



National Strategic Partnerships

Addressing Social Determinants of Health (SDoH) and Building Provider Partnerships through Data & Technology

AZ CVN HCCN 4th Annual Health Information Technology (HIT) Symposium

Angie Meyer

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Welcome & Introductions



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Objectives



- ✔ Provide an overview of UHC's Social Determinants of Health (SDoH) program to the Healthy Communities Collaborative Network and its partner Primary Care Associations
- ✔ Review the UHC collaboration focused on the exchange of SDoH data from FQHC Population Health Management Tools
- ✔ Learn the advantages of participation and the value proposition

Our Commitment to Social Determinants of Health



We are a **health care** company

We help people **live healthier lives** through better care delivery

We are **redefining access to care** for underinsured and underserved populations

Our Hypothesis – Initiated January 2017



By building an infrastructure around social determinants of health, we can help:



Redefine health to consider the whole person – not just medical care.



Remove barriers that limit access to care and address health disparities.



Improve overall health and well-being of all vulnerable populations.

Concurrent Happenings: Socioeconomic & Health Care



Related findings/changes validate the need for SDoH inclusion in health care.

53% of US households have no emergency savings; over half of these are people 50 and older¹

78% of Americans live paycheck to paycheck²

80% of health is determined by what happens outside of the doctor's office⁴

Large employer groups are requesting SDoH product offering⁷

Many SDoH can have a considerable effect on COVID outcomes³

CMS has initiatives that require health plans to screen for SDoH and provide referrals

91% of Medicaid plans report activities to address SDoH⁵ and 35 states require this⁶

¹ AARP Public Policy Institute, Unlocking the Potential of Emergency Savings Accounts, October 2019.

² Harris Poll survey on behalf of CareerBuilder, August 2017.

³ Abrams, EM & S.J. Szefer, COVID-19 and the impact of social determinants of health, Lancet Resp Med, July 2020.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7234789/#>.

⁴ Robert Wood Johnson Foundation. County Health Rankings, 2014. Relationships between Determinant Factors and Health Outcomes. Retrieved from <https://www.rwjf.org/en/library/research/2014/03/>

⁵ Artiga, S & Hinton E. 2018. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Retrieved from <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>.

⁶ Advisory Board. 2019 Medicare Advantage Growth Outlook, April 2019. Web Conference.

⁷ Thomas, S. Large employers are on board with social determinants of health and virtual care strategies. Retrieved from <https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/health-care-current-august27-2019.html>. Governor's of the Federal Reserve System. Report of the Economic Well-Being of U.S. Households in 2017. Retrieved from <https://www.federalreserve.gov/publications/files/2017-report-economic-well-being-us-households-201805.pdf>.

Our Process



1

Identify populations that can benefit from assistance via formal screening or informal identification

