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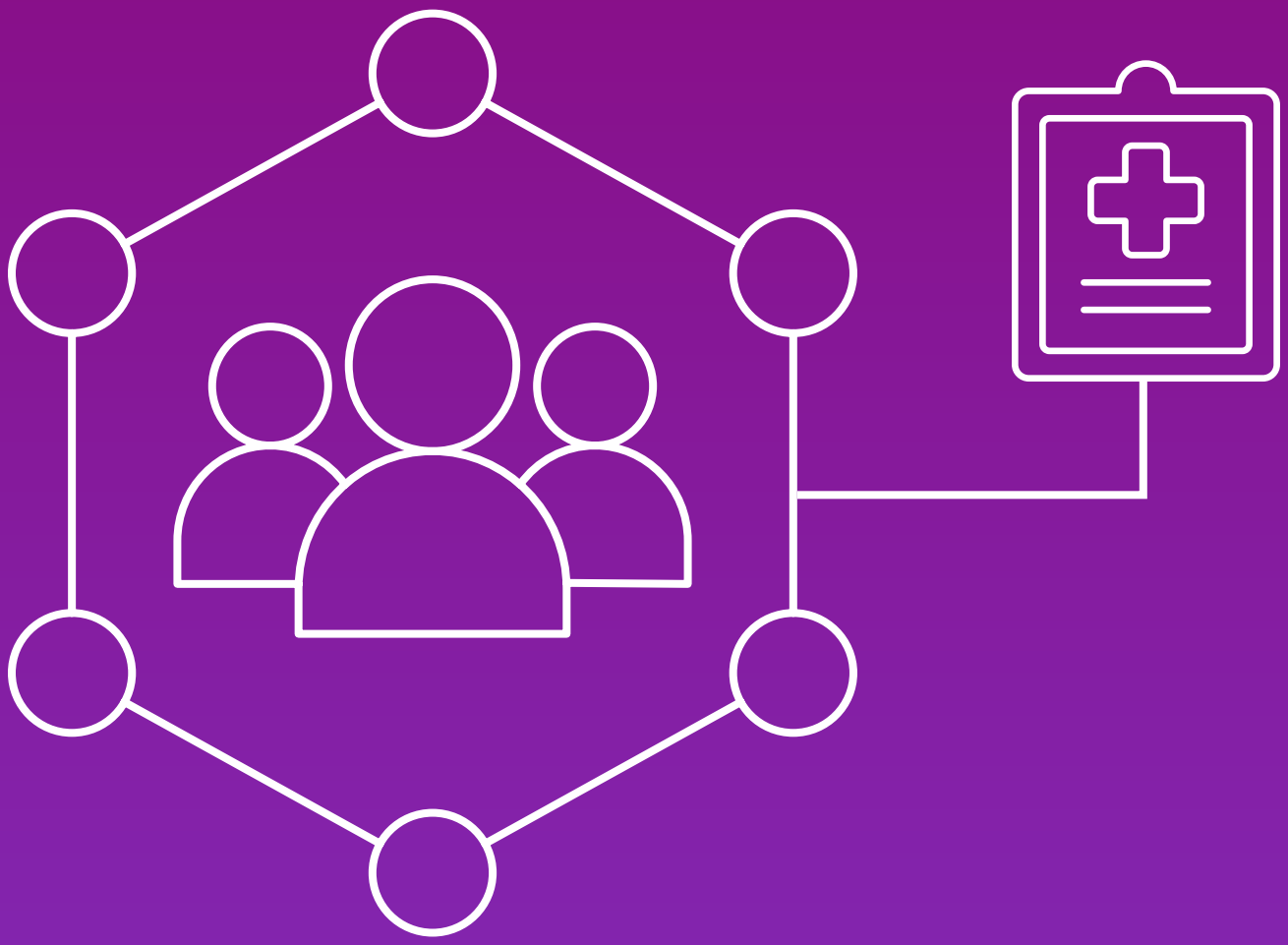
3M Health Information Systems

Case study:

Community Care Plan

Sunrise, Fla.



