UNITE US

Integrating Social Care Services to Improve Quality Performance:

A Five-Step Guide for Health Plans

Steps

1 **Understand** Market Dynamics and the Impact of SDoH on Quality Performance

2 **Align** the Organization

3 **Identify** Membership Insights & Opportunities

4 **Connect** Members to Social Care Resources

5 **Measure** the Impact of Social Care

Health equity and social determinants of health (SDoH)—such as access to secure housing, adequate nutrition, and transportation—strongly influence healthcare utilization, costs, and outcomes, especially in aging, chronically ill, and populations with elevated economic and social needs.

This means social care services can be just as important as clinical care services in improving quality scores for Medicare and Medicaid beneficiaries. However, most health plans still lack a practical understanding of the actual impact of social care services on key quality measures.

This paper offers a five-step guide for how health plans can address their members' social determinants of health and measurably improve the organization's quality performance. It describes a practical path for integrating social care services into the strategic goals, operations, and workflows of a health plan's quality program.

In other words, this approach connects the dots between social care needs, social care services, and quality scores. This gives health plans the ability to make strategic decisions around social care with the same rigor and confidence they already apply to clinical care.

While all health plans, providers, and government agencies can benefit from such understanding, this paper has been written specifically for Medicare Advantage, Managed Medicaid, Commercial/Individual and Family Plan (IFP), and Federal Employee Program (FEP) health plans that measure quality through Medicare Star Ratings, NCQA/HEDIS, and CAHPS scores.

The five steps detail how health plans can:

- **Understand** how quality performance is affected by market dynamics, SDoH, and health equity.
- **Secure** executive buy-in and establish the fundamental drivers of a successful quality program.
- **Gain** data-driven insights into how SDoH impacts member population and quality performance.
- **Connect** members to targeted, effective, community-based social care services that improve quality scores.
- **Measure** and demonstrate the impact of social care services on quality scores.

It's time to close the gap between an academic understanding of social barriers to health and a practical understanding of how social care interventions measurably impact quality scores. With this five-step guide, health plans can improve their bottom line by better meeting the social care needs of their members.

1

Understand
Market Dynamics and the Impact of SDoH on Quality Performance

Health plan quality teams primarily focus on internal administrative data and supplemental healthcare datasets to understand quality trends and determine how the organization can move the needle on quality performance.

Typically, that analysis includes eligibility and claims data, compliance and adherence data, and operational data. But those data sources create a limited view of the overall quality picture. Two other major components are missing:

1. **Competitor Benchmarking:** A detailed understanding of the health plan's quality performance compared to a peer group with similar characteristics
2. **SDoH Impact:** Deep insight into social and economic circumstances of plan members and the corresponding impact on quality scores

With a more complete view, health plans can determine the right strategic priorities for addressing quality measures and make investments that will meaningfully improve quality performance, member experience, and health outcomes.

Benchmarking Competitors

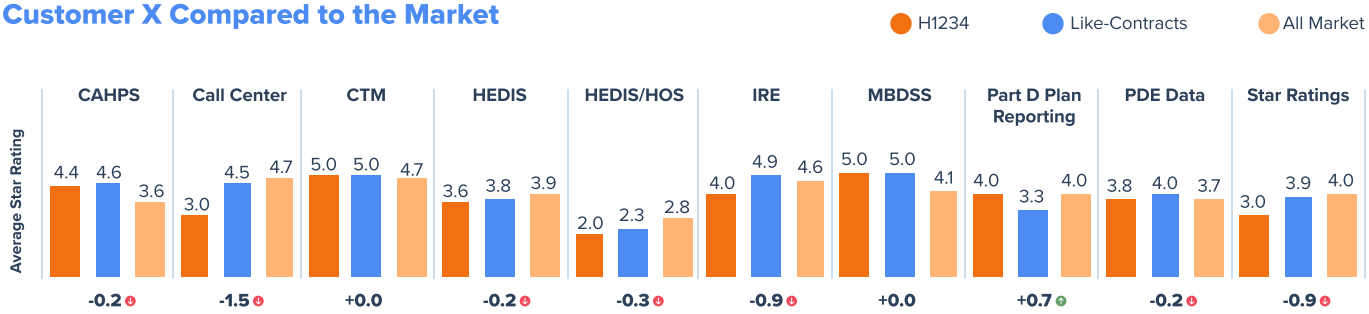
How well is your health plan performing compared to competitors? What opportunities are there to improve your performance in key areas?

To accurately benchmark your health plan against "like plans" in the market, it's important to analyze performance across specific contract and market attributes rather than relying on overall market performance.

For example, in Medicare markets, plans should benchmark their performance against competitors with shared attributes like contract type (e.g. HMO vs. PPO), contract benefit features, contract age, membership mix (e.g. percent SNP and LIS), and geographic attributes (e.g. rural vs. urban).

Many health plans use advanced reporting tools that allow them to benchmark performance against a competitor peer group using attributes like these. An example of this advanced reporting approach is illustrated in the visual below, leveraging the Unite Us Insights Quality platform.

Customer X Compared to the Market



Our Insights Quality product is a leading analytics and reporting solution that leverages consumer-centric, data-driven insights to optimize Star rating performance and maximize reimbursement revenue.

Connecting Quality Performance to SDoH

With data-informed insights, quality teams can identify strategic investments the organization could make to improve quality performance in a given market, and bring that analysis and budget request to leadership.

Medicare

The link between SDoH and Medicare Star Ratings can be seen by comparing quality performance measures across key characteristics of Medicare contracts, specifically Contract Type, Contract Age, Urban vs. Rural, and $0 Premium Plans.

