# Leading by Example AND Moving Upstream Together

## A FRESH LOOK AT ADDRESSING SOCIAL NEEDS AND SOCIAL DETERMINANTS OF THE WORKFORCE

National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

LVBCH℠
Employers for Healthcare Value Since 1980

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# EXECUTIVE SUMMARY

A key issue facing the American healthcare system is the impact of social needs, social risks, and social determinants of health (SDoH) on healthcare. Each of these "social" terms brings a slightly different focus to forces that can impact communities and their members. For employers, understanding these impacts within the context of a population health strategy can foster a broader approach to closing gaps in care and in access to services across employee populations.

To learn what employers need to begin their journey to more effectively address social needs, social risks, and social determinants, the Centers for Disease Control and Prevention's (CDC) Office of the Associate Director for Policy and Strategy, the National Network of Public Health Institutes (NNPHI) (bit.ly/3DAxUCj), and the National Alliance of Healthcare Purchaser Coalitions (National Alliance) began a collaboration in late 2020 to engage employers and regional business coalitions through the project "Leading by Example and Moving Upstream Together." The goal was to identify options for developing a process model to enhance employee and community well-being.

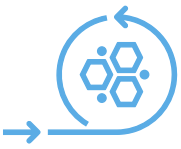
This project included two National Alliance regional coalitions, Kentuckiana Health Collaborative and Pittsburgh Business Group on Health, each of which was already engaging members in the exploration of social determinants, health equity, and racial bias. Each coalition recruited three employer members to participate in the project.

Employers participated in the project through a learning collaborative environment—a forum enabling participants to share individual progress, challenges and lessons as they navigated their organizations' efforts. The process helped employers determine the tools and resources they needed, including potential data sources to inform an action plan designed to address at least one component of the social determinants of health (SDoH) continuum that impacts their workforce.

The following key areas were identified during the project:

- Improving employee access to healthcare.
- Addressing economic instability.
- Improving community health and well-being.
- Using data differently to address social risks.
- Addressing social risk factor challenges.

# Key Recommendations for Employers



## Gather data

- Use community data to identify potential issues and prevalence of social needs and risk by employee ZIP code, and validate findings with demographic data on employees and their families.
- Recognize and analyze correlating social risk factors across subpopulations to identify which specific populations are most adversely affected.
- Use a combination of data sources to better identify population health challenges and/or health inequities (e.g., access to care, quality gaps).

## Use data to assess and prioritize

- Validate data observations and dive deeper by engaging site management, internal survey data, and employee subgroups such as employee resource groups (ERGs) and diversity and inclusion (D&I) groups. Leave assumptions at the door.
- Engage public and/or private organizations that can help highlight the intersection of community data with internal data; prioritize actions based on the broadest impact and the relative feasibility of improvement.

## Develop and execute a workplan

- Consider all levels of potential interventions, both within health and well-being programs and initiatives and beyond them.
- Work with existing health plans and other vendors and also new partners (internal, external community) to examine, develop, and maintain accountability for a multi-pronged workplan.
- Partner with community resource organizations that serve populations in employees' ZIP codes and demographic groups.

## Measure and sustain gains

- Integrate health equity (not limited to social needs and risks) into existing organizational structures and objectives (similar to organizational approaches to quality, safety and well-being).
- Establish a baseline and monitor progress using a system of accountability that includes process and outcomes metrics.
- Establish a periodic review process to assess progress and identify opportunities for improvement.

# BACKGROUND

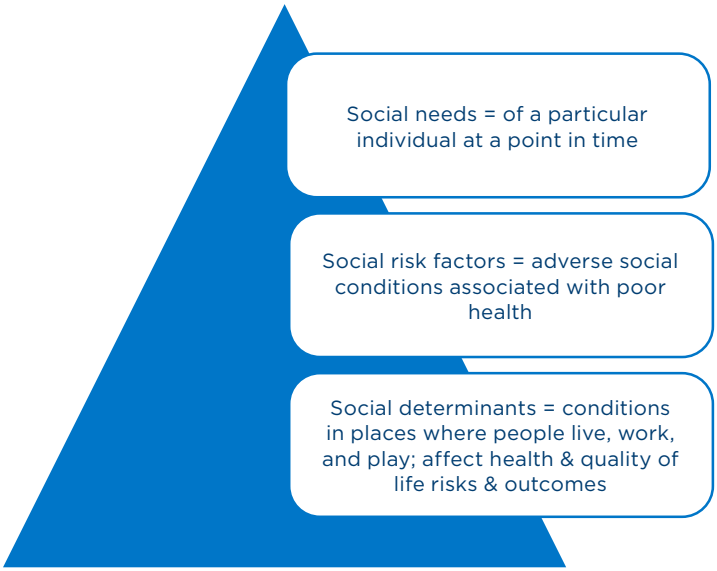
A key issue facing the American healthcare system is the impact of social needs, social risks, and social determinants on health and in healthcare. Social needs are the basic health needs of a particular individual at a certain point of time, while social risks are adverse social conditions (e.g., income, safety) associated with poor health. SDoH are defined as the "conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes" (bit.ly/3pGe2bU).

Social determinants—such as economic stability, access to healthcare, or living environment—all play a role in how employees and their families are able to address health challenges and achieve better or, ideally, optimal health. When employers understand health risks within the context of a population health strategy, they are better able to identify and address care gaps.

