UNITE US

Supporting the Shift to Whole-Person Care:

Measuring the Impact of Social Determinants of Health

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01

Executive Summary

This paper describes how health organizations can measurably improve the health outcomes and close the care and social gaps of socially vulnerable populations through effective social determinants of health (SDoH) interventions. Such carefully designed interventions will also reduce overall costs and improve organizational performance.

SDoH are the conditions in which people are born, grow, live, work and age—and these conditions shape health. Research shows strong connections between the social and economic needs of patient populations and their health challenges.

Fortunately, health plans and providers can now use advanced data and analytics to accurately measure the SDoH needs of their patient populations. With such analyses, they can design and implement effective interventions that will close social gaps and improve health outcomes with a measurable return on investment while also improving organizational performance.

The success of these interventions will unlock new funding streams, galvanize the next generation of health policy, and reinforce incentives for collaboration and data sharing. Most importantly, they will help engage traditionally underserved patient populations and communities, ensure they feel heard the first time they tell their story, and lead to meaningful improvements in health and quality of life.

Today, the U.S. healthcare industry has an unprecedented opportunity to address social and economic gaps and improve health outcomes.

Traditionally, the industry has been reluctant to make meaningful investments to address and remedy such gaps despite the lower downstream costs that would result. There are several reasons for that reluctance, including the need for better data to predict and address social gaps, barriers, and care needs; the alignment of financial incentives to link payment with care outcomes and overall health; and the challenges of coordinating care services outside the four walls of the hospital.

With the emergence of value-based care and at-risk contracting, today's health plans and providers are increasingly responsible for total care costs and health outcomes for their members and patients. As a result, more organizations are beginning to focus on nonclinical and upstream factors that drive costly healthcare utilization and diminished health status.

Effectively addressing SDoH remains difficult for several reasons. Eliminating social and economic gaps for vulnerable populations requires the involvement of a wide range of stakeholders, including the people receiving those services and care. In addition, it's often difficult to coordinate activities, share data and information, align incentives, and collaborate on decisions and strategies among all parties. Funding streams are often inadequate, largely due to outdated policy measures or insufficient appreciation for the impact of upstream interventions.

The ability to accurately and comprehensively measure the impact of SDoH on social care gaps and care needs makes it possible, however, to design interventions that show short-, medium-, and long-term return on investment. **This is a game-changing opportunity.** It's time to strengthen the evidence for the effectiveness of well-designed interventions, and disseminate those best practices more broadly.

02

Digging Into the Impact of SDoH and SDoH Countermeasures

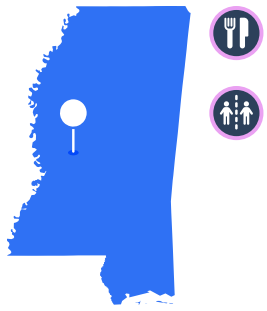
Where social and economic inequities exist, patient populations lack care services and social infrastructure and support. This can lead to diminished health status, productivity and lifespan, and higher overall care costs.

Figure 2: **SDoH Impact on Health**

As we know, SDoH are estimated to drive 80 percent of health outcomes. Social and economic inequities are driven by access to nutritious food, adequate housing, quality healthcare, transportation, and health literacy, among other factors. According to the Kaiser Family Foundation, 30 percent of direct medical costs for Black, Hispanic, and Asian Americans are related to health inequities, including life expectancy, condition prevalence, infant mortality, delaying or skipping needed care, and more. In addition, the U.S. economy loses an estimated $309 billion annually due to the direct and indirect costs of such disparities.[1]

In determining the health impact of and solutions to SDoH challenges, organizations must take into account a specific population's demographics (age, gender, ethnicity, family structure), geography (rural Mississippi, suburban Atlanta, urban Chicago), and outcomes to be measured (self-reported health status, lab values, care compliance, hospital admissions). **SDoH challenges vary from one population and individual to the next. Food insecurity and loneliness might represent the greatest influences on the health of a diabetic living alone in rural Mississippi, while financial insecurity and health illiteracy might be the driving factors for a diabetic living with a spouse and children in a suburb of Atlanta.**

Mississippi



Georgia

1 https://www.ajmc.com/view/the-importance-of-considering-the-social-determinants-of-health

To systematically measure the impact of SDoH challenges across a variety of demographics, geographies, and health outcomes definitions, Unite Us has developed an innovative analytics approach that defines and measures social and economic vulnerability.

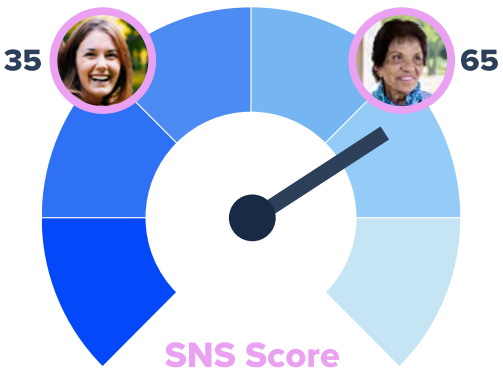
Unite Us' Social Needs System (SNS) classifies and organizes SDoH to help the healthcare industry understand, identify, measure, and quantify the specific social barriers and circumstances in which people live. The SNS provides the ability to measure the effectiveness of our healthcare and social care system over time, evaluating corresponding impacts on health, economic mobility, social well-being, and more.

The SNS produces a composite SNS score (from 0 to 100) driven by four SNS domains: behavioral, social, economic, and environmental. This score can be applied to every adult in the U.S., with 0 representing the lowest social and economic vulnerability and 100 representing the highest.

The four SNS domains are composed of 12 SNS factors, including loneliness, housing instability, health literacy, food insecurity, and others. Depending on the segment of the population and region of the country evaluated, different social and economic inequities (or combinations of inequities) can show greater impact on health outcomes.

To develop and validate the SNS, Unite Us studied external literature and conducted analyses on its database that integrates consumer, healthcare, social care, and actively collected voice-of-consumer data, totaling hundreds of millions of data points.

Controlling for age, gender, and other attributes, a 10-point increase in the SNS score equates to a 13-percent increase in total cost of care, an internal analysis in 2021 showed. This is because underlying social and economic challenges accelerate disease progression and lead to intensified use of the healthcare system (specifically emergency department and hospital services), as well as higher rates of adverse health events.[2]



SNS Factors

- Childcare Needs
- Financial Insecurity
- Food Insecurity
- Health Illiteracy
- Housing Instability
- Housing Quality
- Lack of Broadband Access
- Loneliness
- Transportation Needs
- Unemployment
- Uninsured
- Utility Needs

[2] Throughout this paper, the "socially vulnerable" are defined as members with an SNS score of 60 or above.

