ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY

INTELLIGENCE BRIEF | JUNE 2021

SOCIAL DETERMINANTS OF HEALTH AND VALUE PART II: PRIVATE SECTOR EFFORTS

Community-based organizations have long been engaged in addressing the social needs of their communities. More recently, health care providers, payers, and technology vendors have emerged as key players to attenuate upstream impacts on health outcomes. This brief describes collaborative strategies that are producing promising outcomes for addressing social determinants and health-related social needs.

As the health care system continues to transition away from a fee-for-service (FFS)-based system to one that rewards improvements in cost and quality outcomes, organizations experienced in value-based payment and delivery transformation are now beginning to understand how to isolate the most effective population health management strategies – moving beyond emergency department (ED) diversion protocols and chronic care management programs to also include other proactive tactics for preventing an escalation of health care needs. Importantly, achieving the objectives of the Triple Aim often requires providers and payers to change the way patients are cared for both within and *outside* of traditional care settings. Increasingly, risk-bearing organizations are expanding their efforts to work upstream, investing in community and social supports that will ultimately improve the lives and health of individual patients and populations.

This brief—the second in a three-part series on the social determinants of health (SDOH) and value—takes a look at notable private sector initiatives to better track, understand, and address patients' health-related social needs (HRSNs). The first brief in the series detailed the Accountable Health Communities model and other efforts directed by initiatives of the Centers for Medicare & Medicaid Services Innovation Center (CMMI). While not a comprehensive overview, the content below shares various examples of SDOH-related efforts among providers, payers, and technology vendors, analyzing the different roles of these private sector stakeholders, and sharing some promising initial outcomes to date.

The Alignment of Value and Social Needs

By aligning payment models with the total cost of care, providers can have the revenue flexibility and incentive structure to invest in much needed social supports. For example, while **access to transportation** is a major barrier to care for an estimated 3.6 million Americans, under a FFS system, providers are often unable to invest in creative solutions despite their shared interest in shoring up reliable transportation to medical visits, the pharmacy, and other important health care settings. Similarly, despite the mounting

evidence that nutritional interventions can prevent, improve, and even reverse chronic diseases—such as obesity, diabetes, hypertension, and heart disease—without the aligned reimbursement and policy structure, providers may not perceive food insecurity as an area within their direct influence. According to a 2016 analysis, the cost associated with **food insecurity** translates to approximately $52.9 billion in excess health care expenditures – a situation made even more dire since the COVID-19 pandemic. Lastly, observational studies have shown that being without a stable home is detrimental to one's health. In contrast, providing access to **stable housing** can improve health and reduce health care costs in meaningful ways. While it may be considered a "nontraditional intervention," investing in stable housing can lead to many of the same desirable outcomes that risk-bearing providers seek from other population health management efforts, including diverting patients from the ED and increasing access to primary and behavioral care services in the community.

Major Private-Sector Players

Health care providers, payers, and technology vendors are three of the major private-sector actors working to address SDOH that also have resources and financial incentives to do so. These three players, though described here separately, are not mutually exclusive, as many payers and providers collaborate with technology vendors and start-ups in leveraging innovative software and technology elements to increase their impact on SDOH for their patients and members. Community-based organizations (CBOs) also play a significant role in addressing the HRSNs of individuals, and frequently are responsible for directly fulfilling these needs. While these organizations are essential partners to the health care system, they are traditionally viewed as community-based rather than health care entities. Because of this, their efforts are recognized in the brief, but not addressed extensively. The three groups introduced below will be reviewed in additional detail related to specific strategies in subsequent sections.

Providers

Organizations first beginning the shift away from FFS tend to focus on population health management fundamentals—ED diversion, readmissions reduction, and chronic disease management programs, for example. Subsequent care delivery transformation efforts often include high-value specialist referrals and optimizing post-acute care networks. As accountable care organizations (ACOs) and other risk-bearing provider organizations advance in their population health management abilities, investments in SDOH become more common. Each provider has its own geographic and demographic circumstances, as well as varying motivations to invest in SDOH-related services. While most provider organizations invest in social services with an eye on total cost of care, some risk-bearing providers focus on preventing the escalation of health conditions, while others invest or engage in SDOH interventions in order to connect patients with CBOs or public entities to fulfill their social needs. Over time, many providers have recognized the extreme health inequities that exist in their communities, often exacerbated by COVID-19, and are investing in SDOH interventions as a result. Health care providers (including health systems, clinics, and individual clinicians) are well-positioned to conduct SDOH screenings and refer patients to relevant resources. Some providers have also taken the initiative to conduct research related to understanding SDOH needs, compile resource directories, and partner with non-traditional community entities, such as faith-based organizations, grocery stores, and schools, to address SDOH needs in their communities.