As employers evolve their approach to overall employee health, they must examine factors that affect individuals outside the workplace. The COVID-19 pandemic highlighted an increased need to address the social risk factors and social determinants that contribute to clear and unintended disparities in health impacts and outcomes. Additionally, the pandemic presented increased opportunities for employers to partner with community-based organizations and social support groups, and to adopt health coverage and strategies to address evolving employee needs.

Employee population health and, by extension, community population health—can be optimized when employers build systems of workforce support that address these issues in the context of a total person health approach. Employers who address these factors in their overall health and well-being strategy may reduce healthcare costs and improve health and well-being outcomes. (CMS Roadmap, January 7, 2021, go.cms.gov/3DCrlzh)

An important question for employers, then, is at what level to engage along the social needs, social risk factors, and SDoH continuum. Social needs and risks can be directly attributed to employees and their families, while social determinants are more broadly defined and impact communities at large. For that reason, many employers are more likely to address social needs and risks and to invest in social determinants only when broader organizational interests are served.




Many employers lack access to appropriate tools and resources for effectively and efficiently implementing the evidence-based population health interventions within their scope of direct influence and control. To learn what employers may need to begin the journey to more effectively address social needs, social risk factors, and social determinants, the CDC's Office of the Associate Director for Policy and Strategy, the NNPHI, and the National Alliance collaborated to engage employers and regional business coalitions over an extended period to identify options for a process model that can improve employee and community well-being.

## Project Objectives

1. Bring together regional business coalitions and their employer members with other relevant employer-sponsored health plans and community stakeholders (e.g., state/local public health departments) to:
    a. Learn the distinctions between social needs, social risk factors, and social determinants of health.
    b. Identify and share evidence-based examples and data sources that can be used to enhance workforce health and well-being.
    c. Ask employers to develop a plan of action to improve at least one component of the SDoH continuum that impacts their workforce.
2. Provide employers with ongoing opportunities to learn with, and from, subject-matter experts and other employers how to better address social needs, social risk factors, or social determinant challenges.
3. Provide coalitions with an opportunity to be part of a collective effort across the country to move employers and their communities closer to the goal of improving community health and well-being.

## Participating Regional Coalitions and Employers

This project engaged two National Alliance regional coalitions, Kentuckiana Health Collaborative and Pittsburgh Business Group on Health, which were already conducting educational programs for their members in the area of social determinants, health equity, and racial bias. Each coalition recruited three employer members to participate.

The Kentuckiana Health Collaborative (KHC) is a nonprofit coalition of businesses and healthcare stakeholders working to solve the complex health problems that face local communities, with the goal of improving the health status of, and healthcare delivery in, Greater Louisville and Kentucky. KHC works to accomplish this mission through a variety of healthcare measurement and community health initiatives that leverage employer engagement, multi-stakeholder collaboration, and education to transform and optimize healthcare.

> ***"Social determinants of health (SDoH) are an irrefutable component of achieving optimal health outcomes. With organizational strategies for improving healthcare quality, making healthcare more affordable, and building healthier communities, addressing SDoH had become an increasing priority for KHC. In late 2019, the KHC Board of Directors selected SDoH as a priority."***
>
> **—NATALIE MIDDAUGH, Community Health program manager**

Since the 1980s, the Pittsburgh Business Group on Health (PBGH) has been driving change in healthcare—giving a voice to employers in their efforts to contain the rising costs of care and prescription drugs that are suppressing the ability of their employees to receive the care they need when they need at a price they can afford. More than 100 leading employers from across southwestern Pennsylvania enjoy the benefits of, and solutions provided by, PBGH—one of the nation's leading nonprofit organizations dedicated to helping companies protect and promote their ability to provide high-quality, equitable and affordable healthcare for their employees. From award-winning prescription drug containment initiatives to nationally renowned educational programs for human resources, benefits managers, and C-suite officers, PBGH delivers the comprehensive cost savings and health and wellness solutions companies need to drive and implement change in healthcare. PBGH's targeted voice advocates for employers at the highest local, state and federal levels—lobbying and pursuing real transformation in the way healthcare is delivered and paid for, so companies and organizations have the power to be competitive and succeed, so the region thrives.

> ***"The inequality between Black and white maternal mortality rates is greater in Pittsburgh than in 84% of similar cities. Fetal deaths are two times more likely among Pittsburgh's Black women compared to white women. Other findings confirmed many social factors were contributing to the negative health outcomes in our region. The PBGH board was presented with these staggering statistics, which could not be ignored any longer. Members determined we needed to educate, engage and promote data transparency to create cultural change at every level within our communities."***
>
> **—CHRISTINA BELL, director of programs, PBGH**

## The Learning Collaborative Approach

To embed education throughout the project, the National Alliance launched a "learning collaborative" involving the two regional coalitions, their participating employer members, and the project sponsors. During meetings, employers and coalitions heard from various industry experts (e.g., United Way, Sharecare, and the US Chamber of Commerce) in case study examples that highlighted the value of public-private partnerships. These meetings served as a forum to support project participants and helped employers determine the tools and resources they needed, including potential data sources to inform their plans of action to address at least one component of the SDoH continuum affecting their workforces. The learning collaborative environment also allowed participating employers to share individual progress, challenges, and lessons learned during the year-long project.

After a December 2020 kick-off meeting, the National Alliance conducted virtual technical assistance calls with the employers and their respective regional coalitions. Two additional meetings were conducted in March and June of 2021 to highlight case studies that included approaches employers could consider for addressing employees' social needs and social risk factors. Participating employers also provided action plan updates. A final meeting was held in August 2021 to highlight key lessons and insights. Most of the employers plan to continue advancing their action plans and will share updates with the learning collaborative in early 2022.

