BRIEFING PAPER

Special Needs Plans and Social Determinants of Health: Issues, Efforts, Recommendations

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Social Determinants of Health

Over the last several years, the Special Needs Plan Alliance (SNP Alliance) gathered information through surveys, research and expert committee reports, and published data on the impact that social determinants of health (SDOH) have on health outcomes. This paper presents key findings from that work, examining the social determinants of health (SDOH) risk factors, the efforts by special needs health plans to identify and address such factors, and some recommended actions.

Background

Special Needs Plans and the SNP Alliance

The SNP Alliance is a national leadership nonprofit organization of health plan organizations, representing over 1.9 million enrolled beneficiaries. Special needs plans (SNPs) are specifically authorized and designed to meet special care needs of Medicare beneficiary groups with high care and condition complexity. SNPs have additional requirements beyond general Medicare Advantage health plans. For example, they conduct health risk assessments, have an interdisciplinary care team and care management approach, and coordinate an extensive service array with specialized provider networks.

Some plans exclusively serve people who are *dually eligible* for both Medicare and Medicaid. These dually eligible individuals often require community services and supports, behavioral health services, medical, pharmaceutical, and condition-focused care, and usually have adverse *social determinant of health risk* factors.

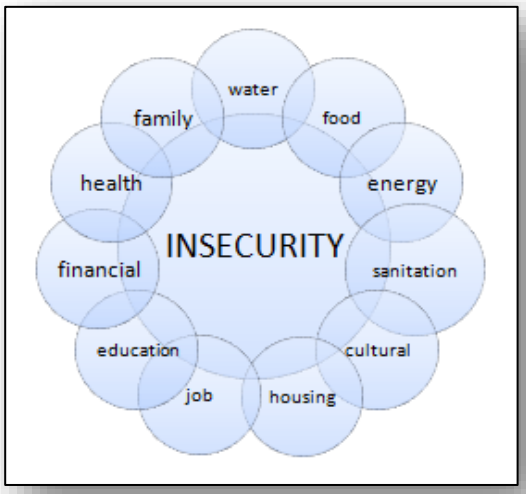
Definition

The Centers for Disease Control and Prevention defines **social determinants of health** as: *the circumstances in which people are born, grow up, live, work, and age.* Such characteristics are important to consider for all people. Researchers from Harvard and Yale recently reported on a 10-year analysis where: "a major conclusion . . . is that social determinants of health are essential to the lives of Americans from a range of backgrounds and income levels" (Bradley, Sipsma, & Taylor, 2017). For high risk, complex care individuals, these factors greatly compound complexity and impede treatment or support for medical and behavioral health issues also faced.

Research

The importance of SDOH risk factors on health and health outcomes is extensively researched and widely recognized. Several scientific expert committees and panels have produced sentinel reports pertaining to Medicare Advantage plans.

National Academies - In 2015 and 2016 the National Academies *Committee on Accounting for Socioeconomic Status in Medicare Value-based*



Payment Programs conducted a thorough examination of socio-economic and social determinant of health risk factors. They released a series of 5 reports (see: NASEM: SES-in-Medicare-Payment-Programs).

The Committee identified measurable social risk factors:

- Low income/poverty status
- Low education level
- Dual eligible status (Medicare and Medicaid eligible)
- Non-White Race/Ethnicity
- Limited English proficiency
- Nativity (non-U.S. birthplace)
- Lives alone
- Neighborhood deprivation – including lack of transportation, access to fresh food, water, or primary care services
- Housing instability

The examination revealed that many of these social risk factors impacted outcomes. The Committee recommended that these factors be taken into account in quality measurement and value-based payment

ASPE Report to Congress – In its 2016 *Report to Congress* the Assistant Secretary for Planning & Evaluation (ASPE) found that dual beneficiary status was *the most significant predictor of* poor health outcomes as measured by the Medicare Star Ratings. Furthermore, dual, low income, and disability status impacted outcomes i*ndependent of provider or plan behavior*. This was found across the board—for all Medicare programs (e.g., hospitals, clinics, health plans, etc.). See: ASPE.HHS - Report to Congress 2016