03
Using the Social Needs System to Measure the Impact of SDoH

To assess the impact of social needs on health outcomes and to design effective services that overcome those gaps, health plans need predictive SDoH tools. The following health behaviors, outcomes, and experiences have a direct effect on health plan performance:[3]

Table 2: Evaluating the Impact on Social Vulnerability

Healthcare Costs	Adverse System Utilization	Compliance & Adherence	Health Outcomes	Consumer Experience
Total Cost of Care PMPY	Hospital Inpatient Admissions	Preventive Care	Health Outcomes Surveys (HOS)	CAHPS Surveys
	Hospital Inpatient Readmissions	Chronic Condition Management		Plan Retention
	Emergency Department Visits	Medication Adherence		

1 Healthcare Costs: Total Cost of Care PMPY

Total cost of care represents the cumulative total of net paid amounts across institutional, professional, and Rx claim types. Total cost of care is represented in per-member, per-year (PMPY) terms. Because we evaluated consumers ages 18 and up across all lines of business, Unite Us controlled cost of care by age and gender.[4]

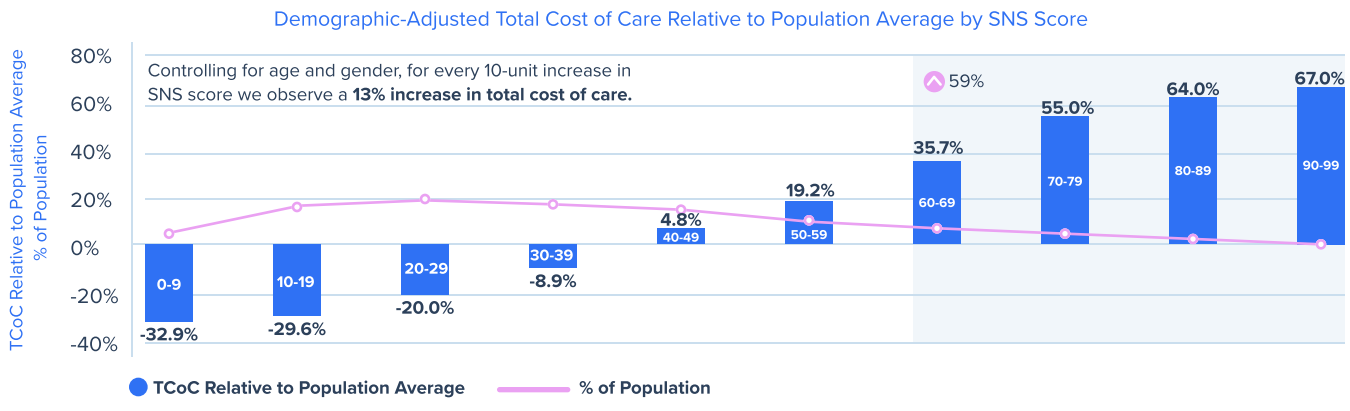
Across a geographically and demographically representative population, the average total cost of care PMPY was $13,347. Socially vulnerable members represented a 59 percent higher demographic-adjusted cost of care than the rest of the population. Controlling for age and gender, every 10-unit increase in SNS score led to a 13.0-percent increase in total cost of care.

The Research

Across each domain, Unite Us evaluated a subset of health-plan customers with populations across Medicaid, commercial, and Medicare lines of business, and within Medicare included Special Needs Plans (SNPs) and Employer Group Health Plans (EGHPs).

In aggregate, Unite Us evaluated 3.35M unique individuals across 56 health-plan contracts and 1,513 unique health-plan offerings. All analyses were conducted in September 2021, with the reporting activity ranging from 2016 to 2021.

Figure 5: **Total Cost of Care by Social and Economic Vulnerability**



[3] Note that all findings highlighted in this paper are statistically significant at a 99.9 percent confidence level.

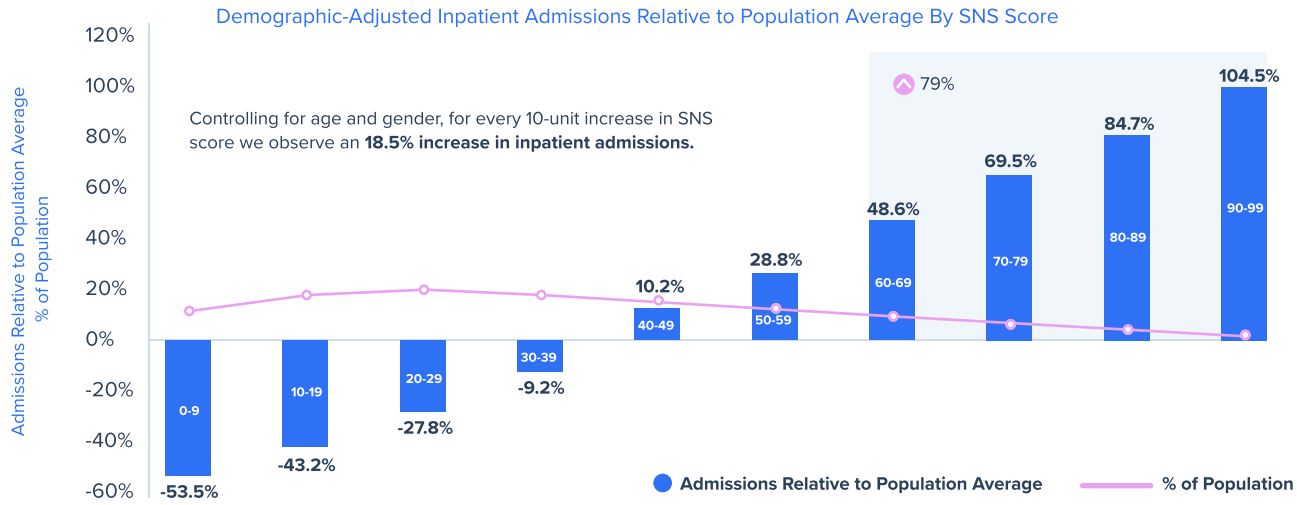
[4] Unite Us' analysis included a subset of its portfolio of health plan Insights customers. The analysis evaluated all members, including Medicaid, commercial, and Medicare plans (including SNP and EGHP).

2 Adverse System Utilization: Hospital and ED Visits

Using the same cohort evaluated for total cost of care, Unite Us studied the connection between social vulnerability and hospital and emergency department utilization.[5]

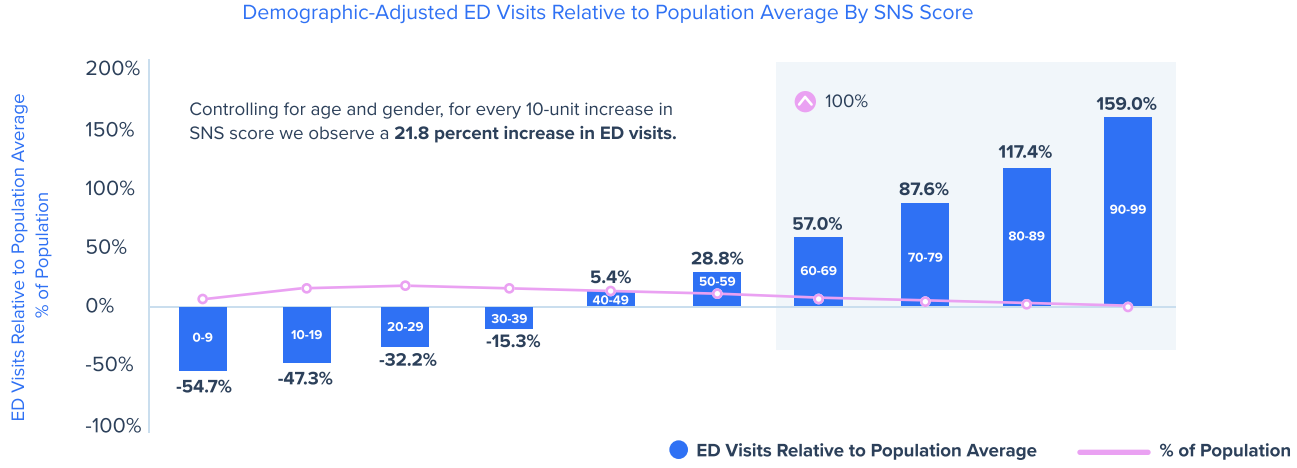
Across the population, the average hospital inpatient admission rate PMPY was 0.24. **Every 10-unit increase in SNS score led to an 18.5-percent increase in inpatient admissions**. Socially vulnerable members represented 79 percent higher demographic-adjusted hospital admissions than the rest of the population.

Figure 6: **Hospital Inpatient Admissions by Social and Economic Vulnerability**



The average emergency department visit rate PMPY was 0.65. Controlling for age and gender, **every 10-unit increase in SNS score led to a 21.8-percent increase in emergency department visits**. Socially vulnerable members represented 100 percent higher demographic-adjusted emergency department visits than the rest of the population.

