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ADVANCING VALUE-BASED CARE PROGRAMS WITH COMMUNITY HEALTH RESOURCES



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EXECUTIVE BRIEF

Identification and mitigation of social determinants of health (SDoH) is vital to the success of value-based care (VBC). Addressing unmet health-related social needs (HRSN) substantially influences an individual's well-being and healthcare utilization, crucial elements in VBC initiatives. However, health systems and insurance plans are challenged to implement strategies that focus on these socioeconomic factors within VBC programs.

Developing partnerships with community-based organizations to integrate nonclinical services into a VBC program can be instrumental in achieving its main objective – improving health outcomes while reducing healthcare costs. By harnessing the potential of community health resources to meet people's broader needs, providers and payors can deliver more effective, equitable and sustainable care.





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SDoH: POTENTIAL ROADBLOCKS TO EFFECTIVE VBC INITIATIVES

“Inequities across the US health system limit underserved people’s access to affordable, high-quality care, create avoidable costs and financial waste that span society and impact every individual’s potential to achieve health and well-being.”

– Deloitte²

The core concept of VBC is that providers work collaboratively to address individuals’ physical, mental, behavioral and social needs, treating people holistically rather than focusing on a specific health condition. The goal is to provide high-quality, coordinated and efficient care for each person.

Given that SDoH account for up to 50% of health outcomes,¹ these conditions in the environments where people are born, live, learn, work, play, worship and age often lead to health inequities.

THE SDoH DOMAINS

- **Economic Stability**

11.5% of Americans, about 38 million, live at or below the poverty level.³

- **Education**

Lower education levels correlate with poorer health.⁴

- **Access to Healthcare**

People with transportation barriers are more likely to skip needed care.⁵

- **Neighborhood Quality**

Substandard housing, high rates of violence and unsafe air or water have a negative impact on health and longevity.⁶

- **Social & Community Context**

Social connections can help prevent chronic and serious conditions, such as heart disease, stroke, dementia and depression.⁷



UNDERSTANDING THE SCOPE AND IMPACT OF UNMET HRSNs

“Health systems, insurers and employers have an opportunity to better support consumers by improving experiences across core offerings and providing greater support for unmet HRSNs.”

– McKinsey & Company⁹



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SDoH represent the broader social conditions that affect an individual’s immediate HRSNs. Unmet HRSNs, such as housing instability, food insecurity, transportation challenges and financial strain, negatively influence health outcomes and increase healthcare utilization, complicating value-based care delivery.⁸

According to a consumer survey on HRSNs:⁹

- 45% of people regularly experience ≥ 1 unmet HRSN.
- People are 3x more likely to visit the ED frequently if they have ≥ 2 unmet HRSNs.
- Unmet HRSNs cut across socioeconomic levels and insurance types but disproportionately affect minority groups.
- People with unmet HRSNs are more likely to report poor physical and mental health and barriers to accessing care.





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COMMUNITY-BASED RESOURCES: OPPORTUNITIES AND CHALLENGES

“Providing comprehensive, whole-person care requires a team of practitioners who can address the patient’s medical and social needs, along with a payment model that rewards them for the quality of care they provide, not for the quantity of services rendered.”

– Vivek Garg, MD, MBA, Chief Medical Officer of Humana’s Primary Care Organization¹¹

Nonclinical community-based resources can play a pivotal role in delivering holistic care by supporting HRSNs and bridging gaps in health equity. But time constraints and lack of information may prevent healthcare organizations from connecting people in need to the appropriate services.

Surveyed physicians cited the following challenges in directing patients to community-based resources.¹⁰

- 89%: Limited time during patient visits
- 84%: Insufficient workforce
- 77%: Inadequate information about availability or access to community resources
- 73%: Lack of reimbursement for screening for or addressing SDoH
- 57%: Unavailable or inadequate community resources



INTEGRATING COMMUNITY HEALTH RESOURCES WITH VBC PROGRAMS

Snapshot:

A CBO and Health Plan Partnership in Action

Program: Health Opportunities Pilots (HOP)¹⁶

Population served: Medicaid patients with HRSN in defined regions of North Carolina

Purpose: To test and evaluate the impact of providing select evidence-based, non-medical interventions related to housing, food, transportation, interpersonal safety and toxic stress

Cost coverage: 29 interventions

Success Story:

When an enrollee was unable to pay her utility bill, her family's electricity was shut off. An HOP organization and the enrollee's care management team worked together to explore all resources – both HOP and health plan-related – to support the family with housing stability and a utility payment plan. Electricity was restored, and the HOP team monitored the enrollee in her housing situation and new employment.

Community-based resources fill gaps in clinical care by providing services that health systems and plans typically do not, such as housing and food assistance. Integrating these programs with traditional healthcare can improve health outcomes and meet population health goals, essential components of VBC.¹²

By adopting the following strategies, healthcare providers and payors can effectively incorporate community health-based programs into their VBC models.^{13,14,15}

- ✓ Develop strong partnerships with community-based organizations (CBO)
- ✓ Address regulatory and funding challenges
- ✓ Leverage multidisciplinary teams for navigation
- ✓ Prioritize and assess patient-centered outcomes
- ✓ Educate and engage patients and providers on available resources
- ✓ Ensure equitable access to community-based health services





Photo by Ketut Subiyanto

CONNECTING THE DOTS WITH DATA ANALYTICS

For a deeper dive into how to use SDoH to manage healthcare costs, utilization and outcomes for your VBC programs, [download our eBook.](#)

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Community health resources addressing unmet HRSNs are crucial to advancing VBC programs. Connecting patients with the appropriate social services allows for comprehensive care beyond clinical settings, paving the way to better outcomes and lower healthcare utilization.