Client snapshot

- Provider-sponsored health plan
- Serves more than 100,000 members
- NCQA Commendable Status
- Close to 120 community partners
- Established in 2000

Challenge:
Ensure a comprehensive and holistic approach to population health management and health equity

3M solution:
3M™ Social Determinants of Health (SDoH) Analytics

> *"Community Care Plan's member focused, collaborative, care management model has strengthened member engagement by having the ability to integrate social risk with other care coordination activities."*
>
> **—Miguel Venereo, M.D., chief medical officer**

Evaluating social determinants of health opportunities

According to research, more than 60 percent of health outcomes are the result of social determinants of health like economic strain, food insecurity and housing instability. These social risk factors in people's lives create significant impacts in their health outcomes, utilization patterns and costs. Community Care Plan (CCP) wanted to strengthen its member engagement and improve health outcomes by integrating social risk with other care coordination activities.

CCP evaluated the relevance and application of social determinant risk information in support of care management and population health as a complement to an existing program which targeted chronic conditions. The goals of the program were two-fold: care management and population health.

The goals of the program were two-fold – care management and population health. For care management, CCP wanted to determine the incremental value of additional social determinant risk information vs. in-house care management, learn how to integrate social determinants into existing care management processes and establish the value of a data driven, quantifiable approach for a more efficient identification of populations in need. For population health, CCP aimed to evaluate the incremental value of social risk scores beyond the clinical risk and target preventable events, disease progression, total cost of care and utilization patterns.

Assigning members social and clinical risk scores

Using 3M SDoH Analytics, all CCP members were assigned a clinical risk and community social risk score, while CCP members over the age of 18 were also assigned an individual social risk score. The community and individual social risk score(s) use a combination of federal, state and public data sources. These metrics, scored from one to five, can identify elevated social risk in any one area. 3M combined those scores with **3M™ Clinical Risk Groups** (CRG) scores and **3M™ Potentially Preventable Event** (PPE) methodology, to get to integrated clinical, social and population health analytics.

[1] Data sources are in alignment with privacy and data use guidelines.

Social risk metrics quantify the following risk factors:*

Individual

- Financial strain
- Food insecurity
- Housing instability
- Health literacy challenges
- Transportation barriers

Community

- Economic climate
- Food landscape
- Health literacy
- Housing environment
- Transportation network
- COVID-19 Susceptibility

*Social risk metrics included in 3M SDoH Analytics provided by Socially Determined®

Improving processes for member engagement, partnering with the community

By incorporating social risk, CCP addressed clinical risk and care management needs by identifying members who weren't initially targeted solely through existing care management criteria. As a result of targeting members with varying demographic factors, CCP enhanced its care management platform to include this additional information upfront for proactive member engagement.

Social risk scores highlighted needs that didn't otherwise surface through the normal protocol of plan-driven member outreach activities. When CCP targeted an area of elevated risk, such as food instability, additional risk could be identified and addressed before it reached a critical junction, alleviating the need for future outreach.

After using 3M CRGs to fairly risk adjust population health status, 3M Potentially Preventable Emergency Department Visit analytics highlighted elevated ED usage. Although more analysis is needed, early indications showed a relationship between social risk with disease progression, lower professional and inpatient utilization and a heightened need to target new members with multiple areas of elevated risk.

With 3M SDoH Analytics, CCP built a healthier community by answering these questions:

- Who are the new members with high social risk or current members with high social risk?
- Where could CCP make the greatest impact?
- What programs could be implemented and tracked?

CCP's member-focused, collaborative, care management model, known as Concierge Care Coordination (C3) has strengthened its member engagement by integrating social risk with other care coordination activities. Identifying social risk offers the C3 team the necessary information to address clinical risk and care management needs, including identifying members who weren't initially targeted solely through existing care management criteria.

The results

As a result of this initiative, CCP expanded its understanding of the correlation between social risk and the propensity for PPVs. This knowledge has led to the development of proactive initiative intended to avoid high ED utilization rather than actively pursuing super utilizers. With this newly available combined data, CCP can begin incorporating this into a care management program to track success over time. CCP also learned the important role that health literacy plays with their members, especially those with chronic conditions. Establishing programs to address health literacy, not only for its members, but in the community at large is a major goal for the company.

CCP is also proactively planning to launch a community center outreach initiative targeted to maternity patients to increase member engagement to specifically offset preterm labor and delivery. The information derived from 3M SDoH Analytics has also been used to identify potential locations for a community resource center where programs will be tailored specifically to the SDoH risk most prevalent in the appropriate community.

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