Medicare Star Rating Components Analyzed

- **HEDIS:** Measures related to cancer screenings, condition management, and inpatient and emergency room utilization.
- **PDE:** Measures for medication adherence, statin use in persons with diabetes, and MPF price accuracy.
- **CAHPS:** Measures captured via the CAHPS survey, primarily related to patient experience but also including flu vaccination.
- **HEDIS/HOS:** Process measures from the HOS related to falling and balance, bladder control, and monitoring physical activity.
- **MBDSS:** Measure related to members choosing to leave the plan.

Developing Organizational Commitment and Alignment

Medicare (continued)

The table below summarizes performance trends by these contract characteristics and shows the connection to member SDoH profiles. Understanding these dynamics can inform program planning and investment prioritization.

Attribute	Connection to Quality Performance	Interpretation: Why?	Action	Connection to SDoH
Contract Type	Overall Star Ratings are higher for POS and PPO contracts. • PPOs outperform on CAHPS, PDE, and MBDSS measures. • HMOs outperform on HEDIS and HEDIS/HOS measures.	HEDIS: In HMOs, PCP is quarterbacking care for the member, there is a more structured network. HEDIS/HOS: In HMOs, higher levels of engagement and communication with PCP, members feel heard. CAHPS: Benefits and flexibilities make PPOs more pleasing to member perceptions of the plan. MBDSS: Strong connection between member experience and retention.	Cross-functional collaboration—between quality teams and product, marketing, and sales (growth team)—is key to ensuring the growth team understands the implications of decisions when building new products or deciding what counties to sell those products in.	Lower-income and more marginalized members are more likely to enroll in lower-cost HMOs. Consider implications of HMO membership makeup on downstream quality and health program design, accounting for SDoH programs and services.
Contract Age	Contracts with greater longevity perform better across all measure types. • MBDSS: Full Star Rating difference between contracts <5 years old compared to 20+ year contracts.	It takes many years of experience to achieve mastery of complex programs like Star Ratings. Provider partnerships and relationships, vendor partnerships, establishing strong analytics and reporting frameworks, and building comprehensive profiles of members are critical components.	For newer contracts, this understanding helps the leadership and finance team justify further investment in your Star Ratings program with a clear ROI. New plans coming into the market fight an uphill battle; it's critical to make investments early.	Newer contracts are more likely to offer richer supplemental benefits at lower costs, attracting lower-income and more marginalized members. Newer contracts are also more likely to have a younger membership mix, associated with higher levels of diversity and social needs.
Urban vs. Rural	The overall star rating doesn't correlate with urban/rural trends. Urban contracts perform better on HEDIS, PDE, and HEDIS/HOS measures, and underperform on CAHPS and MBDSS measures.	Members living in urban areas have greater access to doctors and pharmacies, resulting in improved HEDIS and PDE measures. Members in rural areas report stronger member experience and higher levels of plan retention, likely connected to lower levels of competition.	A data-driven strategy must be tailored to your contract and your members' geographic makeup. For example, if you're in an urban environment and you have a CAHPS weakness but your HEDIS is really strong, you should disproportionately invest in CAHPS and not HEDIS.	Levels of social risk and needs vary in urban vs. rural areas. For example, housing instability and utility needs are over-indexed in urban geographies while transportation, food insecurity, and loneliness are over-indexed in rural geographies. Design programs accordingly.
$0 Premium %	Contracts with 100% of members on a $0 premium plan perform worse on all measure types except for HEDIS/HOS.	Demographics of a $0 premium population correlate to members that have a negative impact on Star Ratings. $0 premium plans also skew toward HMOs, which perform worse on most measure types. Higher HEDIS/HOS scores can be driven by more care coordination and engagement with complex members, especially in urban areas where $0 plans are more prevalent.	The recent growth of $0 premium plans should influence the strategy of sales, product, and marketing teams. Products and benefits Unite Us designs and geographically targets dictate who health plans serve and influence Star Ratings. Operational activities and downstream investments should align with the appropriate product design mix.	Lower-income and more marginalized members are more likely to enroll in $0 premium plans. Consider the implications of $0 premium membership makeup on downstream quality and health program design when accounting for SDoH programs and services.

Medicaid

To understand the role SDoH play in quality scores in Medicaid plans, Unite Us assessed NCQA performance by state, and segmented performance into states with low social risk versus states with high social risk using the Social Needs System (SNS).

The analysis using Unite Us' SNS shows the connection between SDoH and quality performance. For example, plans in states with high levels of social risk perform:

