

How Health Insurance Providers Are Tackling Social Barriers to Health

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As much as 80% of a person's health is linked to factors other than medical care, such as where one lives, grows up, works, and ages. However, many Americans have significant unmet social needs that affect care quality, health status, and use of care services. For instance, access to healthy foods is central to good health, but 35% of respondents in a recent study stated that they experienced food insecurity and were more than twice as likely to have multiple emergency department visits.¹

Investing in prevention is key to healthier people, healthier communities, and lower healthcare costs. Knowing this, health insurance providers and other healthcare professionals are increasingly investing in innovative solutions that address social barriers to health and wellness, also referred to as social determinants of health (SDOH). Although clinicians, health insurance providers, and hospital executives are well versed in studying the impact of medical care like drug dosages, clinical settings, and treatment options on patients' outcomes, emerging SDOH factors require different kinds of research and different kinds of programs to tackle social issues.

Social Barriers to Healthcare

When people are healthier, care is more affordable for everyone. For the healthcare industry, it is a common-sense decision to confront nonmedical factors that affect people's health so dramatically. These factors include the proximity between a person and fresh produce or other healthy foods, how easily a person is able to access transportation to medical appointments, whether the person is living in safe and high-quality housing, if the person is living alone or has a social support system in place, and the underlying financial well-being of people and their families and how that affects how they pay for healthcare services.

Research has shown that these SDOH factors have a huge impact on people's health outcomes. Some have estimated that medical care alone (eg, doctor's visits, medications, treatment plans) addresses only about 20% of health outcomes.

Box 1. Geisinger Health Plan Offers Food as Medicine

Geisinger Health Plan, an integrated healthcare system operating in Pennsylvania, designed a program for patients with type 2 diabetes (glycated hemoglobin [A1C] levels >8) after research showed that 1 in 4 people with type 2 diabetes is food insecure. Geisinger modified its electronic health records to include a screening tool to identify patients who are food insecure. These patients receive a "prescription" for Geisinger's Fresh Food Pharmacy, which provides access to a food pantry stocked with healthy foods and increases access to diabetes self-management courses, registered dietitians, health managers (registered nurses), health coaches, and community health workers. The location of the Fresh Food Pharmacy, in Northumberland County, was chosen because research showed that 12% of the county's residents 20 years or older have diabetes and 1 in 3 residents is considered food insecure. Geisinger's investment has paid off in improving results. In addition to achieving financial savings, participating members experienced an average reduction in A1C of 2 points and a decrease of 18% or more from baseline for other clinical metrics including low-density lipoprotein cholesterol, triglycerides, weight, and blood pressure.

Health Insurance Providers Are Tackling Social Barriers

Whole-person care requires more than just medical treatment. That's why health insurance providers are coupling medical care with social approaches to foster an environment that supports the patient's health goals (Box 1).

For instance, to support a patient who has received a diagnosis of type 2 diabetes, an insurance provider may go beyond medications and follow-up appointments to help the patient improve their overall lifestyle. The insurance provider may connect the patient with a dietitian or nutritionist to better support healthy eating habits, or it may work with a local food pantry or grocery store to establish a discount program to improve access to healthy fruits and vegetables.² For patients who live in areas with limited access to fresh produce, health insurance providers are partnering with mobile food pantries³

Box 2. WellCare's Community Connections Program Links Members Based on Social Needs

In 2011, WellCare began implementing solutions to address social determinants of health by creating a multifaceted Community Connections program. The program consists of 5 distinct elements: data and technology, evaluation, local field teams, an innovation team, and a community connections help line.

WellCare's model has proved successful in improving quality outcomes and lowering costs. Recent studies conducted by the University of South Florida's College of Public Health revealed that peer coaches effectively used their own personal experiences to provide social support to study participants (callers) experiencing a broad array of stressful life circumstances such as homelessness, food insecurity, and financial difficulty. Further, those who accessed services through the program experienced a nearly 10% reduction in healthcare costs, which equates to nearly \$2500 per person per year. In recognition of these efforts, WellCare's Community Connections model has been acknowledged by the Commonwealth Foundation as an "innovative international best practice for models of care for patients with complex health and social care needs."

and food delivery services⁴ to make it easier for patients to connect with healthy foods.

Health insurance providers are contributing to vital research efforts to advance the national dialogue on effective SDOH interventions. For example, in recent years, social isolation and loneliness have become recognized as factors that play a critical role in health outcomes. To better understand their effect, in 2018, Cigna released a study highlighting the results of a survey of more than 20,000 US adults that revealed that although nearly half of all Americans often feel alone, younger people are particularly at risk. Generation Z (including adults aged 18-22 years) is the loneliest generation, with the highest loneliness scores. The survey was the basis for a peer-reviewed original research article in the *American Journal of Health Promotion*.⁵ The article examines the survey data to better understand what individual factors are most strongly related to loneliness and provides actionable insights that programs can use to improve social connectivity.