The Report noted that beneficiaries with social risk factors "had poorer outcomes on many quality measures. . . even when comparing beneficiaries at the same hospital, health plan, ACO, physician group, or facility." Furthermore, they found that: "In every care setting examined, providers that disproportionately cared for beneficiaries with social risk factors tended to perform worse than their peers on quality measures. . . As a result, safety-net providers were more likely to face financial penalties across all five operational Medicare value-based purchasing programs in which penalties are assessed" (ASPE, 2016, p. 8, 9).

An ASPE Report to Congress noted that "*in every care setting examined, providers that disproportionately cared for beneficiaries with social risk factors tended to perform worse than their peers on quality measures. . .*"

Complexity and Interaction

Access to nutritious food, clean water for drinking and bathing, and a safe, warm, dry place to sleep are basic needs. The barriers individuals face around mobility/transportation, isolation, mental health conditions, lack of social supports, housing and food insecurity—are also hurdles for care. They affect what can be done, where, when, and how.

SDOH factors affect what can be done, where, when, and how.

On top of these issues, the presence of persistent and ongoing functional limitations (for example in moving, thinking, eating) greatly complicates daily life and affects adherence to medical advice. For vulnerable or "at-risk" individuals, medical advice to check insulin and weight daily, maintain a healthy diet, get a flu shot, have a colonoscopy or take blood pressure medicine regularly feels beyond reach—out-of-touch—with the reality of daily existence.

Clinicians, behavioral health providers, social workers, and others working primarily with people who have significant social risk factors explain that optimal health outcomes can be difficult to achieve, even when provision of medical care for conditions meets the highest standards of care or treatment guidelines. They describe the interaction between risk factors and vulnerabilities as being important.

It is often not a single factor, but a multiplicity of factors and how these interact—which compound the negative effects of adverse social risk factors and complicate care provision. Two people of the same age with the same conditions but who have different risk levels in terms of social determinants of health—may have different outcomes even if they receive the same medical advice and treatment.

To illustrate we use an example. A low-income person ("Sally") has Diabetes and Congestive Heart Failure has low reading comprehension, unstable housing, no family nearby, and lack of access to proper fresh fruits and vegetables. She finds it difficult to conduct daily insulin checks, follow the doctor's advice about eating the right foods at the right times, check on insulin, monitor weight gain/loss, track changes in fluid retention and access medications needed daily. Sally's living situation and access to resources complicates everything.

"Samantha" has the same diagnoses, and she is the same age and gender. However, Samantha has a higher reading comprehension level, higher income, a stable home, family members to help her, transportation, and access to insulin, a scale, refrigerator, and medications. Samantha has greater capacity to follow through on medical advice for her conditions. It is likely that Samantha would not require as extensive support from her clinical, social work, or care management team.

In this way, resources (including medical and other expenditures) for a similar condition can differ substantially. This variation can also arise from other complexity characteristics interacting with poor SDOH (such as dementia, chronic mental health disorder, significant functional impairment or disability, or frailty due to advanced age).

Medical expenditures for a similar condition can differ substantially, and this variation may be due in part to SDOH interacting with other characteristics.

Special Needs Plans Responding to SDOH

Most Frequent SDOH Factors Observed

SNP Alliance Survey

In two recent surveys (*SNP Alliance Annual Member Survey,* 2017 and 2018) health plans reported the top social determinant of health risk factors observed in their enrolled SNP and MMP populations. Plans were asked to involve their care managers and examine available internal data to respond to this question.