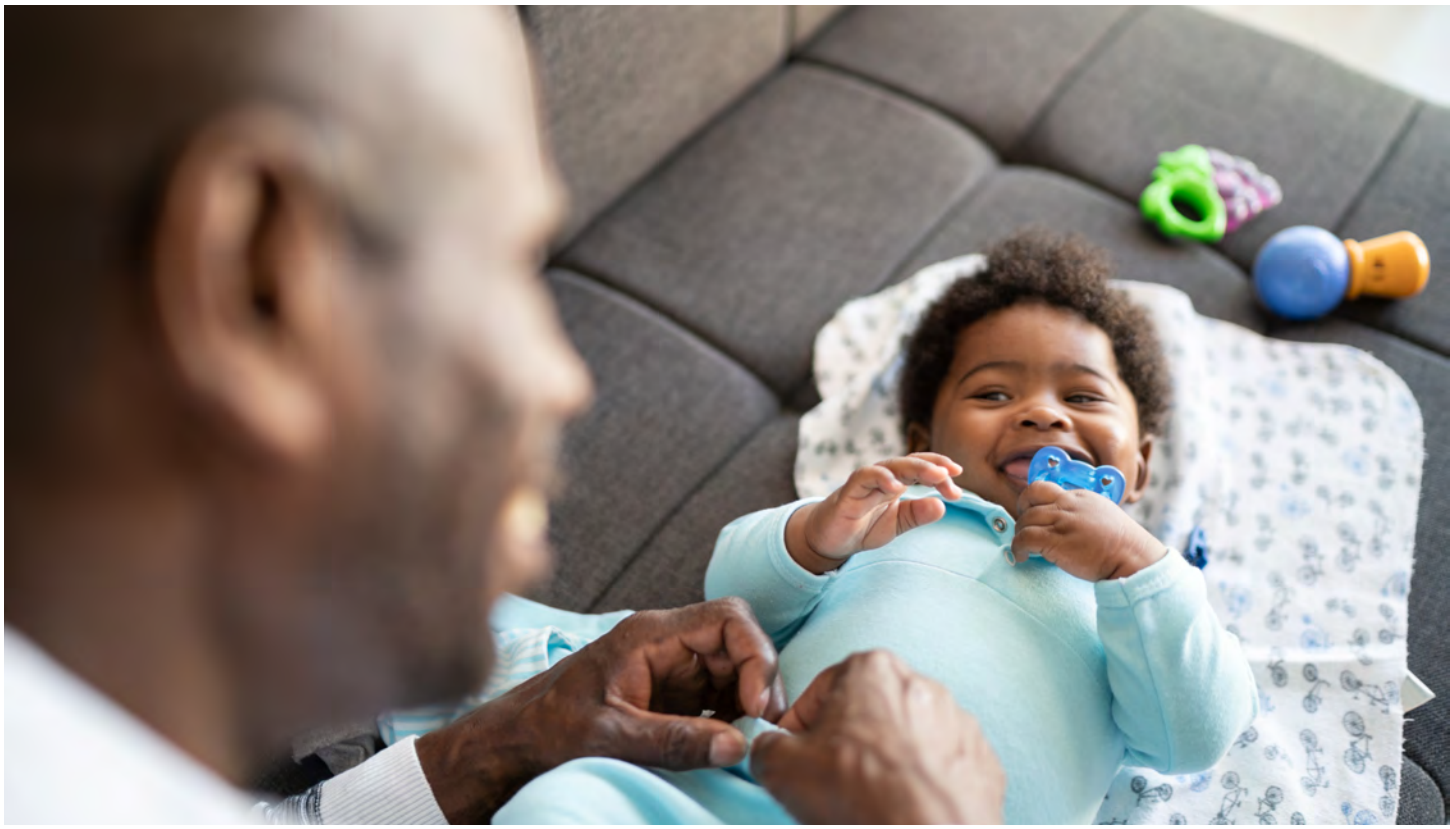
- **18 percent worse on flu vaccination compliance**
- **8 percent worse on breast cancer screening compliance**
- **63 percent worse on follow-ups after emergency department visits for alcohol or other drug abuse or dependence**
- **107 percent higher inpatient utilization for acute inpatient days related to maternity**

Social Needs System (SNS)

Unite Us Social Needs System (SNS)—a standardized framework for predicting and measuring SDoH—systematically predicts and measures social, environmental, and economic disparities, allowing for proactive identification of social needs.

Medicaid NCQA Quality Score Components Analyzed

- Access and Availability of Care
- Effectiveness of Care
- Experience of Care
- Health Plan Descriptive Information
- Measures Reported Using Electronic Clinical Data Systems
- Utilization and Risk Adjusted Utilization



Medicaid (continued)

Comparing state average medication adherence and chronic disease care compliance rates with average SNS Scores reveals substantial connection between the two. In this view, Unite Us highlights the R-squared value between the SNS Score and two compliance measures. The R-squared value represents the proportion of the statewide variance in compliance that is explained by the SNS Score, not controlling for any other attributes. The SNS Score shows a 51 percent R-squared value for statin therapy compliance and a 35 percent R-squared value for diabetes blood sugar control compliance at the state level, representing significant connection and that states in areas with higher levels of social needs perform significantly worse on these measures, among others.

State Average Compliance Percent vs. Average SNS Score

Overall, plans in states representing higher levels of social needs score 0.34 points worse on their NCQA rating on average. Only three percent of these plans achieved a 4.0 rating or higher—versus 33 percent of plans in states with lower levels of social needs.

Increased Role of SDoH and Health Equity in Quality Measures

CMS, state Medicaid programs, NCQA, and other measure developers are expanding their emphasis on SDoH and health equity in quality scores.

CMS

In Q2 2022, CMS included health equity in its 2023 Medicare Advantage (MA) and Part D Advance Notice. Their aim is to reduce disparities among MA members in three areas by:

1. **Adding SDoH into the CMS-HCC Risk Adjustment Model.** Current clinical risk scores used to allocate payments to health plans do not reflect the full complexity or needs of beneficiaries. Without adequate payments to reflect social needs and complexities, health plans will continue struggling to improve quality and outcomes for beneficiaries with elevated social needs. CMS is looking at how additional data can enhance the CMS-HCC risk-adjustment model to reflect social risks.

2. **Incorporating SDoH data into performance stratification.** CMS is evaluating how to report differences in contract performance on additional Star Ratings measures to account for the impact of SRFs on member experiences, behaviors, and outcomes.

3. **Introducing social need performance measures into Star Ratings.** In addition to considering social care process and outcome measures, CMS is developing a health equity index to enhance Star Ratings. The index will summarize performance for beneficiaries with SRFs into a single score.