Payers

As with risk-bearing provider organizations, payers have long been interested in developing innovative programs and interventions to improve the health outcomes of members and in managing members' total cost of care needs. Payers may be particularly interested in upstream investments

that can improve members' short- and longer-term health, though the specific investments may vary depending on the type of insurance product, the typical turnover rate of the population, and the specific health and social needs of attributed patients. Even within health plans that often experience frequent churn as well as a higher percentage of high-risk members, such as managed Medicaid plans, payers remain highly interested in managing the utilization needs of the population in cost-effective ways. Additionally, COVID-19 has pushed payers to reconsider their benefit arrangements and engage in SDOH partnerships.

Technology Vendors

Technology is a key factor in the initiatives that various health care entities have taken to address SDOH. Technology vendors, many of them start-ups, are well-positioned to use their expertise to improve data collection and analytics related to SDOH, to create infrastructure for referral systems, to catalogue resources, and to create ways for multiple platforms to work together to connect patients with the necessary resources. Digital solutions have significant potential to augment and scale labor-intensive and manual processes by identifying patient social needs, making connections to appropriate resources and tracking patient progress over time.

Strategies in Social Determinants of Health

The three stakeholders highlighted in this brief – providers, payers, and technology vendors – all take slightly different strategies to help meet the HRSNs of patients. The activities undertaken by each of these stakeholders are discussed in three broad categories: 1) Screening and Referral; 2) Partnerships that Directly Address Social Needs; and 3) Innovating with Data. However, each of these categories are interrelated and overlapping, and many strategies span categories. For instance, the data collected during the screening process may be used to refer patients to services administered by CBOs and be utilized to target patients for services developed internally.

Screening and Referral

Screening patients for unmet HRSNs is the first step to ultimately meeting those needs. Health care providers and payers are often well positioned to administer screenings to their attributed patients and members, and technology vendors streamline the screening process by building screenings into existing platforms or designing new interoperative solutions to share screening results. Sometimes, payers and providers can meet identified needs directly, but frequently this process involves a referral to a CBO who can provide services to fulfill patients' unmet HRSNs.

Providers

Providers are increasingly seeking ways to standardize approaches to screening and implement closed loop referral systems, which allow providers to follow up on patients after referral to a CBO (discussed in more detail in Technology Vendors below). Screening patients for potential HRSNs can take many forms, including both simple and high-tech solutions. For example, Baptist Health Hospital in Louisville is using an algorithm originally meant to reduce readmissions, dubbed LACE, to track social determinants of health. In addition to the LACE algorithm, which scans medical records to measure variables like length of stay, acuity of admission, and co-morbidities, Baptist implemented an effective discharge protocol in which care managers ask questions about housing, ability to afford medication, food, and transportation to appointments. Hospital staff have access to resources if patients need them.

In February 2019, Northwell Health implemented an SDOH screening tool designed to connect newly discharged patients with the support they need for recovery and to avoid readmission. The tool consists of a 15-item questionnaire intended to be administered within 48 hours of admission

that provides care teams with information about patients' HRSNs. A patient who screens positive for one or more HRSNs is connected to resources that aim to address those needs. HRSNs are then documented in a patient's electronic health record (EHR) to ensure providers are aware of and can track SDOH that affect their patients.

Rather than provide resources directly to patients with unmet HRSNs, often providers help patients locate existing services administered by community partners by compiling SDOH resource directories. In 2018, Reliant Medical Group and UMASS Memorial Health Care partnered to develop a comprehensive online directory of community-based resources, named "Community HELP." The goal of the directory is to enable individuals in need to find and apply for government programs and be referred to other social services.

Payers

While payers do not typically deliver care to patients in office or hospital settings like providers do, many have still found opportunities to administer surveys and collect data on patients' HRSNs. Kaiser Permanente has partnered with CBOs to collect data on patients and contributed funding to these organizations' efforts to address the needs identified. In partnership with Kaiser Permanente, Health Leads screened patients in Southern California and found that 78 percent of those screened had unmet social needs. This screening allowed the insurer to target outreach, community health initiatives, and preventive programs to patients with the most need.