Data is a vital component for guiding the trajectory of VBC initiatives integrated with CBOs. With data analytics, healthcare providers and insurance plans can identify patients' SDoH, optimize resource allocation and measure program outcomes, enabling them to make more informed decisions to constantly improve program performance.

Gray Matter Analytics' scalable, cloud-based CoreTechs[®] Analytics Solution captures and synthesizes data and enables users to see quickly and clearly the most prevalent SDoH and health conditions within a population. Payor and provider subscribers may use these insights to customize outreach and care plans. Targeted interventions help control quality and cost, including boosting performance on VBC contract measures and reducing unnecessary high-cost utilization.



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² Davis, A., Dhar, A., et al (2022, June 22) US health care can't afford health inequities [Blog] *Deloitte blog*. Available at: <https://www2.deloitte.com/us/en/insights/industry/health-care/economic-cost-of-health-disparities.html> (Accessed: 21 February 2024).

³ *National Poverty in America Awareness Month: January 2024*, *Census.gov*. Available at: <https://www.census.gov/newsroom/stories/poverty-awareness-month.html> (Accessed: 11 February 2024).

⁴ Montez, J.K. and Cheng, K.J. (2022) 'Educational disparities in adult health across U.S. states: Larger disparities reflect economic factors', *Frontiers in Public Health*, 10. doi:10.3389/fpubh.2022.966434.

⁵ Smith, L., Gonzalez, D. and Morriss, S. (2023) *More than one in five adults forgo healthcare because of Transportation Barriers*, *RWJF*. Available at: <https://www.rwjf.org/en/insights/our-research/2023/04/more-than-one-in-five-adults-with-limited-public-transit-access-forgo-healthcare-because-of-transportation-barriers.html> (Accessed: 12 February 2024).

⁶ *Neighborhood and Build Environment – Healthy People 2030* (no date) U.S. HHS. Available at: <https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment> (Accessed: 11 February 2024).

⁷ *How Does Social Connectedness Affect Health?* (no date) CDC. Available at: <https://www.cdc.gov/emotional-wellbeing/social-connectedness/affect-health.htm> (Accessed: 11 February 2024).

⁸ *Defining Health Equity* (no date) National DPP Coverage Toolkit. Available at: <https://coveragetoolkit.org/health-equity/defining-health-equity/> (Accessed: 12 February 2024).

⁹ Baer, T., Esho, A., et al (2023, November 14) Consumers' perceptions of their health-related social needs [Blog] *McKinsey & Company blog*. Available at: <https://www.mckinsey.com/industries/healthcare/our-insights/consumers-perceptions-of-their-health-related-social-needs> (Accessed: 12 February 2024).

¹⁰ *2022 Survey of America's Physicians: Part One of Three: Examining How the Social Drivers of Health Affect the Nation's Physicians and their Patients* (2022) The Physician's Foundation. Available at: <https://physiciansfoundation.org/wp-content/uploads/SDOH-Survey-Report.pdf>. (Accessed 13 February 2024).

¹¹ Vivek, G., (2022, June 14) Reinventing Primary Care to Improve the Lives of Seniors and the Physicians Who Treat Them [Blog] *Healthcare Innovation blog*. Available at: <https://www.hcinovationgroup.com/population-health-management/care-management/blog/21271055/reinventing-primary-care-to-improve-the-lives-of-seniors-and-the-physicians-who-treat-them> (Accessed 14 February 2024).

¹² Gold, R., Kaufmann, A., et al. (2022) 'Cross-Sectional Associations: Social Risks and Diabetes Care Quality, Outcomes' *American Journal of Preventive Medicine*, 63(3) [Online]. Available at: <https://www.sciencedirect.com/science/article/pii/S0749379722001672> (Accessed 21 February 2024).

¹³ Crumley, D., Houston, R. and Bank, A., *Report: Incorporating Community-Based Organizations in Medicaid Efforts to Address Health-Related Social Needs: Key State Considerations* (2023) California Health Care Foundation. Available at: <https://www.chcs.org/resource/incorporating-community-based-organizations-in-medicaid-efforts-to-address-health-related-social-needs-key-state-considerations/> (Accessed 15 February 2024).

¹⁴ Wang, P., Vienneau, M., and Vogeli, C. (2023) 'Reframing Value-Based Care Management Beyond Cost Reduction and Toward Patient Centeredness' *JAMA Health Forum*, 4(6) [Online]. Available at: <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2806235> (Accessed 15 February 2024).

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¹⁶ *Healthy Opportunities Pilots* (no date) NCDHHS. Available at: <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots#PilotLaunch-5217> (Accessed 14 February 2024).



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