Improving Healthcare Outcomes Through Social Care

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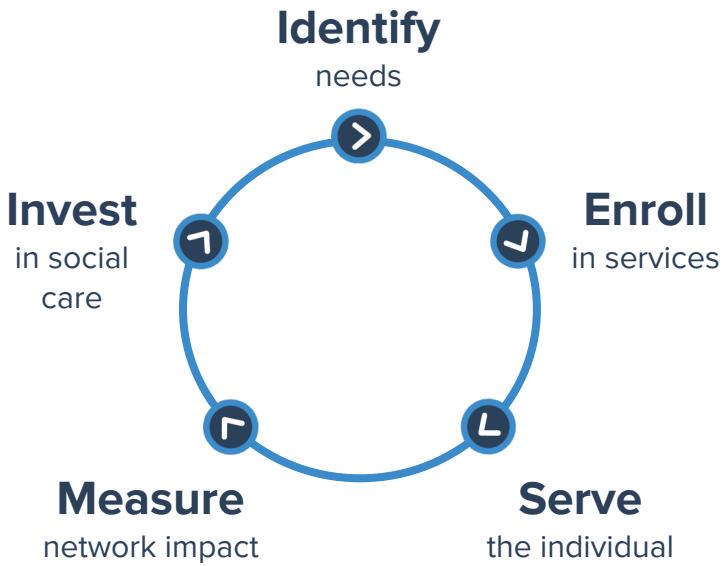
I. Brief Introduction to Unite Us

The only end-to-end solution for social care



- We are **committing to improving health outcomes** by promoting access to social services as part of overall well-being.
- We are creating not just the future of healthcare but the **future of health.**
- We are building **sustainable infrastructure for social services** to not only survive but thrive.
- We are creating a **functioning ecosystem to support paid service delivery** to improve well-being and ensure equitable access to care.

UNITE US + CARROT HEALTH + NOWPOW

II. Social Care Context

The Need to Move Care Into the Community

The U.S. overspends on healthcare, seeing poor results because of failures to address social needs

Impact on **Patients**

2x
Higher death rate for individuals unemployed for more than six years

16 years
Decrease in life expectancy across six mile stretch in Chicago neighborhoods

5x
Higher risk of developing mental health conditions due to exposure to violence and feeling unsafe during childhood

2x
Increased risk of developing coronary artery disease due to social isolation

Impact on **System**

$2,320
Per capita annual health system expenses due to housing instability

24% to 67%
Higher likelihood of readmission for patients dually enrolled in Medicare and Medicaid

60%
Higher risk of ED utilization for patients requiring language services

$155B
Annual cost to the U.S. health system due to food insecurity

Source: https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.1515

Growing National Focus on Social Needs

Healthcare policy and regulations are pushing a focus on social drivers of health

- Government Programs and Policies
- Quality and Data Requirements
- Accreditation & Certification Requirements
- Increased Focus on Cross Sector Partnership

Non Medical Drivers of Health: A Focus on Texas

Non Medical Drivers of Health Action Plan

- Texas HHS Medicaid and Chip Services created action plan to reduce costs, improve health outcomes and reduce avoidable utilization through focus on food insecurity, transportation and housing
- Goals:
  - Build data infrastructure for quality measurement and evaluation.
  - Coordinate services and existing pathways in delivery systems
  - Develop policies and programs that encourage MCOs and providers to identify and address health-related social needs while containing costs.
  - Foster opportunities for collaboration with key partners.