The top SDOH observed risk factors reported in the 2018 survey were:

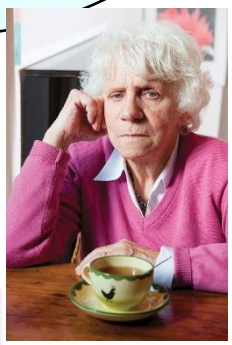
- low income/poverty (80% reporting)
- low health literacy/education (73%)
- lives alone/few social supports (67%)
- lack of available mental health services and supports in the community (60%)
- housing instability/transience (53%)
- transportation challenges (47%)
- food insecurity (40%).

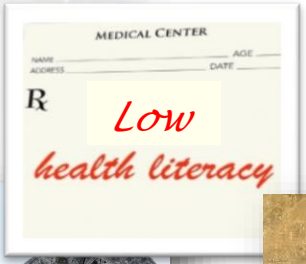
Other observed risk factors reported by the plans via open-ended response/comments included:

- non-English speaking
- limited availability of home care or help given rural area
- unsafe environment
- history of trauma or abuse

Plans shared additional descriptive information about their special needs plan enrolled populations, describing language diversity, education levels, poverty, age, and other characteristics indicating a high level of vulnerability and complexity (see quotes shown in call-outs).

PLAN Quote: "We reviewed the characteristics of our special needs health plan enrolled members, and found they live with many social determinants of health challenges in addition to their physical, medical and behavioral conditions. For example, 76% are non-English speaking, 44% did not graduate from high school, and 49%





PLAN Quote: "We have an average age of SNP members of 82 years, 76% have a high school degree or less, 7% speak a language other than English, 72% are single, 85% live in a rural area, and 41% have an income of $10,000/year or less."

Data and Identification Issues

In other SDOH-related questions on the SNP Alliance Annual Survey, responses revealed that special needs and Medicare-Medicaid plans are using *multiple sources of information* to understand the social risk issues in their enrolled groups.

The SNP Alliance Survey discovered plans are using multiple sources to locate social risk factor information on their members in order to proactively reach out, tailor care strategies and avoid negative outcomes.

These data are being collected, accessed, and reviewed to better define needs, identify those most at risk, and initiate more proactive outreach to affected individuals.

Sources of **SDOH information** included:

- Health risk assessments (HRA)
- Internal care management records
- Member services information gathered through phone contact
- Claims data, encounter data, including ICD-10 "z" coded visits
- Member surveys
- Initial member enrollment forms
- Medical record information from providers
- External care management records
- State long-term services and supports data
- State Medicaid data
- American Community Survey data
- Census data
- County data, county health rankings
- Community (regional) health assessments

Limitations

However, plans also shared limitations with these data sources and barriers to securing reliable, accurate, timely and useful information. SNP Alliance gathered additional information to identify common issues in SDOH identification and proactive use of data for outreach, service support and quality improvement that SNPs and MMPs are experiencing.

These include:

- *Engage* - The person is hard to find, reach, or engage—or he/she does not want to answer these questions.

- *Privacy and confidentiality* - The individual, providers, health plan and state and federal government agencies are concerned about protecting the privacy of the person. Federal HIPAA and State privacy laws inhibit sharing of some SDOH items. There are also rules about obtaining permission from the individual for specific purposes. Plans and providers respect and follow these laws and the individual's right to privacy.

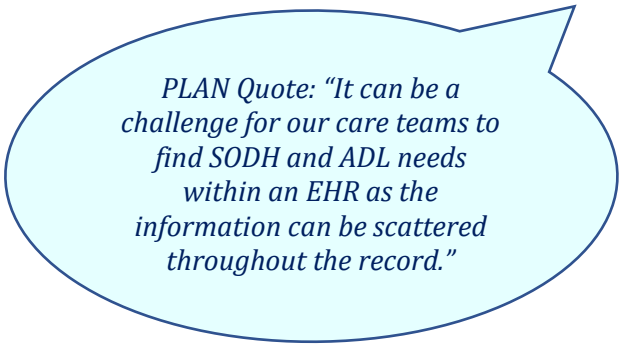
- *No standard data elements* - There are many screening forms and many SDOH assessments—but there is a lack of standardized data elements, (different definitions, scales, scoring methods)

- *Multiple organizations and timeframes* - SDOH data is captured by multiple organizations and across time periods and the information may be inconsistent; SDOH data is in multiple databases that are hard to access.

