Session 5B: Provider-Payer Collaboration to Address Social Determinants of Health (SDOH) through Data, Analytics and Technology

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October 27, 2020
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Overall, the relative contributions of socioeconomic factors, health behaviors, clinical care, and the physical environment to the health outcomes composite score were 47%, 34%, 16%, and 3%, respectively. Although the CHR model performed better in some states than others, these results provide broad empirical support for the CHR model and weightings.

Social Determinants of Health Defined

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Presenters

• Anyi Chen, Ph.D, CIO of the Staten Island Performing Provider System in Staten Island, New York

• James M. Dolstad, ASA, MAAA, VP in Optum’s Payer Actuarial team
Provider-Payer Collaboration to Address Social Determinants of Health (SDOH) through Data, Analytics and Technology

Anyi Chen, Ph.D
Chief Information Officer
Staten Island Performing Provider System

October 27, 2020
Staten Island Performing Provider System

**Partners**

**DSRIP Goal:**
Improve quality of care, transform the health care delivery system on Staten Island, and reduce preventable ER use and hospitalizations by 25%

**Financial:**
Invested $150 million to date to transform and innovate the SI Healthcare Ecosystem

**Partners:**
- Over 75 fully engaged organizations
- 22 Population Health practices
- 20+ Community-Based Organizations

**Impact:**
- Care Outcomes Already Doubled Expected
- 4 out of 10 Staten Island residents impacted
PPS investments in SDOH

- System Transformation/Project Implementation
- DSS Bridge Home Pilot
- City Harvest Rx for Food - Prescription for Food/Nutrition Counseling
- Patient Navigation & Insurance Enrollment
- Behavioral Health Infrastructure
- Medication Adherence Program
- Healthy Partnerships Community Health Literacy
- Re-housing Shelter Residents

- Health Literacy
- Care Management
- Housing
- Food/Nutrition
- Workforce
- Transportation
- Behavioral Health
- Hospital
- Safety
- Immigration/Legal
- Clothing
- Social Services/Benefits

- Workforce Consortium Employment and Job Placing
- Mobile Food Pantries at Clinic Days
- Timebank Volunteer Exchange
- DEI Building Equitable Healthcare Organizations
- Emergency Department FDNY/NYPD/EMS Diversion
- SI CARES & HEALTHi Superutilizer Care Coordination
- Asthma Home Visit Program
- Yoga and Empowerment Project

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WeSource SDOH App – Why Now?

- Over 3 years various tools and methods were in use in our network of 180,000 clients
- SI PPS had several goals:
  - Simple to use App that is mobile and could be used in any setting on phone, tablet, laptop
  - Data connectivity to Regional Health Information Exchange and link back to data warehouse
  - A standardized assessment tool set with closed loop referral
  - Tracking and data management of multiple variables
  - Hot spotting and geo-mapping capability
  - Give immediate feedback to client and allow them “Agency” over their choices
  - Tool that could be used by public agencies, MCOs, providers and Community organizations
  - Create curated list of referral partners that is update monthly
360 View of Patient’s SDOH needs

Curated Social Services Directory

Closed Loop Referral System

SDOH Platform Overview

Providers

$ Payor

Health Systems

CBOs

Health Homes

Medical PCPs

API

EHR Integration

Interoperability

HIE Data Exchange

Portal Access

Mobile Apps

Analytics / Dashboard

Secure Text Message
Social Determinants of Health

The social determinants of health are the conditions in which we are born, we grow and age, and in which we live and work. The factors below impact on our health and wellbeing.

- Childhood experiences
- Housing
- Education
- Social support
- Family income
- Employment
- Our communities
- Access to health services

Source: NHS Health Scotland
Highlighted Features

Healthcare Analytics: Dashboards

Google Map Integration
Explore Transportation Mode and Directions

Social Agency

Client Location

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High Level Information Exchange / Interoperability

Use Case

Client & Navigator
Meet in Medical Practice
Annual Primary Well Visit
As part of completed visit template
SDOH Screen is completed
Needs are identified, referrals made
Clients EHR updated and F/u Planned

Medical Practice

Navigator works with clients to complete SDOH survey

Social Needs identified (Housing, Food etc.)

