Whole Health Toolkit

For Medicare insurance agents for the 2024 plan year

Addressing the health needs of the whole person

Learn how to talk to your members about social determinants of health—like food insecurity, loneliness, transportation, financial security and housing problems—and how to connect them to the resources and support they need to maintain their health. At Humana, we dig deeper and work harder to help our members in ways beyond what they might expect. We call it human care.

Humana®

HealthEquity.Humana.com

Dear valued agent,

Together, we put health first. As the front-line contact for Humana members, you may witness firsthand the social, behavioral, physical and economic circumstances that stand in the way of our members achieving their full health potential. This may include members having regular access to healthy food, a ride to a doctor's appointment, safe housing, and friends and family for support. Humana works to improve health for all members by reducing disparities, removing barriers and addressing health-related social needs—**because 80% of what impacts an individual's health happens outside the doctor's office.**[1]

Now you can play a more active role by discussing health-related social needs with members. This can create deeper, more meaningful relationships as well as help Humana better understand the prevalence of these needs and how to address them in the future. **Remember, these discussions are for Humana members only, and should only take place post-enrollment. These discussions are also optional for members—if they do not want to participate or express hesitation at any point, you should not proceed.**

Thank you for contributing to Humana's Health Equity and Social Impact vision, which is to influence and enable an equitable healthcare ecosystem, so that every person has a fair, just and dignified opportunity to reach their full health potential. We look forward to supporting you on this mission to improve the whole health of our members.

Sincerely,

J. Nwando Olayiwola, M.D., MPH, FAAFP
Chief Health Equity Officer & Senior Vice President
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Humana

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Social determinants of health

According to the Robert Wood Johnson Foundation, social determinants of health (SDOH) are "conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes." They can also be referred to as health barriers in a person's daily life.

This toolkit addresses these five SDOH:

Food insecurity

Food insecurity is a household-level economic and social condition of limited or uncertain access to adequate food and nutrients, according to the U.S. Department of Agriculture (USDA). In comparison, hunger is an individual-level physiological condition that may result from food insecurity.

30% of Humana Medicare Advantage (MA) members are food insecure.[2]

Loneliness and social isolation

Loneliness is a feeling of sadness or distress that individuals have when they feel disconnected from the world around them. Social isolation occurs when someone is physically separated from others and doesn't have (or can't access) their desired social connections.

30% of Humana MA members report feelings of loneliness and/or social isolation.[2]

Transportation

Lack of transportation can limit many things, like going to doctor appointments, picking up medications, obtaining healthy foods, and/or connecting with friends and family.

11% of Humana MA members have a transportation barrier.[2]

Sources

1. "County Health Rankings Model", University of Wisconsin Population Health Institute, last accessed April 12, 2023, www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model.
2. "Social determinants of health guide to social needs screening," American Academy of Family Physicians, last accessed March 21, 2023, www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-guide-sdoh.pdf.

1. Terminology

Financial strain

Financial strain is composed of cognitive, emotional and behavioral responses to financial hardship where an individual cannot meet financial obligations. It also encompasses other core needs, such as housing instability and food insecurity. Individuals experiencing financial strain may forgo medical care and prescriptions to meet their essential needs, such as housing and food, and may make more affordable, but less healthy food choices.[2]

47% of Humana MA members are financially strained.*

Housing insecurity

Housing insecurity refers to when an individual cannot make rent payments, doesn't have a stable place to live, or is nearing or already homeless. Housing insecurity can expose individuals and families to a number of health hazards that can lead to injury, disease, mental illness, and behavioral health issues.

5% of Humana MA members are housing insecure.*

SDOH impact on Humana MA veterans†

Food insecurity

29% of Humana MA veteran members are food insecure.

Financial strain

41% of Humana MA veteran members are financially strained.

Loneliness and social isolation

41% of Humana MA veteran members report feelings of loneliness and/or social isolation.

Housing insecurity

5% of Humana MA veteran members are housing insecure.

Transportation

9% of Humana MA veteran members have a transportation barrier.

* Humana SDOH General Medicare Advantage Population Survey conducted June – July 2022.
† Humana SDOH Medicare Advantage Veterans Survey conducted June – July 2022.

Conversation instruction guide

Focus on health literacy

Health literacy, a social determinant of health, is defined as "the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others."[3]

In a 2022 survey, Humana found that 21% of Medicare Advantage members experienced health literacy barriers.[‡] However, according to the Agency for Healthcare Research and Quality (AHRQ), there is "broad recognition that everyone—not just those with limited literacy—face challenges in understanding health information and navigating the healthcare system."[4]

Experts recommend assuming that everyone may have difficulty understanding and taking steps such as simplifying communication and confirming comprehension of information to reduce the risk of miscommunication.

