

NIHCM Foundation Webinar, January 27, 2020 – Social Determinants of Health: Technology and Workforce Approaches

- Kathryn Santoro: [00:00:00](#) Thank you and good afternoon. I'm Kathryn Santoro, Director of Programming at the National Institute for Healthcare Management Foundation, and on behalf of NIHCM Foundation, welcome to our webinar today. At NICHM, we've been examining the social determinants of health, their implications for health outcomes and costs, and solutions to address unmet needs. I'd like to start today by sharing some key points from an infographic we released on social determinants of health last fall.
- Kathryn Santoro: [00:00:28](#) Social determinants of health are the conditions in which people live, work, and play. While there are many factors that influence health, a few of these determinants of health include housing, food security, economic stability, among others. In fact, studies suggest that social factors have more of an impact on our health outcomes than our medical care or our individual health behaviors.
- Kathryn Santoro: [00:00:53](#) This past fall, McKinsey released their consumer social determinants of health survey that looked at unmet social needs in communities. The survey found that food insecurity and community safety are the most commonly reported unmet social needs. The survey also found that respondents who self reported poor health or higher health care youth were more likely to report multiple unmet social needs.
- Kathryn Santoro: [00:01:19](#) Successfully addressing social determinants of health could ultimately improve health outcomes and reduce costs to the healthcare system and to society more broadly. However, the challenge is figuring out where investment and social determinants of health will really make a difference. A recent study on the Camden Coalition of Healthcare Providers Hotspotting Program, which is designed to address unmet social needs, evaluated its impact on hospital readmissions. The study found no difference in repeat hospitalizations between program participants and patients who did not get the intensive care coordination, though the study did not measure patient experience.
- Kathryn Santoro: [00:02:00](#) This study highlights the need for continued collaboration and evaluation to drive change through strong cross sector partnerships, and by breaking down traditional silos between public health, healthcare, and social service systems, there are opportunities to address social determinants of health and ways that advance health equity. Today we will hear about programs and approaches that take advantage of these opportunities. We've convened a prestigious panel of experts to share their innovative efforts.

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- Kathryn Santoro: [00:02:32](#) Before we hear from them, I want to thank NIHCM's President and CEO, Nancy Chockley and the NIHCM staff who helped to convene this event today, including Cate Ellis, Kaitlin Swanner, Harpur Schwartz and Kirsten Wade. You can find biographical information for all of our speakers along with today's agenda and copies of slides on our website. We also invite you to live tweet during the webinar today using the hashtag #SDOH.
- Kathryn Santoro: [00:03:01](#) I am now pleased to introduce our first speaker, Rivka Friedman, Group Director for the State Innovations Group and Acting Director of the Prevention and Population Health Group at the Center for Medicare and Medicaid Innovation. In this capacity, she oversees CMMI's work on state-based multi-payer models as well as Medicare and Medicaid prevention and population health focus models.
- Kathryn Santoro: [00:03:26](#) We're so grateful that Ms. Friedman is with us today to provide an overview of the accountable health communities model, which is the first CMMI model to focus on health related social needs of Medicare and Medicaid beneficiaries. She'll discuss how the model addresses health related social needs through enhanced clinical community linkages and how this can improve health outcomes and reduce costs. She'll also talk about a newer model focused on at-risk children and pregnant women. Rivka.
- Rivka Friedman: [00:03:58](#) Thanks so much Kathryn and thanks to everybody at NIHCM for having me today. I'm thrilled to be here with so many folks who are interested in addressing beneficiary's health related social needs. As I think you all know, this is an issue of paramount importance for our industry at large and has relatively recently become an area of interest for CMS and CMMI. I want to spend a little bit of time today talking about really two models that CMMI has developed in this vein and then perhaps talk a little bit about how we've learned from each of these models, one of which is quite a bit more mature than the other, and thinking about how we at CMMI and we as the broader CMS can address our beneficiaries health related social needs.
- Rivka Friedman: [00:04:47](#) So first, as you can see on the slide here, I think there is sort of a timeline of CMMI engagement in social determinants of health issues that started before 2014, but formerly in 2014 when we announced the Accountable Health Communities Model, which is a model that funds community based organizations to screen and navigate beneficiaries for health related social needs. And the most recent second points on that timeline was in 2018 when we announced the Integrated Care for Kids Model, which actually started in January of this year and which funds

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communities to establish multidisciplinary care teams for children and pregnant women who are covered by Medicaid and CHIP who are at-risk for a number of different, both medical and behavioral health needs.