PLAN Quote: "Data about social risk is itself fragmented… we need a straightforward narrative about the status of the member's health and wellbeing."

- *Point in Time/Information Decay* - These SDOH data are often a point in time/static and the electronic technology used is not advanced enough to allow the SDOH data to be "refreshed" by new information. SDOH risk factors change and must be re-assessed. Inaccuracies or old information can perpetuate—and this may cause harm.

- *Non-searchable Data Fields* - Even when SDOH information is collected, the data elements may not be searchable (for example if in a clinical note).



- Additional programming (and finances) are required to design additional fields, search tools, or reporting formats. Each electronic health record information system (EHR) has its own operating and user issues which complicate data aggregation, transmission, and reporting; also, these systems are proprietary.

- *Large Geographic Areas* - In the census and community SDOH data, geographic reporting units are often too large; they do not offer neighborhood level information that would help pinpoint SDOH issues neighborhood by neighborhood.

- *Timing* - There is wide variability in when and how data are released –hard to plan, hard to predict, difficult to use consistently for proactive outreach, care support, quality improvement

Possible Solutions to Data Issues

Awareness of these issues is growing. The SNP Alliance recently participated as a member of the National Quality Forum – National Quality Partners "SDOH Data Integration Action Team"—a group of over 40 experts and stakeholders. Some of the possible solutions explored by this team echo similar ideas discussed or presented by others working in this area. One of the first steps in addressing these challenges is to:

- *Standardize SDOH Fields and Data Elements Across EHR Platforms* - Efforts to select specific domains and improve standard definitions would be helpful to encourage consistency across EHR platforms. As part of our background work we refer to the Institute of Medicine of the National Academies of Sciences, Engineering and Medicine report from on issues around capturing social and behavioral health domains in electronic health records (NAP, 2014). This may offer further guidance to EHR developers and providers.

  Standardizing data elements and definitions would have to go farther than only EHR platforms, however. Thus, the concurrent effort to attention to EHRs would be to:

- *Extend Health Information Exchanges & Build Capacity Across Service Sectors.* – Use of standard definitions for SDOH would have to also be applied and used within public health, community-based home support and long-term services and support settings, as well as behavioral health providers. This would be necessary so that the same elements and definitions would be used by plans, providers and community organizations and within the Medicare and Medicaid programs across all

50 states. Capacity building in data infrastructure and information exchanges is needed for many of these settings.

This would require significant cross-sector stakeholder involvement and investment. However, this effort is needed to bridge across the settings that the person with high SDOH and complexity uses. Such settings need to be linked for better identification, outreach, service/support, tracking, monitoring, evaluating outcomes, and reporting.

Plans would like to see standardized SDOH screens or instruments, data reports.

PLAN Quote: "Standardizing the SDOH elements and capturing them in a systematic way would assist care teams in identifying and addressing needs."

We heard from health plans that some resources to address one or more social risk factors can be limited. Scarcity of adequate mental health resources was frequently mentioned by health plans.

PLAN Quote: "We see a lack of mental health and behavioral health services in our region."

Other gaps mentioned were around long-term services and supports (LTSS), such as personal care attendant or companion care.

PLAN Quote: "LTSS staffing shortages exist, especially within personal care attendant, companion and individual community living supports."

Attention to Resources after SDOH Risk Identified

Even if all practitioners and the individual are aligned in what is important given the SDOH and care complexity issues, there are still challenges in responding. For example, the availability of supports can be limited. These plans and providers/clinicians rely on community resources such as food, housing, and transportation services, social supports, home care, and other providers being available and accessible. If the person lives in a low-service community, such as in a rural area with few transportation options or an urban area with a shortage of low-income housing, how does the plan or provider respond to the SDOH risks they uncover?