Overall, the growing emphasis on SDoH and health equity means health plans must take into account:

- The increasing importance of member experience (57 percent of overall rating in 2023)
- The introduction of social care quality and health equity measures
- The inclusion of social risk factors in risk adjustment
- **Requirements to:**
  - Identify members' social care needs and collect related data.
  - Collect Race, Ethnicity, Language (REL) data.
  - Stratify quality measure performance by SNF and REL.

State Medicaid Programs

Many states leverage MCO contracts to promote strategies that address SDoH. The number of SDoH and health disparity-related requirements in those state MCO contracts is growing. In 2020:

- 35 out of 41 MCO states reported leveraging Medicaid MCO contracts to promote at least one strategy to address SDoH. 31 MCO states required MCOs to screen enrollees for social needs.
- 31 states required enrollee referrals to social services.
- 28 states required MCOs to partner with community-based organizations (CBOs).
- 19 states required MCOs to employ community health workers (CHWs) or other non-traditional health workers.
- 12 states required MCOs to track the outcome of referrals to social services.
- 7 states encouraged or required providers to capture SDoH data using ICD-10 Z codes.

The majority of Medicaid Managed Care plans are actively working to help beneficiaries connect with social services related to housing, nutrition, education, or employment. This momentum shows no signs of slowing down. Some states like Massachusetts, Minnesota, and Rhode Island are also experimenting with including SDoH factors in their Medicaid risk adjustment reimbursement models.

NCQA

In line with its long-term focus on health equity, NCQA announced changes to its Healthcare Effectiveness Data and Information Set (HEDIS) in measurement year 2023. These changes will include:

1. **Race/ethnicity stratification.** Stratification will cut across eight additional HEDIS measures. Integration with additional measures is also planned over the next several years.
2. **Gender-affirming approaches.** To ensure HEDIS accounts for gender appropriately, plans will acknowledge and affirm member gender identity.
3. **New social needs screenings and interventions measures.** HEDIS measures will encourage plans to assess and address members' unmet food, housing, and transportation needs.

NCQA has already added programs like Health Equity Accreditation to emphasize health equity. In NCQA's Population Health Program Accreditation program, plans must show that they identify SDoH and collaborate with community partners to address barriers.

2

Align
the Organization

How can a health plan establish a quality program that successfully meets social care needs and organizational goals?

Quality team leaders can secure resources and organizational commitment by engaging key organizational leaders and decision-makers in deep discussions around the importance of social equity to the community, the organization's mission, and the bottom line. Dialogue can be enhanced by sharing insights and perspectives from community partners and invoking real stories of members whose health, quality of life, and experiences were improved through better social care.

Out of those discussions comes a strategic plan that helps align departments, encourage cross-functional collaboration, deploy resources, direct investments, and build effective partnerships with the right CBOs.

To strengthen organizational alignment, departments need governance and structural support, as well as proof points and use cases that demonstrate how social care can be embedded into the organization's culture and existing operations.

Each department must develop priorities and goals consistent with the new strategic plan while examining workflows and ensuring effective deployment of people and resources.

Further dialogue with members and community partners helps identify the right CBOs to provide targeted programs, interventions, and services.

The following table articulates the process.

Developing Organizational Commitment and Alignment

Phase	Main Goal	Actions	Key Considerations & Recommendations
Engage	Establish an understanding of how the organization currently addresses non-medical needs for members. Connect the mission of the organization with the goal of better meeting social care needs and improving health equity.	Host Executive Session with key leaders and decision-makers. Connect health equity and social care with quality scores and the bottom line. Clarify the need for funding, investment, and resources to create meaningful impact.	Highlight individual member journeys and experiences. Invite partners in the community to participate. Reframe quality goals to align with the work of each department. Establish health equity as a programmatic priority, not a performative priority.
Enable	Clarify accountability, strategic plan, and roles. Demonstrate Proof Points, Models, and Use Cases that enable data-informed decisions for addressing non-medical needs.	Establish Governance Structure and Advisory Board. Develop strategic plan. Develop operational plan. Create implementation team and assign roles and responsibilities. Determine staffing and resource needs.	Use existing structure and people as much as possible. Emphasize that social care is not a separate activity but must be embedded into existing culture, operations, workflows, teams, etc. Connect to the work of each department to create ownership over organizational priorities and goals. Identify systems and activities that must be integrated.
Effect	Implement plans across all departments.	Engage champions/leads. Reshape workflows. Provide appropriate training and resources. Connect the use of specific tools to specific KPIs. Establish measurable goals to engage and motivate.	Create cross-functional collaboration and alignment.
Empower	Meaningfully impact and engage the organization, member population, and community partners. Measure ROI and drive continuous improvement.	Create awareness around the importance of collecting data. Establish quarterly reviews and check-ins. Listen empathetically. Celebrate wins. Identify ways to sustain and improve.	Win hearts and minds. Create a sense of shared purpose and accomplishment.

“Health equity is a driving strategic priority at UCare. Improving the health of members through a health equity lens begins and ends with data. Recognizing that every member has unique needs, we try to offer personalized solutions. We couldn’t do that without the timely and accurate data we receive from Unite Us. It helps us identify social and health care needs, connect members to services, and design interventions that have a meaningful impact on health and racial equity.”

– Greg Hanley, Vice President of Quality Management and Population Health at UCare

Through this approach, UCare, a leading Medicare, Medicaid, and Individual and Family health plan provider in Minnesota, achieved a 4.0 rating on its Medicaid plan and a 4.5 and 5.0 rating on its two largest contracts in 2022, representing all contracts' highest-ever performance.