The final two months of the project period (September and October 2021) were used to evaluate findings from the learning collaborative, develop this summary report, and develop an Action Brief highlighting key takeaways and lessons learned, which will be shared with other regional coalitions and employers across the country.

| MODULE 1<br>**Setting the Baseline** | MODULE 2<br>**Developing Action Plan & Implementation** | MODULE 3<br>**Evaluation** |
|---|---|---|
| ▸ Technical assistant/coaching call<br>▸ Determine internal sponsorship &work team<br>▸ Explore key SDoH areas for consideration/population segments<br>▸ Determine data (sources, resources, etc.) | ▸ Identify key social risk/ SDoH metrics<br>▸ Determine overall goals & outcomes<br>▸ Execute action plan<br>▸ Identify & resolve challenges<br>▸ Technical assistant/coaching call<br>▸ National collaborative meetings throughout to check on progress, share learnings | ▸ Final technical assistant/ coaching call<br>▸ Current status – key social risks/SDoH goals & metrics<br>▸ Final collaborative meeting (May)<br>▸ Highlight key areas of progress in organization<br>▸ Report on key learnings/ findings<br>▸ Look at potential future opportunities |

## Methods

The initial learning collaborative module, "Setting the Baseline," was used to help employers begin their project planning. This step included establishing an internal team of three to five individuals whose job functions affect employee health, well-being and equity (e.g., compensation and benefits, human resources, safety, and diversity and inclusion), and who would support the project work.

Participating employers first reviewed data from within their own companies—such as health claims, medical utilization, and medication adherence data—to identify potential disparities in workforce engagement, absenteeism/presenteeism, etc. Many of the participating employers assessed internal data using as many demographics as possible (e.g., gender, race, ethnicity, salary level, type of position) to allow for identification of various workforce subpopulations.

To better understand the social needs of these workers, employers were then offered the opportunity to overlay workforce demographic data over the backdrop of community data. This "overlay" process was done by pairing the employer with a community data partner to provide interpretative insights as to possible social needs and risk factors, for example:

- Community ZIP code data on employee needs relating to **access to healthcare** (e.g., access to primary care, hospitals, clinics).
- **Neighborhood and built environment** (e.g., housing, transportation, access to healthy foods, air/water quality) .
- **Economic stability** (poverty rates, food insecurity, housing stability).
- **Education** (e.g., rate of high school graduation, college attainment).

For this project, one partner, the digital health company Sharecare, provided access and interpretative insights to four of the six participating employers. Sharecare's mission is to help people, providers, employers, health plans, government organizations, and communities optimize individual and population-wide well-being by driving positive behavioral change.

### Taking the Deeper Dive

Employers should pair demographic-based data with community profiles and acknowledge the influence these profiles can have upon how the employee shows up to work and is able to be their best professional self.

As part of the "Leading by Example and Moving Upstream Together" pilot, Sharecare applied its proprietary Community Well-Being Index (bit.ly/3rLGVWQ) framework, developed in collaboration with Boston University School of Public Health's Biostatistics and Epidemiology Data Analytics Center. For each participating employer, Sharecare started by determining the social risks and social determinants experienced by employee and worksite communities, as well as potential implications for well-being, equity, and pandemic recovery goals.

Sharecare also evaluated the health equity, pandemic vulnerability, and/or specific social determinants of participating worksites and employee communities, including food access, transit considerations, healthcare resources, and more. In most cases, participating employers also elected to provide dimensions of the "equity trifecta" context: the racial and ethnic composition of employee populations, their salary ranges, and their benefits enrollment eligibility and status. Through these additional data points, participating employers were able to view not only the risk factors experienced by their employee populations at work and at home, but also which specific populations were most impacted, including medically underserved non-white and lower income employee populations, as well as those lacking employer-sponsored benefits.

As a result of its analyses with these four employers, Sharecare identified insights across:

- Social risks experienced by employee subpopulations, including healthcare access, transit, and workforce advancement needs for non-English-speaking employees and their families.
- Access deserts for underserved populations, including low levels of health literacy; financial barriers; and resource deficiencies for women, children, and seniors.
- Forms of institutional racism (such as redlining) that perpetuate the existence of racially segregated neighborhoods, which exacerbate inequalities that impact health outcomes, such as cardiovascular and reproductive health, COVID-19 transmission, infant and maternal mortality, and more. Specific examples include physical boundaries that separate individuals across income and educational attainment levels, housing quality, and access to healthcare and community resources.
- Impact of urban environments, from gentrification to pollution and heat-wave days.
- Health risks and lifestyle behaviors stemming from surroundings and worksite proximity, including the impact on employees of long commutes and public transit use, broadband and technology access, and more.

Two of the six employers elected to partner with either a health plan's vendor who had the ability to provide this type of community-based analysis or with their local community health partners.

To meet the project's first objective, "Bring together regional business coalitions and their employer members, and other relevant employer-sponsored health plans and community stakeholders (e.g. state/local public health departments)," employers were also given case examples from community and public health agencies that had created similar employee data/community data crosswalks or gleaned interpretive insights.

- United Way of Atlanta provided an example of how its Atlanta Child Well-Being Index (bit.ly/3oBshPY), which analyzes by ZIP code data on educational attainment and food and healthcare access, informed the location of an employer's worksite in the Atlanta area.


