affiliates to enhance their data collection capabilities. For example, Meals on Wheels has extended its partnership with select health plans to serve as an important information source for care managers. Theilheimer described one such arrangement: "A plan wanted us to deliver the Meals on Wheels service, but they [also] wanted us to collect more data, daily and weekly observations; some questions they have that we'll be feeding back to plan care managers on a regular basis. So, for them, it was the **access to their members on such a regular basis that will give them deeper insights into what's happening with that individual and what their needs might be, and what other services they maybe should be providing for those individuals**."

Best Practice:

Plan-Provider Partnerships using a Personalized Referral Platform and Community Health Workers to Address SDOH

Case Study:

NowPow (Technology Company)

NowPow is a technology company offering a community resource referral platform that helps health plans and providers connect members to vital social service community-based organizations. Grounded in science, NowPow was founded by Dr. Stacy Lindau—a physician and professor at the University of Chicago—and is focused on providing evidence-based interventions and generating data to measure impact. "NowPow is a personalized community referral platform for every need and every person," said Gillian Feldmeth, Director of Insights and Evaluation Strategy. "The technology helps connect people to the right services so they can stay well, meet basic needs, manage their illness and care for others. Our platform is configurable to meet the partner where they are, which is important, and we also provide a free tool to all community-based organizations." NowPow can integrate with care management and electronic health record software and support three different types of referrals[7]: shared (one-way) referrals, closed loop referrals, and self-serve referrals—all of which are highly personalized to the unique needs of the member.

- **Shared Referrals -** The process in which a health care provider at one level of the health care system, seeks the assistance of a health care facility or health care provider at the same or higher level of the health care system, to assist in or take over the management of the client's case
- **Close Loop Referral -** Provides a means for health care professionals to send patient information to a community-based organization (CBO) to help address a patient's needs
- **Self-Serve Referral -** A physician referring their patient to another care site with which they have a financial relationship in a health care facility

[7] https://medcraveonline.com/IJFCM/a-look-at-the-twondashway-referral-system-experience-and-perception-of-its-handling-by-medical-consultantsspecialists-among-private-medical-practitioners-in-nigeria.html