3

Identify Membership Insights & Opportunities

The next step is to identify opportunities within your health plan's member population to improve quality scores by addressing social barriers to health. That's a sophisticated undertaking requiring access to expanded sources of SDoH data and a comprehensive data infrastructure and analytics ecosystem.

Health plans already rely on their clinical and claims data analytics ecosystems to track and improve quality measures. They need an equally powerful SDoH data and analytics ecosystem to integrate social care into their member experience strategy, address social care gaps, and bring quality scores to the next level.

SDoH data and analytics ecosystems require the same minimal features and capabilities as claims data analytic ecosystems, including:

- **Structured utilization data**
- **Risk analytics**
- **Compliance and gaps in care detection**
- **Identification and stratification of members for care programs**

To build out their SDoH data and analytics infrastructure in a comprehensive and effective way, health plans must address significant gaps in access to member SDoH data.

For example, current approaches to SDoH data collection typically include SDoH screeners; publicly available geographically aggregated data; and commercial SDoH data and analytics solutions. While these are valuable inputs, each source has limitations.

> **Screeners** have problems with selection and response bias, limited population coverage, under-representation of certain population segments, a lack of timely updating, and high administration costs.
>
> **Publicly available datasets** can be up to 10 years out of date. They use limited data points, have minimal actionability, and apply broad assumptions to diverse communities while overlooking important characteristics of unique individuals in those communities.
>
> **Commercial data and analytics vendors** use individual-level data that are slow to change. As a result, scores fail to register the impact of social care engagements and aren't useful in determining actionable social care recommendations. Commercial predictive models trained on limited and non-representative sets of SDoH needs and outcomes data will also be less accurate.

A Comprehensive SDoH Data and Analytics Ecosystem

Unite Us features the industry's leading SDoH data and analytics solution.

Unite Us' enables your organization to analyze SDoH screeners, assessments, structured outcomes data, healthcare claims, and clinical insights in order to:

- **Manage the longitudinal health and social care journey of your members.**
- **Utilize predictive analytics with dynamic responses.**
- **Demonstrate impact through ROI measurement.**

Unite Us' solution is driven by its core foundational data infrastructure and analytics capabilities, which eliminate gaps and limitations of other SDoH data and analytics approaches.

Combining a new SDoH analytics ecosystem with an existing data and analytics infrastructure creates a comprehensive framework for integrating health and social care programs.

The following diagram illustrates a complete population health data ecosystem for health plans.

A Complete Quality Data Ecosystem for Health Plans

Integrated SDoH and Health Data is Foundation to Quality Improvement

SDoH

- **Predicted Social Needs**
- **Social Needs Screeners & Assessments**
- **Program & Service Engagement**
- **Detailed Service Outcomes**
- **Longitudinal Social Care Record**

Whole Member Needs

Member 360° View

Health

- **Health Needs Assessments**
- **Medical & Rx Claims**
- **Compliance & Adherence**
- **Member Experience & Health Outcomes**
- **Longitudinal Health Care Record**

Parallel data sources feed parallel analytics engines, which enable the plan to develop targeted health and social care programs, evaluate the impact of those programs, and continue to optimize them over time.

The result is a system that enables whole-person care by leveraging robust data and analytics to inform targeted interventions that achieve measurable results.

With a robust SDoH data and analytics ecosystem in place, it becomes possible to develop a meaningful quality improvement strategy based on comprehensive member insights and stratified reporting.

That starts by establishing baselines or benchmarks around how SDoH, race, ethnicity, and language (REL), and other factors affect quality performance. With this information:

- Identify social care gaps that negatively impact quality measures.
- Develop strategic priorities for addressing them effectively with appropriate programs, services, and outreach.
- Measure and optimize the impact of those interventions over time.

Once created, those stratified views can be streamlined and automated with self-service reporting tools that enable insights and learnings to be shared throughout the organization. This creates the foundation for a culture of quality performance improvement built on metrics and shaped by the priorities of health equity.

The stratified reporting view below shows how quality measures can be tracked and visualized across REL or SDoH through a web-based tool.

Social Needs Scores Enable Stratified Reporting

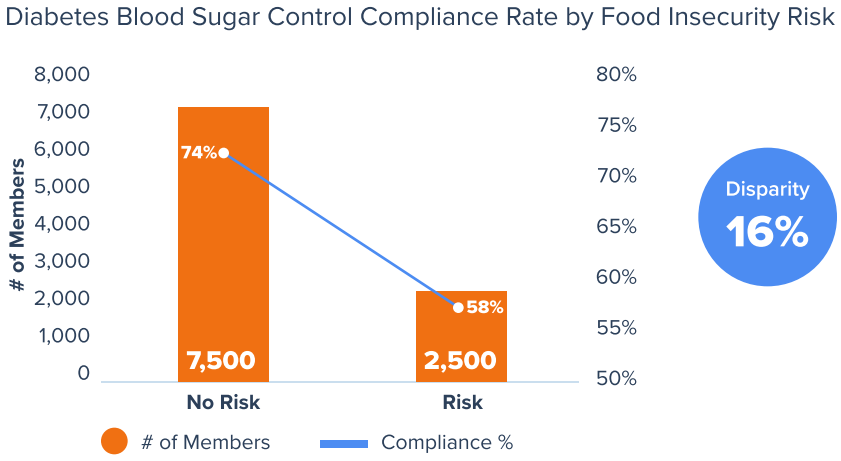
Stratify HEDIS, CAHPS, HOS, and other measures across REL and Social Needs
Identify top connections, barriers, gaps and disparities.