- Michigan Blue Cross Blue Shield provided an example of an approach to address social determinants of health through behavioral health and pharmacy initiatives.**
- The Madison County (New York) Department of Health embraced the National Institute for Occupational Safety and Health (NIOSH) Total Worker Health® (TWH) program model (cdc.gov/niosh/twh) for workplace health and safety. The model integrates wellness with traditional health and safety for the purpose of improving employee health and productivity, and ultimately improves the employer's bottom line.**
- The US Chamber of Commerce provided an example of a pilot project with Goodwill Industries to address economic insecurity and help eligible Goodwill employees claim the earned income tax credit.

** Additional information on these projects can be found in the Appendix.

# KEY EMPLOYER LESSONS AND INSIGHTS

As a result of this process of employer/community analysis, the participating organizations were able to identify the following steps toward a plan of action designed to improve at least one aspect of the SDoH continuum for their workforces:

## Improving Employee Access to Healthcare

- Establish relationships with local health systems to improve communications, workforce education, and access to appropriate care.
- Work with local provider and health plan to offer access to local health centers to improve quality of care for employees and their families.
- Coordinate with HR teams on the development of COVID-19 vaccine information in specific language dialects to support the workforce, and provide onsite COVID-19 vaccine clinics.
- Gain access to community data that integrates with claims data to allow for a more intentional focus on the gaps in care that can be better addressed with health plan and vendor partners.
- Address health literacy issues, so various subpopulations can better navigate the healthcare system.
- Adapt healthcare options to changing needs, such as the almost-overnight pivot to increased telehealth options to meet demand during the pandemic.

## Community Data Comparisons with Workforce Demographics

- Review internal data (e.g., medical claims, utilization of preventive care and care for chronic conditions, medication adherence) to identify potential disparities in workforce engagement, absenteeism/presenteeism, etc.
- Review external demographic data (e.g., gender, race, ethnicity, age, salary level) to identify unique communities that may need special assistance in using their benefits and the healthcare system optimally.
- Overlay workforce and community data to gain insights into social needs and risk factors (described in greater detail on page 7):
  - Access to healthcare where employees and their families live and work
  - Neighborhood and built environment
  - Economic stability
  - Education

## Addressing Economic Instability

- Assess issues not typically addressed, such as food insecurity and lack of public transportation.
- Tailor financial well-being communications and programs to the diverse needs of the population based on a better understanding of the day-to-day issues faced by segments of the employee population.

## Improving Community Health and Well-being

- Review all health and well-being programs and services for engagement and effectiveness numbers, customizing communications to address issues such as high rates of burnout, mental health and stress, childcare issues, deferral of health screenings, chronic condition management, and lack of exercise.
- Review benefits for all populations when considering any benefit changes and weigh the impact the changes will have on each group.
- Address childcare challenges that affect the workforce.

## Using Data Differently to Address Social Needs

- Seek community data that integrates with organizational data to yield a clearer picture of workforce challenges and needs.
- Use data as a feedback loop to determine whether metrics are being met and, if not, how to enhance overall benefit delivery and effectiveness.
- Use data to better assess workforce mental health.
- Collect better demographic data (such as race, ethnicity and salary) during open enrollment to help determine where to assign available resources.
- Encourage coalitions to participate in a collective effort across the country to move employers and their communities closer to the goal of improving community health and well-being.

## Addressing Social Risk Factor Challenges

- Hold discussions with department heads across the organization on key issues to help them understand and address key workforce needs.
- Bring health benefits to the forefront of organizational priorities to accelerate enhanced benefits and initiatives.
- Identify limitations in the current data to help build a healthcare planning strategy that will include community data.
- Determine how to better collect demographic data/contact information for employees and their families.
- Understand key drivers of low utilization in subpopulations, especially among low-wage workers, to reduce emergency department visits and increase use of preventive care.
- Identify what is contributing to compromised employee health outcomes, including the lack of economic stability, health access, health literacy, and transportation.
- Appreciate that equality and equity are not the same thing; providing identical benefits to all does not mean everyone can access care equally.
- Forge strong community relationships and connect employees to community resources.
- Assemble a group of experts who are committed to ensuring alternative pathways to needed care.
- Shift toward action-oriented priorities rather than theoretical and broad-reaching discussions of social needs, social risks, and social determinants.

# KEY OBSERVATIONS AND CONSIDERATIONS FOR EMPLOYERS

To inform and improve employee population health in a meaningful way, it is important for employers to bring to this type of work an open mind and a willingness to persist in the pursuit of a comprehensive understanding of workforce issues and challenges. Some essential findings include:

- Organizations should not hesitate to supplement internal employee demographic data with public and community data, which can provide context for possible solutions.
- When designing benefits, consider surveys and focus groups to better understand employees' social needs and social risk factors. The pandemic's health equity challenges highlighted the limitations of a "one-size-fits-all" approach to benefits. As one employer stated, "You cannot move forward without the voices of those you are trying to help." Follow up with internal leadership conversations to align proposed solutions with employee needs, determining what senior leaders are willing (or not willing) to support. Follow up with employees on key decisions in order to build trust and improve morale.
- Eliminate silos within organizations in order to improve employee health and well-being. Consider developing a diverse internal team that brings together appropriate people from across the organization to better address issues and take advantage of opportunities.