PLAN Quote: "There is the concern about collecting data without having a way to address the needs identified with meaningful interventions to support the individual."

Effective Practices by SNPs

Strategies Deployed

Special needs health plans and Medicare-Medicaid plans are deploying strategies that promote earlier identification, outreach, and enhanced care management for a proactive approach to addressing SDOH issues in their enrolled populations. These are briefly described below, together with emerging promising practices that are also being tested or woven in to the plan's model of care.

Identification- Depending on the characteristics of the social risk subgroup targeted (e.g. younger people with physical disabilities, behavioral health needs and primary social risk factors such as housing instability, or low income frail elderly persons who live alone and have functional impairment and no social supports), different outreach strategies are being deployed to reach the person as early as possible and engage them in discussion about their situation, goals, and concerns.

Care plan as part of enhanced Care Management – Among SNPs, efforts to address SDOH issues are usually part of a care plan. A coordinated care plan with involvement of multiple parties can yield results for specific high-risk individuals when targeted and sustained. Such efforts often require involvement and resources beyond what a general managed care organization typically provides. The enhanced effort involves working across medical, mental health, home/community resource providers and non-traditional service organizations, as well as across service sectors in the community.

Enhanced Service Provision - Some plans refer to services, some are paying for community services for high risk beneficiaries when tied to health/medical goals, and some plans provide services directly. The connection to specific community resources and ongoing touchpoints with the member/person through care managers is considered a proven strategy to address *some* of the needs of targeted high risk/high need, complex care individuals.

Care managers spend considerable time learning about and working with community services providers. There are increasing examples of plans setting up contracts with aging service provider collaboratives, housing providers, transportation and food service agencies, or other types of service providers—for defined sub-groups of enrollees under high risk care management. Such services are tied to medical treatment/health care and are deemed at highest risk. These individuals receive the most intensive level of care management.

Proactive Care Manager to Member Assignment – Some special needs plans proactively assign a care manager (we will use the term care manager to also refer to plan care coordinator or delegated care coordinator) to each member as standard practice. This is because all of the plan's enrolled members are identified as high risk (e.g. all are low-income, dually eligible, with multiple chronic conditions, and/or physical disabilities).

The plan proactively makes an assignment, and the care manager follows through to connect with the individual and discuss SDOH and care complexity issues. Through one-on-one interactions between the care manager and the member/beneficiary, the manager gathers information about the individual's unique culture, health beliefs, ethnicity, language, religion, priorities as well as other characteristics, such as living arrangements, social supports, sexual orientation.

Care manager guidelines and protocols set up by the plan support consistency and comprehensiveness in the approach. Care managers recognize the need to identify barriers

(including SDOH barriers) to access and to following through on treatment, care plans, and self-care goals. They work to create the communication pathways and relationship with the member to encourage the member to share challenges around financial assistance, food/meals, housing, legal assistance, transportation, and other social risk issues.

The greatest asset in this approach (according to the plans) is the trusted and ongoing relationship between care manager and individual member. To develop this relationship, plans must invest heavily in care management resources to allow for face-to-face interactions which includes sometimes extensive "dashboard time" getting to the member's residence, particularly in rural areas.

PLAN Quote: "We have partnered with an organization that is integrating Community Health Workers into the clinical setting and utilizing mobile care to address social determinants of health and treat and close identified gaps in care."

Community Health Workers and Extenders - Many special needs health plans report working with and/or employing Community Health Workers, particularly in ethnically diverse and low-income neighborhoods where they have substantial number of enrolled members. Other community-embedded workers being deployed successfully include peer navigators who work as an extension of the care managers serving people with mental health and behavioral health needs. Some plans have other kinds of care management "extenders" in the community, such as community social workers within Area Agencies on Aging, social service organizations, and disability services organizations.

PLAN Quote: "To overcome transportation barriers and improve access to preventive care, our SNP members are provided transportation to medical appointments and other rides, such as transportation to a health club."