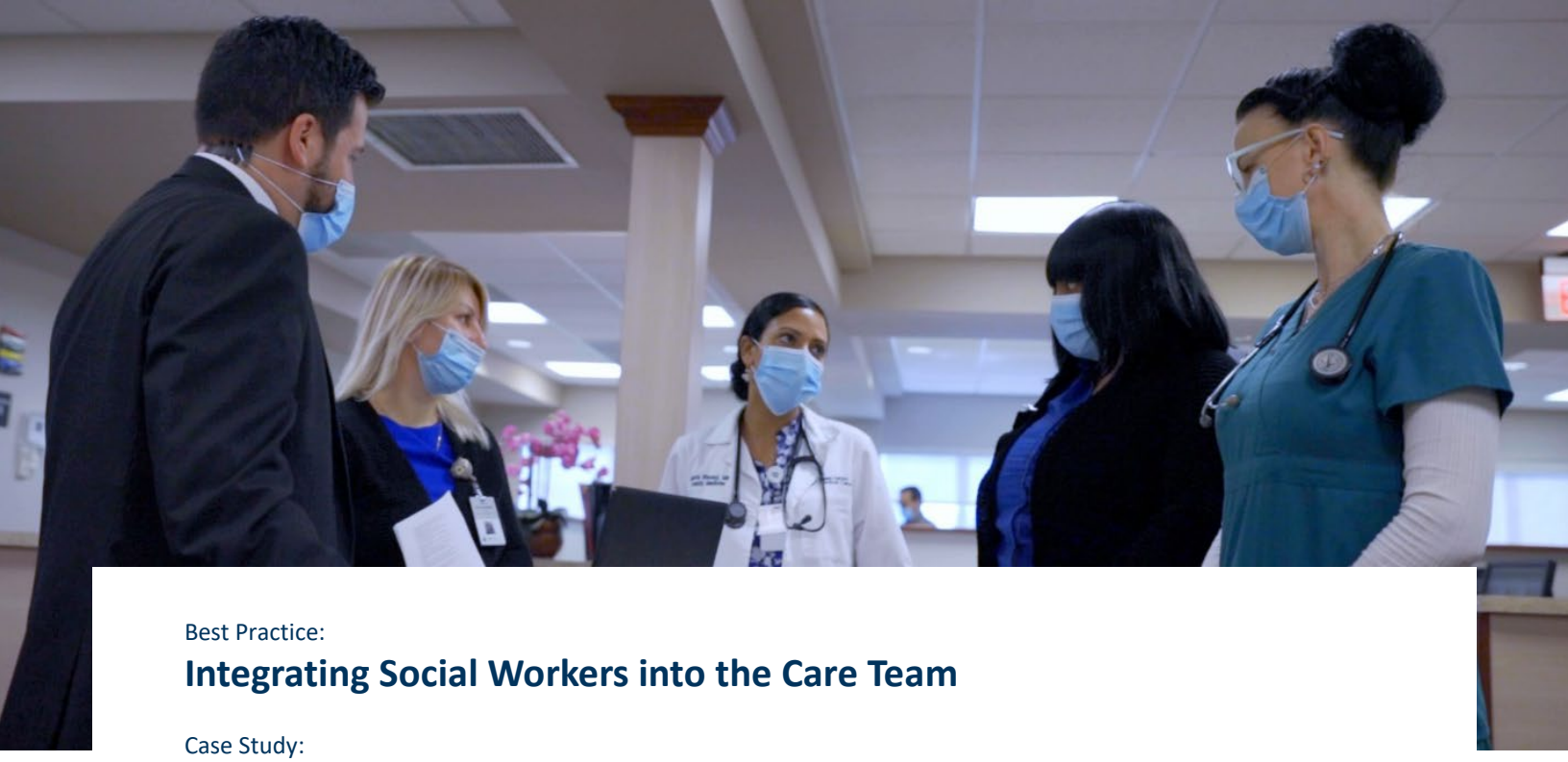
In one implementation of its software, NowPow supports Horizon Blue Cross Blue Shield of New Jersey ("Horizon") in its Neighbors in Health program. Launched in Spring 2020, Neighbors in Health is a Horizon co-funded partnership with health systems across the state of New Jersey where community health workers (CHWs) are trained through the Penn Center for Community Health Workers and deployed to clinical and community settings to provide health coaching and care coordination.[8] The CHWs use the NowPow platform to refer people to CBOs aligned with a person's specific health and social support needs. The initiative targets 24,000 Horizon commercial, Medicaid, and Medicare Advantage (Horizon and Braven Health) beneficiaries across the state of New Jersey.

> **"These are people who not only live in the community but reflect and understand the diversity, values, and culture of the communities they serve. Training is provided by the Penn Medicine IMPaCT Training and Certification Program and CHWs are based at the provider partners, working in consult with Horizon Personal Health Assistants."**
>
> **— Gillian Feldmeth,**
> **Director of Insights and Evaluation Strategy**

Hyper-local connection to CHWs is a critical component for this three-year $25 million investment—NowPow's Feldmeth applauded Horizon for including CHWs in the program and emphasized their importance to the program's success.

NowPow helps **manage SDOH needs in the community by building and managing community networks and facilitating referrals, but also by capturing data to track, measure, and act on outcomes at the individual and community level**. A pilot of the Neighbors in Health program with one Newark health system reportedly produced a 25 percent reduction in total cost of care and a 60 percent increase in behavioral health utilization for engaged beneficiaries over the course of one year.[9] "When we think about outcomes and evaluation, both NowPow and Horizon are able to provide important data points," said Feldmeth. "Data provided by NowPow includes what needs are being identified, how the CHW is interacting with the members, and how often. What resources have been referred and what was the outcome of those referrals? The Horizon team can use this data, in tandem with member-level data on health outcomes and utilization, to enable rigorous program evaluation and ultimately effect real change to improve the health equity of its members."

[8] https://www.horizonhealthnews.com/horizon-neighbors-in-health/
[9] Horizon Blue Cross Blue Shield of New Jersey. "Horizon Neighbors in Health: Progress in 2020, Hope for the Future." 2021.



Best Practice:

Integrating Social Workers into the Care Team

Case Study:

ChenMed (Provider)

ChenMed is a family-owned network of almost 100 primary care clinics in 12 states. Founded by Dr. James Chen more than 35 years ago, ChenMed is currently led by his son, Dr. Chris Chen. A cancer survivor, the elder Dr. Chen designed the ChenMed care model to ensure his own primarily low-to-moderate income patients could avoid the impersonal, uncoordinated care he experienced after receiving a terminal cancer diagnosis.