Figure 7: **Emergency Department Visits by Social and Economic Vulnerability**



[5] Hospital Inpatient admissions represent the count of distinct hospital inpatient admission dates. Emergency Department Visits represent the count of distinct emergency department encounter dates. Utilization is represented in Per Member Per Year (PMPY) terms. As with total cost of care, consumers were evaluated across all lines of business and all ages 18+ to control for age and gender.

While the relationship between social vulnerability and cost of care, inpatient admissions, and emergency department is strong, it varies by region, line of business, population density, and other factors. For example, social vulnerability shows a greater connection to cost of care and adverse utilization in rural geographies and with individuals on Medicaid.

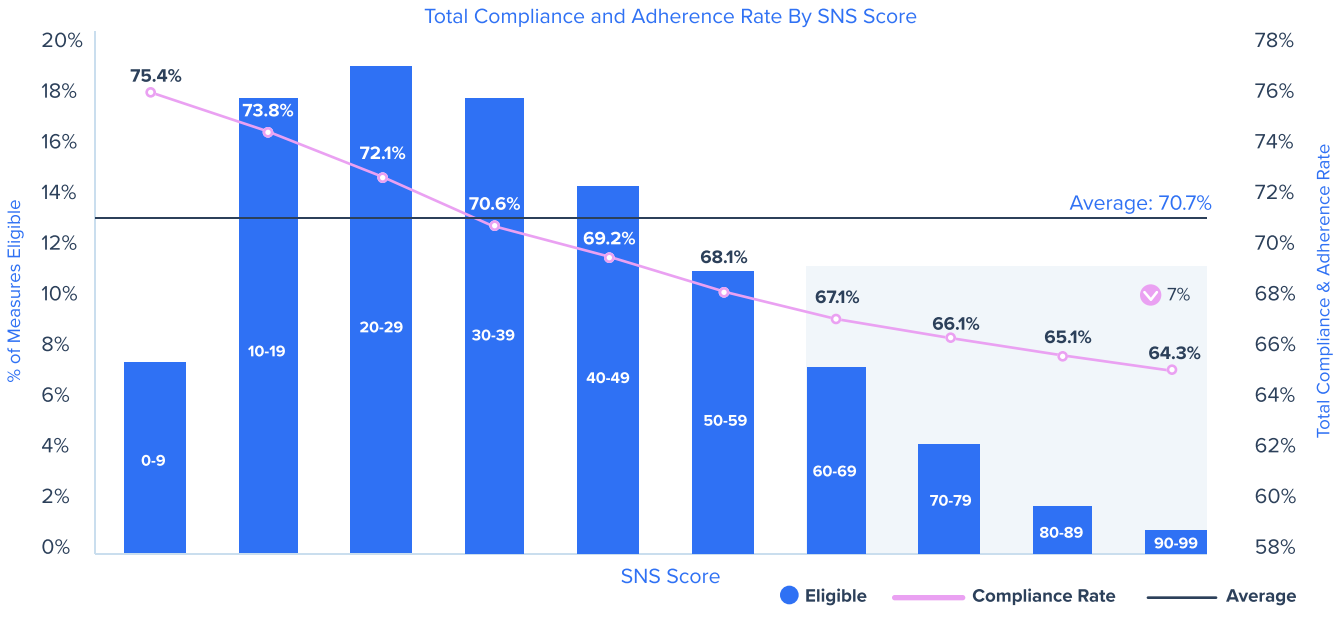
Specific social factors showing the greatest connection to cost of care and adverse utilization also vary by demography and geography. For example, loneliness is one of the most impactful social needs factors among Medicare beneficiaries in suburban and rural geographies, while housing instability is far more impactful among Medicaid beneficiaries in urban geographies. Age, population density, socioeconomic status, and availability of community resources contribute to the varying effects of social and economic needs.

3 Compliance and Adherence:
Care-Plan Compliance and Medication Adherence

To understand the impact of social needs on care-plan compliance and medication adherence, Unite Us uses CMS' Medicare Star Ratings HEDIS, PDE, and administrative measures. In total, Unite Us examined 45 measures across 1.8M Medicare Advantage members, representing a total of 10,370,162 measures eligible. This analysis evaluates all members, including SNP plans, EGHP plans, and members under the age of 65.

When aggregating nine key measures,[6] Unite Us found that **socially vulnerable members have seven percent lower care compliance and medication adherence.**

Figure 8: **Compliance and Adherence by Social and Economic Vulnerability**

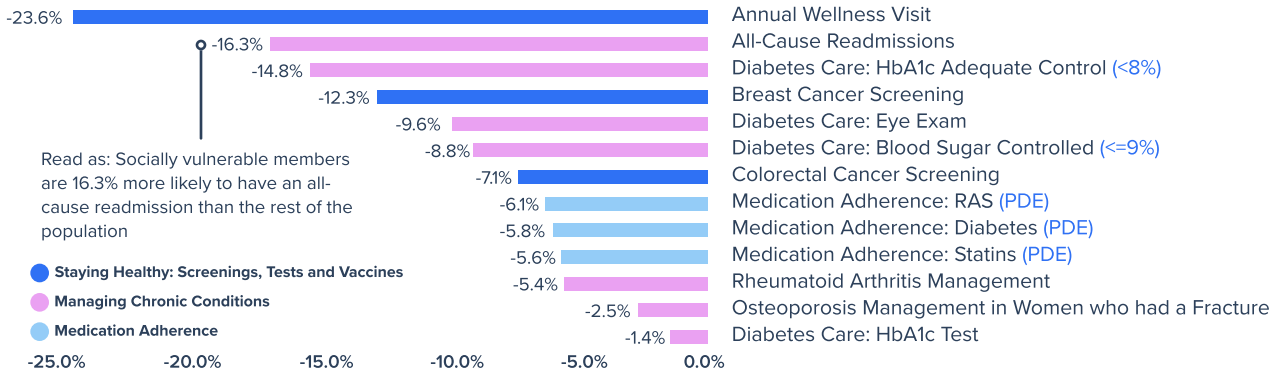


Breaking down the component parts of compliance and adherence, Unite Us observes significant variance in the connection to social vulnerability. The most socially vulnerable members are most likely to be noncompliant with annual wellness visits, all-cause readmissions, and adequate diabetic control of HbA1c. The data shows a smaller margin of underperformance related to osteoporosis management in women who had a fracture and diabetic HbA1c testing.

6 Measures included: Breast cancer screening, colorectal cancer screening, medication adherence: statins (PDE), medication adherence: diabetes (PDE), medication adherence: RAS (PDE), osteoporosis management in women who had a fracture, annual wellness visit, diabetes care: HbA1c test, primary care visit. 5.5M total measures eligible, 3.9M total measures compliance (70.7 percent compliance rate)

Figure 9: **Compliance and Adherence Measure Variance by Social and Economic Vulnerability**

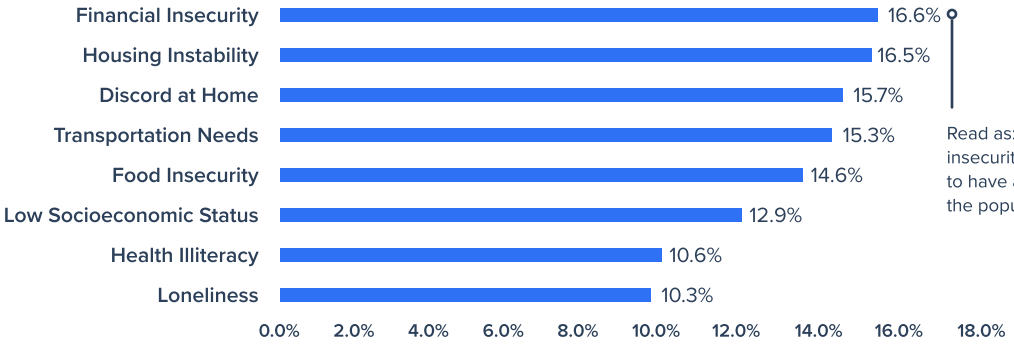
Socially Vulnerable Members
Compliance and Adherence Underperformance vs. Rest of Population



In Figure 9 (above), we noted that **socially vulnerable members are 16.3 percent more likely to have an all-cause readmission**. Breaking down the component parts of social vulnerability through Unite Us' SNS framework highlights significant variance in the connection to all-cause readmissions. The specific social needs factors most connected to the increase in readmissions are financial instability, housing instability, and discord at home, while health literacy and loneliness show a less significant connection.