Participating coalitions recognized that, in order to attain more meaningful healthcare for their employees, employers and healthcare purchasers need to raise the issues identified in this project to the same level as other healthcare priorities. This project has deepened their understanding of how employers can operationally address these issues.

Below are additional key observations and considerations to help employers determine the next steps to improve their employee population health at all levels:

| Gather Demographic Data | Use Data to Assess & Prioritize | Develop & Execute Workplan | Measure & Sustain Gains |
|---|---|---|---|
| **KEY OBSERVATIONS** | | | |
| ▸ Employers have detailed data on healthcare costs, health behaviors, performance factors, and demographics that include income, race, ethnicity, home address.<br>▸ Employers can no longer afford to resist analyzing data by key demographics such as race, ethnicity, social risk factors.<br>▸ Insights are possible by analyzing community data based on home ZIP codes of employees.<br>▸ Multiple contributing factors may need to be considered for some employees (race, ethnicity, income, food deserts, healthcare deserts, etc.).<br>▸ Pre-conceived employer notions may not align with these data, and pre-conceived biases may adversely affect interpretation of the data. | ▸ Most employers have traditionally not prioritized social needs and risk factors in health and well-being strategies.<br>▸ Validating observations from the data can benefit impacted employee subgroups, diversity and inclusion, and site management and can engage community leaders (including public health).<br>▸ It is easier to prioritize issues that clearly represent social needs and risk for a significant subset of employees than broader community goals ("choose a lane").<br>▸ Alignment of organizational culture, mission and trust will be critical to internal engagement.<br>▸ The business case (value proposition) is critical to overcoming resistance.<br>▸ Focus on employees differently based on their unique needs. | ▸ Health and well-being has tended to focus on organization-wide programs or "silver bullet" solutions, which are not always created with employee demographics in mind.<br>▸ "Buy-in" is critical, and the number of stakeholders grows when addressing social needs.<br>▸ Include senior leadership and appropriate people within the organization.<br>▸ Advanced employers will integrate workplans with the broader scope of organizational strategies and priorities.<br>▸ Recognize that integration of social needs and risk factors into strategy is a journey, not a destination. | ▸ Multiple factors are critical to success, including stakeholder partnership, program design and impact, strategic communications, building trust, and employee engagement.<br>▸ Defining interim and ongoing success—including expected timeline—will be critical to sustaining execution.<br>▸ Addressing social needs, social risks, and social determinants is a key part of a broader organizational health equity strategy.<br>▸ The infrastructure and cultural capacity of a broader organizational health and equity strategy can be leveraged to accelerate and sustain efforts to address social needs, risks, and social determinants. |

| Gather Demographic Data | Use Data to Assess & Prioritize | Develop & Execute Workplan | Measure & Sustain Gains |
|---|---|---|---|
| **RECOMMENDATIONS** | | | |
| ▸ Use community data to identify by employee ZIP code potential issues and prevalence of social needs and risk.<br>▸ Validate, as much as possible, with demographic data on employees and their families.<br>▸ Recognize and analyze correlating social risk factors across subpopulations to identify which specific populations are most impacted.<br>▸ Use a combination of data sources to better identify health inequities (e.g., access to care, quality gaps). | ▸ Leave assumptions at the door.<br>▸ Validate and dive deeper on data observations through engagement of site management, employee subgroups.<br>▸ Engage with public or private organizations that can help highlight the intersection of community data with internal data.<br>▸ Prioritize based on broadest impact and relative potential for change.<br>▸ Develop a multi-pronged value and business case for addressing social needs and risks.<br>▸ Seek buy-in and partnership across the organization. | ▸ There is a full range of opportunities and wide variation in willingness and empowerment to pursue identified opportunities.<br>▸ Reemphasize and tailor existing offerings to bridge gaps.<br>▸ Target education and communication efforts, considering unique social needs and risk.<br>▸ Consider all levels of potential interventions, both within the purview of health and well-being and beyond.<br>▸ Engage with existing health plans and vendors and with new partners (internal, external community) to examine, develop and maintain accountability for a multi-pronged work plan.<br>▸ Partner with community resources within employee ZIP codes and demographics. | ▸ Integrate health equity (not limited to social needs and risks) into existing organizational structures and objectives.<br>▸ Establish a baseline and monitor against a system of accountability measures, including process and outcomes metrics.<br>▸ Establish a periodic review process to assess progress and identify opportunities for improvement. |

# KEY COALITION LESSONS AND INSIGHTS

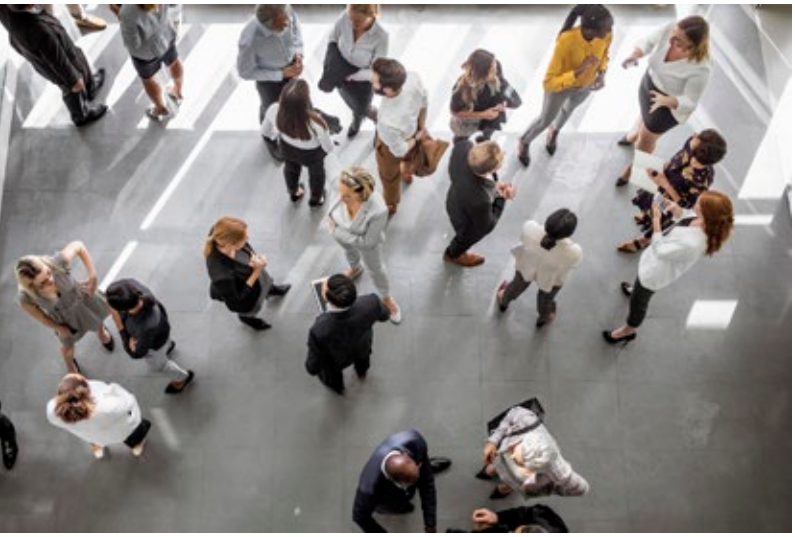
Participating coalitions were critical to this process and helped create a forum for employer sharing and learning throughout the project. They helped coordinate periodic calls with the employers and provided support between national collaborative meetings. As each coalition maintained that forum throughout the project, they each learned a number of key lessons themselves, which are highlighted below.

