

Introducing our social determinants of health program



Remove social barriers for your members

From food insecurity to transportation needs to housing concerns, many of your most vulnerable members encounter a range of social and economic obstacles that can lead to overall poorer health and even lower life expectancy.

Our program identifies and addresses these barriers and can improve your members' quality of life and health outcomes. And our digital technology keeps care providers and your care management team connected every step of the way.

Two-visit engagement model

See how our program works:

Visit 1:

We conduct a comprehensive assessment to identify barriers and recommend mitigations. We assess:

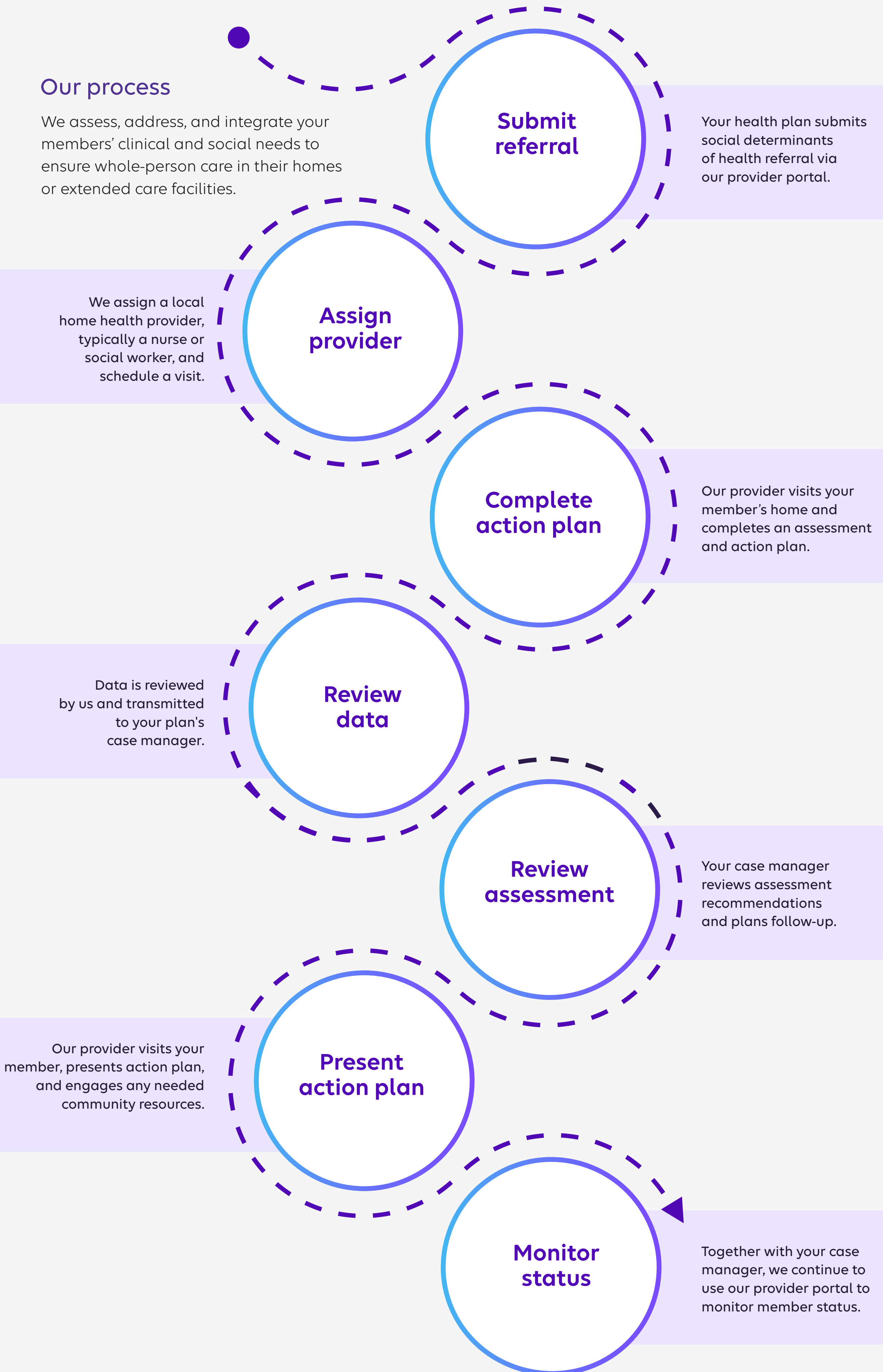
- Caregiver information
- Medications
- Provider coordination (home care, payers, and physicians)
- Housing challenges
- Education and literacy
- Personal safety
- Food security
- Lack of transportation
- Utilities
- Financial strain

Visit 2:

We perform recommended interventions and organize support for addressing identified social barriers to care.

Our process

We assess, address, and integrate your members' clinical and social needs to ensure whole-person care in their homes or extended care facilities.



Your health plan submits social determinants of health referral via our provider portal.

We assign a local home health provider, typically a nurse or social worker, and schedule a visit.

Our provider visits your member's home and completes an assessment and action plan.

Data is reviewed by us and transmitted to your plan's case manager.

Your case manager reviews assessment recommendations and plans follow-up.

Our provider visits your member, presents action plan, and engages any needed community resources.

Together with your case manager, we continue to use our provider portal to monitor member status.

See how we can help address the full spectrum of your members' needs. [Learn more at carelon.com](https://www.carelon.com)