Select Measure

- Breast Cancer Screening
- **Diabetes Blood Sugar Control**
- Care Coordination Experience
- Med Adherence: Diabetes

Stratify By

- Race
- Ethnicity
- Social Needs Score
- **SNS: Food Insecurity**

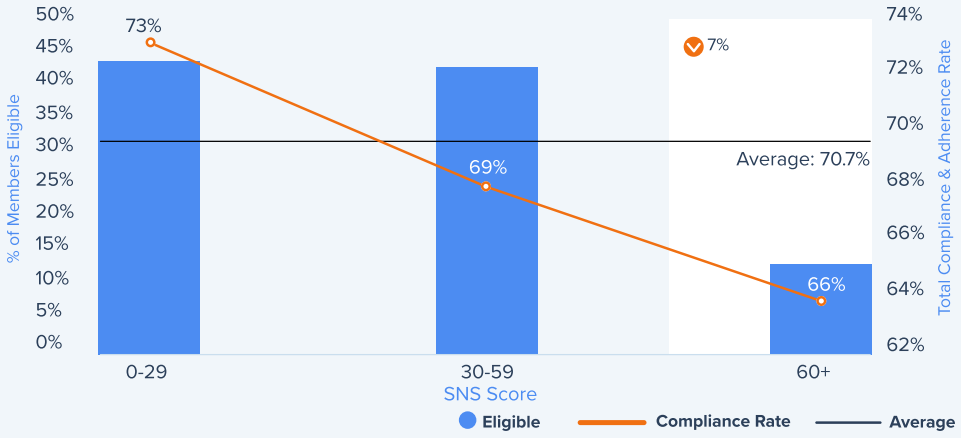


Unite Us performs such analyses for our health plan customers using our Social Needs System (SNS). Recognized by CMS in 2023 as one of the leading SDoH data assets for Medicare Advantage Star Ratings and risk adjustment, our SNS Score reveals the connection between SDoH and compliance/adherence, member experience, and health outcomes. Here are some examples:

Care Compliance & Medication Adherence

Aggregating nine key measures, Unite Us found that socially marginalized members have **21 percent** higher gaps in care compliance and medication adherence. These members are most likely to be noncompliant with annual wellness visits, all-cause readmissions, and adequate diabetic control of HbA1c. Housing instability, transportation needs, and food insecurity are the social needs most highly correlated to noncompliance.

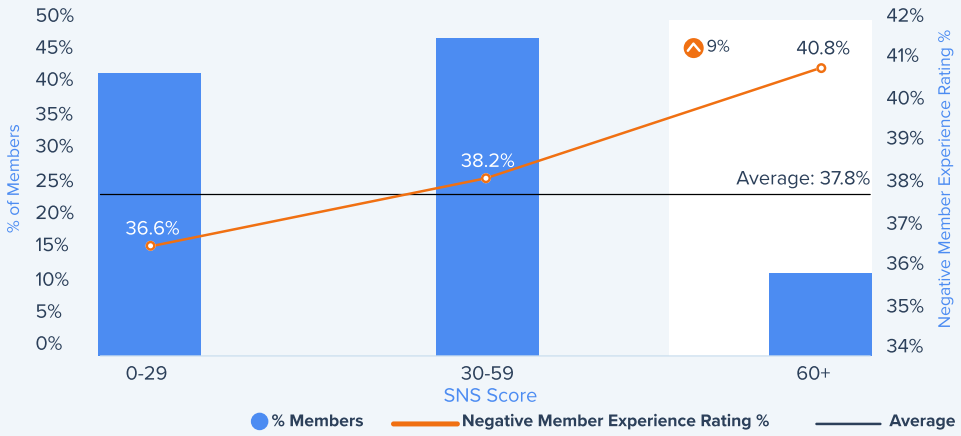
Total Compliance & Adherence Rate
By SNS Score



Member Experience

Aggregating the eight key member-experience domains in the CAHPS survey, Unite Us found that socially marginalized members report negative healthcare experiences at a **nine percent** higher rate. These members are most likely to report negative experiences related to care coordination and getting appointments and care quickly. Housing instability, financial insecurity, and health illiteracy are the social needs most highly correlated to poor member experience.

Member Experience by Social & Economic Marginalization
Negative Member Experience Rating Percent
By SNS Score



Quality and REL

As a result of structural inequality, we observe significant variance in care compliance and other quality of care metrics across race, ethnicity, and language. Specifically, when comparing quality measures between beneficiaries of Black vs. White race, we observe an **18 percent** lower rate of overall compliance/adherence, a **seven percent** increase in negative member experience, and a **26 percent** increase in mental health decline for Black beneficiaries. By consistently stratifying quality performance by member race and ethnicity, health plans can identify opportunities to address disparities and contribute to improving care delivery with relevant, diverse, and effective programs

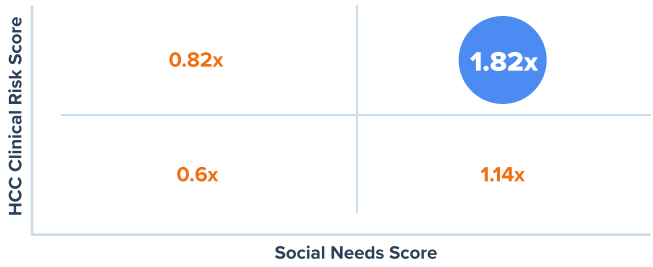
Members with elevated levels of social needs—specifically, those with an SNS Score above 60—have a **51 percent** greater impact on overall star ratings. Greater measure eligibility and likelihood to respond to member experience surveys contribute to this disproportionate impact. Understanding and serving social care needs of members creates a significant impact on health plan quality performance.

4 Connect Members to Social Care Resources

Quality performance and member experience can be improved by connecting high-risk and noncompliant members to relevant social programs.