Addressing Non Medical Drivers of Health to Improve Maternal Health

- HB1575 addresses non medical drivers of poor maternal health outcomes
- Requires creation of new standardized NMDOH screening for pregnant Texans to identify and mitigate social risk factors
- Allows CHW and Doula reimbursement through Case Management for Children and Pregnant Women program

III. The Importance Addressing Social Drivers of Health


BUT WHY ARE OUR HEALTH CARE COSTS HIGHER THAN OTHER COUNTRIES?..
...WHO SAID THAT?..
USA
SUPER GULP
WAT HANDELSMAN
Newsday

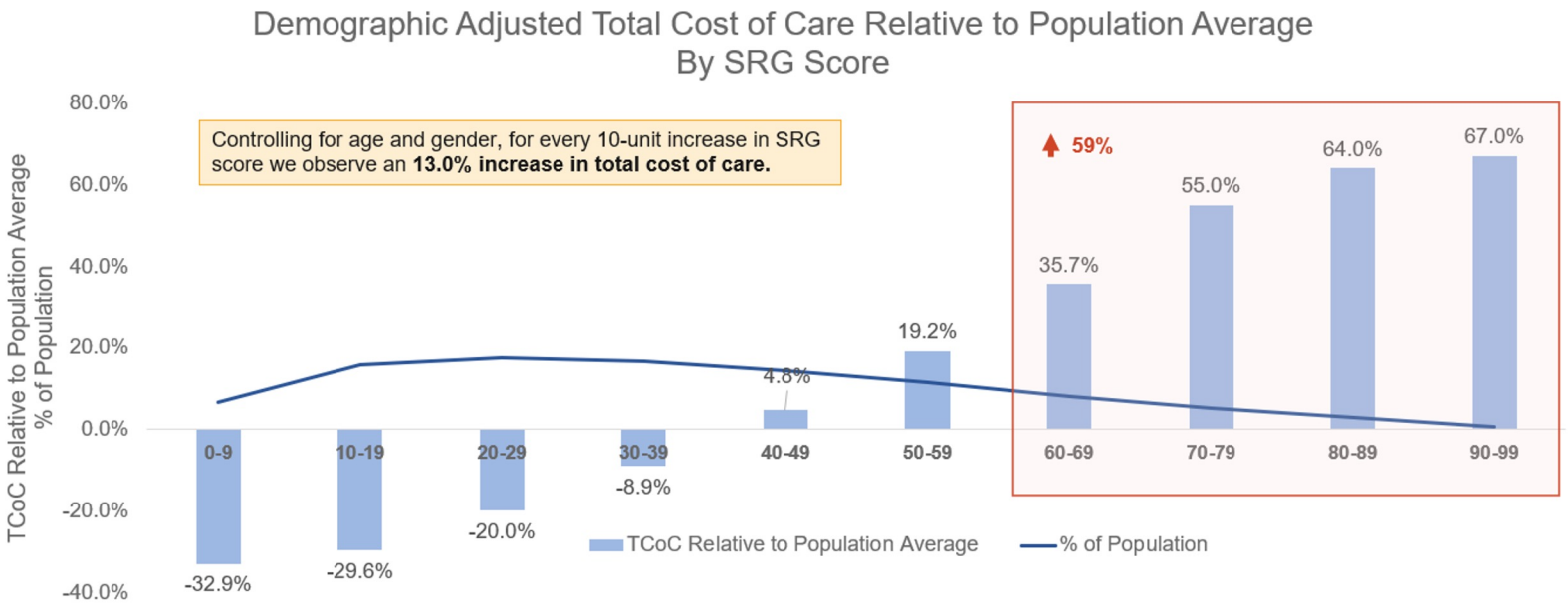
High Social Needs* Are Associated with Adverse Health Behaviors, Experiences & Outcomes

- **37% higher** maternal complications
- **59% higher** total cost of care
- **79% higher** inpatient hospital admissions
- **100% higher** emergency department visits
- **30% higher** regression in health status
- **102% higher** reported “unhealthy days”
- **21% higher** gaps in care compliance and medication adherence
- **9% less** favorable experience with healthcare