- An inability to access data should not be a barrier. Public information and data partners are readily available to fill employer data gaps.
- Leave assumptions at the door, remaining open to unanticipated data findings, employee feedback, and other factual insights. It is important to take a fresh look through a health equity lens trained on data insights informed by community, socio-demographic, behavioral, and medical outcomes data.
- Employee input identifies needs and priority areas, serving as a valuable source of data to better understand low engagement levels or lack of trust.
- Determine how best to support employers who are hesitant to integrate data, especially if they have union populations. It may be important to involve union leaders up front to best address their concerns.
- The collaborative learning format affords the time and focus to review data and understand how best to enhance the lives of the workforce and its communities.
- For organizations, internal teams are an important strategy to better address issues in a comprehensive way. People from these teams can also foster new and valuable relationships with their regional coalition, as well as with public partners such as the CDC and local community organizations.
- Employers are growing more interested in the role they can play in addressing the social needs and social risk factors of their workforces. Many have developed new roles within their organizations under a diversity and inclusion umbrella or a health equity/SDOH focus. Over the next 12 months, we anticipate employers will continue to monitor the socioeconomic impact of their businesses' health and employee well-being, and we will continue our education on the important role organizations can play in addressing these workforce needs.

## Participating Employer Recommendations for Coalitions

- Employers need to be educated about how raising these issues to the same level of urgency as other healthcare priorities will yield better overall healthcare value for their employees and organizations. This education should address specific strategies and approaches they can implement to best address health equity issues.
- Build strong community relationships in order to address social risks and social determinants. Help employers connect to local and grassroots community resources.
- Highlight case studies with more action-oriented priorities—rather than theoretical and broad-reaching discussions—to address social needs, social risks, and social determinants. Encourage employers who participated in this project share their experience and continue their education and action.

# RECOMMENDATIONS FOR FUTURE WORK



This project has provided the opportunity for both regional coalitions and employers to more deeply address the key social needs and social risk factors of employers' populations. The learning from this project is, quite frankly, still occurring. Many of the participating employers have stated they consider themselves on a journey and are more engaged than ever in addressing the needs of their populations in a meaningful way.

As we move forward, it is important to keep the following in mind:

- Continue to assess data in new ways, keeping in mind the social risks and social determinants of the workforce and viewing data in a more social, cultural and environmental context.
- Don't view lack of data as a roadblock to taking on initiatives of this nature. Start with publicly available community data to understand, at least at a broad level, what impacts or challenges the workforce may face.
- Analyze workforce data to understand the disparities that exist across diverse groups. Identify opportunities to address real issues and root causes impacting various sub-populations. Regional coalitions can support employers in determining what type of information is needed and what data could be accessed, as well as appropriate actions.
- Many SDoH issues are created by systemic discriminatory policies and practices. Lean in to recognize which issues will yield a better understanding of the broader story about why they exist and help determine the best approach for making course corrections.
- Sharing the details of this project can help regional coalitions and employers across the country think differently about their priorities when addressing the social needs and social risks of their workforce. By learning what a population really needs, they can better determine meaningful ways to invest in comprehensive and customized resources, services and programs.

For the future, National Alliance is committed to expanding its efforts to help other coalitions and their employer members take part in this important work. It is also committed to building public partnerships with organizations such as the CDC and NNHPI, so that employers can leverage key strategies that support their employee populations where they live, work and play. The insights and lessons from this project have built a stronger foundation to work from. Both the National Alliance and its regional coalitions can better support employers' understanding of what they needed to identify and address their employees' social needs and social risks. The ultimate goal is to help organizations address these challenges in a meaningful, realistic way so that they can move towards a thriving workplace with people who are motivated, engaged, healthy and productive.

# APPENDIX

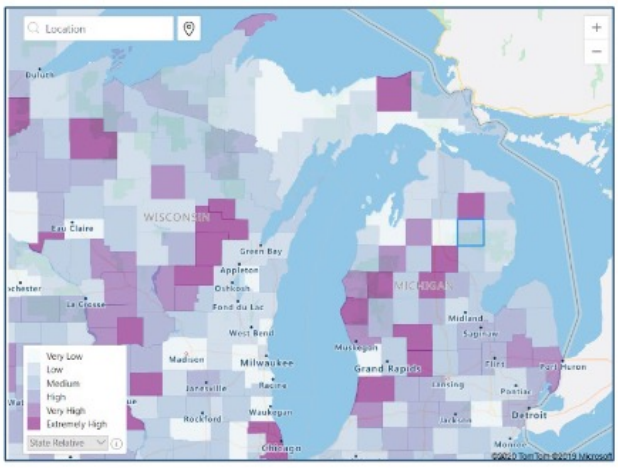
## Exhibit A: Health Plan Example of Addressing Social Determinants of Health

### Blue Cross Blue Shield of Michigan

(View Full Report, bit.ly/31wMyO9)

In response to the COVID-19 pandemic, Blue Cross has implemented several programs and initiatives to address social determinants of health in their membership.