CareSource, the largest Medicaid managed care plan in Ohio, launched a pilot program for members in Ohio, Indiana, and Georgia, aimed at identifying members who could benefit from job training or employment assistance, and connecting them with community services to fill these gaps. The tool, called JobConnect, also shares job postings from partner companies offering full-time, benefited positions that pay between $10-15 per hour. "Life Coaches" assigned by CareSource help members navigate existing community resources and build a plan to advance up their career ladder and out of poverty.

SelectHealth also makes an effort to identify unmet HRSNs among members. The insurer employs Care Managers which administer a "Social Check Assessment" for members across all lines of business. These Care Managers refer patients to 2-1-1 Utah or 2-1-1 Idaho and demonstrate the use of the tool for those that are unfamiliar. Members of SelectHealth's Medicaid program or dual-eligible members also have access to Community Health Workers to provide additional support and referrals if needed.

Through their program, called "The Social Determinants of Health Value-Based Program," Humana equips enrolled providers to identify a host of social needs and compensates these providers for performing SDOH-related patient screenings, documenting their findings, and connecting patients with appropriate community resources. Ochsner Health has signed on to be the inaugural participant in Humana's program. Similarly, Aetna has partnered with Unite Us (discussed in more detail in Technology Vendors below), providing a platform to help clinicians connect patients to community resources. Aetna has also extended access to this platform to certain Aetna Medicaid members and those enrolled in Aetna's Dual-Eligible Special Needs Plan, empowering these patients to connect with available resources directly. In late 2020, Priority Health announced its plans to pilot new incentives for providers who screen patients and submit information on SDOH, becoming one of the latest payers to financially support this type of data tracking.

Technology Vendors

A variety of vendors now offer technology solutions for facilitating referrals between medical and social services settings. A primary benefit of using these platforms is to have a "closed loop"

exchange where a medical provider can transmit an electronic referral for a patient to a social services organization using the same technology platform, and on a subsequent visit view documentation on whether the patient followed through on accessing the service. Many of these systems are cloud-based with a standalone interface but can also integrate into EHRs or common account management programs. Most commonly the platforms are licensed by the providers or payers and offered to the CBOs at no charge. A primary challenge in markets where more than one vendor exists is the burden on CBOs in navigating multiple platforms that do not interoperate. In part to resolve this, some states have selected a single vendor to service the whole state, such as North Carolina's NCCARE360 which combines a vendor platform with the local 211 Resource Directory.

Unite Us is a tech company that builds HIPAA, SAMHSA, 42 CFR Part 2, and FERPA-compliant networks for their shared technology platform. The platform aims to help CBOs, safety net health care providers, health systems, insurers, and other groups improve health outcomes for the people they serve by directly tracking and addressing SDOH. The Unite Us Platform has five primary functions: 1) screening and decision support that identifies HRSNs for a client and identifies next steps to address those needs; 2) electronic referral management that tracks where and when clients get referred, whether they visited that location, and which health issues were addressed; 3) assessment and care plan management that is saved and carried over for each client consultation, streamlining the process; 4) bidirectional communication and alerts built into the platform and configurable for each client (similar to telehealth messaging); and 5) outcome tracking of standardized data for specific needs, highlighting areas to advance quality of care, improve service gaps, and minimize costs. Unite Us' partners include CVS Health, Northwell Health, Alliance for Better Health, Public Health Solutions, and Goodwill.

NowPow, another technology vendor with prominent SDOH-related offerings, created a Community Care Referral Utility within their multi-tool platform, to help address SDOH within communities. The company builds community referral networks to support organizations in health care, human and social services, and education. The platform integrates with EHRs and health information exchanges (HIEs), patient and member portals, and care/case management systems. In February 2021, Health Current, Arizona's HIE, announced NowPow as their vendor for a closed loop referral system to address SDOH needs in Arizona. The goal of the partnership is to use NowPow's technology to provide a statewide solution that facilitates screening for social risk factors, refers individuals to community resources, and serves as a closed loop referral platform for social-service fulfillment. Other partners include Humana, Chicago Department of Public Health, Horizon Healthcare Services, Inc, and Northwell Health.

Aunt Bertha (with its search tool known as findhelp.org) began as a portal to access a nationwide database of CBOs that address SDOH but now also includes closed loop referral services. The database is accessible to anyone with internet access. The user enters a zip code into the search bar and is then directed to select from available resources for food, housing, general goods, transit, health, care, education, work, legal, and other needs.

Partnerships that Directly Address Social Needs

The previous section detailed the many efforts of providers, payers, and technology vendors to identify unmet social needs among patients and refer patients to community resources to address those needs. This section focuses on the efforts these stakeholders have taken to directly address those needs. Many of the following examples still rely on partnerships with CBOs, however in these examples the health care stakeholders either fund

or take a more hands-on approach to administering services to meet the social needs of patients.