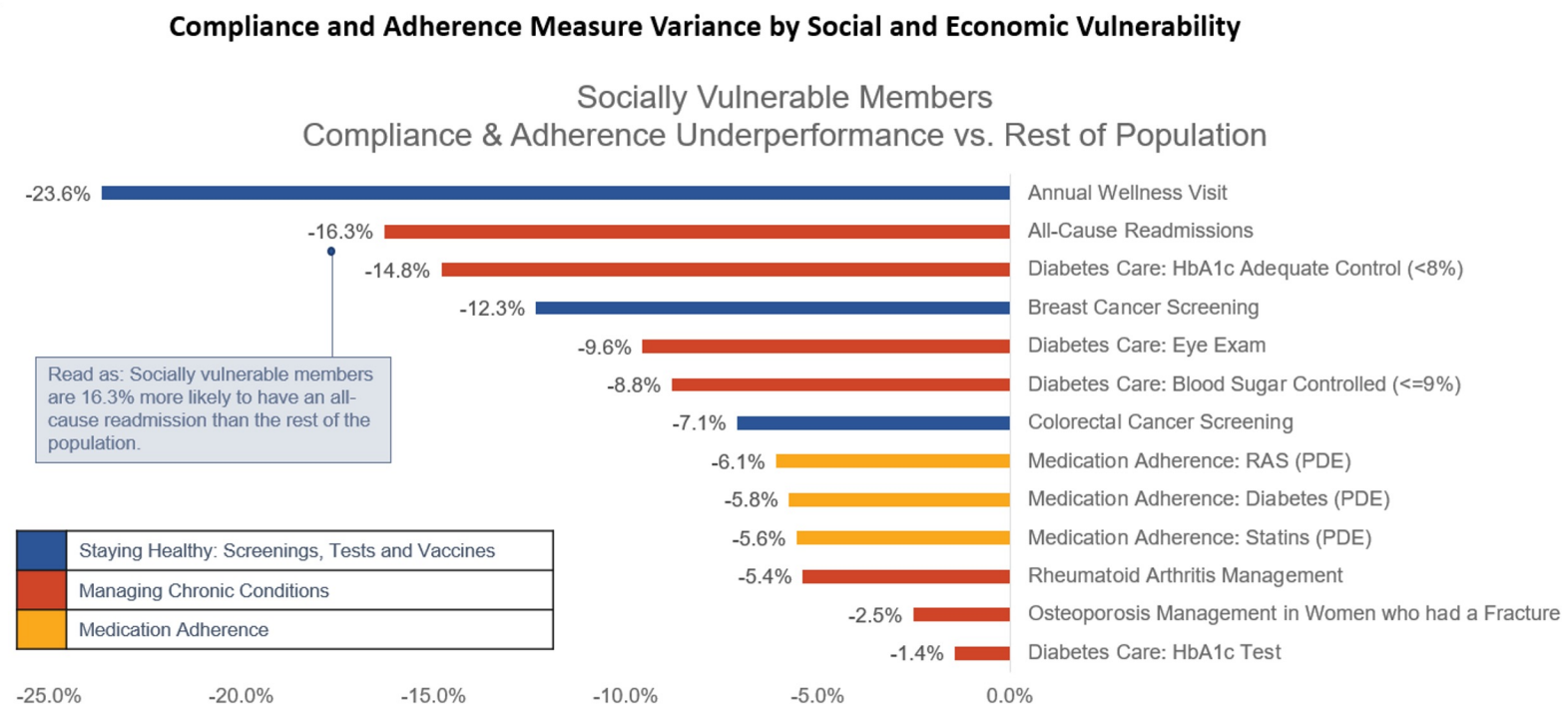
**Note: High social needs defined by Unite Us data showing social needs scores >60*

Individuals with High Social Vulnerability Have Significantly Higher Total Cost of Care

Total Cost of Care by Social and Economic Vulnerability



Social Vulnerability Affects Quality Outcomes



Addressing Social Needs Generates Value

Insights

- Uncover member needs and where they receive services
- Increase social care data for risk modeling and prediction

Cost Savings

- Reduce total cost of care
- Reduce avoidable utilization and improve compliance with preventive care

Efficiency

- Improve social care navigation
- Maximize provider system efficiency and improve value of care delivered

Quality

- Promote healthcare quality (ex: HEDIS scores)
- Compliance with quality standards (ex: NCQA, NQF)

Satisfaction

- Increase customer and provider satisfaction
- Increase member retention

IV. Challenges to Social Care Initiatives

Health Plans have struggled with barriers to meaningful investment in SDoH.

