Launching Thrive Local
Kaiser Permanente's Social Health Program

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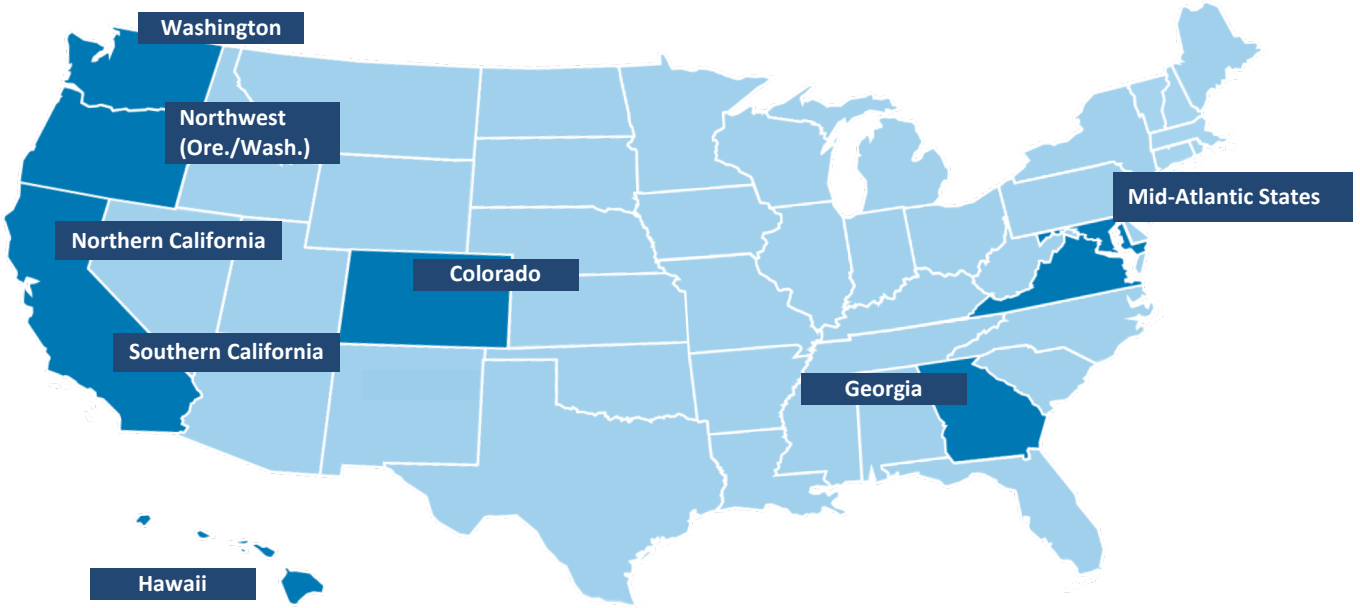
KAISER PERMANENTE®

Our Mission

Kaiser Permanente is committed to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve.