Providers

As previously discussed, providers more frequently rely on CBOs to deliver services to support patients' social needs. However, the operationalization of this partnership can take many forms beyond simple screening and referral. The Los Angeles County health system took a hybrid approach of shared accountability with their "Maternity Assessment Management Access and Service synergy throughout the Neighborhood" program (MAMA's Neighborhood). At their first pregnancy visit, patients undergo assessments and screenings to identify their personal life stressors, including food scarcity, trauma, housing insecurity, violence, and behavioral health issues, which are used to calculate a "global stress score". Based on this score, care managers and nurses develop an individualized care plan which includes referral to community-based resources and internally developed resources to address needs identified in the screening. The program takes special care to ensure care managers are linguistically and culturally aligned with the patients they serve and that they make every effort to connect with patients in convenient settings, including by text, over the phone, or in the home. After launching this program, the Los Angeles County health system saw a 60 percent increase in postpartum follow-up visits.

The Children's Hospital of Philadelphia designed a program intended to help the families of their pediatric patients take advantage of federal financial support. The hospital partnered with the Volunteer Income Tax Assistance program and Campaign for Working Families to offer onsite tax preparation services in pediatric clinics, with the intent to help parents take advantage of the Earned Income Tax Credit. In two years, the program has helped 337 families prepare their federal tax returns, resulting in $700,000 worth of refunds that may have otherwise gone unclaimed.

Payers

While providers may favor directing patients to existing community resources, payers frequently directly fund the development of community resources. One social need where payers have focused investments is improving food security, as access to healthy, affordable food is a key contributor to health outcomes. Many payers are undertaking projects that seek to connect patients in need with nutritious food by subsidizing the cost of healthy food, delivering personalized meals, or connecting patients to food resources. The Anthem Foundation recently funded a $350,000 grant to the Food Trust Program for its Health Food Retail Initiative. The money will help subsidize the cost of fresh produce and other healthy food to be sold at low cost in 37 existing brick-and-mortar markets and convenience stores and launch beta testing to expand the initiative to additional locations.

Centene recently partnered with a nationwide nutrition-focused non-profit to improve access to affordable food. In collaboration with Feeding America, the insurer donated one million meals a month over 12 months to local food banks, provided assistance to those applying for the Supplemental Nutrition Assistance Program, and donated additional funds to food banks in their market. Through another partnership with Feeding America, Humana has developed a food insecurity resource toolkit designed to raise awareness of the impacts of food insecurity, guide both health care and non-health care professionals in screening patients for food insecurity, and provide ways for professionals to refer people at risk to resources and support.

Earlier this year, Humana announced a related effort to help address food insecurity for children and families. Called the "Family is More" initiative, Humana Healthy Horizons (Humana's Medicaid business) will provide a $1.75 million investment and partner with No Kid Hungry to sustain healthier communities through grants to schools and community organizations.

Improving access to safe and stable housing is another area of focus for payer investments. Safe and stable housing is essential to maintaining and improving health outcomes but helping patients in need gain access to such housing can be complex. Health care stakeholders have approached this issue in several different ways, with some directly providing housing or improving existing homes for patients who need it, while others have focused on investing in affordable housing initiatives and partnering with local organizations to address housing insecurity. UnitedHealth Group Inc. invested $500 million in the development of over 4,600 new, affordable homes across the country. Anthem Healthkeepers Plus, Anthem's Medicaid plan in Virginia, has partnered with PadSplit to provide 12 affordable housing units to members in Richmond who need assistance with affordable housing after receiving medical care. PadSplit offers affordable, furnished rooms in shared homes with fixed utility costs and 24/7 access to telehealth. This unique partnership with Anthem is a first of its kind for PadSplit and will serve as a model for future community assistance programs that help individuals who may be unhoused.

Anthem has invested in improving access to safe housing for its Medicare Advantage (MA) members as well. The insurer has contributed funding to several initiatives in its markets, including those aimed at expanding access to short-term residences for patients discharged from the hospital or participating in counseling programs who are unhoused. Anthem has also helped MA members make their homes safer by paying for the removal of black mold.

Earlier this year, CVS Health announced it is investing $12.4 million to build 60 new affordable housing units in south Phoenix and will also expand its no-cost biometric screening program, Project Health, to the greater Phoenix community. This initiative is part of the company's $600 million commitment to address racial inequity.