Navigator refers clients to CBOs

Provider EHRs

WeSource EDW

Health Information Exchange (HIE)

Navigator and Social agencies work together to f/u with Patient(s) and close referral

Patient
Email/Text
Receive survey summary

Navigator
Email
Receive a list of referrals

Social Agencies
Email
Receive a list of referrals
SI PPS Launches COVID Chatbot to Identify Worsening SDOH Needs

COVID Chatbot
To Identify Worsening SDOH Needs

Text START to 347-970-2476 to begin
WeSource: Project Overview

July 1, 2019 – September 11th, 2020 Network Partner Activity

20,030
Total SDOH
Validated Surveys

28,610
Total # SDOH
Factors Identified

19 PPS partners use WeSource App to:

- Identify any barriers patients have
- Make immediate linkages to resources for urgent needs
- Facilitate linkage for social factors to CBOs
- Connect patients to insurance who do not have one
- Connect patients to PCP who do not have one
- Schedule PCP appointments for patients who have not been to their medical doctor in last 12 months
- Goal is to close the referral loop within 4 weeks
# SDOH Competed Surveys and Referrals Analysis

<table>
<thead>
<tr>
<th>SDOH Factor Identified</th>
<th># of Clients with Referrals</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>5483</td>
<td>47.5%</td>
</tr>
<tr>
<td>Income</td>
<td>1631</td>
<td>14.1%</td>
</tr>
<tr>
<td>Literacy</td>
<td>1026</td>
<td>8.9%</td>
</tr>
<tr>
<td>Transportation</td>
<td>910</td>
<td>7.9%</td>
</tr>
<tr>
<td>Clothing</td>
<td>822</td>
<td>7.1%</td>
</tr>
<tr>
<td>Social</td>
<td>733</td>
<td>6.3%</td>
</tr>
<tr>
<td>Housing</td>
<td>582</td>
<td>5%</td>
</tr>
<tr>
<td>Safety</td>
<td>169</td>
<td>1.7%</td>
</tr>
<tr>
<td>Child Care</td>
<td>195</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

## Total # Valid SDOH Competed Surveys
- 20,030

## Total # SDOH Factors Identified
- 28,610

## Total # of Regular/Urgent Referrals Made
- 11,551

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Opportunities: Engage High Utilizers

12-Month Healthcare Utilization (7/1/2018 – 6/30/2019)

<table>
<thead>
<tr>
<th># of Patients</th>
<th>2,141</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cost</td>
<td>$15M</td>
</tr>
<tr>
<td>Preventable (42%)</td>
<td>$6.3M</td>
</tr>
</tbody>
</table>

**Total Emergency Room (ER) Cost**

- 3,614 # Visits
- $5.4M

**Total Hospitalizations Cost**

- 1,127 # Visits
- $9.6M

### Insurance Plans by Volume:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Insurance Name</th>
<th># Patients</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Fidelis</td>
<td>514</td>
<td>24.0%</td>
</tr>
<tr>
<td>2</td>
<td>Anthem</td>
<td>510</td>
<td>23.8%</td>
</tr>
<tr>
<td>3</td>
<td>Healthfirst</td>
<td>452</td>
<td>21.1%</td>
</tr>
<tr>
<td>4</td>
<td>United</td>
<td>109</td>
<td>5.1%</td>
</tr>
<tr>
<td>5</td>
<td>ADAP</td>
<td>75</td>
<td>3.5%</td>
</tr>
<tr>
<td>6</td>
<td>HIP</td>
<td>67</td>
<td>3.1%</td>
</tr>
<tr>
<td>7</td>
<td>Affinity</td>
<td>63</td>
<td>2.9%</td>
</tr>
<tr>
<td>8</td>
<td>Metro Plus</td>
<td>51</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

Subtotal # of Patients: 1,841 (86.0%)

**Potentially Preventable ER Visits**

- 2,914 # Visits
- $4.4M

- 4 out of 5 ER visits is preventable

**Potentially Preventable Admissions**

- 253 # Visits
- $2.1M

- 1 out of 5 Hospitalization is preventable

Data Source: NY Department of Health Claims data and WeSource Platform File Extracts