Members with high clinical risk and social needs have an 82 percent greater impact on health plan quality ratings, largely driven by unmet social needs. **Knowing this makes addressing their social care needs a high priority.**

Adverse Impact on Quality Performance
By Clinical and Social Risk



In the above diagram, the upper right quadrant represents a segment of members whose needs can be appropriately met through targeted social services, programs, and outreach. Within the quadrant, unique member cohorts with similar needs and opportunities can be identified.

For example, John and Melinda represent high-risk cohorts with specific social needs and barriers that can be met with the right community-based social care resources.

Summary	 Housing-Unstable with High Risk of Negative Member Experience	 Food-Insecure and Non-Compliant with Diabetes Care
	John	**Melinda**
Demos	Male, living alone, white, urban dwelling	Female, married, Hispanic, rural dwelling
SDoH	**High** Top need: Housing	**High** Top need: Food
Clinical Risk	**High** Primary condition: Heart disease	**High** Primary condition: Diabetes
Engagement	Poor engagement with primary and preventive care. Likely to respond to member experience surveys. Prefers digital communication.	Poor engagement with primary and preventive care. Poor care compliance and adherence. Prefers telephonic communication.
Social Care Opportunities	Navigate member to community-based housing programs, services and resources.	Navigate member to community-based meal and food programs, services and resources.

Housing insecurity contributes to John's social risk and negative healthcare experience. That need can be met by referrals to housing programs, services, and resources. Melinda's food insecurity, which affects her diabetes, can be remedied with meal and food programs, services, and resources.

A social care infrastructure must be in place to effectively serve members and measure the impact of interventions. This requires:

A Closed-Loop Referral Platform

To engage plan members on their social needs, care teams must be equipped to consult, screen, collect consent, and deliver closed-loop social care referrals. The health plan must be able to track every member's social care journey over time, including the impact of every referral and interaction generated on their behalf.

Community-Based Resource Network

Traditionally, social services are accessed or referred through a simple directory of resources; but these services may be outdated, unavailable, or not right for the member's needs. To effectively close social care gaps, health plans need access to a coordinated network of CBOs that provide targeted, high-value social care programs and services. The CBO network must be actively managed and monitored to maintain standards of care and service.

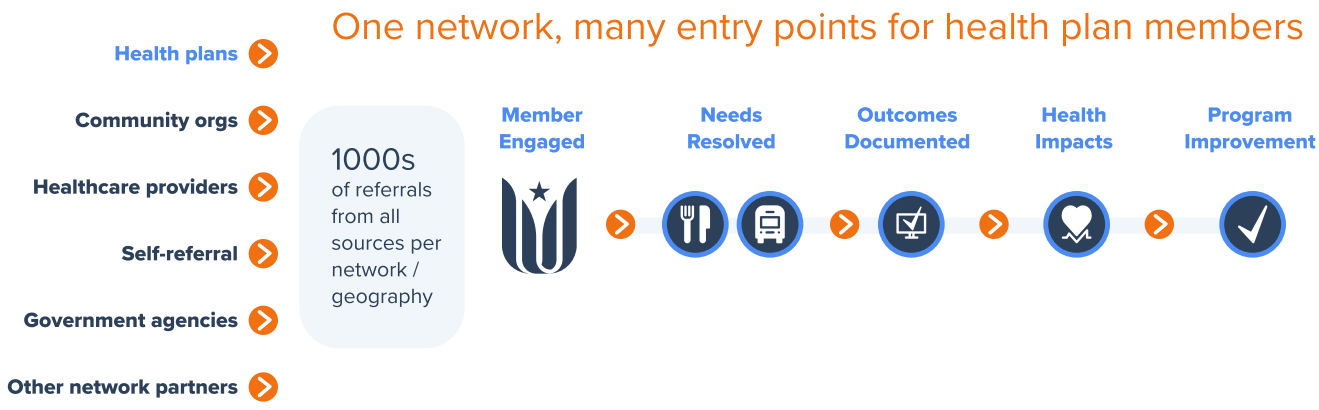
When a strong CBO network is in place and member needs are actively tracked, the health plan will discover that members often access services in a variety of ways. The impact of those services can be measured regardless of how they are initiated or delivered.

For example, members who are unengaged with the health plan can be five to 10 times more likely to receive care and support in the community through network partners like CBOs, government agencies, and local health providers.

When the health plan can identify members with greater social needs more accurately, it can connect targeted members to social care services through proactive outreach—aligning the outreach channel with the member's preference—or by integrating social needs assessments into existing care workflows.

The health plan can also help meet those needs by coordinating with cross-sector network partners and building a strong social care delivery ecosystem.

The point is not to restrict how members' social care needs are met, but to create a web of access in which there is no wrong door for the member to seek and receive appropriate services.



The quality of those CBO network partners is key. Health equity can't be achieved without inclusive, representative, high-value partners capable of meeting member needs.

5

Measure the Impact of Social Care

Historically, health plans have treated social care and health care as separate and distinct. Health plans now recognize the potential that targeted social care interventions can also have on improving quality score performance.

How can organizational focus on social services be sustained? By developing the ability to measure the impact of social service investments, regardless of whether those services are provided directly by the health plan or through outside agencies and organizations. Such measures are also critical for improving quality performance over time, as the organization gains new insights and develops new approaches.

Social care interventions can be measured for their direct and/or indirect impact on health and social care quality.

Direct impact on healthcare quality measures is easier to assess. For example, a social services organization in the community might identify a health need or social care gap in a member, and then refer that person to the health plan or provider partner to address directly.