Specific Issues, e.g. Nutrition, Housing, Transportation - Other promising practices include attention to specific SDOH issues with special services. Plans proactively set up additional support services with the member's permission, e.g., around nutritional needs. The nutritional need is identified as part of a current assessment of the individual's condition and situation. It may be triggered by a recent event, such as a discharge to home.

For example, some plans are offering medically-tailored meal programs to members with nutritional needs discharged from hospital, rehab, or nursing facility to home, or to individuals diagnosed with specific chronic conditions and identified as having a period where meal supplements are needed. These efforts are supported with dietitians offering nutritional health education tailored to individual needs and preferences. The care manager or care coordinator will then work with the member to seek out and set up extended nutritional/meal delivery services that are available in the area for meeting long-term nutritional needs. Other examples include assistance with applying for SNAP benefits, food delivery partnerships with

meals on wheels, and vouchers or other help to access food pantries or grocery delivery services.

PLAN Quote: "To address some of the nutritional needs, SNP members recently discharged from a hospital or nursing facility may receive in-home medication-reconciliation and home-delivered meals."

Assistance with applying for housing support, guidance and referral to subsidized housing, application for supportive housing and Section 8, assistance with application for transitional housing or family shelter programs, and other temporary or longer-term housing programs. Some plans work with community providers to obtain rental assistance and direct rental payments, e.g., through partnerships with nonprofit housing providers, city, county and state housing services programs or others. A few plans have even participated in a partnership to purchase housing units directly for high risk members.

Many SNPs provide rides. This may include authorizing a substantial number of rides through providing vouchers, directly offering adapted van transport to medical appointments, providing a transportation line to set up rides through a contracted ride service program or county-operated regional bus service, or other transport service, such as with specially adapted vans. Plans also help members connect to local volunteer driver programs and other ride services (e.g., medical Lyft). A particular focus is on getting members to medical and mental health, dental or related appointments.

Focus on Function and/or Frailty - Another frequent focus is on functional ability at home—particularly among plans serving dually eligible beneficiaries who have both Medicaid long-term services and supports coverage and Medicare coverage under one health plan product. These plans coordinate such services as an occupational therapy assessment of the home for safety/falls hazards and bathroom safety devices and other home safety adaptations—for example to support health and functional needs of community-dwelling frail elderly individuals. A functional assessment combined with SDOH information on vulnerability around home, social supports, health literacy, and informal caregiver capability can be the starting point to initiate this home adaptation and environmental support. Plans also report explicitly screening for frailty, especially after a hospitalization—or even prior to discharge.

Mental health – We hear frequently from member SNP that attention to mental health issues is very important—and that many SDOH vulnerabilities are connected to poor mental health status and/or behavioral conditions which are not consistently managed. Health plans have invested in training such as Motivational Interviewing for staff positions (e.g., care management, customer service, navigators, etc.) who have direct interaction with consumers/members. The skills and techniques for active listening, coaching, and responding to members in a way that builds the

PLAN Quote: "To overcome financial barriers to using in-home safety equipment, our plan offers additional funding for specific non-Medicare covered bathroom safety devices."

member's capacity and confidence are part of an overall strategy to deepen understanding of the issues, preferences, current coping behavior or actions, and barriers to self-care.

PLAN Quote: "All SDOH as well as clinical and other factors have a much bigger impact for members with mental/behavioral health and dementia co-morbidities."

Telehealth, Mobile units – Plans and providers are working together around key vulnerable populations or communities to address SDOH and other factors that restrict a person's ability to get necessary care. The use of telehealth including virtual visits and remote monitoring is one strategy, where plan care managers work with providers who have such capability within their clinic or health organization.

Plans also collaborate with community agencies, clinics, and other organizations to support the use of mobile units for screening, prevention, and treatment (e.g., dental, vision, diagnostic, and preventive care) is very promising. Mobile units have also been used for delivery of fresh produce and other nutritional needs. In some cases, health plans have mobile physicians and nurse practitioners—that is, the primary care provider goes to the individual's home rather than expecting the person to go to a clinic setting.