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Payor A: SDOH Intervention: 7/1/2019 – 03/26/2020

SDOH Factors %

<table>
<thead>
<tr>
<th>Income</th>
<th>Food</th>
<th>Transportation</th>
<th>Social</th>
<th>Clothing</th>
<th>Saving</th>
<th>Housing</th>
<th>Chis</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>38</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SDOH Factors Monthly Trend

- Completed Surveys: 1,639
- Factors Identified: 2,626
- Referrals Made: 1,196
- Validated: Non-Referrals: 524
- Closed Referrals: 364
- Referral Rate: 46%
- Referral Closure Rate: 30%

Survey Date
- 7/20/1991
- 3/27/2020

Partner
- All

Navigator Name
- All

SDOH Factor
- All

Age Group
- All

Financial Class
- Medicaid
- Other

Payer
- Health First
Payor A: SDOH Intervention: 7/1/2019 – 03/26/2020

Ethnicity

- Hispanic/Latino: 31.6%
- Other: 11.0%
- White: 23.0%
- Black: 19.3%
- African American: 18.2%
- Asian: 6.9%
- American Indian: 0.1%
- Other: 0.6%

Gender

- Male: 51.9%
- Female: 48.1%

Language

- English: 1,552
- Spanish: 82
- Arabic: 4

SDOH Factors by Age Group

- 0 - 13: 176
- 14 - 19: 80
- 20 - 29: 219
- 30 - 44: 482
- 45 - 64: 425
- 65+: 86

SDOH Factors by Zip Code

- 10702: 545
- 10701: 427
- 10703: 271
- 10710: 358
- 10722: 263
- 10742: 241
- 10705: 234
- 10706: 231
- 10708: 91
- 10712: 81
- 10707: 55
- Total: 2,879

Survey Date

- 7/20/1991
- 3/27/2020

Partner

- All

Navigator Name

- All

SDOH Factor

- All

Age Group

- All

Financial Class

- Medicaid
- Other

Payer

- HealthFirst
Payor A:
3-Month Pre/Post SDOH Intervention
ED and Hospitalization Reduction

26% ED Reduction
# Patients: 658

42% Hospitalization Reduction
# Patients: 283
Lessons Learned

- Using Data and Technology has accelerated identification and quantification of specific needs and facilitated services and new partnerships.
- SDOH investments demonstrate positive impact on avoidable hospital utilization.
- A focused and streamlined assessment that is community specific supports client and Agency engagement.
- Health Exchange partnerships will sharpen insight into client needs throughout a network, reduce duplication and improve care coordination.
- Homegrown SDOH Platform, WeSource has supported Community-Based Organization (CBO) partners in their work and improved population health.
Thank you!

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Payer and Provider Collaboration through SDOH

*Using social determinants of health to improve clinical, financial and operational performance*

Jim Dolstad ASA, MAAA, FCA
Vice President, Optum Advisory Services
October 29, 2020
Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.¹

Definition of social determinants of health

The ‘social determinants of health’ (SDH) are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life.²

¹ https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
² https://www.who.int/social_determinants/en/
Public Health and Actuarial Perspective

- **Worksite health**: Health and well-being programs, condition management, advocacy, Employee Assistance Program (EAP)
- **Community health**: Housing, transportation, food, recreation, health services
- **School health**: School nurse, nutrition programs, health education and safety

Your ZIP Code is a better predictor of your health outcomes than your genetic code*

* https://www.hsph.harvard.edu/news/features/zip-code-better-predictor-of-health-than-genetic-code/

Actuarial pricing indirectly reflects some level of SDOH at the employer level using allowable rating factors:

- Age/Gender
- Industry
- Geographic Area
- Income (historically)
SDOH ICD-10 Codes

Valuable information, but coded on few members

**Contact with and Suspected Exposure to Arsenic, Lead or Asbestos**
- Z77.010 Contact with and suspected exposure to arsenic
- Z77.011 Contact with and suspected exposure to lead
- Z77.090 Contact with and suspected exposure to asbestos

**Educational Circumstances**
- Z55.0 Illiteracy and low level literacy
- Z55.1 Schooling unavailable and unattainable
- Z55.2 Failed school examinations
- Z55.3 Underachievement in school
- Z55.4 Education maladjustment and discord with teachers and classmates
- Z55.8 Other problems related to education and literacy
- Z55.9 Problems related to education and literacy, unspecified