Good measurement comes from structured, standardized, and detailed social care utilization data that tracks referrals, interventions, and outcomes.

- What services does the member need?
- Are they getting timely referrals to those services?
- Is the health plan providing those needs directly or indirectly?
- What other organizations are receiving those referrals?
- When did the member engage in the service provided?
- What was the outcome of the service provided?
- What is the ongoing impact of the service on member experience and health outcomes?

A Unite Us community partner in Louisiana identified a behavioral health issue in a Medicaid beneficiary and referred that person to a community-based behavioral health provider. The provider documented the services and outcomes provided. The health plan was able to track this need, referral, and outcome, and realized a direct improvement to the HEDIS Mental Health Utilization (MPT) measure as a result.

Measuring indirect impact on healthcare quality may require a broader view. For example, a diabetes medication adherence program in three states improved glycemic control, fruit and vegetable intake, and member experience by addressing food insecurity with food pantries. Likewise, a national study showed that members receiving social needs assistance at community health centers were significantly more likely to rate perceived quality of care as "the best." These sources can be used to predict the impact of similar interventions for similar cohorts.

As quality programs and policy continue to evolve, social care processes and outcome measures will become more prevalent in quality scores. SDoH data, technology, and services are a critical foundation for future performance success. Data collected, screeners administered, and community-based interventions delivered all contribute directly to the numerator of these social care quality measures. The insights will inform ongoing social care quality improvement activities and investments.

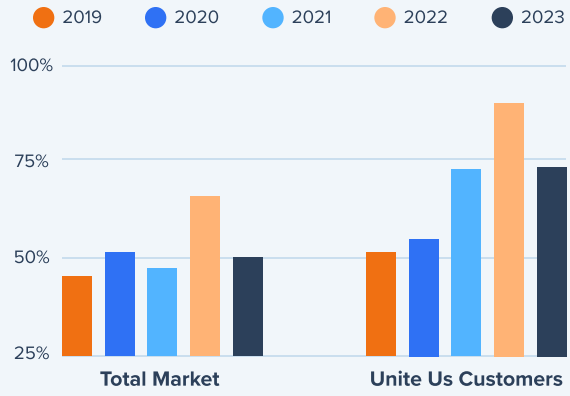
A robust, collaborative, and holistic community-wide approach to identifying and addressing unmet social needs can improve individual health and quality of life, improve community health, reduce healthcare costs, and drive health equity. **In this way, the health plan achieves a measurable impact on quality performance and the bottom line.**

"Unite Us customers continue to outperform the market in 2022"

Improving Medicare Advantage Star Ratings with Unite Us

- **Fifth straight year** outperforming the market
- Continuous improvements each year at a pace that exceeds general market trends
- 77% earned the **Quality Bonus Payment** for the '23 rating year at 4.0+ stars, versus 51% contracts in the total market

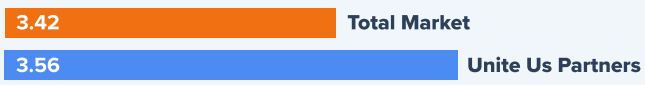
% of Contracts Rated 4.0+ by Year



Outperforming Medicaid Market

Our Managed Medicaid partners' quality improvements and population health initiatives are driving a strong performance on NCQA ratings (3.56 on average) relative to broad market trends (3.42 on average)

Average NCQA Rating



A Call to Action

Unite Us has facilitated more than 10.4 million quality social care service interactions throughout the country and can provide structured outcomes for each interaction to demonstrate impact and improve plan quality. Unite Us' infrastructure enables health plans to coordinate social care needs and care journeys for members across different communities while tracking every referral, interaction, and outcome.

By integrating social and clinical care, health plans can target social care services that measurably improve quality performance and member health.

Unite Us data and technology helps health plans:

- Understand how quality performance is affected by market dynamics, SDoH, and health equity.
- Secure executive buy-in and establish the fundamental drivers of a successful quality program.
- Gain data-driven insights into how SDoH impacts member population and quality performance.
- Connect members to targeted, effective, community-based social care services that improve quality scores.
- Measure and demonstrate the impact of social care services on quality scores.

Today's health plans must address health equity and social care gaps to compete and thrive. With Unite Us, health plans can meet the social care needs of their members while also improving the bottom line.

About Unite Us

Unite Us is the leading enterprise technology company connecting health and social care. We provide the only end-to-end solution to seamlessly connect health and social services in coordinated care networks that expand the traditional healthcare reach and increase value. With Unite Us, health plans can better identify risk and needs in their member population; coordinate with community partners to augment engagement strategies and deliver proactive, targeted interventions; and track in real time impact on reducing disparities and improving health outcomes.

Our data capabilities and collaborative tools are integrated into systems of record to create an intuitive experience and increase efficiency for care teams and ultimately members.

Proven track record: Since our launch in 2013, we have successfully established high-performing collaborative networks across 44 states, including 20 statewide networks. We proudly work with health plans like Aetna, Kaiser Permanente, Humana, and UHC, among others, in pioneering health equity innovations. Unite Us' clients have been consistently outperforming peers in quality performance across Medicaid and Medicare Advantage markets.

About the Author

Spencer Pratt

Spencer Pratt is Vice President of Market Solutions at Unite Us, where he works at the intersection of product, technology, and the market to support growth strategy and execution. 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. He has authored dozens of articles and papers on the topics of consumer engagement, risk stratification, and social determinants of health. Prior to joining Unite Us, Spencer led high-performing teams at Carrot Health and built the Consumer Analytics & Strategy function at Optum.

Partner with Unite Us today to address health equity and social care gaps.

Learn more at
www.uniteus.com/health-plans