Integrated payer-provider organizations are also investing in stable, affordable housing. For example, Kaiser Permanente, in partnerships with Enterprise Community Partners and East Bay Asian Local Development Corporation, has set up an equity fund that will ensure a California apartment building is preserved as affordable housing and provide additional funding to develop and preserve affordable homes. In its Housing is Health initiative, Providence, a large integrated delivery network with provider and health plan assets, joins with community partners that offer housing and related social services to those who experience housing instability or are unhoused.

Technology Vendors

Many technology vendors have emerged to help fulfill unmet HRSNs. As discussed previously, several vendors have developed platforms to streamline and standardize HRSN screenings and data collection and deploy closed loop referral services. Some organizations have taken this a step further, integrating technology solutions with care coordination. Cityblock, for instance, is a health startup focused on addressing SDOH through technology by creating better care provider teams. Through their proprietary platform called the "Commons," they integrate primary care, behavioral health, social services and 24/7 virtual care. Commons was built to address gaps in technology infrastructure for community-based care, such as integrated modalities of care delivery with communication between the patient and care team and a comprehensive view of the diverse factors impacting an individual's health. Their team-based model for primary care includes doctors, nurses, social workers, and a Community Health Partner, which is hired from the local community and trained in empathy and relationships. Cityblock partners with several organizations - including EmblemHealth, ConnectiCare, Tufts Health Plan, and CareFirst Community Health Plan for DC – targeting Medicaid and lower-income Medicare beneficiaries.

Signify Health also combines an SDOH-related technology platform with innovative care delivery strategies. The company connects payers, providers, employers, and care coordinators to identify social risk factors and predict patient needs. The company aims to facilitate in-home evaluations of patients and will help organizations recruit, train, and onboard personnel to make the most of its suite of SDOH-focused tools.

In addition to developing these advanced care delivery platforms, technology vendors, like payers, have also begun to focus on improving access to healthy food. For instance, Project Well, a Connecticut-based startup, is an online marketplace that delivers personalized meals to consumers with diet-sensitive chronic disease and food insecurity and MA members. Project Well connects a variety of health entities, including at-risk provider groups and their patients, or health plans and their members, to food vendors that can provide nutritionally-targeted, customized meals. Project Well recently gained financial backing from the venture capital firm S2G Ventures, which the firm's chief investment officer says was motivated by a post-COVID emphasis of collaboration with public health, an aging population increasingly suffering from chronic diseases, and the movement away from FFS to value-based care. Additionally, NowPow, which offers closed loop referral services to connect providers with CBOs (discussed above in Screening and Referral), recently forged a relationship with NYC Health + Hospitals to help address food insecurities among millions of patients, allowing providers to "prescribe" nutrition interventions to patients in need.

Although not traditionally considered technology vendors, rideshare companies have recently begun to leverage their network of drivers and user-friendly apps in partnership to help address transportation as a common barrier to accessing medical care. Uber and Lyft, for example, have begun to collaborate with health care entities to offer their services to patients for non-emergency medical transportation. In some cases, patients can schedule transportation directly from their EHR. Lyft also partners with Allscripts Sunrise EHR to allow providers to order their patients rides to and from appointments. Leveraging technology to streamline transportation services is becoming more common, as seen in Ride Health, which automates ride coordination within existing health care systems. A Ride Health partnership with the Virtua Health system showed a 75 percent reduction in patient no-shows for oncology appointments.

Innovating with Data

Providers

In order to effectively address the HRSNs of patients, providers must be able to gather the right data at the "right" time of need, as well as track progress and outcomes of interventions in order to effectively iterate. Providers are increasingly leveraging new technologies to improve their data collection and analysis methods and diversify the type of data they collect.

CommonSpirit Health leverages data indicating neighborhood social vulnerability to help predict which patients suffering from chronic disease are most likely to have unnecessary ED utilization and experience hospital readmissions. The provider uses the Social Vulnerability Index (SVI) developed by the Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry, which ranks each census tract based on 15 social factors, including poverty, lack of transportation, and crowded housing. Although the SVI is intended to help public health officials prepare for and respond to emergencies, CommonSpirit overlays SVI maps with maps of disease incidence to help prioritize population health efforts.

Some providers have found value in collecting robust qualitative data on patients to help reveal specific needs that would not be reported in a standardized assessment or screening. Research conducted by the Fox Chase Cancer Center, for

instance, found that in addition to a nurse patient navigator, connecting patients with a "lay" navigator can help decrease disparities in access to cancer care. These lay navigators understand the culture of the patient's community and can help care teams better understand the cultural and linguistic barriers their patients may be facing.