Based on personal experiences that include poverty and homelessness, the Chens believe their organization has a moral imperative to address the SDOH that decrease life expectancy by as much as 20 years in many lower income minority neighborhoods compared to more affluent neighborhoods just a few miles away.

ChenMed fulfills its mission by incorporating social work directly into the clinical setting. "We go into some of the most underserved neighborhoods in America," said Colleen Mourra, Associate Director of Population Health Management.

Mourra explained that **rather than referring patients out to a social service agency, they rely on their own internal social workers who can readily intervene and identify the SDOH need**. "The initial concern could come from a member of the front desk team, who might be the first to notice that something was not quite right during the check in process, or a nurse case manager who notices something during a hospital or home visit. Sometimes a call from a family member triggers a social work consult."

> **"We serve patients where economic, health literacy, transportation, housing and food insecurity issues often negatively impact our patients' ability to have positive health outcomes. In order to be as effective as possible, we've incorporated social work into our care model."**
>
> **— Colleen Mourra,**
> **Associate Director of Population Health Management**

In these situations, the information is relayed to the appropriate people to get the patient the help they need. In addition to organic patient interactions, Mourra noted that ChenMed attempts to screen every patient for social needs using a Health Risk Assessment (HRA), which generates a large volume of social worker referrals.

One particularly challenging element of integration involves finding the right way to share sensitive information about health-related social needs while respecting patient privacy. "As you develop that relationship of trust with your patients, they may tell you something very personal, and reveal things about their lives that maybe they don't want others to know. We do inform all of our patients that we have a collaborative care model, and that we have teams that regularly meet to try to optimize care, so some information may be shared on a need-to-know basis," said Mourra. She explained how ChenMed has worked to securely share clinically relevant social needs data. "The social work documentation that we've created feeds into our medical records, in a secured section of our EMR, where only specific roles have access. We're always looking for that fine line between communicating to try to optimize the care versus over-communicating or over-exposing. We cherish their trust and strive to maintain that confidentiality as best as possible."

Best Practice:

New Ways to Deliver Supplemental Benefits that Address SDOH

Case Study:

Aetna (Health Plan)

Aetna, a CVS Health company, is one of the largest providers of Medicare Advantage plans, with over 2.9 million beneficiaries nationwide. Aetna has been an early adopter of supplemental benefits related to SDOH, becoming one of the first of nine health plans in the nation to participate in the Value-Based Insurance Design (VBID) demonstration. Aetna used its participation in VBID to develop an enhanced model of care for beneficiaries with congestive heart failure (CHF) and introduced supplemental benefits to address SDOH including non-emergency medical transportation and home-delivered meals. For Aetna, the ability to target additional benefits is key.

Aetna's spirit of early adoption continued when Congress created the Special Supplemental Benefits for the Chronically Ill (SSBCI) option, with Aetna participating in 2020 during the program's first year of implementation. **The plan offered benefits targeting social isolation and food insecurity to individuals with a variety of chronic illnesses**. To address social isolation, Aetna is working with Papa Inc. Papa connects older adults to younger "Papa Pals" who provide companionship as well as help with tasks such as car rides, household chores, and using technology. During the pandemic, Papa Pals shifted to virtual visits to keep members safe, and members report high satisfaction with the program. Aetna believes this model provides a meaningful way to address social isolation and other SDOH and plans to expand the program in the future

Another SDOH initiative Aetna put forward is a food program, which consist of two separate supplemental benefits — home-delivered healthy meals and a food card providing access to healthy grocery items. The food programs have proven to be quite popular during the pandemic, since many beneficiaries were operating under stay-at-home orders. The utilization has been high, and members really appreciated the help.

"We have long been supportive of this idea that not all benefits are appropriate for all people, that everyone has different needs, and meeting them where they are is critical,"

—Rose Mollitor,
Senior Director of Medicare Product Innovation

Looking forward, Aetna continues to explore how these flexibilities allow for new benefits and programs that bring value to their members and address their unique health care needs.

Best Practice:

Bringing SDOH and Care Coordination Services into the Home

Case Study:

Partners in Care Foundation (Community-Based Organization)

Partners in Care Foundation ("Partners") is a California-based non-profit organization that works with health care organizations, government agencies, and other community-based organizations to deliver programs and services that support individuals with complex health and social service needs. The organization's programs include home- and community-based services, chronic condition management, medication management, and transitional care management services. Many of Partners' programs are intended to directly address SDOH – a priority reflected in its organizational mission to "align social care and health care to address the social determinants of health and equity disparities affecting diverse, under-served and vulnerable populations."