If you would like to learn more about how to enhance support for members of all health literacy levels, please refer to the AHRQ Health Literacy Universal Precautions Toolkit, 2nd edition at **www.ahrq.gov/health-literacy/improve/precautions/index.html**.

Here's when to have these discussions

It's only permissible to have these discussions with members after enrollment, or within 30 business days of the application signature date, if the member agrees to participate.

Step 1: Conduct Health Risk Assessment post-enrollment

After completing an online enrollment, you may ask the member if they would like to participate in the optional Health Risk Assessment (HRA) survey. Remember that this is an optional survey for the member, so if they do not want to participate, you should not continue discussing the survey. If a member chooses to self-enroll using **digital marketing materials/agent online application** or you submit a paper enrollment, you have 30 days to reach out to the member to ask them whether they would like to complete the HRA survey. For more information on the HRA or to complete the mandatory HRA training, reference the **HRA Resource Guide** after logging in with your username and password.

Step 2: Prepare for plan-year discussions

Since the HRA includes SDOH-related questions, take note on how members respond, as they may screen positive for one or more SDOH, which indicates a social health barrier. You can offer community resources to enrollees at any time, and once the plan year begins, you can start having conversations with members about any barriers and connect them to plan resources that may help. To prepare for these discussions, agents are encouraged to read through this guide to get familiar with all the tips, tools, talk tracks and helpful resources that are provided to support your conversations.

Step 3: Leverage your regular checkpoints to discuss any social health challenges

During your regular checkpoints with members throughout the plan year, use these conversations as an opportunity to discuss their social health needs, especially if they screened positive for one or more SDOH during the HRA. If they originally declined the HRA, you could offer the **Humana SDOH Assessment** within this guide if you pick up on cues and scenarios that may indicate a social health barrier is affecting their health. As you know, a member's situation may change—so use the Humana SDOH Assessment during the plan year to reassess members if needed, and if they agree to participate.

Step 4: Provide informational materials and make resource referrals

For those who screen positive for one or more SDOH need, provide the respective informational flyer **(section 4)**. Offer assistance connecting them to a plan benefit or resources and services that may be available through government programs and other community organizations through the Humana Community Navigator at **Humana.FindHelp.com**. See the resource referral guide **(section 4)** for more details.

Step 5: Take notes on your conversation

Remember to keep notes of when you screen members, what their results were and what resources you referred. You can do this in your Customer Relationship Manager (CRM) or the customer interaction tool you use. This way, you can reference details at your next checkpoint meeting. Remember to keep all member information safe, secure and confidential.

Step 6: Stay on alert

A member who screens negative for SDOH could experience changes by your next checkpoint with them. Review the conversation cues **(section 2)** for scenarios that may call for a new assessment.

‡ Humana Health Equity Survey conducted Nov. 2022 – Dec. 2022.

3. "What is Health Equity?" Centers for Disease Control and Prevention, last accessed March 21, 2023, www.cdc.gov/healthliteracy/learn/index.html.
4. "About Health Literacy," Agency for Healthcare Research and Quality, last accessed March 21, 2023, https://www.ahrq.gov/health-literacy/about/index.html.

Conversation cues for member assessment

Throughout your checkpoints with members, look for cues and scenarios that would trigger an assessment. Remember to record results so you can follow up and track changes over time.

Though your initial assessments may show negative screening results for any/all social determinants of health, members' social needs and health could change throughout the year.

These scenarios would cue you to assess members for specific social determinants of health. This list is not exhaustive.

Food insecurity

- "I want to start meal planning and find healthier recipes, but it's too expensive."
- "I want to lower my cholesterol and improve my diet, but I can't afford healthy foods."
- "I had to choose between food and medication this month, and I chose medication."
- "I have a difficult time grocery shopping and finding healthy foods that won't break my budget."
- They talk about skipping meals or having a difficult time making meals stretch.

2. Conversation

Loneliness

- "I don't want to hang around old people who have nothing better to do than compare health problems."
- They made you aware of an anxiety attack they had during an everyday activity.
- They made you aware that they recently lost their spouse or a close family member and have been feeling sad lately.
- They live alone or they have kids who are leaving the house.
- They rarely leave their home.
- They experience a major life event such as retirement, divorce or moving to a new home or area.
- They have recently been diagnosed with a chronic condition.
- They have a physical or mobility impairment.
- They are a caregiver for a family member or friend.
- They have a culture/language barrier.
- They live in a rural area.
- They live in an unsafe community.
- They are experiencing financial issues.