Challenges:

- Lack of data on social needs to identify at risk populations
- Lack of standardized information on CBOs and their capacity to meet patient needs
- Difficulties determining which CBOs to work with and structuring partnership arrangements
- Sustainable funding in the face of short funding cycles and need for ROI
- Organizationally and technically oriented toward medical services and medical providers, not social services

V. Leveraging Communities to Improve Health Outcomes

A Case Study from Unite Us

Case Study

Background: a large payer wanted to implement a program to improve maternal health outcomes, and wanted to focus on screenings for social needs, referring out to organizations that could meet those needs, and paying for doula services

They needed infrastructure to:

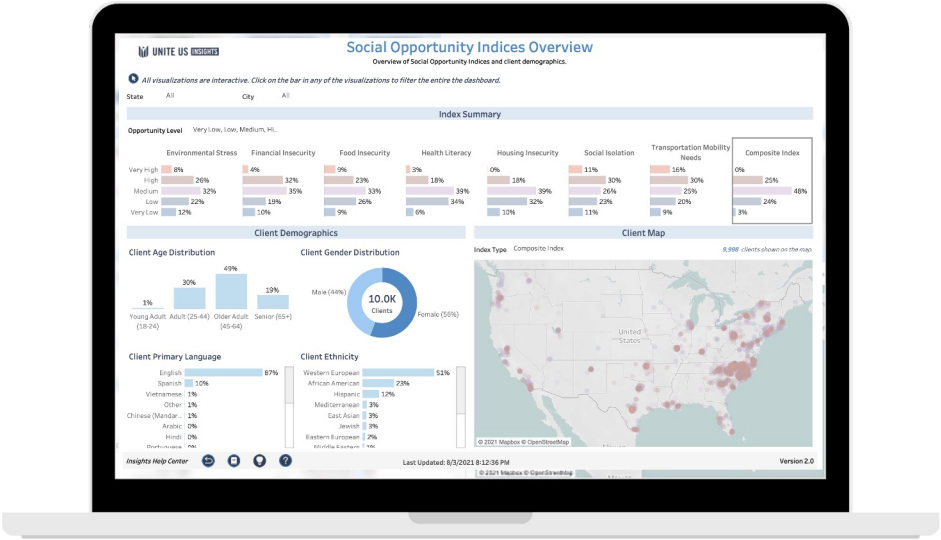
- Identify which individuals were likely to have social needs that could impact their health outcomes
- Connect individuals with social needs to a doula to who can refer them to the **appropriate organizations** to serve their social needs, in addition to supporting them through pregnancy
- Track and measure **whether or not their members received social services**
- **Reimburse doulas** for their services
- Evaluate the impact on outcomes and determine **return on investment**.

The payer partnered with Unite Us to implement a maternal health program **focused on addressing social needs**.