Figure 10: **All-Cause Readmissions by Social Need Factors**

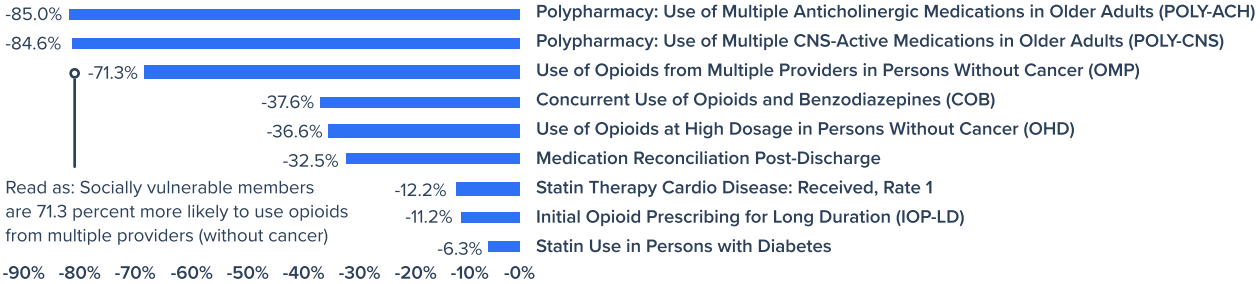
Social Need Factors
Increase in All-Cause Readmissions vs. Rest of Population



Unite Us finds that socially vulnerable members are more likely to be the recipients of improper medication prescriptions as well. Most notably, these members are more likely to be prescribed opioids from multiple providers and more likely to be using multiple drugs to treat a single condition. This suggests providers might tend to use quick fixes for socially vulnerable populations as opposed to more holistic care that addresses underlying needs and transient lifestyle patterns.

Figure 11: **Drug Safety by Social & Economic Vulnerability**

Socially Vulnerable Members
Drug Safety Underperformance vs. Rest of Population

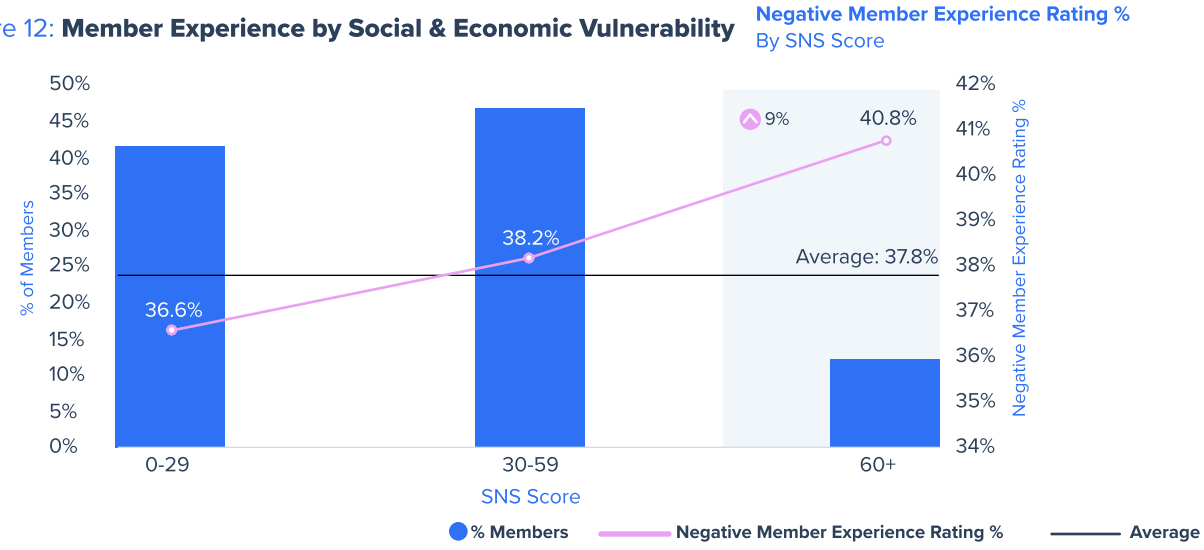


4 **Consumer Experience:** CAHPS Surveys and Retention

To understand the impact of social needs on member experience, Unite Us used off-cycle CMS' CAHPS survey instrument. In total, Unite Us examined eight member-experience domains across 49,596 Medicare Advantage members who responded to off-cycle CAHPS surveys. Respondents from 2019, 2020, and 2021 are included. This analysis evaluates all members, including SNP plans, EGHP plans, and members under the age of 65.

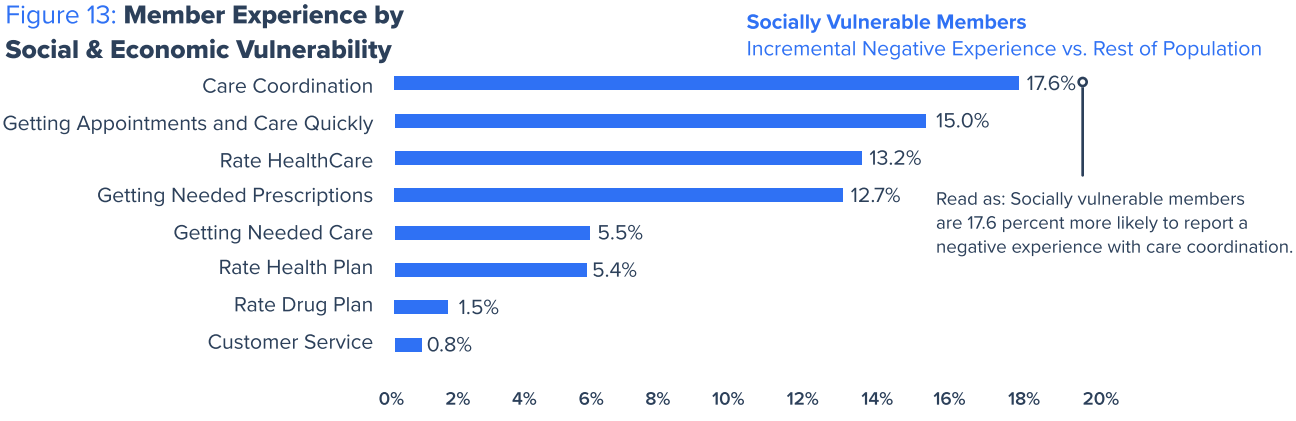
When aggregating the eight key member-experience domains, Unite Us found that **socially vulnerable members report negative healthcare experiences at a 9 percent higher rate.**