PLAN Quote: "For more homebound people, our SNP provides in-home fitness kits, live video physician or psychologist visits via Doctor on Demand, and the option to receive at-home preventive care screening kits (e.g., colorectal cancer, A1c, bone scan)."

PLAN Quote: "To overcome low health literacy and to decrease social isolation, we focus on delivering face-to-face care in the home, when possible."

Linguistic Diversity – Plans offer interpreter services and translators and increasingly employ multi-lingual staff. They also work with ethnic and cultural community service agencies who are embedded in the neighborhoods and can serve very effectively to share information about access, services available, and how to get the help individuals need.

Improving member engagement – Improving the level and rate at which people with multiple chronic conditions, high SDOH risk factors, and other complexity issues engage is a vital step in the approach for addressing SDOH risk issues. Plans reported multiple ways and methods they are testing to do so.

Plans are experimenting with various ways to improve reach, tailor and enhance member communication, and engage members in the way they prefer. Plans are also exploring ways to better understand current risk, past behaviors, and how to effectively intervene with targeted members.

One health plan describes their approach that they have been testing and fine-tuning over several years:

"We implemented a technology solution that specializes in cost and quality management,

revenue management, and customer engagement to assist in SDOH data collection.

We experimented with a variety of communication tools such as phone calls, email, social media, and text messages to reach out to beneficiaries in need of additional management. We used the technology to record engagement rates and then survey members about socioeconomic healthcare challenges. Some members pick up the phone and some don't--At the end of the day, we want the member to respond. Members are more likely to engage in their health when we are contacting them according to their preferences. Over time we started to record if members prefer text messaging and opt into text message engagement.

Now we have data to determine how to apply the appropriate intervention tactic to engage each member, and to have the best response rate."

The engagement strategy incorporating SDOH information into the plan's risk stratification approach allows for additional information gathering such as member surveys about SDOH challenges. This also facilitates better outreach.

This plan believes that the strategy has led to improvement in some of the chronic disease control measures, such as Diabetes, Managing High Blood Pressure, and Medication Adherence. There is higher member engagement and response to text message or other reminders and better follow-up. The plan attributes the improvement in chronic disease management measures to their concerted efforts around outreach to members regarding their communication preferences and plan follow-up that includes customized alerts and proactive attention to members' concerns.

Patient/member engagement and activation – that is how willing and ready the person is to be part of the ongoing care management is very important. The person himself must be willing to consider how his choices and actions are impacting health. He needs to get to the point where he wants to change and is willing act on advice. Motivational interviewing, health coaching, and other approaches show promise in supporting people to become more active and motivated in their self-care.

Collaboration & Partnerships

Special needs plans are also actively collaborating in their communities. They are working in partnership with others, including service providers and non-traditional sectors (e.g. housing, education), to address SDOH issues in their communities. In the *SNP Alliance Annual Member Survey*, a high number of health plans said they had a collaborative partnership underway addressing one or more social risk areas. Areas for partnership are shown below.

Area of Focus for Partnerships:

- Food insecurity/nutrition (71%)
- Transportation (57%)
- Social support (57%)
- Health Literacy (50%)
- Housing (36%)

Several plans reported working with specific clinics and mental health providers or hospitals in partnership around specific vulnerable or at-risk individuals. For example, one health plan added a licensed social worker and two nurses in a particular clinic/hospital/ER that serves many low-income and at-risk members. The nurses work on health literacy/education and clinical/medical follow-up and the social worker connects individuals to community resources, particularly around housing, social support, and food. The plan contracts for these services.

Conclusion

The information we gathered offers insights into what it takes to be successful in addressing complex care populations with high social determinant of health risk factors. Successful strategies include: sustained attention and commitment, involvement with partners and members of the community, and trial of various methods for outreach, integration, care management, and provider network development over many years to see what works best.