Rivka Friedman: [00:05:37](#) Those are the two points on this timeline. I hope that there will be other points going forward and I also just want to acknowledge again that each of these announcements was the result of a significant amount of work. I think one of the unique things about our work on the Integrated Care for Kids Model or InCK is that we were able to learn from prior experience in AHC. And so I'm hoping to shed some light today on what we've learned from AHC so far and how that has informed subsequent design efforts.

Rivka Friedman: [00:06:12](#) As I mentioned, the Accountable Health Communities Model was our first foray into social determinants as a center and that model represented a key first step for us, and again was the result of a significant amount of work and we published on it, actually twice for us to announce the model and to talk about the evidence base behind it and then subsequently to talk about a proprietary screening tool that we developed as part of the model that I can touch on later.

Rivka Friedman: [00:06:41](#) At the core of the model's intervention is an effort to equip what are called bridge organizations to achieve scale. The bridge organizations vary in type and in size. Some of them are YMCAs, others are health system related organizations, others are independent organizations in their communities. There are a lot of different kinds of bridge organizations.

Rivka Friedman: [00:07:06](#) The core goal of the model is to fund bridge organizations to do a number of different things. One of which, as you can see on this slide, is to connect with social service providers. I think this is the core of the model for a lot of bridge organizations in terms of getting those social service providers plugged in, making sure that there's sufficient capacity of social service providers and then helping connect beneficiaries to the relevant social service provider given their needs.

Rivka Friedman: [00:07:36](#) I will also just share, again, because we're really in the middle of this model and continue to learn from our efforts every day that some of what we've heard from bridge organizations really relates to this question of how we scale social determinants related interventions. This is a topic that has come up in our conversations with bridges in AHC. It's a topic that came up in our design efforts for the Integrated Care for Kids Model. It also is a discussion that has arisen in other contexts when we've

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discussed CMMI's potential future efforts in the social determinant space.

Rivka Friedman: [00:08:12](#) Is that CMMI can serve a number of different roles. We have funding, we have flexibilities that we can offer and of course we have our statutory mandate. We at core have to help organizations on the ground to build scale and to achieve capacity. We can't build the capacity ourselves. I think this is one limitation of our efforts in this area but also again has been a tremendous worth of learning for us.

Rivka Friedman: [00:08:38](#) The AHC model has two tracks. It has what's called an assistance track and then what's called an alignment track. The tracks are quite similar in that in both tracks, bridge organizations are doing all of the things that are listed on the left here, so they're building relationships with clinical delivery sites that are going to implement the model in terms of screening beneficiaries and then connecting them through to navigation.

Rivka Friedman: [00:09:04](#) They're developing processes for screening, referral and navigation; and then in the case of the assistance track, they're also developing processes for randomization because that track is randomized and we randomize which beneficiaries are actually navigated. And then they're hiring and training staff. And I think that goes to what I was mentioning before about the importance of really building capacity. They need to build the capacity at their own site. They need to build the capacity at their delivery sites and ultimately I think they're quite motivated to help build the capacity of social service providers.

Rivka Friedman: [00:09:38](#) In addition, the alignment track is intended to establish an advisory board to start collecting community level data on where there are opportunities, again, at a community level to really improve quality and fill key needs that are currently unaddressed. One of the things that we believed when we designed the AHC model that has become even more apparent over time is that we often don't know what we don't know, and one of the goals of the alignment track was to set up some systems in place at a community level for understanding where there were gaps in care. That's something like a bridge organization or the AHC model could address.

Rivka Friedman: [00:10:18](#) I wanted to share a bit of a profile of the awardees that received the funding through the Accountable Health Communities Model. As with everything, we have learned a lot from examining the performance and also the challenges that each of our awardees has faced. As you can see, we have quite a range of awardees. At start of the model there were 31

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awarded communities across 23 states and they were spread quite a bit geographically. We have representation in the Northeast, the Midwest, the South, the West. We had a mix of urban and rural communities, a mix of smaller and larger communities and again, we've learned a lot about the different dynamics in play at a local level and how those inform and affect participation in the model.

Rivka Friedman: [00:11:04](#) I will note, just because I think it's relevant to some of the other conversations that are happening nationally now, that it has become apparent that rural awardees of the model struggle with different things than their urban counterparts struggle with, including in particular the ability to achieve scale; scale of clinical delivery sites and scale in terms of processes that work across sites. And that again is something that we have heard across other models with a significant number of rural participants. But things can just be more challenging when the population and the set of providers, the health care and others are spread so disparately.