Figure 12: **Member Experience by Social & Economic Vulnerability**



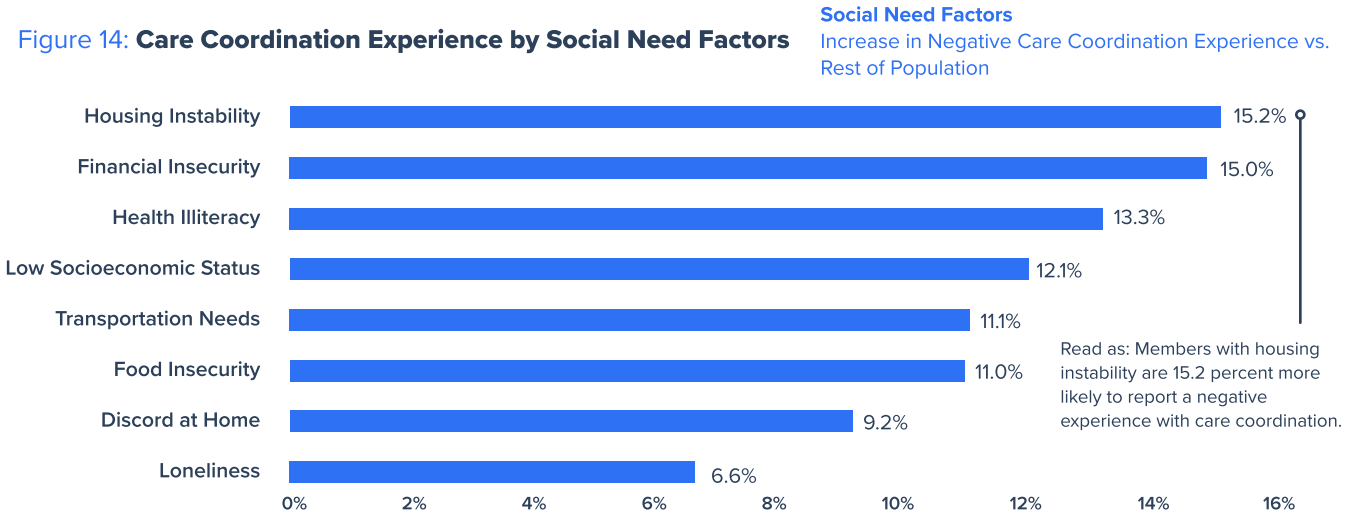
Breaking down the domains of member experience reveals significant variance in the connection to social vulnerability. Members who are most socially vulnerable are most likely to report negative experiences related to care coordination and getting appointments and care quickly. They are also most likely to report experiences similar to less vulnerable populations for drug-plan measures. Socially vulnerable members tend to perform worse on care coordination measures due to the lack of social care coordination. In contrast, these members tend to perform better on drug-related measures due to heavier reliance on subsidies.

Figure 13: **Member Experience by Social & Economic Vulnerability**



In Figure 13 (previous page), **socially vulnerable members are 17.6 percent more likely to report negative experiences related to care coordination**. Breaking down the component parts of social vulnerability through Unite Us' SNS framework reveals significant variance in the connection to experience with care coordination. The specific social needs factors most connected to negative care coordination experiences are housing instability, financial insecurity, and health literacy, while loneliness and discord at home show a less significant connection.

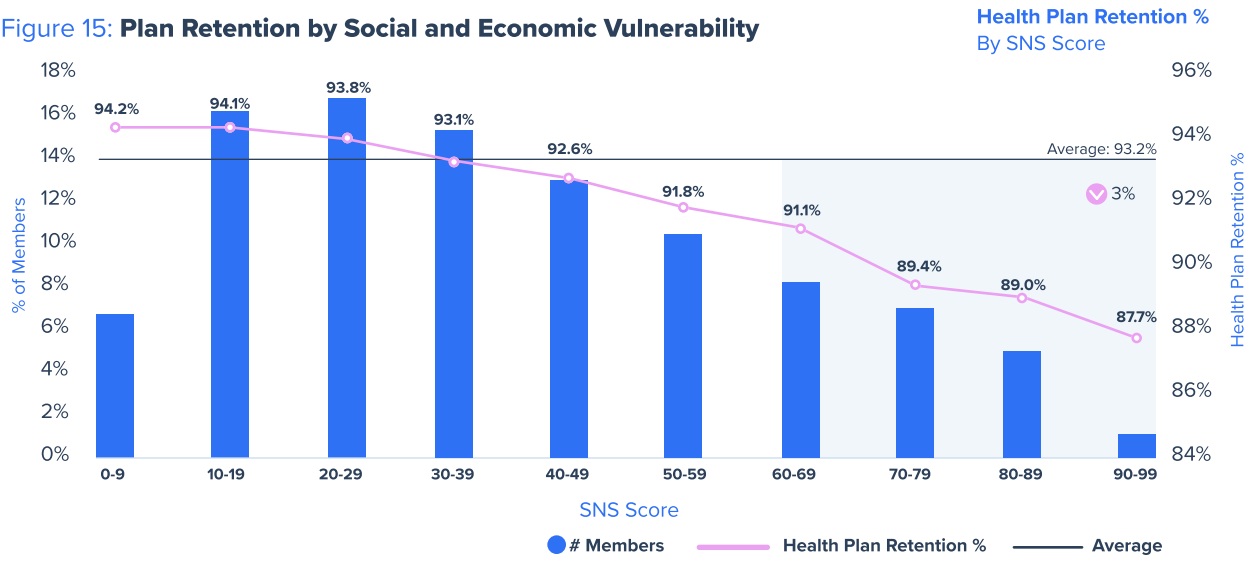
Figure 14: **Care Coordination Experience by Social Need Factors**



Analyses led by Unite Us' Research and Evaluation team, as well as studies from Deft Research and others, reveal a strong connection between member experience and retention. To understand the impact of social needs on member retention, Unite Us evaluated retention during the 2021 Medicare Advantage Annual Enrollment Period (AEP), comparing plan enrollment from December 2020 to February 2021 across 1.2M members spanning 60 contracts and 361 plans. This analysis evaluates all members, including SNP plans, EGHP plans, and members under the age of 65.

Socially vulnerable members report less favorable experiences with their health plans, and are three percent less likely to stay enrolled with their Medicare Advantage plan through AEP.

Figure 15: **Plan Retention by Social and Economic Vulnerability**



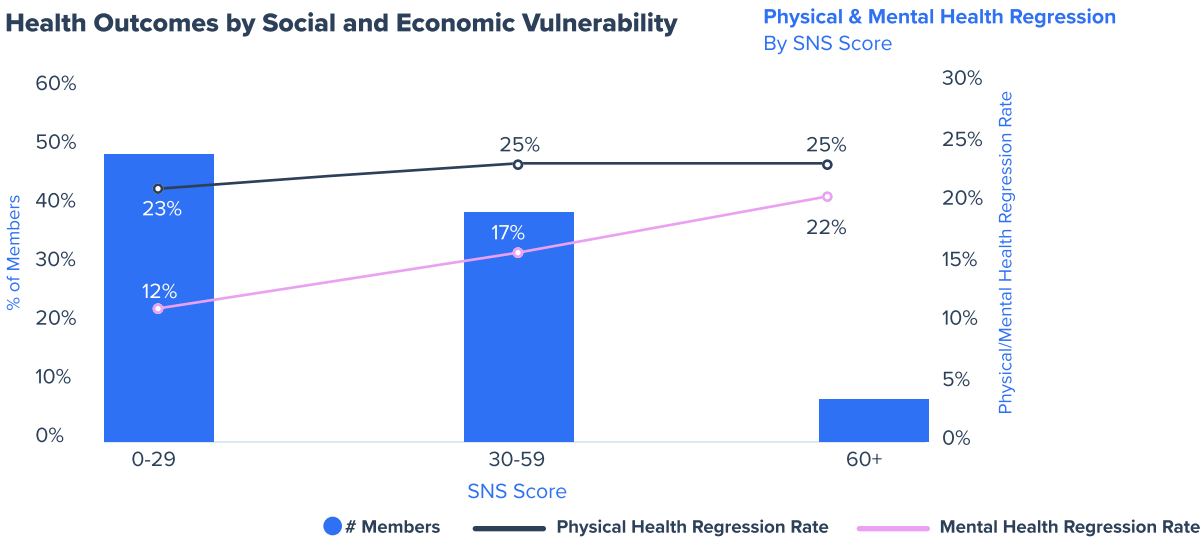
Unfavorable experiences and higher disenrollment rates characterize the socially vulnerable population in aggregate. However, this trend doesn't hold for every Medicare plan across the country. Take a regional health plan in New York City, for instance. They manage 75,000 Medicare Advantage members, 50 percent of whom have high social vulnerability. Through innovative benefit design that takes advantage of socially and economically relevant supplemental benefits—and an organizational focus on and investment in appropriate SDoH counter measures—this health plan has demonstrated that it is possible to deliver strong experience and retention. The plan's vulnerable population is now complying with care and adhering to medications at the baseline rate of the mainstream population. Retention rates exceed those of less socially vulnerable members.