While most of Partners' programming is funded through Medicaid, the organization also works extensively with Medicare patients through partnerships with health plans for all business lines, health systems, and providers. **Many of the programs involve bringing aligned care coordination and SDOH services directly into the patient's home**. "We have a variety of services we can provide, depending on the needs of the individual and the goals of the organization paying for our services. But with COVID, we did have to shift many of our programs to telephonic models," said Ester Sefilyan, Vice President of Network Services.

Partners collaborated with an MA plan where Partners serves members with complex needs and who are at risk of hospitalization. "The plan's care managers refer beneficiaries to SDOH programs using open criteria, focused mainly around diagnoses," said Sefilyan. "Maybe a recent hospitalization triggers the need for a community partner to go out and see what is really going on with the person and set them up with the appropriate post-discharge services. Partners helps identify and connect those members with SDOH services and resources."

> **"We deploy evidence-based programs. One of them is the Care Transitions Interventions model, CTI, a coaching program to reduce hospital readmissions by empowering patients to take charge and build skills to know what to do before they pick up the phone and call 9-1-1. Another is the Bridge Model of Transitional Care, a person-centered, social work-based, telephonic care coordination program focused on improving health, safety and quality of life."**
>
> **— Ester Sefilyan,**
> **Vice President of Network Services**

Partners staff expressed optimism about the potential to grow their services in Medicare—specifically Medicare Advantage. President and CEO June Simmons described applying current Medicaid services to the Medicare population: “Medicaid long-term services and supports home visits provide eyes and ears in the home to see what's really going on and identify the risk factors in the physical environment that impact the individual’s health or recovery. Are they taking their medicine with food? Is there food in the house? Is there mold and mildew from roof leaks? Are they regularly falling because of loose rugs, poor lighting, or medication interactions? Discovering and addressing these factors drives proper recovery, re-stabilization, and effective use of health care - the trinity of right care, right place, and right time. These interventions work well for Medicare Advantage.” Sefilyan agreed, “I think it's going to expand for Medicare Advantage, especially non-medical home care services that we're starting to see more of with health plan offerings here in California. We're eager to see Medicare flex up and recognize whole person care and get out of fee-for-service wherever possible.” June Simmons recognized that “Medicare Advantage is a great step forward and obviously increasingly taking hold in our country”.

Evaluation

Best Practice:

Building a Strategy to Evaluate Interventions

Case Study:

Unite Us (Technology Company)

Unite Us is a technology company that provides an end-to-end solution, connecting health plans and providers to CBOs that address health-related social needs. The Unite Us platform provides the ability to make referrals and directly track beneficiary interactions with CBOs to confirm service delivery and health outcomes. The list of organizations partnering with Unite Us include some of the largest Medicare Advantage plans in the country, though implementations tend to be built out around networks of services at the local level.

The referral and tracking functions within the Unite Us platform facilitate efforts to evaluate the effect of interventions. "Health plans are paying for access to our network, which means those providers who connect with patients– care managers, discharge managers, social workers, or community health workers–can send referrals and see in real time which organizations can meet this person's needs. They can also know if that person actually got services and receive the reporting data specific to the people they refer," said Melissa Sherry, PhD, Vice President of Social Care Integration. "They're saying, 'I want to know what happened when I referred somebody: where they went, what they received, what that looks like, how long it took, which organizations are my members going to, and whether they've been helped.'"

