



# Thrive Local Kaiser Permanente's Social Health Program

*Anna Bavykina, MD*

*Medical Director of Complex Needs and Continuum, TPMG NCAL*



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# Complex Patients Have Diverse Needs

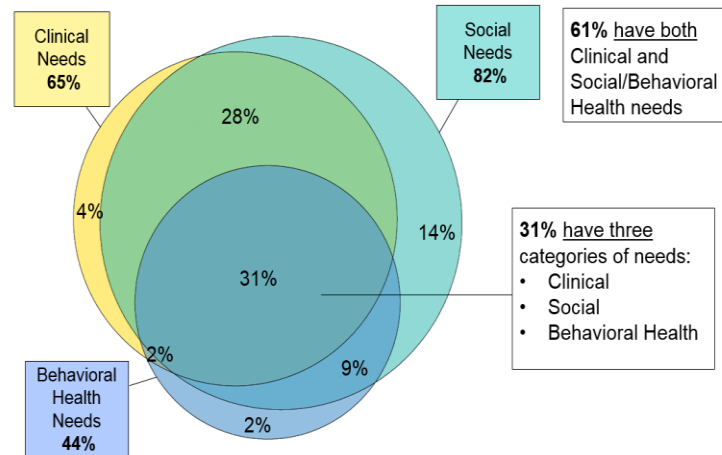
( Data based on 631 complex NCAL KP patients )

## Top Patient Reported Barriers to Health

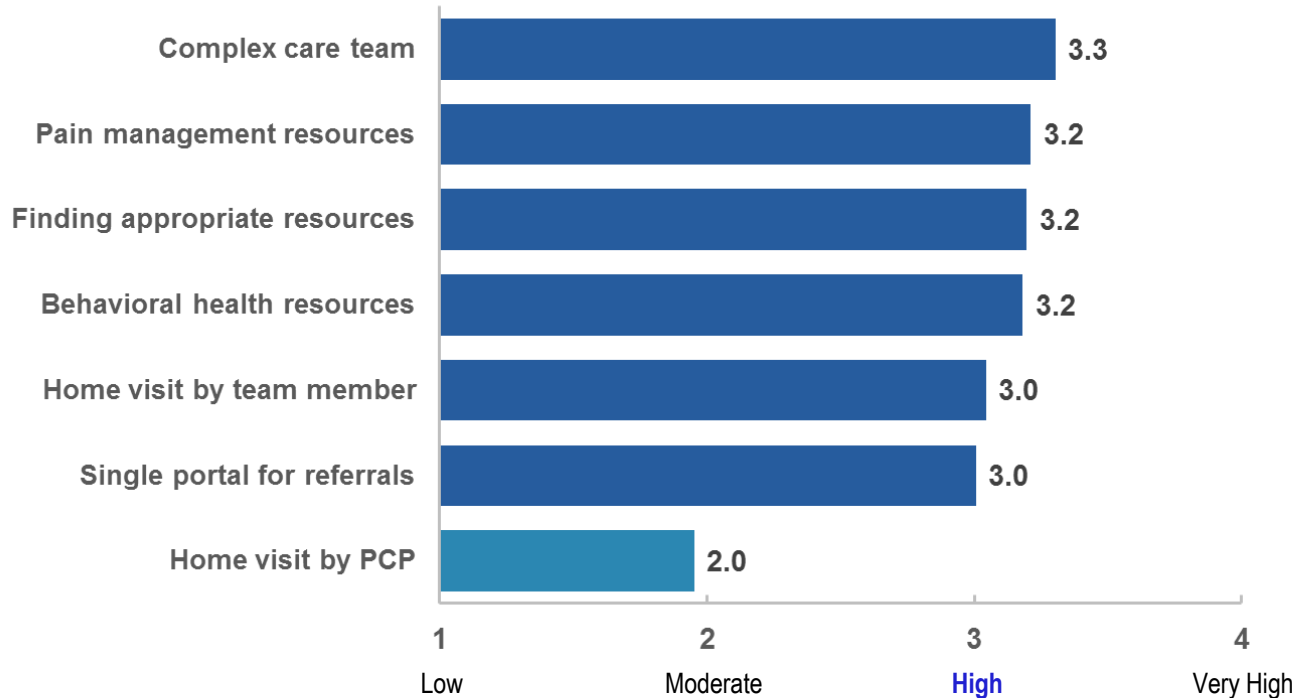
- 50% very/moderately stressed in the past month
- 37% need help reading health information
- 33% pain interferes with daily activities
- 28% have trouble paying for basics in the past 3 months
- 22% live alone
- 21% have unmet need for assistance with activities of daily living

## Multidisciplinary Team Identified Patient Needs

86% have Social or Behavioral Health needs



# Primary care Physicians Perspective: What Resources are Most Important?



# Creating Kaiser Permanente's Social Health Program

We are making a **bold move to transform health care** by building social health networks for the communities we serve to help meet people's basic social needs beyond the medical setting. In so doing, we write the next chapter in Kaiser Permanente's history of being the nation's leading integrated, prevention-oriented delivery system.

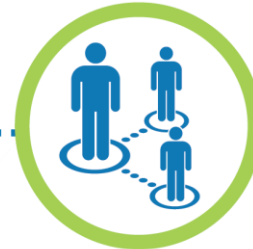
## Identification

Social needs are identified by health care system staff, provider, member, caregiver or community partner



## Information

Network provides information on community resources and tracks referrals with community partners



## Connection

The network locates resources from health care systems, community organizations and the government to meet those needs



## Optimization

Data will be used by health care systems and community partners to better understand social needs and provide programs, care and services that address community conditions for health



# Introducing Kaiser Permanente's Social Health Network: Thrive Local

## Resource Directory



Online platform allows users to search and filter for community resources.

Resources updated regularly by contracted vendor

## Community Partner Networks



Community Based Organizations (CBOs) and health care systems use vendor platform

Users send and track referrals to and within the Community Partner network

## Technology Platform



Closed loop referrals

Bidirectional exchange of information between health care systems and among CBOs participating in the Community Network

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Integrated clinical and social care, supported by data integration and partnership with community

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# Key Benefits

## For Patients



Reliable referrals to organizations that can address patients' most pressing needs



Help navigating complex systems



Improved experience of care due to built-in capabilities for referral and feedback



Improved health and well-being

## For Communities



Community-wide asset created through free access for community health centers and community-based organizations



More revenue from public and private sources through referral volume and proof of impact



Increased organizational capacity through more targeted referrals and connections among community-based organizations



Community-wide analysis to inform policy, investment decisions and community advocacy

## For Health Care Systems



Improved satisfaction among frontline providers



Improved performance on health outcomes and patient well-being



Reduced utilization and total cost of care



Adoption of community-wide social health networks that address patients' needs

# How do we develop Community Partner Networks?

- **Define geographic scope**
- Use data to **identify** the most prevalent social needs and core partners to prioritize for initial network build
- **Engage external partners** – community based organizations, community health centers, and other health systems
- **Register** and **onboard** partners to the vendor platform
- **Activate** bi-directional, closed loop referral and feedback system
- Generate and analyze data on **system and organizational performance**