**Behavioral Health:** Blue Cross Blue Shield of Michigan is committed to whole-person care in all care settings, including the development and expansion of behavioral health programs that include services to address social needs, such as transportation, education and employment. Blue Cross is increasing the number of primary care practices that use the Collaborative Care Model, an evidence-based program that includes psychiatric case consultation and a behavioral health care manager. In addition to offering high-quality integrated health care, the behavioral health care manager links members to resources that address identified social needs, including low-cost medication, financial assistance, and transportation. Blue Cross continues to support members recently diagnosed with psychiatric disorders. This comprehensive program provides robust psychiatric and therapeutic interventions and includes services to address the unique needs of this population, such as supported employment. Lastly, Blue Cross is supporting an intensive, community-based intervention for members at high risk for poor psychiatric outcomes. This program addresses the common social barriers that prevent members from obtaining and continuing treatment for mental health conditions.




**Pharmacy:** Blue Cross has implemented several initiatives to specifically target social determinants of health, such as access issues during the COVID-19 pandemic:

- Increased access to medications by allowing early refills and extending prior authorization renewal dates.
- Met with community leaders throughout the state to educate them on the importance of vaccines.
- Provided education about appropriate use of antibiotics and handwashing.
- Implemented a podcast on vaccines.
- Worked to educate providers about their asthma and COPD patients who are not on controller inhaler therapy.

## Exhibit B: Improving Worker Health in Madison County

Madison County, New York, recognized that most adult residents spend up to half their waking lives at work or commuting, but substantial gaps exist in data on worker health. This led to 2017 the launch of Madison County's Healthy Workforce Initiative (on.ny.gov/3dzqbtM), embracing the NIOSH *Total Worker Health®* (TWH) program model for workplace health and safety.

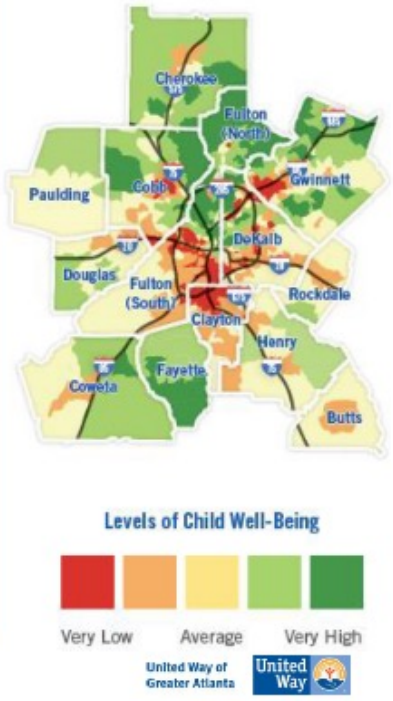
The TWH approach integrates wellness with traditional health and safety for the purpose of improving employee health and worker productivity and, ultimately, has a positive impact on the employer's bottom line.

## Exhibit C: United Way

United Way of Atlanta provided an example of how its Atlanta Child Well-Being Index (bit.ly/3oBshPY)—which analyzes educational attainment and food and healthcare access by ZIP code—was used to inform the location of an employer's worksite in the Atlanta area.

### The Child Well-Being Index

- Established in 2017.
- A diagnostic tool that tells us how children are doing today.
- Helps us forecast.
- Overlays neighborhood-level data for 14 indicators across education, income, health and housing.
- Illuminates the way disparities in both race and place cut across counties and jurisdictions.
- Leveraged as a tool across sectors to drive shared goals:
  - Nonprofits consistently use shared data to targeting support for a set of communities.
  - Corporations identify locations for facilities and where to focus corporate social responsibility.
  - The index helps leverage state and federal dollars to increase resources for mental health and school systems.