5 **Health Outcomes:** Physical and Mental Health Outcomes

To understand the impact of social needs on physical and mental health outcome improvements, Unite Us used CMS' Health Outcomes Survey (HOS). Respondents from cohort 2019 and cohort 2020 are included. Cohort 2019 represents physical and mental health changes from 2016 to 2018, while cohort 2020 represents physical and mental health changes from 2017 to 2019. Unite Us used the CMS Base Group 4 cutoffs to define a "decline" or "regression" in health status. In total, Unite Us examined 17 health outcome components across 7,884 Medicare Advantage members included in the 2019 and 2020 cohorts. This analysis evaluates all members, including SNP plans, EGHP plans, and members under the age of 65.

When aggregating the 17 health outcome components into the overall physical and mental health composite scores, Unite Us found that **socially vulnerable members regress with mental health at a 55 percent higher rate and with physical health at a 5 percent higher rate.**

Figure 16: **Health Outcomes by Social and Economic Vulnerability**



Breaking down the components of physical and mental health outcomes reveals significant variance in the connection to social vulnerability. Socially vulnerable members are most likely to regress related to mental health interfering with their work and accomplishments. Social vulnerability shows a less significant connection to energy levels and other components.

Figure 17: **Health Outcome Component Variance by Social and Economic Vulnerability**

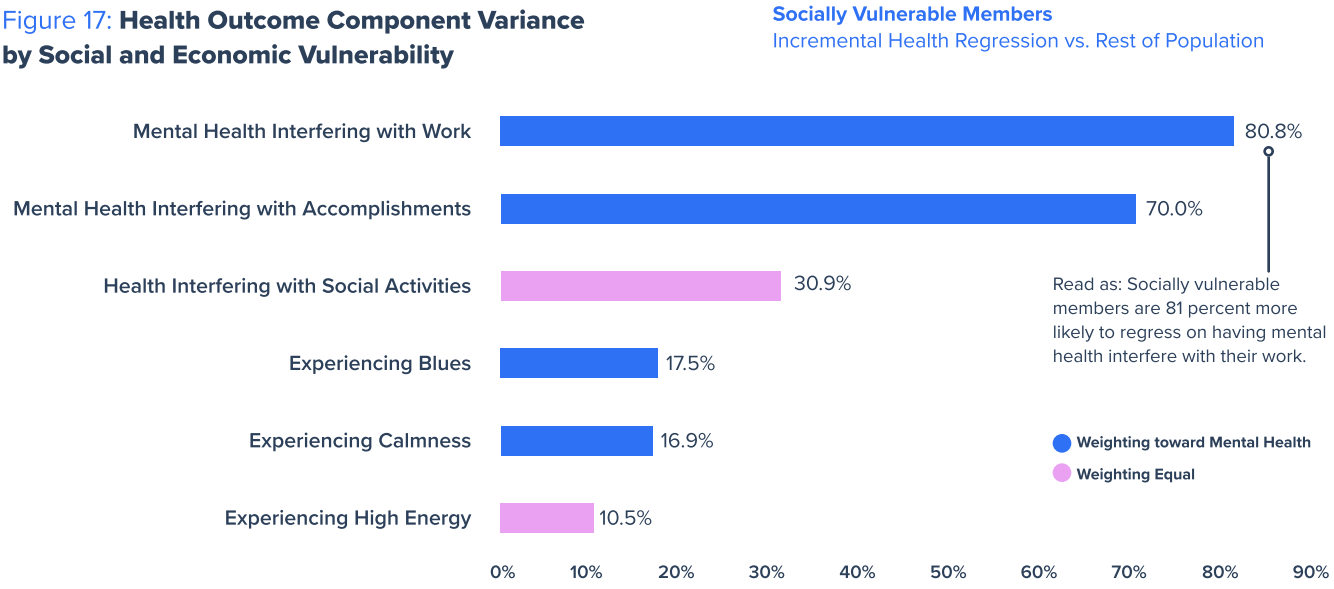
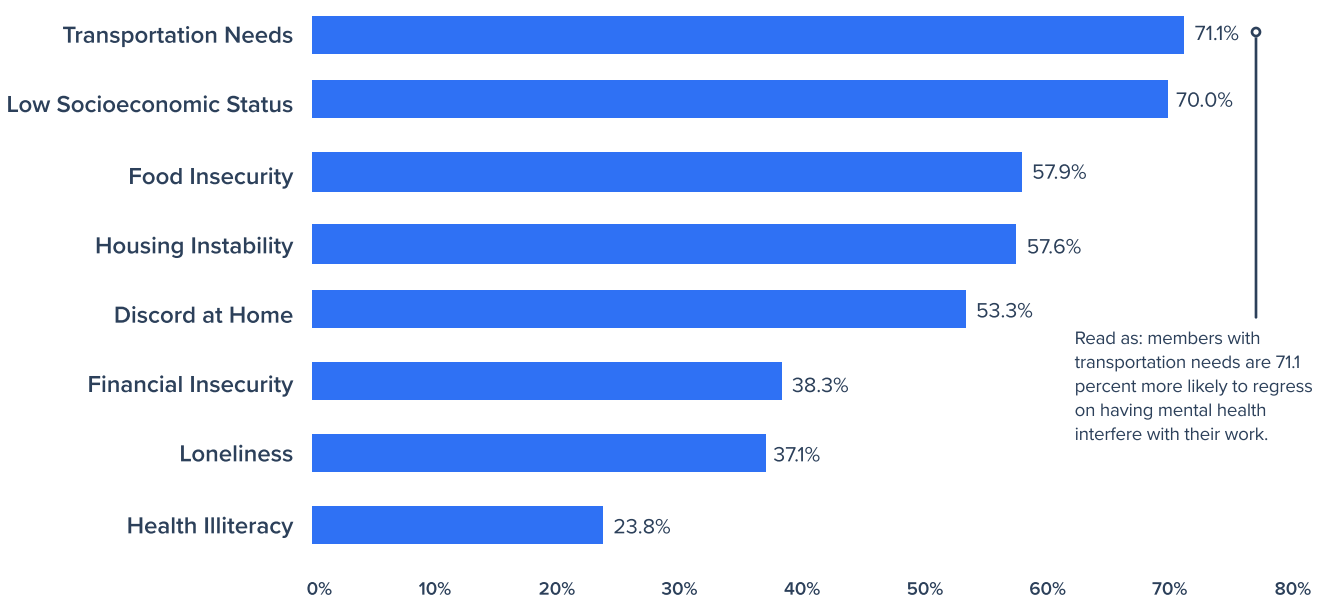


Figure 17 (above) shows that **socially vulnerable members are 81 percent more likely to regress because of mental health issues interfering with their work.** That regression is connected to a wide variety of factors underlying their social vulnerability, particularly their transportation needs, low socioeconomic status, and food insecurity. Loneliness and health illiteracy show less effect.

Figure 18: **Mental Health Interference with Work by Social Need Factors**



6 **Other Measures:** Unhealthy Days and COVID Impact

There are countless additional measures that can—and should—be evaluated when assessing social vulnerability. Each organization should prioritize behavior, experience, and outcome measures that are most relevant to the populations it serves and most impactful to organizational performance. Additional measures of interest to Unite Us and our customers include unhealthy days and the degree to which COVID-19 has impacted people's lives.