Our analysis shows robust efforts across special needs and Medicare-Medicaid health plans. These plans are actively identifying SDOH and other care complexity issues in their SNP and MMP populations. They have identified multiple sources of data and are using these in a variety of ways (referred to by some as "layering information") to tailor response to individual members and to subgroups within their enrolled populations.

Many SNPs have significant resources invested in their care management and care coordination methods, with protocols, pathways, and information systems.

These SNPs and MMPs provided concrete examples on ways they are working to extend across medical, behavioral, and long-term services and supports providers to address care and support needs in a consistent and coordinated way.

Plans are regularly referring to and some are paying for these community services through contracts with aging service provider collaboratives, housing providers, transportation and food service agencies and others. The need is tied to health management and the connection to community resources is part of the care management work. They are attending to key risk factors (conditions and social risk triggers) with alerts to enable early/proactive attention when there has been a change in status.

Plans point out that the persistent and ongoing social risk factors together with other health risk issues, such as presence of substantial functional limitations, frailty, mental health issues and other conditions, often interact and can exponentially increase care complexity. The SDOH and health factors impact the person's daily function and ability to maintain a quality of life (e.g., sleep, eat, move around, think clearly, maintain social connections, follow medical advice, practice good self-care).

Studies support this observation. Total costs of care are greater and quality measures harder to reach, even for people with similar health conditions.

Plans have described multiple challenges with finding and using SDOH data and linking this information to effective care strategies. More can certainly be done.

There is opportunity and promise for identifying effective outreach and care integration strategies that crosses sectors and spreads within communities. For some services and in some communities, however, identification and information exchange and outreach cannot address the lack of services available. There is evidence of scarcity already, even without consistent identification of those at high risk.

Based on the knowledge gleaned from SNPs and MMPs, sustained commitment including time and resources dedicated to these population subgroups is bedrock. It is clear that medical, mental health, and social needs are deeply intertwined. Integrated approaches have demonstrated successes on which to build.

Special Needs Plans have worked with their communities, states, and providers for years to achieve their current care models. SNPs are investing in chronic care expertise, internal structures and processes, member outreach strategies, and communication connections to facilitate engagement and virtual interdisciplinary care management. This is extending beyond traditional medical and behavioral health settings. Plans are making these connections across providers and with LTSS.

Finding multiple ways to proactively reach the member, establishing relationships, and connecting across settings, disciplines, and over time, are some of the ingredients of successful efforts. This happens only over time and with intentional sustained effort.

Social determinant of health deficits experienced by people enrolled in Medicare and/or Medicaid will require long-term community-wide investment and stakeholder involvement by many sectors (including health care) to address the multi-dimensional factors underlying their presence.

Special needs and Medicare-Medicaid plans are at the forefront of efforts by Medicare Advantage plans in addressing vulnerable populations. Many SNP Alliance plans began as community resources and have a long-standing commitment to chronic care populations. They have worked to integrate across services, settings, and over time on behalf of the people they serve. We hope that others build on these strategies developed over many years.

Thanks to Contributing Plans

We greatly appreciate the participation of the following health plans that contributed SDOH information through the 2018 *SNP Alliance Annual Survey*:

Aids Healthcare Foundation
Anthem/CareMore
BlueCross BlueShield Minnesota
Care1st
Care Oregon
Care Wisconsin
Commonwealth Care Alliance
ElderPlan
Gateway Health Plan
HealthPartners
iCare
LA Care Health Plan
Medica Health Plan
Molina Healthcare
SCAN Health Plan
South Country Health Alliance
UCare
UPMC Health Plan

Based on the knowledge gleaned from SNPs and MMPs, sustained commitment—including time and resources dedicated to these population subgroups—is bedrock for addressing the needs of complex care populations with high social determinant of health risk factors.

♦

It is clear that medical, mental health, and social needs are deeply intertwined.

♦

Integrated approaches through specialized managed care plans have demonstrated success on which we can build.

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