**Effects of Work Environment**
- Z56.0 Unemployment, unspecified
- Z56.1 Change of job
- Z56.2 Threat of job loss
- Z56.4 Discord with boss and workmates
- Z56.89 Other problems related to employment
- Z56.9 Unspecified problems related to employment

**Foster Care**
- Z62.822 Parent-foster child conflict
- Z62.21 Child in welfare custody

**Homelessness/Other Housing Concerns**
- Z59.0 Homelessness
- Z59.1 Inadequate housing
- Z59.2 Discord with neighbors, lodgers and landlord
- Z59.8 Other problems related to housing and economic circumstances
- Z60.2 Problems related to living alone

**Inadequate Material Resources**
- Z59.4 Lack of adequate food and safe drinking water
- Z59.5 Extreme poverty
- Z59.6 Low income
- Z59.7 Insufficient social insurance and welfare support
- Z59.8 Other problems related to housing and economic circumstances
- Z59.9 Problems related to housing and economic circumstances, unspecified
- Z75.3 Unavailability and inaccessibility of health care facilities
- Z75.4 Unavailability and inaccessibility of other helping agencies

**Legal Circumstances**
- Z65.0 Conviction in civil and criminal proceedings without imprisonment
- Z65.1 Imprisonment and other incarceration
- Z65.2 Problems related to release from prison

**Other Social Factors**
- Z60.4 Social exclusion and rejection
- Z60.8 Other problems related to social environment
- Z60.9 Problems related to social environment, unspecified
- Z71.3 Dietary counseling and surveillance
- Z71.8 Tobacco abuse counseling
- Z71.82 Exercise counseling
- Z71.89 Other specified counseling
- Z71.9 Counseling, unspecified
- Z72.0 Tobacco use
- Z72.4 Inappropriate diet and eating habits
- Z81.82 Personal history of military deployment

**Parent/Child/Family**
- Z62.810 Personal history of physical and sexual abuse in childhood
- Z62.820 Parent-biological child conflict
- Z63.4 Disappearance and death of family member
- Z63.8 Other specified problems related to primary support Group

* These are supplemental diagnosis codes and should not be used as the admitting or principal diagnosis code to indicate the medical reason for the visit.

Augmenting collection with prediction of SDOH

**Actionable indices developed at the individual member level**
- Accounts for individual level data, as well as socio-economic and community data
- Enables payers with low-lift rapid implementation

**SDOH applies to lines of business and multiple business functions to improve performance at lower operational cost**
- Using data outside the walls of a payer enables knowledge of the customer, not just the patient
- Augments existing workflows and improves the likelihood of success of a given business/clinical function
An uncertain future, although more disruption inevitable

Large wave
Oscillating wave
Hot spots

SECOND WAVE OPTIONS

Urgent COVID-19-specific needs
Plan and execute for future relevance

Balance

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Three anchoring assumptions define this future

**Economic reality**

A global/US economic pull-back, with a slow recovery, will continue for the next ~3 years

**Duration of COVID-19 specific impact**

The immediate impacts of COVID-19 will be felt for at least one-to-three years, including efforts of persistent distancing and recurring outbreaks

Disease epidemiology will impact decision-making and will require organizations to pivot and adapt based on oscillating disease prevalence

**Permanent change**

The impacts of the effects and changes since the outbreak will result in some permanent change to the health care industry — the tried and true solutions pre-pandemic may no longer be applicable in our new environment
COVID 19 Impact

Out of chaos – increased partnership

**Providers**

- COVID-19 Treatment and Cost
- Abatement of Services
- Change in member mix due to unemployment
- Lower risk adjustment revenue
- Recovery curve of services
- Costs incurred to scale up telemedicine
- Costs incurred for operational/waiting room changes
- Potential throughput of patients reduced due to increased sanitation requirements

**Payers**

- Favorable financials in 2nd quarter
- Significant projected gaps in risk revenue relative to bid assumptions
- Unknown future impact of COVID-19, abatement, and recovery curves
- Unknown impact of undiagnosed members
- Recognition data will be incomplete and distorted for at least a few years
- Shifts in lines of business
- Concern over financial viability of some provider groups and timing of addressing those needs potentially impacting current and future rating