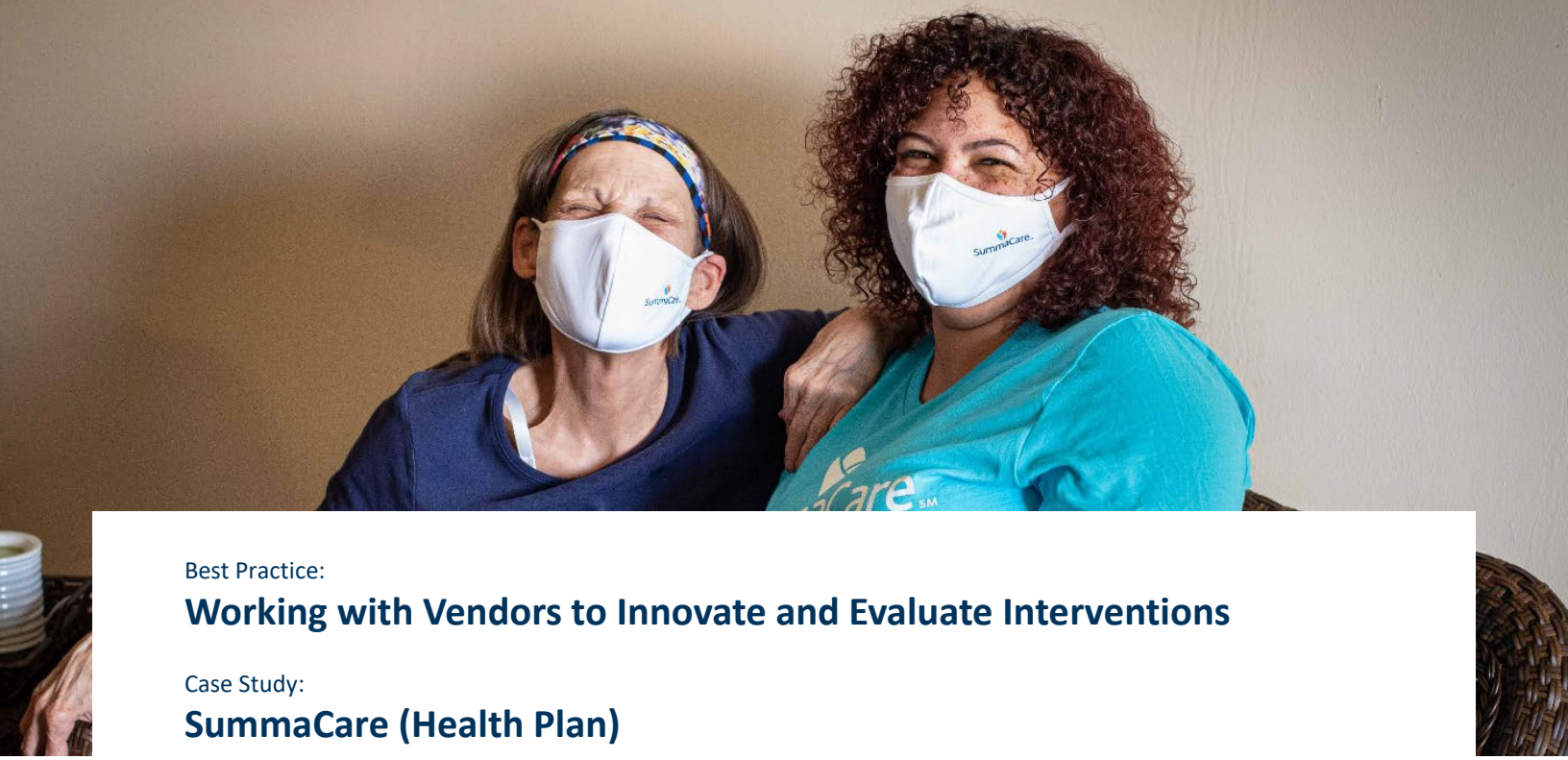
Unite Us is not interested in simply turning over the data to its health plan partners, but rather to actively partner in developing evaluations. "What we're really excited about is partnering around evaluation and **helping health plans think about how to combine data sets to link claims data with the data from [the local community] networks. Combining those [data] allows us to tell the story of what happened when somebody receives social services**," said Sherry. "I think often the narrative from health plans is… 'what's my ROI?' It's not the wrong question, but it's one of many questions that should be answered. So [analyses] like, 'What about provider efficiency? What about quality measures? What about adherence to medication or preventive care that leads to improved self-management?' There are so many different types of value linked back to addressing social needs. We're exploring the types of value that come from meeting people's basic needs and working with different partners to quantify that."

Unite Us is building out a research and evaluation team to perform evaluations of previous interventions and to collect evidence to better recommend new partnerships to address beneficiary and patient needs. In addition to health plans, Sherry also expressed interest in academic and research partnerships to evaluate the effects of SDOH interventions: "Some of our partners have external evaluators, which is great; we welcome having outside sources assessing our solution and products. For example, in North Carolina, the Unite Us Platform is statewide, in all 100 counties. We are partners with Duke University and the University of North Carolina Chapel Hill, who have different plans and some quick-win evaluations that are going to start happening. And I'm really excited about the opportunity there and the data that we'll be able to use because that's going to be large-scale and hopefully lead to a lot of good insights."

