UNITE US

Leverage robust analytic tools to predict and measure social drivers of health across populations

It's well known that non-clinical factors, such as food, housing, and transportation, have a significant influence on a person's overall health and well-being. Connecting people to resources that can address these social drivers of health (SDoH) is critical. But beyond addressing how to connect people to the resources they need, there's another question that many organizations are starting to ask themselves: **"How can we meet peoples' needs before they reach a crisis moment and take a more proactive approach to social care?"**

With Unite Us Social Connector, that's possible. Social Connector helps organizations proactively identify social needs in their communities through the Unite Us **Social Needs System (SNS)**—the industry standard for predicting and measuring individual-level SDoH in populations across the country. It empowers organizations to utilize data to inform care management, community outreach, funding strategies, and intervention design.

With Social Connector, you can:

- **Understand** social drivers of health and predicted clinical conditions and how they vary across demographic groups and geographies at both the population and individual level.
- **Engage** your population of interest by using our engagement preference predictive models to design effective outreach strategies.
- **Act** by connecting individuals with the right services at the right time to meet their needs.

Social Connector includes access to a **Community Needs Map** that allows you to quickly visualize and compare social needs across geographies. Social Connector also includes an **Explorer** dashboard, which allows you to conduct even deeper and more nuanced analysis of your population of interest by comparing social needs and predicted clinical conditions across demographic groups and geographies along with actual clinical outcomes data that you provide.

Understand, engage, and act on:

Social Needs

Population-Level

Understand the **social needs of a population**, explore differences across communities/demographics, and see the organizations equipped to serve the needs of the community.

Individual-Level

Better understand a **specific set of individuals** that you work with. What are their communication preferences? Where they are located? How do their social needs compare to national benchmarks?

Clinical Needs

Population-Level

Understand how social needs **relate to clinical conditions**, such as diabetes and asthma. Explore differences across communities/demographics to better understand projected health system utilization/costs to inform SDoH strategies.

Individual-Level

Supplement the understanding of social and health-related needs in your population by **exploring real condition diagnoses** and healthcare utilization based on claims you provide for your members.

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Use Cases Across Sectors

Government

- Understand and explore the SDoH needs of your constituency, geography, and demography of interest. Identify and connect with high-need constituents.
- Understand veteran needs, proactively engage them, and improve outcomes.
- Identify counties and ZIP codes with high unemployment and understand co-occurring needs/barriers.
- Identify potential partners to offer employment resources and training.

Health Plans

- Understand the most common predicted SDoH factors for members with specific clinical conditions to inform outreach strategies and address key barriers to care.
- Improve health outcomes for those members by connecting them to local organizations that can meet their identified needs.
- Reduce emergency department visits for Medicaid members by addressing transportation needs. Build strategies for offering transportation resources to Medicaid members to address barriers to receiving non-emergency care.

Providers and Life Sciences

- Reduce SDoH barriers to improve clinical outcomes for underserved communities.
- Identify geographic hotspots where the likelihood of chronic conditions in patient populations is higher and equip providers with the tools to connect patients with resources to address specific SDoH needs.

Community-based Organizations

- Better understand co-occurring needs that may prevent an individual from gaining the skills for consistent employment or accessing other services.
- Identify geographic hotspots with high needs and support strategies for targeted outreach and engagement.

Unite Us Care Coordination Outreach Solutions

To proactively address social needs, a hands-on approach is often needed. Connecting individuals to services—while incredibly important—isn't always easy. Our partners often juggle many other responsibilities, depend on clients to come to their offices to begin the referral process, and face potential challenges in knowing where to refer people.

That's why we have a dedicated Care Coordination team to empower easy and positive social care connections for the people you serve. Our team can conduct outreach to your population of interest and connect them to the best local organizations to meet their needs. Unite Us is committed to making it as seamless as possible to support community members.

> "Unite Us is helping us go further to pull together data, insights, and deeper knowledge about our communities and the needs that they experience in real-time. Human relationships coupled with this technology are what will continue to make this work successful."
>
> – **Project Manager**, CONNECT Utah

To learn more, visit UniteUs.com/demo.