Unhealthy days are a self-reported response to the question, "In the last month, how many days were negatively affected by your physical or mental health?" Unite Us conducted a primary research study in May 2020 with 1,982 responses to assess this impact. Respondents were representative of U.S. adults demographically, geographically, and by type of work. This measure is important because it is an indicator of self-perceived health status and a strong predictor of future adverse health events. We found that **socially vulnerable people report 102 percent higher unhealthy days than the rest of the population: specifically, 7.76 unhealthy days for the socially vulnerable vs. 3.84 unhealthy days for the less socially vulnerable.**

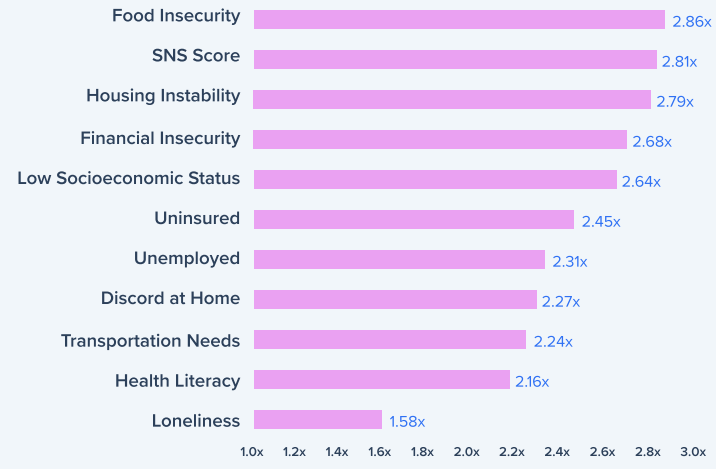
We also evaluated COVID-19's impact on socially vulnerable people. Through analysis of 26,030 people across all lines of business with COVID-19, while controlling for age and gender, we found that **12 percent were more likely to develop mental health-related, long-COVID symptoms.** Additionally, in an analysis of a nationally representative sample of 3,503 respondents we conducted in August 2021, **socially vulnerable people were 47 percent more likely to mistrust American medicine, leading to a lower willingness to be vaccinated. Lastly, from a health disparity standpoint, non-White people represent 2–4 times higher COVID-19 cases, hospitalizations, and deaths.**

A Real World Example

In 2020, the Colorado Hospital Association (CHA) partnered with Unite Us to perform a statewide analysis of the relationship between emergency department (ED) utilization, readmissions, and SDoH. This analysis enables CHA members to understand the unique breakdown of risk within their populations, identify optimal opportunities for intervention, predict which efforts will produce the greatest return on investment, and, ultimately, reduce healthcare costs.

By measuring and analyzing SDoH using the Unite Us SNS alongside CHA de-identified claims data, we saw a distinct correlation between SDoH, ED utilization, and readmissions within the state of Colorado. The analysis showed a positive correlation between individual SNS scores and the rate of ED utilization: the higher the SNS score, the higher the rate of ED super-utilization. The analysis also identified key social factors driving utilization and readmissions, such as food insecurity. The chart below shows how individuals in the top decile of risk for food insecurity (defined as the inability to pay for or access healthy food options) super-utilized the ED at 2.86 times the rate of the general population.

SNS Indexing Against ED Super-Utilization



04

The Opportunity to Make a Difference

Although socially vulnerable people face a variety of social and economic challenges and barriers, **the healthcare industry can significantly improve health outcomes and costs for this population.** Socially vulnerable people are less compliant with care and experience worse health outcomes overall. However, socially vulnerable people are more willing than the rest of the population to participate in health programs and services offered by their health plans.

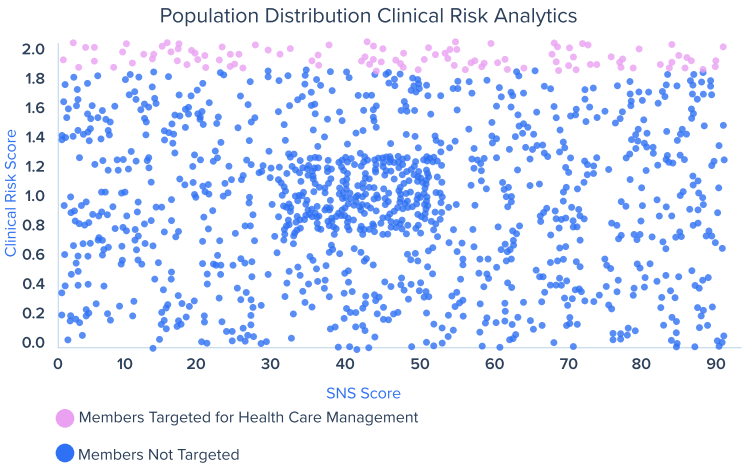
Next-Gen ID-Strat

To comprehensively and effectively improve health trajectories in the U.S., the healthcare industry must flip the traditional care model from reactive to proactive. This involves identifying and stratifying advanced clinical and social needs.

- **59%** higher cost of care
- **79%** higher hospital inpatient admissions
- **100%** higher emergency department visits
- **30%** higher regression in health status
- **3%** lower retention on health plan
- **102%** higher reported unhealthy days
- **7%** lower care compliance and medication adherence
- **9%** less favorable experience with healthcare

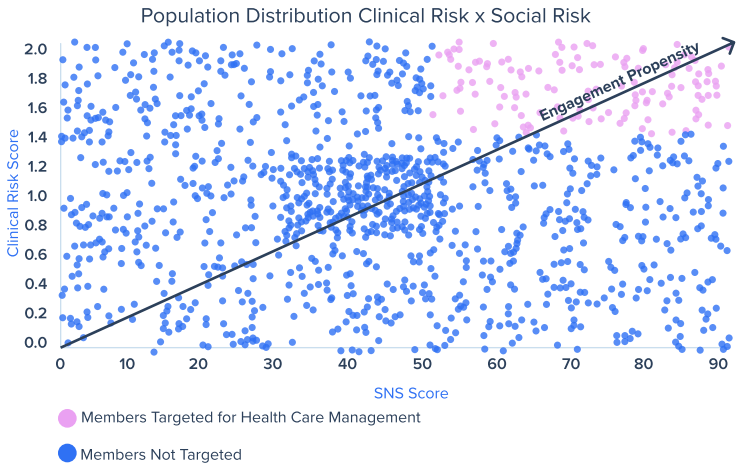
Traditional ID-Strat

Clinical Risk Analytics



Next-gen ID-Strat

Clinical + Social + Engagement Analytics



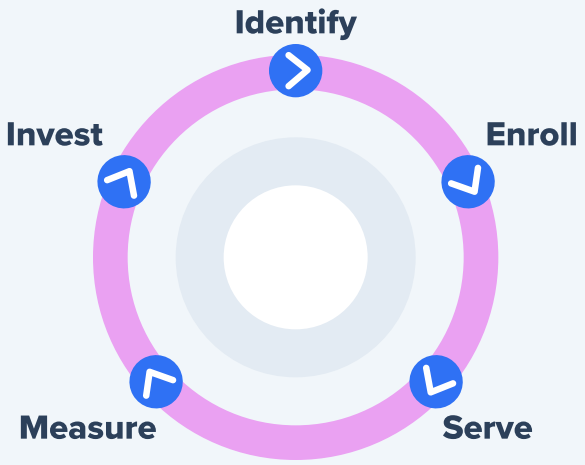
Our internal research shows that socially vulnerable people self-report a 45 percent higher level of interest in participating in health programs and services. Socially vulnerable members also engage in chronic care management and social care coordination programs at more than twice the average rate of the overall population. These individuals are less autonomous with their care but are ready to engage with their health plans, providers, and the community to help manage their health and wellbeing.