"Health plans are paying for access to our network, which means those providers who connect with patients– care managers, discharge managers, social workers, or community health workers–can send referrals and see in real time what organizations can meet this person's needs. They can also know if that person actually got services and receive the reporting data specific to the people they refer."

— Melissa Sherry, PhD, MPH
Vice President of Social Care Integration

Sherry explained that evaluations make business sense and are core to the mission of Unite Us: "We're a mission-driven company, and I think a lot of what we're trying to do on the research and evaluation side is to prove the value of investment in social care and connecting people to care. We are elevating the status of meeting human beings' basic needs."



Best Practice:

Working with Vendors to Innovate and Evaluate Interventions

Case Study:

SummaCare (Health Plan)

Sponsored by the health system Summa Health, SummaCare partnered with Papa Inc. Papa connects older adults to younger "Papa Pals" who provide companionship as well as help with tasks such as car rides, household chores, and using technology. Papa recruits its "Papa Pals" and provides training and access to an app through which the Pals can schedule visits with seniors. Papa has partnered with several Medicare Advantage plans and has recently added telehealth and digital health offerings to its services.

SummaCare engaged Papa to begin providing supplemental benefits in 2020 and was excited to provide its beneficiaries with access to Papa's core services in addressing social isolation. However, the onset of the COVID-19 pandemic forced SummaCare and Papa to reconsider their program design due to obvious safety concerns for seniors and their Pals. Instead of canceling the benefit, the organizations worked to shift to virtual visits and added a focus on addressing care gaps exacerbated by the pandemic, taking advantage of benefit flexibilities afforded by CMS during the public health emergency. "With COVID we had goals to reduce social isolation and loneliness, and we also wanted to close care gaps. So we worked with our clinical team to identify select beneficiaries and the initial file we pulled were plan beneficiaries that weren't compliant on their breast cancer screenings, their colorectal screenings, beneficiaries that hadn't had a wellness visit [in the past 12 months]," said Kerri Towsley, Manager of Product Development and Market Intelligence. "We started in August and [developed] conversation guides for care gap reminders. We also wanted to work [on] questions [related to] urinary incontinence… So it's more a conversational guide so it wasn't awkward and we got a lot of really good data."

> **"One member said, 'I love talking to my Pal in Texas who used to live in Nigeria because my husband and I traveled the world, and we can't do that anymore.'" Armao also indicated that Summa and Papa are continuing to innovate to find additional ways to support member social needs. "Now we have local Pals, and we're doing some stories about where the light housekeeping comes in and the household chores and taking them shopping or doing the shopping for them and dropping it off.**
>
> **— Anne Armao,**
> **Vice President of Member Experience and Product Development**

The close partnership with Papa extended to evaluating program results. Towsley reported that Papa surveyed beneficiaries at the start and end of the 2020 pilot program, using questions from the UCLA Loneliness Scale and the CDC Healthy Days measures. **The survey results indicated that beneficiaries involved in the pilot experienced 53 percent less loneliness and two fewer self-reported unhealthy days.** In addition, SummaCare's already strong net promoter score (NPS) increased among pilot beneficiaries. Beyond the impressive

numbers, Anne Armao, Vice President of Member Experience and Product Development, expressed excitement for the relationships developing under the program and for its post-pandemic expansion.

Best Practice:

Sharing Lessons Learned Around Addressing SDOH

Case Study:

SNP Alliance (National Leadership Group)

The SNP Alliance is a group of leading specialized managed care programs representing Medicare Advantage Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs). SNP types include Dual-Eligible Special Needs Plans (D-SNPs), Chronic Condition Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs). SNP enrollment has grown rapidly in recent years, with D-SNPs accounting for the highest overall enrollment. Of the 3.84 million people enrolled in a SNP, 3.38 million are in a D-SNP. Due to the nature of the populations served, SNP members face significant challenges related to SDOH. "Regardless of SNP type, quite a high proportion of the individuals enrolled are dually eligible and… dual eligibility is a proxy for having substantial social determinants of health risk factors," said Dr. Deborah Paone, DrPH, MHSA Performance Evaluation Lead and Policy Consultant.