UNITE US

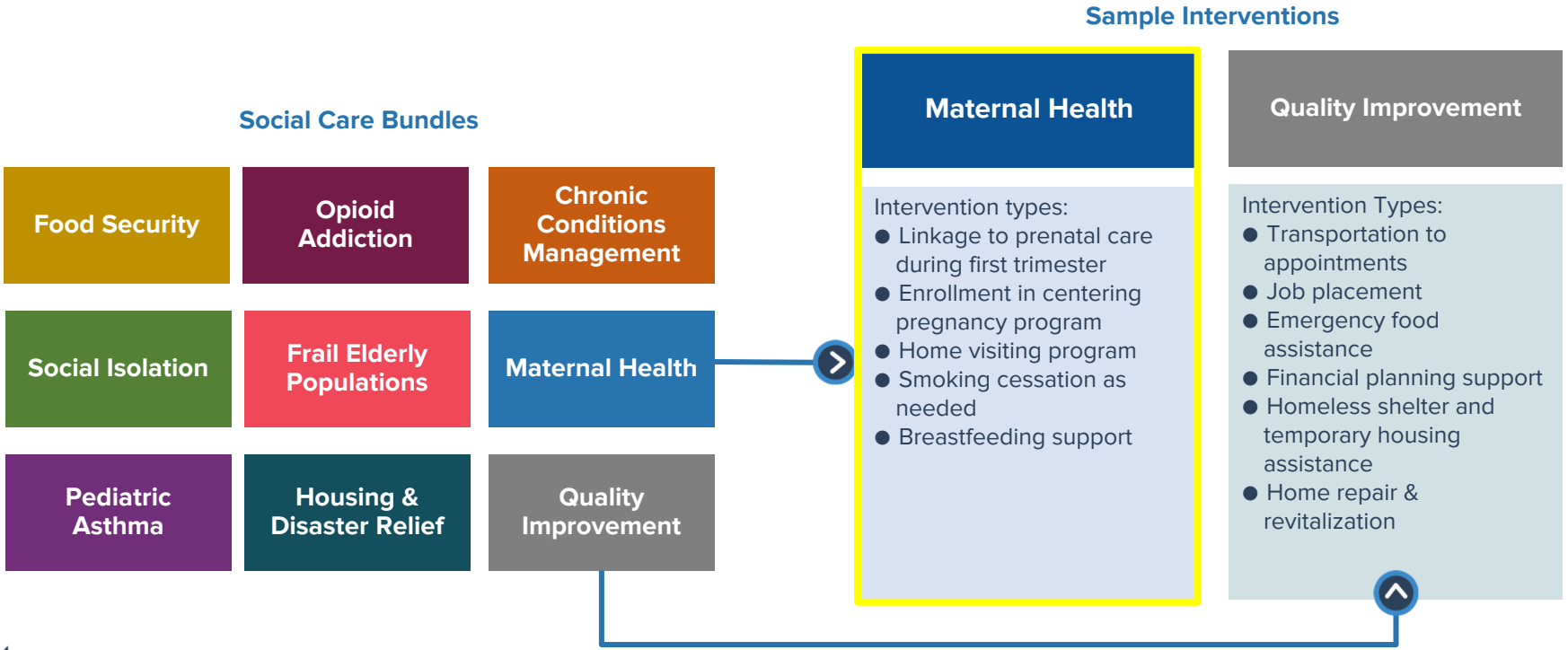
The Payer used predictive analytics to identify the most socially vulnerable members in their pregnant population

More specifically, predictive models from Unite Us identified the individuals who were likely to have social needs that could impact their ability to engage with prenatal care and have a healthy pregnancy



Evidence Based Social Care Interventions

Connect to the right social services and CBOs who can deliver them



Armed with data on the main social needs associated with their pregnant population, the payer designed a social needs intervention.

Establish evidence-based interventions.

The payer identified food insecurity, home visiting programs, transportation, and household goods as critical NMDOH in this population

2. **Use Unite Us data to identify CBOs to partner with and services they will deliver.**

Unite Us identified community based organizations who provide relevant services and engaged with them around participation in outreach and services delivery.

3. **Determine outreach strategy, train users, and configure programs and assessments in Unite Us.**

The payer decided to use care managers and doulas to outreach high risk members and screen them. All users, including those at participating Doula organizations, trained to use Unite Us to screen, determine eligibility, serve the client, and document outcomes.

4. **Choose enrollment criteria and begin outreaching members for screening.**

Using social risk scores, the Payer prioritized members for social needs outreach, screening and enrollment in social care program

Eligible members received social services, referred and tracked through the Unite Us network.

Screening and Referral

CMs and Doulas screen and refer eligible members to target organizations to receive social are interventions.