With a renewed focus on and investment in integrated health and social care coordination, backed by data-derived measures, insights and predictions, U.S. healthcare has a game-changing opportunity to address the overall needs of socially vulnerable people today, particularly when those needs are rooted in social and economic instability.

An End-to-End Approach

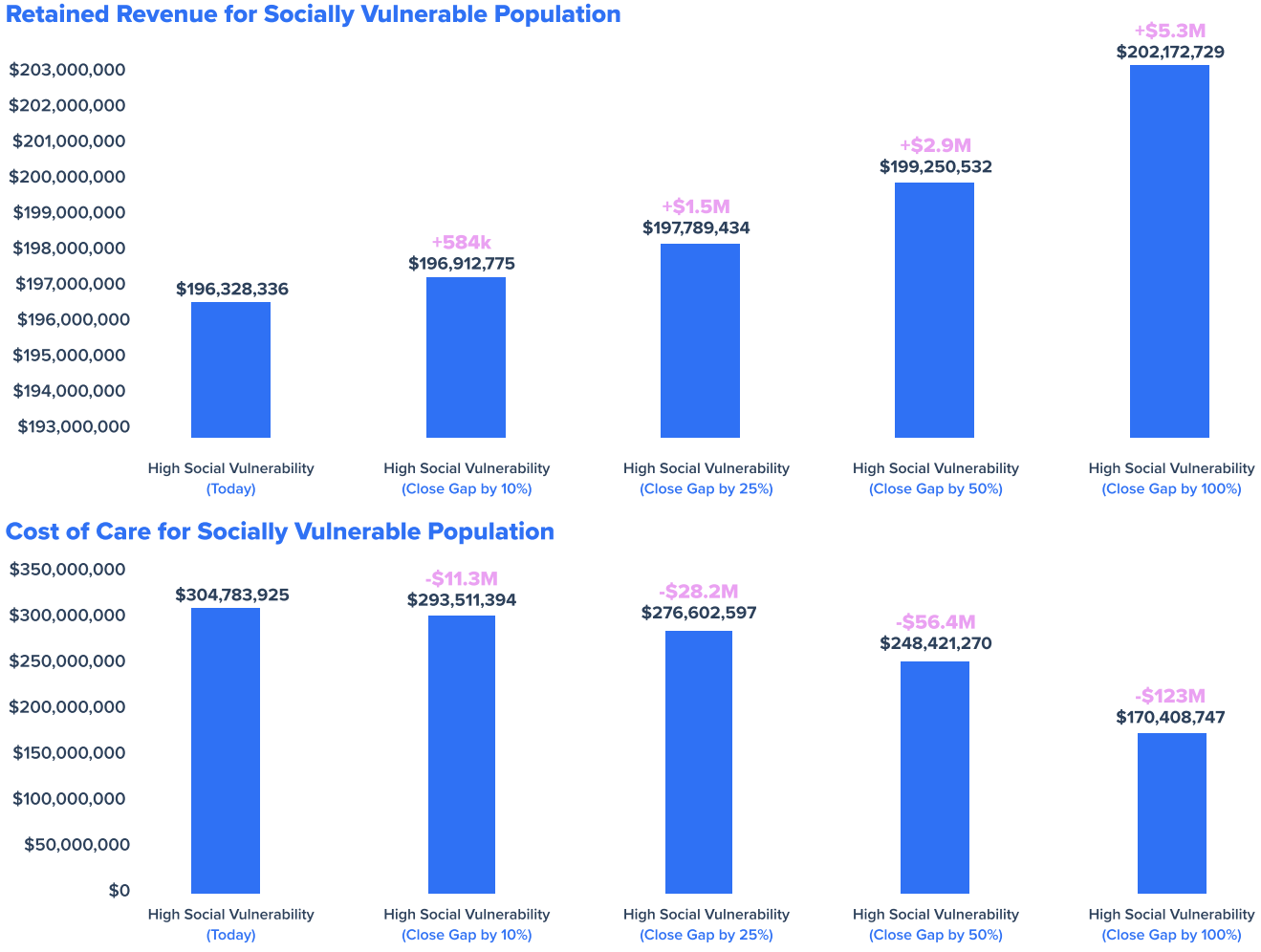
Unite Us' integrated health and social care data and analytics capabilities create an end-to-end SDoH solution. This gives the healthcare industry the tools and strategies needed to make meaningful progress on social inequities and care gaps, patient/member experience, and health outcomes while having a significant financial impact on overall costs. Developed with a determined focus on improving individual and population health, the Unite Us end-to-end solution is built on the need for a community-focused, integrated social and health care system, and is designed to support community-based partners in establishing a new standard of care. Leveraging industry-leading analytics and on-the-ground support, Unite Us enables organizations to assess social care needs in communities, identify optimal engagement strategies, manage the enrollment of individuals in needed services, and effectively deliver social care to communities. Ultimately, this facilitates needed community investment and social care funding at scale.

The only end-to-end solution for social care



Consider a Medicare Advantage population of 100,000 members with an average retention rate of 92.8 percent, an average cost of care of $10,000, and a capitated revenue rate of $10,000 PMPY. The socially vulnerable population represents 21.6 percent of membership, has a retention rate three percent below the rest of the population, and an annual cost of care that is 59 percent higher. When a health plan closes the retention rate gap by just 25 percent—thereby increasing the socially vulnerable retention rate from 90.7 percent to 91.4 percent—it can generate nearly $1.5M in incremental annual revenue. Closing the retention rate gap by 50 percent results in more than $2.9M more in incremental annual revenue. Closing the cost-of-care gap by 10 percent results in annual cost savings of over $11M, while closing the cost-of-care gap by 25 percent results in annual cost savings of more than $28M.

Figure 21: **Closing the Social Care Gap Opportunity, Retention and Total Cost of Care**



This shows that modest improvements in systematically engaging and serving a population of 100,000 lives can increase annual impact by tens of millions of dollars.

Social vulnerability can vary by geography, demography, plan type, cost-sharing structure, supplemental benefit design, population density, and more. Through data and analytic insights, a health plan can identify the specific social vulnerabilities of unique populations and markets, and determine optimal strategies for improving the experience and health outcomes of socially vulnerable members.

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Conclusion

Strengthening the Evidence for the Impact of SDoH

Health plans and providers increasingly appreciate the impact of SDoH on health outcomes and care costs. Efforts to effectively address SDoH, however, have been inconsistent, usually lack federal funding, and have been difficult to scale. The COVID-19 pandemic shone a bright light on this challenge for many communities and populations.

Fortunately, it is now possible to precisely assess SDoH challenges and predict the effectiveness of interventions while taking into account all relevant variables such as living conditions, plan offerings, care access, demographics, etc. Health plans and providers can move the needle significantly on health outcomes and costs by embedding appropriate SDoH programs into their workflow and engaging with responsive community partners.

As health plans and providers design and implement such programs, the insights gained will lead to a wave of new strategies and approaches based on best practices. Given the scope of the challenge and the benefits that can be gained, effective SDoH interventions offer U.S. healthcare its best opportunity to turn the tide on rising costs while dramatically improving the health of populations and communities.

As a pioneer for data-focused SDoH innovation, Unite Us has developed the robust data and analytics capabilities necessary to assess community and individual needs, predict the impact of appropriate community investment, and design optimal outreach strategies.

Spencer Pratt

Spencer Pratt is Vice President of Sales Solutions at Unite Us, where he works at the intersection of product, technology, and the market to support growth strategy and execution in new and existing markets. Spencer has spent his career building and implementing data-driven solutions in the healthcare industry. He has extensive experience in payer and provider markets, having worked with health plans, health systems, and employer groups across the country for over a decade. Prior to joining Unite Us, Spencer led high-performing teams at Carrot Health, a health and social care analytics company, across product development, product management, strategy, and innovation; and built the Consumer Analytics & Strategy function within the Optum Health division of UnitedHealth Group.