Challenges in Designing SDOH Interventions

No one-size-fits-all approach. Designing interventions to address SDOH can be challenging because every person and every community is different. People's needs change over time, and the availability of community resources varies by zip code. As a result, there is no one-size-fits-all approach to addressing social barriers (Box 2).

Let's consider housing as an example. A myriad of terms can be used to describe a community's challenges with housing. One community's major challenge could be that aging housing stock has not been maintained (ie, housing quality) or that a recent boom

Box 3. UPMC Partners With Local HUD Contractor to Support Housing Needs

As part of an integrated healthcare delivery system, the University of Pittsburgh Medical Center's UPMC for You plan worked with their medical providers and hospital discharge planners to determine that at any given moment, 40 to 50 of their Medicaid or Medicare dual-eligible Special Needs Plan members may be homeless. (A dual-eligible Special Needs Plan is a Medicare Advantage plan designed to provide care to people who are eligible for both Medicare and Medicaid.) UPMC partnered with Community Human Services, a local Housing and Urban Development (HUD) contractor, to launch the Cultivating Health for Success (CHFS) program in 2010. The program integrates permanent supportive housing, an assigned medical home, and case management services to coordinate healthcare for eligible members enrolled in the UPMC for You Medicaid plan or Special Needs Plan. To qualify, members must be homeless as defined by HUD, have a medical disability, and have at least 1 year of high healthcare costs. Since 2010, individuals housed through CHFS have experienced declining medical costs and less unplanned care. Access to primary care and specialist visits doubled after people enrolled in the program and pharmacy costs increased, suggesting improved medication adherence. During the first 5 years of the program, 51 of 60 enrolled members were successfully housed through the CHFS collaborating organization. After housing was attained, medical cost savings averaged \$8472 per year and pharmacy costs increased by \$2088 per year, resulting in an overall annual savings of \$6384 for each housed member.

in employment has led to increased demand and costs (ie, housing affordability) with a limited supply of available units (ie, housing availability). Each of these terms describes a particular set of challenges. An intervention that successfully addresses housing quality may not be appropriate for a community facing challenges with housing affordability.

Because every community is different, scalability of SDOH interventions remains a challenge. Even if an insurance provider launches a successful program in one community, there's no guarantee the same model will work in another community.

The need for a sustainable SDOH infrastructure. Health insurance providers are investing in a sustainable SDOH infrastructure that will allow them to identify social needs across populations, quantify the capacity of local community-based organizations, and standardize processes related to assessment and referral for social supports (Box 3).

To better advance use of data, health insurance providers leverage standardized assessment tools to identify social needs at the patient and community level.⁶ Building off their traditional case management experience, insurance providers are bolstering these services to better address an array of social needs.⁷ This may require additional training of case managers so staff can better assist with needs outside of housing.⁸ Others are looking to community health workers and care navigators to better assist their members with

navigating social needs. Stemming from a long tradition of philanthropic support for community-based organizations, health insurance providers are exploring new ways in which they can support these community groups to better connect members with readily available resources.

Tracking and monitoring progress. For these interventions to be scalable and sustained, health insurance providers recognize the need for a more rigorous evaluation of SDOH initiatives to better inform their overall impact, including cost savings, return on investment, and long-term impact on the health of individuals and populations. A sustainable SDOH infrastructure should include efforts to capture data that can be leveraged for planning and scaling. Although some coding for SDOH exists, it is often inconsistently used and may be an administrative burden for clinicians. Some available platforms may serve as a central database or repository of available community resources, but they often lack the ability to track and manage referrals and patient outcomes over time.

Navigating government resources. Navigating the complex web of federal, state, and local resources available to support social needs is another challenge facing health insurance providers, clinicians, and health systems. As a part of their case management support, health insurance providers assist members with these processes. Several opportunities are available to enhance engagement across existing federal and state programs (eg, Supplemental Nutrition Assistance Program eligibility; housing vouchers; Women, Infants, and Children program assistance).

Conclusions

It's clear that innovative programs to address SDOH are effective, but more work remains to be done to build on existing initiatives. That's why America's Health Insurance Plans (AHIP) launched Project Link—an initiative that brings together the best thinking from health insurance providers nationwide on how to effectively address social barriers for their members and their communities.⁹ Through a learning collaborative and new partnership opportunities, health insurance providers will work closely with other organizations to help communities overcome social barriers to good health. Using Project Link as a foundation, AHIP will utilize its extensive expertise to develop a research and policy agenda to improve health, well-being, and financial stability for consumers, patients, and taxpayers.

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