Kaiser Permanente – Over 12 million members



$72 B operating revenue

20,000+ physicians

216,199 employees

39 hospitals

684 medical offices

Many KP Members are Struggling

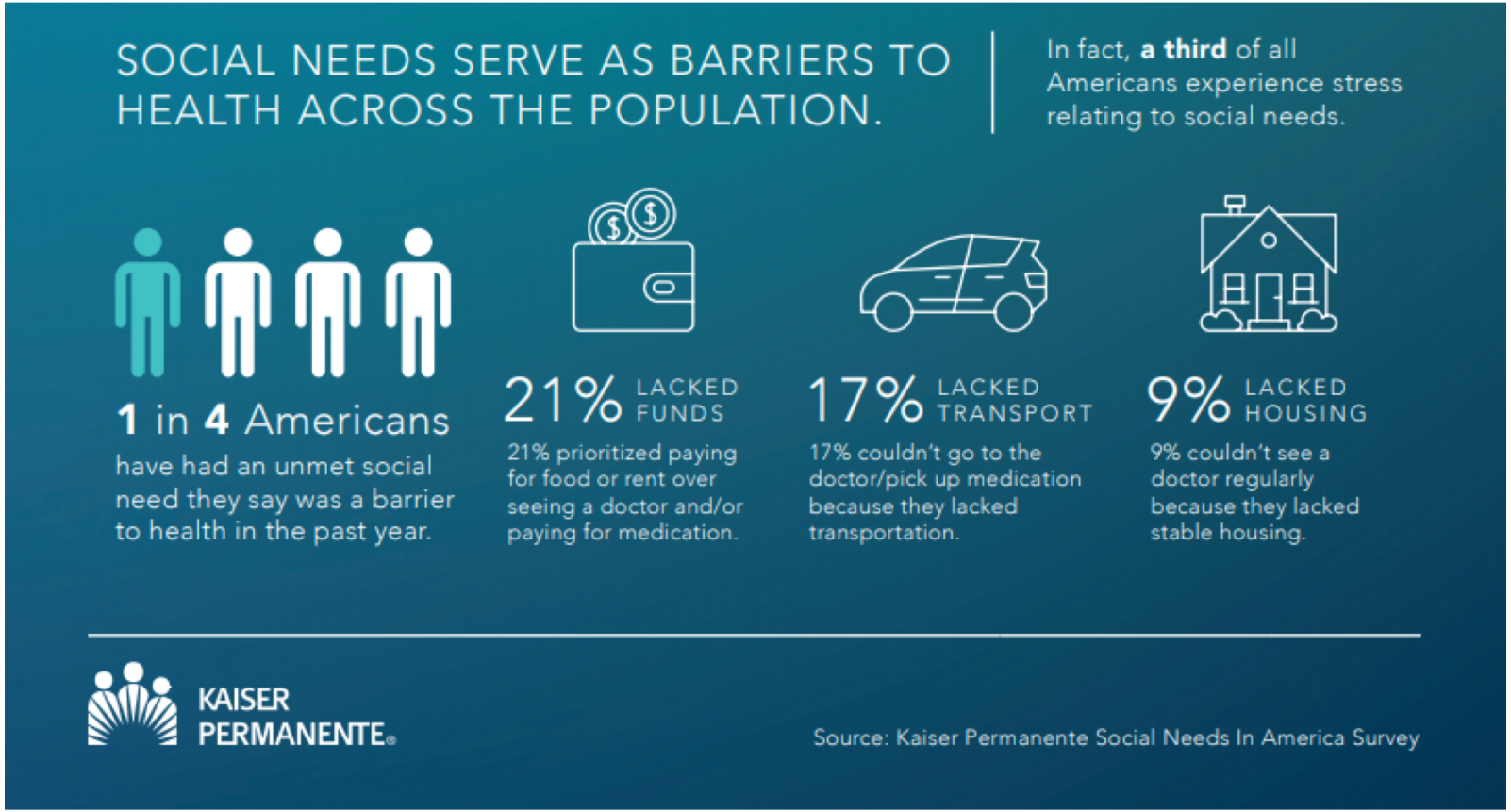
While nearly all of our members will have an unmet social need at some point in their lives, those who struggle financially are at greatest risk.

Nearly **30% of members*** have incomes at or below 250% Federal Poverty Level

~ 3.4 million members

~ Over 50% are members in the commercial line of business

Unmet social needs are barriers to health for all Americans



Carl's KP Health Care Journey Today

How did Carl get there?

- Recently divorced
- Diagnosed with diabetes
- Misses first follow-up visit with his KP primary care provider

ER Admit for diabetic complications

PCP visit. Identifies **goal of controlling diabetes** and **losing weight.**

ER Admit. Diagnosed with **depression.** Referred to care management.

Phone disconnected. Care managers **unable to reach Carl.**

No show for PCP visit.

Admitted to ER for chest pain. Now **morbidly obese** with **cardiovascular disease**. Social worker helps Carl arrange for transportation for follow-up appointment.

Carl's health spirals, causing him to lose his job. Severely depressed, Carl isolates himself and misses several KP appointments. Carl is considered "non-compliant" and dropped from KP's care management program.

Why Focus on Social Needs?

Market Factors	Internal KP Factors
▪ Medicare Sustainability ▪ CMS and State Regulations ▪ Emerging Evidence ▪ Epic Enhancements ▪ Value-Based Payment Models	▪ No standardized approach across regions ▪ Reactive not proactive ▪ Focus on medical needs ▪ KP staff not empowered ▪ Not partnering closely with communities