Transportation

- "I haven't been able to utilize my SilverSneakers® benefit because I don't have transportation."
- "I haven't taken my medications in two weeks because I haven't been able to find a ride to the pharmacy."
- "I don't get out much because I don't have anyone to take me places."
- "I missed my last doctor appointment because I didn't have a ride."
- They talk about not being able to go to church or the grocery store, or missing a family gathering or holiday.

Financial strain

- "I can't afford my [medications/rent/food]."
- "I can't afford to fix my [roof/car/air conditioning]."
- "I can't afford to buy healthy foods."
- "I have a limited budget."
- "I'm struggling this month to pay the …"
- "My food runs out before I receive my next [food assistance]."
- "My prescriptions are getting too expensive."

Housing insecurity

- "I am worried about losing the place I have to live."
- "I recently lost my job."
- They have had frequent evictions.
- They are living in a shelter, in their car or with a friend.
- They live in an unsafe community.
- They live with substandard conditions such as pest infestation, mold, poor ventilation or dirty carpets.
- They are unable to keep up with rent payments or are behind on payments.
- They spend more than 30% of their income on housing costs.
- They have trouble moving around their home.

Assessment questions

Use the button below to view and download the Humana SDOH Assessment document. Remember to keep all member information safe, secure and confidential.

Download the Humana SDOH Assessment document

Required statement to member prior to assessment:

"I'd like to ask you a few questions about your needs around food, loneliness, transportation, financial strain and housing. This will help us learn more about you and your health, so we can better support and offer you possible resources in your area. Please know that answering any of the questions is optional and not required. Should you choose to respond, your responses will be kept private and will not have any impact on your coverage, benefits or premium. Are you comfortable with me beginning to ask you questions?"

Note to agent: If the member states no, or expresses any hesitation or discomfort with participating, do not proceed with the assessment. The same is applicable at any time during the assessment. If the member wishes to stop, you should stop the assessment.

The assessment includes these five questions for members:

Food insecurity

Some people have made the following statements about their food situation. Please answer whether the statements were **often**, **sometimes** or **never** true for you and your household in the last 30 days.

1a. Within the past 30 days, you were worried that your food would run out before you got money to buy more.

☐ Often true ☐ Sometimes true ☐ Never true

1b. Within the past 30 days, the food you bought just didn't last and you didn't have money to get more.

☐ Often true ☐ Sometimes true ☐ Never true

Calculation:

A response of "sometimes true" or "often true" to either question should trigger a referral for food resources.

continued –

3. Assessment

Loneliness and social isolation

2. How often do you feel lonely or isolated from those around you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

Calculation:
A response of sometimes," "often" or "always" should trigger a referral for loneliness resources.

Transportation

3. Within the past 30 days, has a lack of reliable transportation kept you from medical appointments, meetings, work or getting things needed for daily living?

☐ Yes ☐ No

Calculation:
A response of "yes" should trigger a referral for transportation resources.

Housing

4a. What is your living situation today?

☐ I have a steady place to live.
☐ I have a place to live today, but I am worried about losing it in the future.
☐ I do not have a steady place to live.

Calculation:
A response of "I have a place to live today, but I am worried about losing it in the future" or "I do not have a steady place to live" should trigger a referral for housing resources.

4b. If you have a place to live, do you have problems with any of the following? (Choose all that apply.)

☐ Pests such as bugs, ants or mice
☐ Mold
☐ Lead paint or pipes
☐ Lack of heat
☐ Oven or stove not working
☐ Smoke detectors missing or not working
☐ Water leaks
☐ None of the above
☐ All of the above

Calculation:
Any responses other than "None of the above" should trigger a referral for housing resources.

Financial strain

5. How hard is it for you to pay for the very basics like food, housing, medical care and heating? Would you say it is:

☐ Very hard ☐ Somewhat hard ☐ Not hard at all

Calculation:
A response of "very hard" or "somewhat hard" should trigger a resource referral.

3. Assessment

Recommended talk track

If your assessment suggests the member needs resources, take the conversation in the following helpful directions.

Food insecurity

"I've recognized from the questions we've asked that you may have challenges with regular access to healthy food. That must be very difficult, and I'm glad you shared this with me because the kinds of foods you eat are really important to your health."

Loneliness

"I've recognized from the questions we've asked that you may be experiencing some feelings of loneliness. That must be very difficult, and I'm glad you shared this with me because loneliness can have a negative impact on your health."

Transportation

"I've recognized from the questions we've asked that you may be experiencing some challenges with transportation. That must be very difficult, and I'm glad you shared this with me because having transportation to your medical appointments and to other places, like the grocery, is important for your health."

Financial strain

"I've recognized from the questions that we've asked that you may be experiencing some challenges with finances. That must be very difficult, and I'm glad you shared this with me because having financial stability is important for your health."