Social Services Delivered

CBOs receive and accept referrals, outreach member and deliver services, document services delivered, and refer individuals to other social services as needed.

Targeted Reimbursement

Doulas were able to submit claims back to the health plan through Unite Us for milestones such as prenatal care visits, birth attendance, and postpartum care.

Data gathered from intervention was used to monitor and evaluate the quality improvement program.

CBO Performance Review and Management

The payer was able to monitor the program, including seeing data on screenings, top needs, referrals to social care organizations, services delivered, and all data needed to manage performance of the program.

Workforce Management and Health Equity

The payer was also able to monitor the activity of all participating doulas through a workforce management visualization, and tracked whether or not their intervention was reaching target populations of different backgrounds and demographics.

Based on initial results of social care program, the payer expanded doula services and refined program to include grant payments to community based organizations struggling with capacity constraints.

Community based organizations participating in paid arrangements agreed to provide services to eligible members and invoice for their services.

Sustainable social care funding

Data to inform health impacts

Refine as we go

Continue to assess and iterate on our offerings while analyzing the value of social care

VI. Evaluation Case Study: First 1000 Days Initiative

A Case Study from Unite Us

First 1,000 Days Suncoast

First 1,000 Days is a regional initiative of 85+ partner organizations working together to improve coordination and increase access to care for pregnant mothers and families with young children.

2018

Sarasota Memorial Healthcare System was designated as the backbone organization for the First 1,000 Days Suncoast Initiative, to lead the strategy and operations.

2020

Through the First 1,000 Days Initiative, Sarasota Memorial partnered with Unite Us to connect pregnant patients with social care services in the community. Investing in cross-sector collaboration technology helped:

- **Generate community data to identify patients' unmet social needs**
- **Coordinate resources and deliver timely services**
- **Measure impact of interventions**

Study **Design and Main Takeaway**

Study Design

This study used a retrospective, matched, case-control design. The total study sample was **2,456** which included **1,228** patients who screened positive for one or more social needs and were referred for social care through Unite Us between August 2020–March 2022. They were matched based on criteria including demographic characteristics and insurance status.

Main Takeaway

We found **statistically significant reductions in odds of hospital (re)admission up to 12 months postpartum**, for all patients referred through Unite Us compared with patients who received usual care.

Study Sample Characteristics

Characteristic	Cases (n=1,228)	Controls (n=1,228)
Age (mean, SD)		
	28, (5.93)	29, (5.59)
Race		
Black	19%	19%
White	56%	56%
Other	25%	25%
Missing	0.2%	0.2%
Ethnicity		
Hispanic/Latino	28%	28%
Preterm	**(<37 wks)**	
	16%	16%
Low Birthweight	**(<2500g)**	
	14%	14%
Insurance Status		
Government	67%	67%
Private	32%	32%
Self-Pay	1%	1%

Sarasota Memorial Care Coordination Workflow

Ellen (New Mom)

Sarasota Memorial Women & Children's

Nurse conducts brief SDoH screener in Obstetric Emergency Care Center or upon admission to Labor and Delivery

SDoH screening

If positive, Case Management is alerted automatically through Electronic Health Record.

Sarasota Memorial Case Manager meets with Ellen and does a thorough assessment.

Care Coordination

Ellen's screening reveals the need for postpartum supportive care and food assistance. Prior to Ellen's discharge, the case manager refers her for Home Visiting services and food services.

Prior to discharge, families are provided additional resource navigation through First 1,000 Days Suncoast

Home Visiting Services
Ellen receives **Home Visiting** from Healthy Start for wellness checkups, lactation support, and parenting education

Food Assistance
Ellen receives assistance from All Faiths Food Bank.

