Launching Thrive Local
Kaiser Permanente’s Social Health Program

Sarita A. Mohanty, MD, MPH
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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

- Washington
- Northwest (Ore./Wash.)
- Northern California
- Southern California
- Colorado
- Georgia
- Hawaii
- Mid-Atlantic States

$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

SOCIAL NEEDS SERVE AS BARRIERS TO HEALTH ACROSS THE POPULATION.

1 in 4 Americans have had an unmet social need they say was a barrier to health in the past year.

21% lacked funds
21% prioritized paying for food or rent over seeing a doctor and/or paying for medication.

17% lacked transport
17% couldn’t go to the doctor/pick up medication because they lacked transportation.

9% lacked housing
9% couldn’t see a doctor regularly because they lacked stable housing.

Source: Kaiser Permanente Social Needs in America Survey
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. Diagnosed with [depression]. Referred to care management.


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.

ER Admit for diabetic complications

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

Phone disconnected. Care managers [unable to reach Carl].

No show for PCP visit.
### Why Focus on Social Needs?

<table>
<thead>
<tr>
<th>Market Factors</th>
<th>Internal KP Factors</th>
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<tbody>
<tr>
<td>- Medicare Sustainability</td>
<td>- No standardized approach across regions</td>
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<td>- CMS and State Regulations</td>
<td>- Reactive not proactive</td>
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<td>- Emerging Evidence</td>
<td>- Focus on medical needs</td>
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<tr>
<td>- Epic Enhancements</td>
<td>- KP staff not empowered</td>
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<tr>
<td>- Value-Based Payment Models</td>
<td>- Not partnering closely with communities</td>
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- 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

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

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

**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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<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
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<tbody>
<tr>
<td>Resource Directory</td>
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<td>All Regions</td>
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<td>Community Partner Networks</td>
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<td>All Regions</td>
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<tr>
<td>IT Integrations</td>
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### How will we measure success?

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

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

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

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

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.

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 to 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