Housing insecurity

"I've recognized from the questions that we've asked that you may be experiencing some challenges with housing. That must be very difficult, and I'm glad you shared this with me because having a stable and safe home environment is important for your health."

Next, ask if you can share resources with them:

"If you're comfortable, I'd like to connect you to resources available through your plan or in your community that could help. Are you OK with this?"

If they respond YES:

"Great. Sometimes taking the first step is the most difficult. I will look up some community resources through Humana Community Navigator™ that may be able."

If they respond NO:

"I understand it can be difficult to take the first step. If you change your mind, please let me know and I'll be happy to provide you with more information."

Resource referral guide

- Food insecurity
- Loneliness
- Housing insecurity
- Financial strain
- Transportation

Recommend resources based on which social determinants of health the member screened positive for. It's always best to make a resource referral on the spot after you screen the member—so get familiar with what's available and have resources in mind to recommend. If you need more time to research resources, follow up within 48 hours of a positive screening.

Plan benefits

Agents can help a member review plan benefits that might help address social determinant of health concerns. Alternatively, members can call the Customer Care number on the back of their member ID card to see if their plan includes benefits in the areas of food and nutrition, loneliness and social isolation, financial strain, medical transportation and/or housing quality or instability.

See below for possible resources if the cause of the member's loneliness is a behavioral health (BH) concern, such as depression, or if you're unsure what type of BH treatment is needed, or there are problems getting a timely appointment with a BH provider. Agents should not be providing medical advice to members as part of this process.

- Members can call the Customer Care number to ask about behavioral health services. They can also ask about SilverSneakers and Go365® benefits—if included in their plan—which promote physical activity and social connections. Go365 rewards members for certain preventive screenings, which can prompt members to see their doctor and discuss overall health concerns, including behavioral health.
- Agents can call a Humana behavioral health consultant for urgent needs at **866-900-5021**, Monday – Friday, 8 a.m. – 6 p.m., Eastern time, or email **BehavioralReferrals@humana.com** for routine needs. This service is available to all Humana members, but the contact information above is not member facing.
- Some members may have access to virtual medical and behavioral healthcare through their plan benefits. They can ask their local care provider if they offer virtual or telehealth services or call the Customer Care number on the back of their member ID card.

Humana Community Navigator

If an individual has identified health-related social needs and there is not a benefit to fully assist, follow up by offering assistance connecting them to resources and services that may be available through government programs and other community organizations through Humana Community Navigator (**Humana.FindHelp.com**). This tool is used to identify and connect those in need with available food assistance, loneliness resources, and other free or reduced cost programs in an individual's community.

In addition to providing access to thousands of resources, the following features are also available:

- ZIP code search based on service area
- Resources available to share via print, email and text
- Multi-language options for resources.*
- The ability to create folders to save favorites

Humana.FindHelp.com

*Please ensure to note member language preference in order to meet communication requirements

Additional support services for veterans

Veteran service officers

A VA-accredited Veteran service officer can help veterans understand and apply for any VA benefits they may be entitled to including: compensation, education, veteran readiness and employment, home loans, life insurance, pension, health care and burial benefits. They can also help support a range of veteran-centric programming to support social needs like transportation, housing, and food.

To connect with a Veteran service officer near you, contact your preferred veteran service organization: NACVSO, **www.nacvso.org**; VFW, **www.vfw.org**; DAV, **www.dav.org**; WWP, **www.woundedwarriorproject.org**.

Veterans Crisis Line

The Veterans Crisis Line connects veterans and their loves ones in crisis with qualified VA responders standing by to help 24 hours a day, 7 days a week. This is a free, confidential resource available to any veteran, even if they are not enrolled in VA healthcare or registered with the VA.

Veterans can call **988** and press 1, text 838255 or visit **www.veteranscrisisline.net** to chat.

Vets4Warriors Peer Support

Vets4Warriors connects veterans with other fellow veterans to talk anytime, 24 hours a day, 7 days a week.

Veterans can call **855-838-8255 (TTY: 711)**, 24 hours a day, 7 days a week, or visit **www.vets4warriors.com** to learn more.

PATRIOTlink

PATRIOTlink offers an online resource database that includes thousands of programs tailored to the military and veteran community. Users can search vetted, direct, cost-free services specific to their needs. Visit **www.patriotlink.org** to learn more.

Also, see **page 14** for more information on the Humana Community Navigator which is available to all members, including members who are veterans.

Member informational flyers

These educate members on any social determinants of health they screened positive for.

Informational flyers are available for members which include helpful guidance, tips and resources to support their social health challenges.

Food insecurity

Download

Loneliness and social isolation

Download

Social determinants of health assessment

Download

Veterans food insecurity

Download

Veterans loneliness and social isolation

Download

Transportation

Download

Housing insecurity

Download

Financial strain

Download