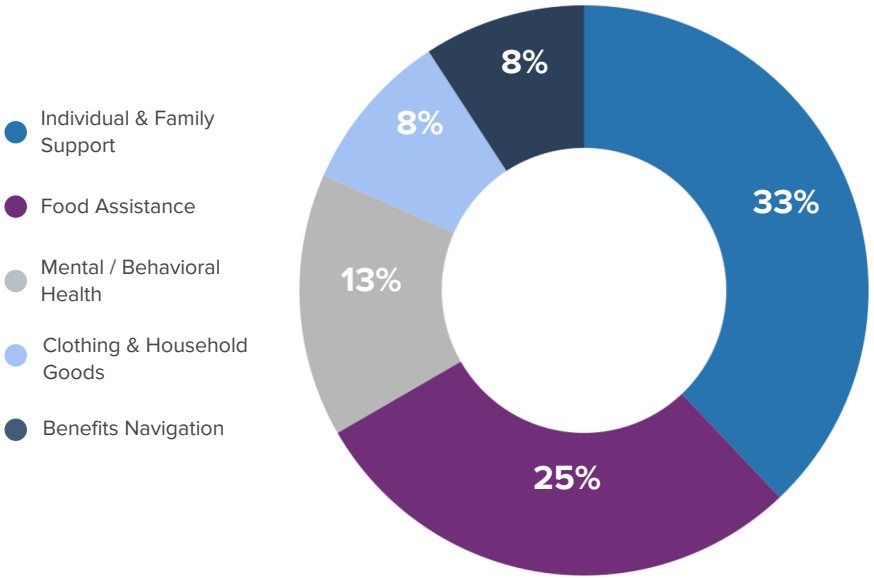
As Ellen receives care, Sarasota Memorial and community resource users receive **automated updates on Ellen's total health journey.**

UNITE US

SARASOTA MEMORIAL HEALTH CARE SYSTEM

FIRST 1,000 DAYS SUNCOAST

Top Five Service Types Referred for Sarasota Memorial Patients



Individual & Family Support
Home visiting programs, Parent education and support, Postpartum support and infant wellness

Food Assistance
SNAP/WIC, Infant formula/food, Prepared meals, Emergency food assistance

Mental/Behavioral Health
Mental health evaluation, Mental health education, Family counseling

Clothing & Household Goods
Diapers/infant supplies, Toiletries/ personal hygiene products, Furniture/home goods

Benefits Navigation
Benefits eligibility screenings, ID/documentation assistance

Sarasota Memorial Results First 1000 Days Results

30 Day Hospital Readmission Rates

Medicaid enrollees

70%↓

Reduction in odds of **All-Cause** readmissions

23 fewer all-cause readmissions per 1,000 Medicaid deliveries

79%↓

Reduction in odds of **Postpartum-related*** readmissions

23 fewer postpartum-related* readmissions per 1,000 Medicaid deliveries

*Postpartum-specific ICD-10 codes (e.g. maternal mental health, labor and delivery complications, gestational diabetes, and Type II Diabetes)

Continued Impact **Over Time**

Postpartum-Related Hospital Admissions

64%↓
Reduction in odds of admission at **3 months**

57%↓
Reduction in odds of admission at **6 months**

53%↓
Reduction in odds of admission at **12 months**

All-Cause Hospital Admissions

58%↓
Reduction in odds of admission at **3 months**

40%↓
Reduction in odds of admission at **6 months**

37%↓
Reduction in odds of admission at **12 months**

UNITE US · SARASOTA MEMORIAL HEALTH CARE SYSTEM · FIRST 1000 DAYS

VII. Summary

Implementation of an End-to-End Social Care Program

To advance quality and improve health

Identify

Individuals target population and associated social needs and **develop engagement strategy**.

Enroll

Target population in **social care bundle that can help ensure outcomes of interest improve**

Serve

identified population with the help of **a curated network of social care providers.**

Measure

Gaps closed and changes in outcomes **by race, age, and percent changes in outcomes.**

Invest

Invest in services and programs proven to produce cost, quality, satisfaction, and other value outcomes.

Get in Touch

www.UniteUs.com

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