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COVID-19 Impact on public health
Better outcomes working together

Health and well-being programs, condition management, advocacy, Employee Assistance Program (EAP)

School nurse, nutrition programs, health education and safety

Worksite health

Community health

Housing, transportation, food, recreation, health services

School health
Holistic view of the member
Enables everyone to work smarter by knowing the customer not just the patient

99.9%  
Percentage of time members spend outside of a clinician’s office

80%  
Percentage of member healthcare costs driven by lifestyle and behaviors
Working together to improve coding and documentation

Use Case

- Abatement of services prematurely ended chart review for 2020 financial year causing a 1% to 2% potential shortfall in projected CMS revenue for many payers and providers

- Abatement of services created a 3% to 7% projected decrease in 2021 financial year risk adjustment factor for many payers and at risk providers

- COVID-19 disproportionately impacting senior population and groups often challenged with health disparities

- Coding and documentation can be improved through in-home visits, in office visits, telehealth visits, and member outreach that results in a visit of some type
Collaboration using SDOH to drive performance

<table>
<thead>
<tr>
<th>Members’ needs</th>
<th>Options to close gaps</th>
<th>Collaboration</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs very significantly by member</td>
<td>Gaps can be closed multiple ways</td>
<td>• Payers can share projected SDOH characteristics of members with providers and stratify</td>
<td>• Improved coding and documentation</td>
</tr>
<tr>
<td>• Propensity to engage</td>
<td>• In-office visit</td>
<td>• Payers can help provider understand which member are most likely to be able to successfully have a telehealth visit</td>
<td>• Improved clinical outcomes</td>
</tr>
<tr>
<td>• Health ownership</td>
<td>• In-home visit</td>
<td>• Payers can understand SDOH from a provider patient base perspective and refine strategies with provider</td>
<td>• Early detection of any undiagnosed conditions</td>
</tr>
<tr>
<td>• Social isolation</td>
<td>• Telehealth visit</td>
<td></td>
<td>• Member satisfaction</td>
</tr>
<tr>
<td>• Financial security</td>
<td>• Encouragement through care management team or member outreach for one of the above means</td>
<td></td>
<td>• Improved quality metrics and potentially improved Star ratings, MIPS performance or value based contracting performance</td>
</tr>
<tr>
<td>• Food security</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Housing security</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Technological savviness</td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

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Example

SDoH interplays

Generally speaking, there is an inverse relationship between willingness to participate in an in-home visit and:

- Social Economic Status
- Education Level
- Financial Security
PCP Backlogs

PCP backlogs will go deep into 2021 in many counties

PCP backlogs differ significantly by county. Telehealth offers significant opportunity to close gaps and relieve some of the backlog. CMS requires visits be both audio and visual to be used for coding, so understanding a member's ability to enable the video portion of the visit is imperative to success.
Understanding the differences between provider group patient bases gives a perspective beyond risk adjustment when assessing provider performance. Provider groups with challenging patient bases may be performing relatively well, after taking into account the social-economic and individual needs of their patients, relative to other patient bases.

Provider Group Patient Base Variance
Recognizing the impact of social determinants on outcomes

Provider Groups by Number of Members and PEI Score

Scoring range for Propensity to Engage and Social Isolation is 1 (Lowest) to 10 (Highest). Population averages are shown above.
Today’s Takeaways

**Actuaries need to understand SDOH and its implications on the healthcare system**
- Short and long term quantification
- Data collection and predictive models
- Impact on CMS revenue, total cost of care, value based contracting, and employee productivity

**We are early in the process and need to collaborate with other disciplines**
- SOA has setup Strategic Initiative Steering Committee of Actuaries and non-Actuaries

**Many payers are actively delivering a wide range of programs today and collaborating with providers**
- Initial focus has been on MA and Medicaid
- Employer demand growing rapidly

**Three years ago SDOH was a buzz word, but not today….it is very real**
- The data is now available
- Payers and providers clearly see the value in understanding the member not just the patient
Thank you.

Contact information:

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