Social Needs Among Subgroups of KP Members

Food Insecurity

29% of high utilizers

25% of elderly Medicaid members

Housing Concerns

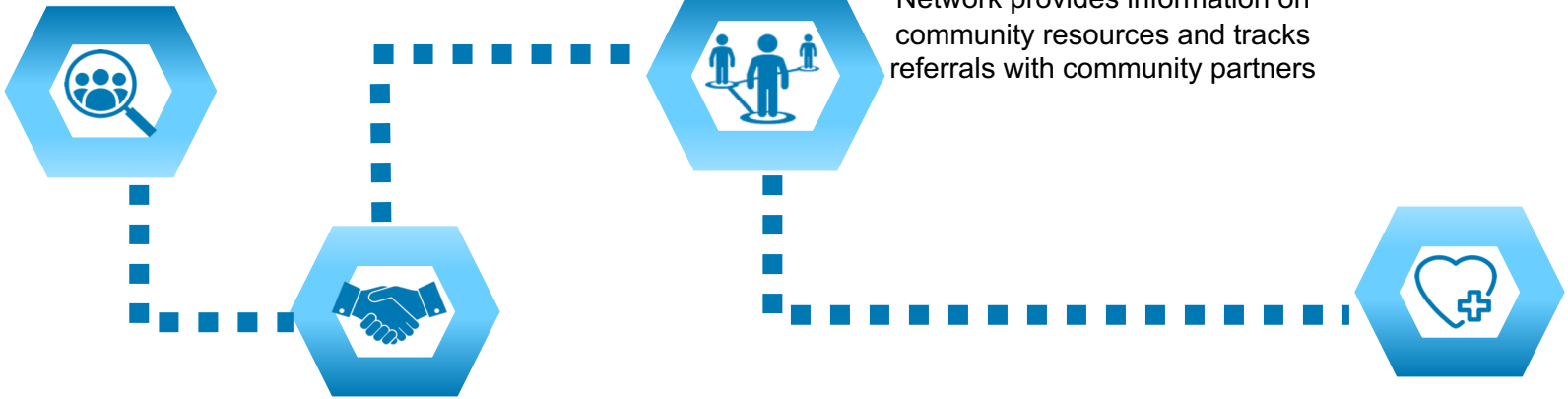
11-23% of high utilizers across regions

Transportation Needs

34% of “dual” Medicare/Medicaid eligible

Creating Kaiser Permanente's Social Health Program

Identification
Social needs identified by KP staff, provider, member, caregiver or community partner



Information
Network provides information on community resources and tracks referrals with community partners

Connection
Network locates resources from KP, community organizations and the government to meet those needs

Optimization
Data will be used by KP and community partners to better understand social needs and provide programs, care and services that address community conditions for health

Introducing Kaiser Permanente's new Thrive Local

Resource Directory

Online platform - search and filter for community resources.

