Making the Case for Addressing Social Determinants of Health

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Aetna proudly serves*

~22.2 million medical members
~13.4 million dental members
~13.8 million PBM services members

> 700k PCPs, specialists
~ 5,700 hospitals

*Information as of April 27, 2018

Americans are getting older and sicker

From 2003-2023, the chronic disease burden is expected to increase 42% while the population grows just 19%

Source: An Unhealthy America: The Economic Burden of Chronic Disease, Milken Institute, 2007 and U.S. Administration on Aging
The physician shortfall is worsening

By 2030, there is a projected shortfall of more than 121,000 physicians.


Health care attempts to compensate for a lack of social services spending in the U.S.

A Variety of Factors Influence Overall Health, Including an Individual's Social and Physical Environment


SDOH Refer to Conditions Where People Live, Work, Learn and Play—Where Most Time is Spent

<table>
<thead>
<tr>
<th>Population Health</th>
<th>Equity</th>
<th>Education</th>
<th>Economy</th>
<th>Housing</th>
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<tr>
<td>Health Behaviors</td>
<td>Health Equity</td>
<td>Edu. Infrastructure Edu. Participation</td>
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<td>Health Conditions</td>
<td>Income Equity Social Equity</td>
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<td>Health Outcomes</td>
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<tr>
<th>Food &amp; Nutrition</th>
<th>Environment</th>
<th>Public Safety</th>
<th>Community Vitality</th>
<th>Infrastructure</th>
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<tr>
<td>Food Availability</td>
<td>Air &amp; Water Natural Environment Natural Hazards</td>
<td>Crime Injuries Public Safety Capacity</td>
<td>Community Stability Social Capital</td>
<td>Community Layout Transportation</td>
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<td>Nutrition</td>
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SDOH: Social Determinants of Health

Factors Impacting Life Expectancy

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<tr>
<th>Health care</th>
<th>Social and environmental factors</th>
<th>Genetics</th>
<th>Individual behavior</th>
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<td>10%</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
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Source: Kaiser Foundation: "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity" 2015

SDOH Can Significantly Impact Life Expectancy and QOL

- 60% of a person’s life expectancy is impacted by social determinants of health
- 33% of total deaths in one year were directly attributed to social determinants of health

QOL: Quality of Life

We need to shift our thinking and start with the definition of health established in 1948.

– Mark Bertolini

“A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

– WHO Constitution

Source: World Health Organization

Aetna Collaborates Across and Within Sectors to Address a Range of Social Determinants of Health

Community Empowerment

Thought Leadership

Enhanced Member Programs
Meals on Wheels America & Aetna – Partnership Overview

Goal: The intent of this partnership is to determine whether a community based organization and a large health plan can work together to provide socially and clinically comprehensive care to a high risk and high need Medicare and Medicaid patient population. We will gather information on the operational feasibility, member experience and health outcomes, as well as financial requirements for a larger scale future collaboration.

Program features:

- Enhanced care coordination services
- MOW technology platform used to share information with Aetna case managers on members’ needs (this application is called the “Change of Condition” application; all MOW volunteers and Aetna case managers will be trained on this platform)
- Ability for MOW programs to offer members solutions that address their SDOH needs
- Additional opportunities for Aetna to provide needed clinical services as identified through members’ engagement with MOW volunteers and case managers

Partnership Details

Size, Scale & Duration:

- In 2018, the pilot will take place in at least 3 counties with 50 Medicare members per county: Wake County (Raleigh), NC, Harris County (Houston), TX, and Pinellas County (Clearwater/St. Pete), FL.
- We will continue to expand the pilot in new locations, to include both Medicare and Medicaid members, with a goal to serve 1,000 members.

Member selection:

- Aetna case managers will identify the high risk/high need beneficiaries who would most benefit from nutrition, socialization, and daily monitoring in order to quickly assess “Changes in Condition” and take action to address their social or clinical needs.
- The pilot is entirely voluntary and members can decline the service and opt out at anytime.
- During the course of the pilot, Aetna will work with MOW to determine how best to transition the member to other clinical and non-clinical services they need and, if necessary, transition the member to a regular meal pilot if they wish to continue receiving meals at the end of the six month period.

MOW will provide the following services in the pilot:

- Deliver a hot meal 5-days a week for a duration of up to 6-months to each member
- Provide daily observations using the Change of Condition technology application to alert Aetna Case Management and MOW Care Coordinators of any observed social and/or clinical needs that might cause the members health from being adversely impacted
- Conduct a qualitative baseline as well as final assessment of member experience in the pilot
- Provide monthly summary reporting of the pilot
Partnership Details Continued

Evaluation:

• We will use the data collected and lessons learned to inform how we can expand this partnership in future years under CMS’ new approach towards more flexible benefit design in Medicare Advantage, as well as in Medicaid.

• Metrics and Measures used to evaluate the pilot will include:
  • pilot member experience survey
  • # of members enrolled in the program
  • # of meals delivered
  • # of members with a clinical change in condition identified
  • # of members with a social change in condition identified
  • Actions taken as a result of the identified change in condition
  • Effectiveness of Change in Condition technology in relaying information on member needs
  • Ability to ensure seamless enrollment of members into the pilot

• The pilot will help us determine if leveraging 5-day a week meal delivery, with a Change in Condition check, and volunteer interaction with the high cost/high need members will result in earlier detection and resolution of both social and clinical needs of these members thus resulting in a positive impact to their health.

Our ultimate goal is to create a health ecosystem around the patient

Social services

Pharmacy/Urgent care

Behavioral health

Nutrition

Mobile applications

Home health

Mindfulness

Health systems

Telemedicine

Physicians

Medical device

Post acute care