The SNP Alliance is comprised of many of the leading SNP and MMP organizations—as measured by both enrollment and quality rating. **Addressing SDOH has been a key focus of the Alliance and its member health plans in recent years, and the Alliance has undertaken numerous efforts to identify and share best practices and lessons learned across its membership.** For the past five years, the SNP Alliance has surveyed health plan members about SDOH efforts, including topics such as screening and HRAs, SDOH data sources, and the evaluation of SDOH interventions and collaborative partnerships. The annual survey has allowed the SNP Alliance and its member health plans to track progress around SDOH issues. "Doing this now for almost five years in a row, we tweak the questions but try to have continuity so that we can see changes," said Dr. Paone. "We've seen more sophistication over the years about SDOH as health plans reported SDOH efforts and responded to our annual survey questions. We see greater understanding and capability to find [and] use [a variety] of data sources for identifying and addressing SDOH issues in their special needs and dually eligible populations. We see greater ability to stratify or categorize different risk issues within their enrolled membership." SNP Alliance has made the survey results available on its website.[10]

In addition to the survey, the SNP Alliance hosts two conferences each year, with topics frequently addressing SDOH. "We tailor content and topics around current issues and interest areas. For example, a couple of years back we focused on health risk assessment. We have also examined issues related to models of care. Special needs health plans are the only type of Medicare Advantage plan where a written and reviewed Model of Care is

[10] https://snpalliance.org/wp-content/uploads/2021/07/SNPA-Member-Profile-Brief-FINAL-June-30-2021.pdf

required. Both the National Committee for Quality Assurance and CMS review and/or audit these Models of Care. We've also focused on quality measurements and person-reported outcomes—the instruments, methods, and measures—to try to advocate for the multi-dimensional needs and characteristics of special needs populations to be recognized in quality measurement and performance evaluation," said Dr. Paone.

Additionally, SDOH issues frequently arise in the Alliance's work groups, including the Performance Evaluation, Clinical Leadership, and Policy groups. The SNP Alliance also forms ad hoc groups to discuss specific topics. "We have had small group discussions among, [for example], a group of health plans that are leading in a certain area, like FIDE-SNPs. And we did an analysis on certain things like frailty and some of the quality measures around advanced illness" said Dr. Paone. The conferences and working groups allow for the sharing of best practices and lessons learned across SNP plans.

"With some of the D-SNPs, FIDE-SNPs, MMPs having decades of experience working with the vulnerable populations, they have best practices that they have baked into all of their work. For more than two decades some of the SNPs in our Alliance have looked at risk factors like housing and food insecurity, social isolation, lack of transportation, etc. All of these things are important, because if the person can't eat well, they can't manage well, they can't manage their diabetes, for example. If they don't have a fridge, they can't keep their insulin cool …When you have that much experience, like some of the SNPs have in this space, you figure out why it's important to focus on SDOH—these plans pay attention to the living environment and social support; they continue to work on these issues in collaboration with others."

— Dr. Deborah Paone, DrPH, MHSA
Performance Evaluation Lead and Policy Consultant

Conclusion & Looking Forward

In recent years, Medicare Advantage plans have taken significant steps to address the SDOH needs of their beneficiaries. In doing so, plans have often formed innovative partnerships with providers, technology companies, and community-based organizations to advance their efforts. Work has focused on three broad areas of development: 1) identifying reliable sources for data on beneficiary social needs and incorporating the information into clinical programs; 2) delivering interventions or connecting beneficiaries to interventions that address social needs; and 3) evaluating health outcomes and ROI associated with interventions. As these case studies demonstrate, many SDOH programs are beginning to prove successful for Medicare Advantage beneficiaries.

Many of the cases in this report focus on efforts enabled by recent CMS policy flexibility surrounding the provision of supplemental benefits focused on social needs. The cases identify best practices that have emerged in the initial years of the new flexibilities, and provide early lessons learned to help the health care community and policymakers expand on these initial efforts to address social needs. Previous research[11] from NORC and BMA identifies several policy recommendations to further enhance the ability of Medicare Advantage plans, providers, and community organizations to address the social needs of their beneficiaries and thereby improve health outcomes and overall well-being.

[11] https://bettermedicarealliance.org/news/report-shows-dramatic-increase-in-medicare-advantage-activity-to-address-social-determinants-of-health-but-barriers-remain/