Resources updated regularly by contracted vendor

Community Partner Networks

Community Based Organizations (CBOs) outside of KP use vendor platform

KP users send and track referrals

Technology Platform

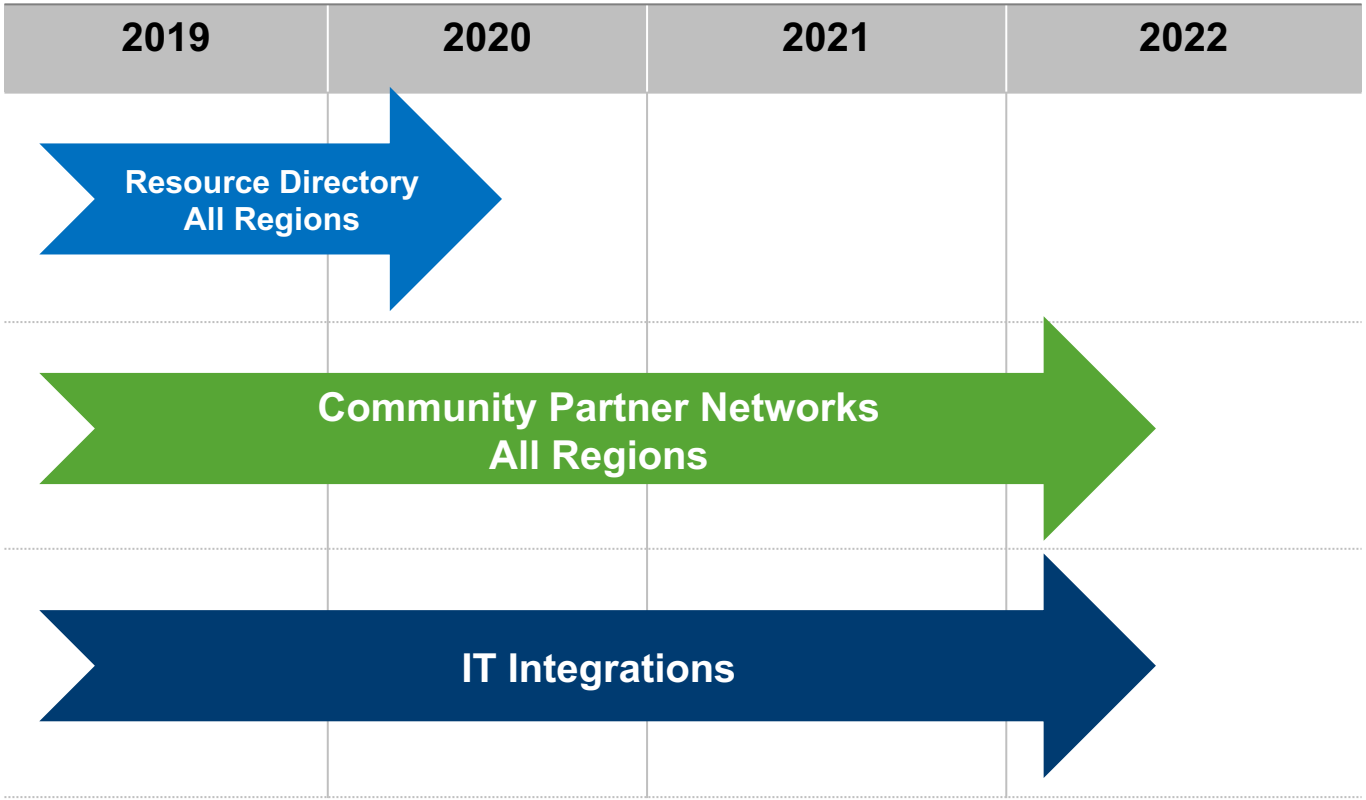
Closed loop referrals

Bidirectional exchange of information between KP and Community Network

Integration with Electronic Health Record and Member Portal

Integrated clinical and social care, supported by data integration and partnership with community

Project Scope and Timeline



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How will we measure success?

Desired Outcomes	Sample Indicators
Closure of social care gaps	• Number of referrals to community based organizations • Number of social needs met
Improved clinical outcomes	• Reduced HgbA1c for food insecure diabetics • Depression, functional impairment for socially isolated seniors • Asthma control for people living in poor quality housing
Improved personal health and wellbeing	• Improved member experience and satisfaction • Improved health-related quality of life • Improved overall wellbeing
Enhanced system performance	• Reduced inpatient and ED utilization and total cost of care • Reduced duplicative solutions across regions and business units • Improved provider satisfaction and retention, increased joy in work
Improved community health	• Improved neighborhood-level measures of health • Reduction in health inequities • Improved performance, financial health of community-based organizations

Business Case – Calculating the ROI

Information Technology (IT) Expenses

- Vendor Fees
- Program Management
- Technology Security & Risk
- Architecture & Solution Design
- Integrations
- Data Solution
- Contingency
- Include investment and ongoing expenses

Business / Non-IT Expenses

- Program Management
- Training
- Evaluation
- Analytics
- Redeployment of Staff
- Contingency
- Include investment and ongoing expenses

Soft Benefits

- Increase staff/clinician efficiency
- Alignment with regulatory requirements
- Avoid duplicative solutions across organization
- Increase staff/clinician satisfaction
- Increase patient satisfaction

Hard Benefits

- Difficult to project because little research and evidence
- Assumed reduction in PMPM costs for low income population if at least 1 need met.
- Phase in benefit realization

How would these capabilities have helped us with Carl?

Recently divorced and diagnosed with diabetes, Carl misses his first follow-up visit with his KP PCP.

We reach out to Carl before he spirals, and we focus on his holistic needs

Predictive Analytics

Algorithm flags Carl for a social needs screening based on his divorce and address change.

Standardized Screening

Carl is screened. Food insecurity and social isolation are identified as his highest priority needs.

Inform and Navigate

Thrive Local – IT Platform

Care manager/social worker uses resource locator platform to find a church-based food pantry where Carl can volunteer and receive support.

We leverage and support the community

Partnership

KP partners with the food pantry through 1) bidirectional information exchange; 2) development of workflows for referral and management; 3) identifying potential future investments to support capacity of CBOs

We close the loop

KP/CBO Data Exchange

Metrics and Reporting

Using the IT platform, data exchange with the contracted food pantry occurs, and KP can see that Carl's social needs are met.

Carl continues to work as a chef. His involvement with his church has helped him stave off depression and keeps him active. While he is still slightly overweight, his diabetes is under control.

Considerations When Addressing SDOH and Health-Related Social Needs

- Align efforts with organizational strategic objectives
- Co-design with key stakeholders to build effective interventions
- Continuous monitoring of performance using metrics→ evaluate and improve interventions
- Develop and constantly manage partnerships
- When designing interventions, need clear timeline and criteria for scale
- Recognizing that financial incentives for states, providers, community-based organizations, and other key partners may not be aligned
  - Provider value-based contracts
  - Risk adjustment