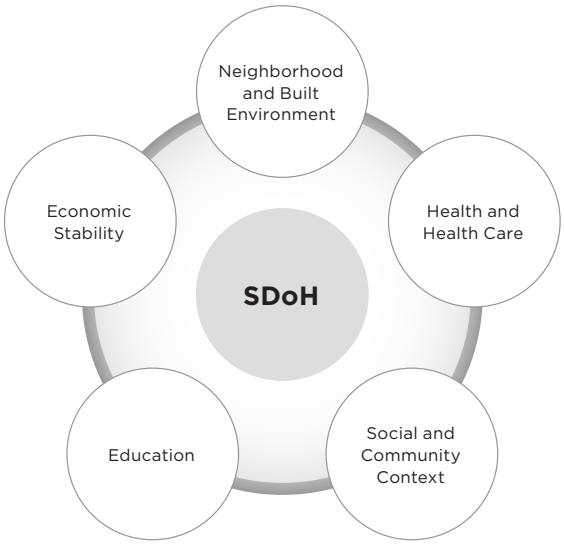


# Exhibit D: Sharecare

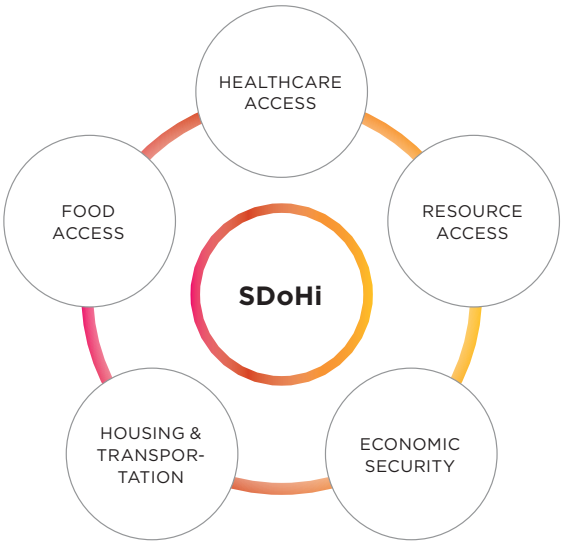
For this project, one partner, the digital health company Sharecare, provided access and interpretative insights to four of the six participating employers. Sharecare's mission is to help people, providers, employers, health plans, government organizations, and communities optimize individual and population-wide well-being by driving positive behavioral change.

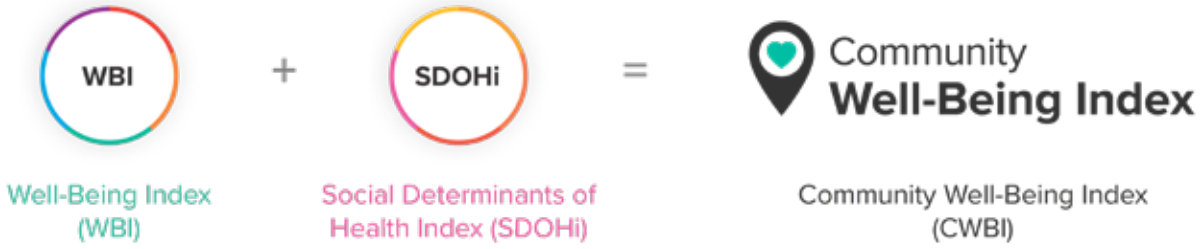
As part of the "Leading by Example and Moving Upstream Together" pilot, Sharecare applied its proprietary Community Well-Being Index framework (bit.ly/3rLGVWQ), developed in collaboration with Boston University School of Public Health's Biostatistics and Epidemiology Data Analytics Center. The index measures well-being across five individual health domains—physical, financial, social, community, and purpose—and five domains of social determinants of health (SDOH)—healthcare access, food access, resource access, housing and transportation, and economic security. As a comprehensive measure, the index highlights the connections between people and places by assessing health across geographies and subpopulations. The index data has also been applied to health-equity and risk targeting, diagnostic intervention, community policy initiatives, coalition building, and more, better informing health interventions and care advocacy through protocols that take into consideration health risks across multiple dimensions.

**First Generation Index Domains**




**Second Generation Index (SDoHi)Domains**



For this project, Sharecare evaluated health equity, pandemic vulnerability, and/or specific social determinants for participating worksites and employee communities, including food access, transit considerations, healthcare resources, and more. In most cases, participating employers also elected to provide dimensions of an "equity trifecta": the racial and ethnic composition of employee populations, their salary ranges, and their benefits enrollment eligibility and status. This additional context allowed participating employers to view not only the risk factors experienced by their employee populations at work and at home, but also which specific populations were most impacted, including medically underserved employees across non-white and lower income populations, as well as those lacking employer-sponsored benefits.

As a result of its analyses with four of the employers, Sharecare identified insights across:

- Social risks experienced by employee subpopulations, including healthcare access, transit, and workforce advancement needs for non-English-speaking employees and their families.
- Access deserts for underserved populations, including places with low levels of health literacy; financial barriers; and resource deficiencies for women, children and seniors.
- Forms of institutional racism (such as redlining) that perpetuate the existence of racially segregated neighborhoods, which exacerbate inequalities that impact health outcomes, such as cardiovascular and reproductive health, COVID-19 transmission, infant and maternal mortality, and more. Specific examples include physical boundaries that separate individuals across income and educational attainment levels, housing quality, and access to healthcare and community resources.
- Impact of urban environments, from gentrification to pollution and heat wave days.
- Health risks and lifestyle behaviors stemming from surroundings and worksite proximity, including the impact on employees of long commutes and public transit, broadband and technology access, and more.

Applying these insights, stakeholders were able to implement new strategies to address social risks and circumstances with, for example, alliances with community-based organizations, enhanced systems to support underserved populations, new company policies that promote and enhance equity, and more.

# RESOURCES

- CDC Initiatives
  - Health Impact in 5 Years (cdc.gov/hi5)
  - 6|18 Initiative (cdc.gov/sixeighteen)
- 100 Million Healthier Lives (bit.ly/3ECQbAe)
- A New CSR Frontier: Business and Population Health (bsr.org)
- Build Healthy Places Network (buildhealthyplaces.org)
- Chief Executives for Corporate Purpose (cecp.co)
- Community Commons (communitycommons.org)
- Good Health Is Good Business (bit.ly/3pWj44r)
- SHRM, Employer Toolkit on Social Determinants
- HERO Publications (Get-HWHC.org) – (bit.ly/3dDJnGt)
  - Category: Healthy Workplaces, Healthy Communities
  - Category: Employer-Community Collaboration Study Committee
- National Academies: Health and Medicine Division (nationalacademies.org)
  - Roundtable on Population Health Improvement
  - Action Collaborative on Business Engagement in Building Healthy Communities
  - Communities in Action: Pathways to Health Equity (bit.ly/3oyY7g5)