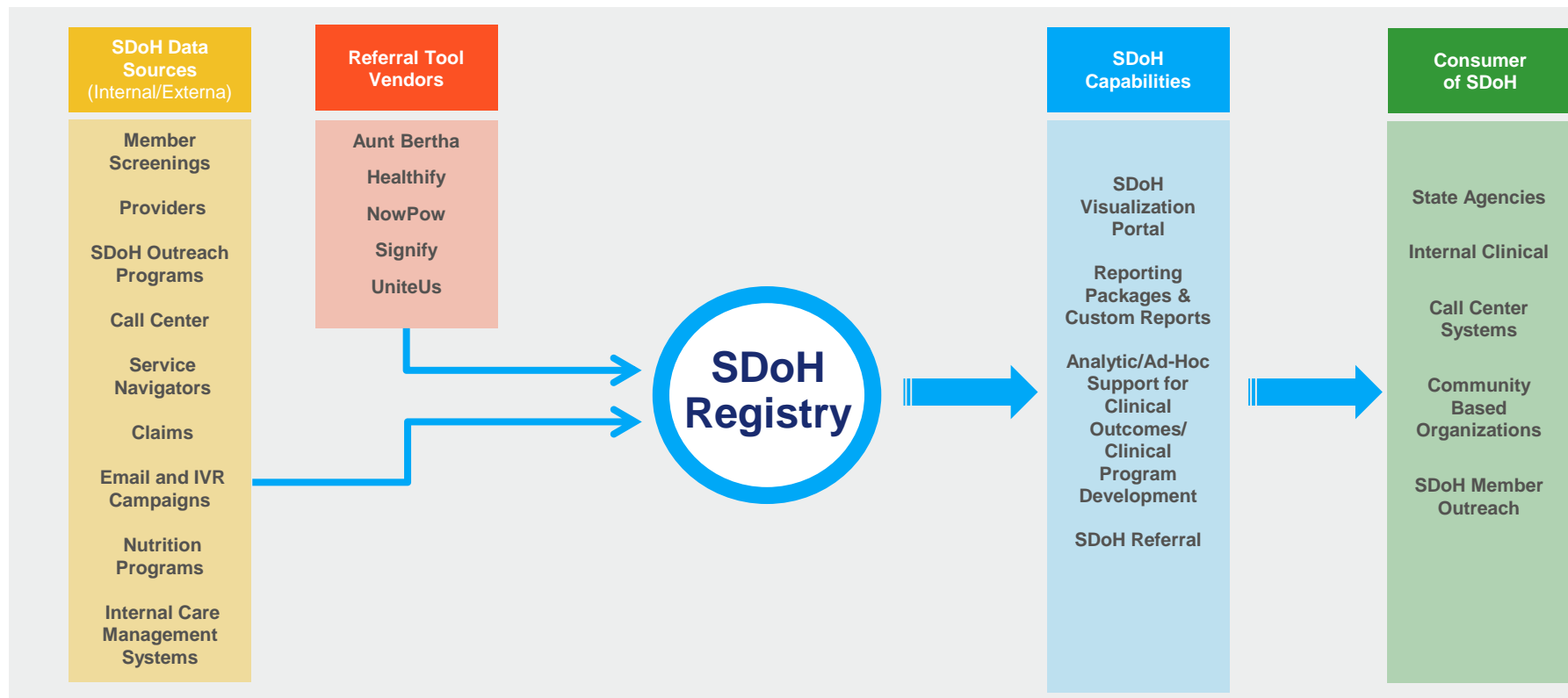
2

Refer members to assistance

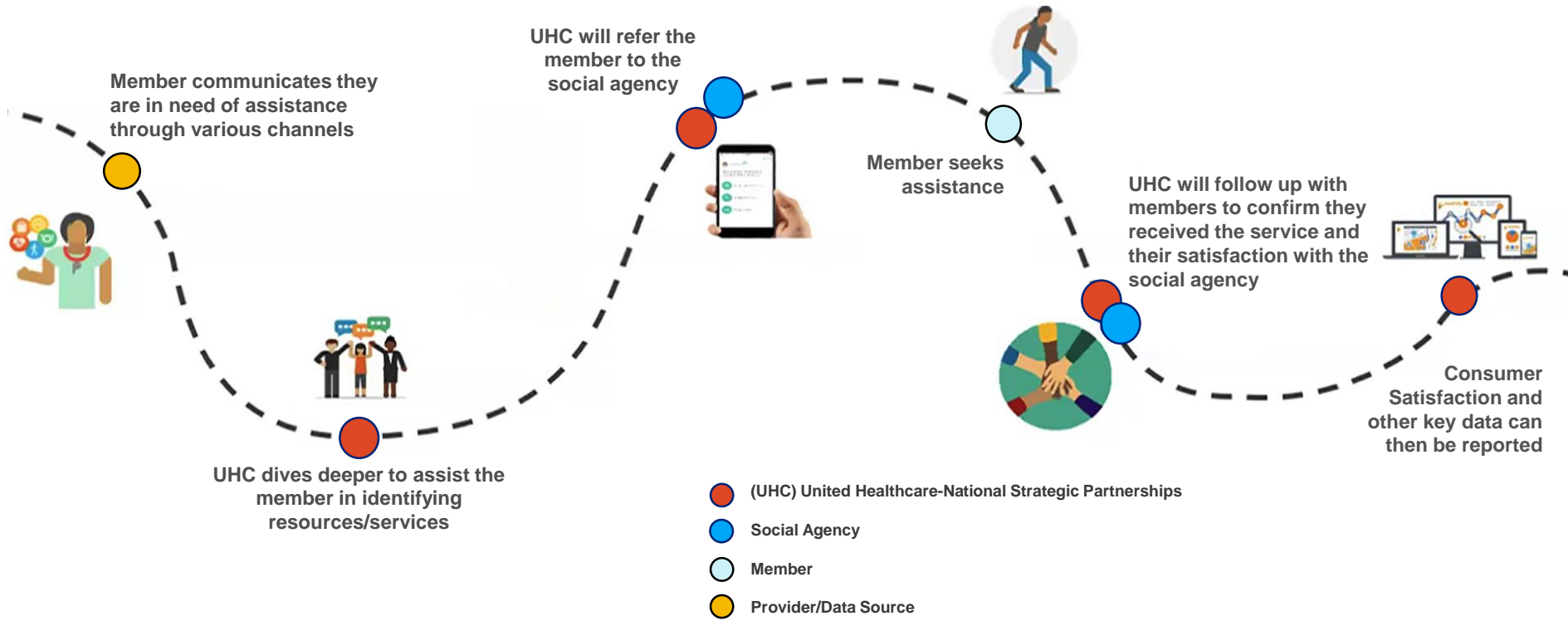
3

National closed-loop model by confirming fulfillment of assistance

How it Works: A National Closed-Loop Model



Member Journey





What We've Accomplished Year to Date Nationally

of Members
identifying with at
least 1 SDoH

942K

TOTAL
MEMBERS

of Members
Referred

321K

TOTAL
MEMBERS

of Referrals to
Community
Based
Organizations

554K

TOTAL
REFERRALS

Confirmed Service
Assistance Provided

316K

TOTAL
CONFIRMED
ASSISTANCE

Percentage Confirmed
(# of Confirmed Assistance /
of Referrals Provided for
services received in 2020)

57%

CONFIRMED
ASSISTANCE

Data from 1/1/2020 – 8/31/2020

Our Partners in Addressing SDoH

AARP Foundation®

AMA

PEOPLES HEALTH

CHRT

ab aunt
bertha

BeneLynk™

Healthify

CHANGE
HEALTHCARE

EL RIO
HEALTH



AHCCCS
Arizona Health Care Cost Containment System

EQUALITY
HEALTH

JORDAN VALLEY
COMMUNITY HEALTH CENTER

OPTUM™

NATIONAL ASSOCIATION OF
Community Health Centers®

Mom's Meals
NourishCare.

NCQA
Measuring quality.
Improving health care.

NOWPOW

Lutheran
Services
in America

signifyhealth™

UNITE US

Value Proposition



- UHC can assist members and their providers with referral support and assistance on a broader scale
- Partnership allows for the integration of social data into a patient's UHC health profile and allows for the creation of comprehensive care solutions to drive better health outcomes
- UHCs strives for 100% confirmation of all referrals - National closed loop model for assisting members with SDoH
- Practice level Reporting on top SDoH barriers, referrals, confirmations and valuation
- Access the SDoH Data Visualization Tool (December 2020)

What We All Can Do – Together



Thank you!

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