Payers

In order to resolve patients' HRSNs, it is essential to collect robust and accurate data on these needs and share that data with parties who can deliver appropriate services. Several payers have implemented tools and programs to facilitate this. UnitedHealthcare made a significant effort to standardize the way data on social needs is collected by health care providers. In partnership with the American Medical Association, UnitedHealthcare is developing over two dozen new ICD-10 codes to be used by providers across the health care system to identify and aggregate SDOH-related information.

Technology Vendors

Technology vendors are also working to collect more robust SDOH data and use this data in new and unique ways. For instance, Carrot Health, an organization that specializes in health care business intelligence software for health systems and payers, is adding SDOH factors to its existing models to provide better predictive analytics for their customers. The company recently announced a collaboration with LexisNexis Risk Solutions, a leading global provider of legal, regulatory and business information and analytics. Through the collaboration, Carrot Health will integrate clinically validated SDOH attributes from LexisNexis Risk Solutions into their existing predictive models and software with the intent of providing insights that lower healthcare costs and prevent readmissions. Using the insights gained from this modeling, Carrot Health will inform consumer-centric strategies to improve health disparities and SDOH, while reducing costs and preventing readmissions.

mySidewalk—a tech company that boasts an extensive data library and mobile-friendly publishing platform— is focusing on data transparency to bring attention to health disparities across communities in California. In collaboration with Blue Shield of California, the company developed the "Neighborhood Health Dashboard," to increase transparency around community health and to address health disparities. The Neighborhood Health Dashboard uses data intelligence to create a holistic picture of a community's health which includes the following: 1) health outcomes; 2) preventive health care; 3) utilization and access; 4) health behaviors; 5) social risk factors; and 6) environmental and economic health conditions.

Outcomes to Date

While measuring the impact of SDOH initiatives is complex, some initiatives have begun showing positive outcomes, including reductions in health-related spending and increases in access to social services for patients. Health*Connections*, a program administered by WellCare Health Plans, Inc., a managed care organization, is one example of an SDOH-focused initiative that has shown promise. HealthConnections is a model of medical and social service coordination that acts as a referral program. The program focuses on addressing HRSNs for vulnerable patients by referring beneficiaries to social resources. One analysis of the program found that beneficiaries enrolled in Health*Connections* that had all their needs met experienced an 11 percent reduction in health care costs, equivalent to $2,601 per patient. Advocate Health Care, an ACO in the Chicago area, has also implemented a program which successfully demonstrated a positive impact. A 2017 *American Health & Drug Benefits* study found that Advocate Health Care reduced health care costs within six months by an estimated $3,800 per patient, totaling $4.8 million, by implementing a nutrition aid program at four hospitals. The program involved screening all patients during admission for their risk of malnutrition. Patients with an elevated risk score received an oral nutritional supplement

and high-risk patients were referred to an enhanced nutrition care program.

Unite Us has documented various positive outcomes in many of their initiatives. For example, Unite Us partnered with Public Health Solutions on The Food and Nutrition Services Bundle in New York City to coordinate health plan members, hospitals, and food providers over a 10 month period starting in 2018. The number of families in need of emergency food resources who accessed these resources increased from 6 percent to 56 percent during this time period. Out of all the referrals conducted in this program, 57 percent enrolled in services. The estimated Medicaid savings from this program were $320,000 annually.

Conclusion

This brief has highlighted some common strategies taken by private sector players to meet the social needs of patients. Health care providers, payers, and technology vendors have all recognized the significant role that social needs play in determining health outcomes and have made targeted investments and developed innovative programs to address these needs. However, challenges remain that prevent the health care system from fully recognizing and fulfilling patients' social needs, including difficulties measuring the return on investment of SDOH interventions, barriers to collecting accurate SDOH data, and the limited capacity resources of CBOs. These challenges and others will be explored in the third and final installment of this series, along with several emerging trends with promising outlooks.

About the ACLC

The Accountable Care Learning Collaborative (ACLC) is a non-profit organization with a mission to accelerate the readiness of health care organizations to succeed in value-based payment models. Founded by former Secretary of Health and Human Services, Gov. Mike Leavitt, and former Administrator of the Centers for Medicare and Medicaid Services, Dr. Mark McClellan, the ACLC serves as the foundation for health care stakeholders across the industry to collaborate on improving the care delivery system. To learn more about the ACLC, visit accountablecareLC.org.