Rivka Friedman: [00:11:49](#) Briefly I wanted to touch on which health related social needs are touched by this model. I think that certainly recently we have started to see some different definitions of health related social needs emerge. You can see here the list of our core needs that are addressed by AHC, which are housing, utility, food, interpersonal violence and transportation. This is the core set of health related social needs for the model. And then there are a number of what we're calling supplemental needs that are addressed as well, including individuals with disabilities, education and employment related needs, family and community support, financial strain, mental health, physical activity, and substance abuse.

Rivka Friedman: [00:12:31](#) We've learned a lot about which of these needs is more or less frequent and which is easier or harder to address. Certainly one thing we've seen is that food insecurity tends to be the most common need and that the easiest need to resolve as reported by our AHC awardees thus far has been utility needs. I think this data has been very valuable to us as we've been thinking about what it looks like for the InCK model, for example, to develop a multidisciplinary care team around beneficiaries who have a number of parallel issues and also what a bridge organization can and can't do to make a difference for these beneficiaries. So again, just a lot of lessons learned here.

Rivka Friedman: [00:13:14](#) I do want to take... actually I'm going to talk just briefly about the screening tool and then I'll come back to the case study. You can see there's a piece that has been published about the

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screening tool back in 2017. The screening tool is a critical component of this model and it's a place where I would say we over-invested in terms of both time and money to really make sure that we had the appropriate tool in place for bridge organizations to use this model. I think those who are familiar with AHC will also know that that has been a source of some challenge in part because this is a space in the industry that is changing so rapidly.

Rivka Friedman: [00:13:50](#)

Today, in 2020, there are many more options for screening beneficiaries and patients for health related social needs than there were when the AHC model was designed. And we also of course have a really strong interest in making sure that to the extent that we can standardize things for evaluation purposes we do. And so, building a standardized screening tool was one way to sort of control for any variation. I will share that we have also learned a lot about how important the process steps are around screening, not just the tool itself, but really the process, the different bridge organizations and even different clinical delivery sites use for administering the tool. So that continues to be an area of significant learning for us.

Rivka Friedman: [00:14:36](#)

With that, I wanted to jump into just one case study that we've been able to publish and it comes from St. Joseph's Hospital Health System, which is a bridge organization in AHC. And I think it's exciting in part because their data, you can see here on the slide have risen steadily over the course of a year, which is really significant. We haven't published broad data across bridge organizations, but these data are quite significant in terms of showing continuous improvement in building capacity and in just being able to deliver more and more screenings for new beneficiaries over the course of a year.

Rivka Friedman: [00:15:17](#)

I want to just illustrate a couple of things about why seemingly slow but steady progress is actually so significant here. In order to achieve these data, St. Josephs had to set up processes in place to have sufficient clinical delivery sites and an increasing number of clinical delivery sites such that it could actually find and screen and refer to navigation on the same number or more new patients that it hadn't yet seen in any of its other sites.

Rivka Friedman: [00:15:47](#)

One of the challenges that I would say we anticipated seeing and that we have seen is that once penetration into a community hits a certain saturation point, it becomes more challenging for bridge organizations and their sites to find new patients that haven't yet been screened. And so, in some ways the later efforts to find beneficiaries to screen and navigate are

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more challenging than the earlier efforts, even though there are more processes in place at that point and ideally more clinical delivery sites at which to sort of capture patients, so to speak.

Rivka Friedman: [00:16:20](#) But I think St. Joseph's has done a really fantastic job at getting the message out at various levels to both make sure that everybody understands how big of a priority this is for the organization and to identify places where different sites or staff are encountering difficulty executing on the mission of the model.

Rivka Friedman: [00:16:41](#) One of the things that we've heard from them was about the power of being able to use data and data that they could share across sites to really both motivate staff but also inform their internal decisions on things like staffing levels at different sites and where to prioritize efforts to try to grow and achieve more scale. And that just at a high level is a set of messages that we've heard time and time again that it's really important to have a champion at the top who really makes implementing AHC a priority. It's also really important to be able to have and share performance data at different sites to guide staff efforts and also to guide leadership's efforts about where to prioritize.

Rivka Friedman: [00:17:33](#) In the interest of time, I want to shift to the Integrated Care for Kids Model, which as I mentioned was announced in 2018 and launched this month. The Integrated Care for Kids Model is a child centered local service delivery and state payment model. That's a mouthful. But what it's doing is two key things. The first is it is building multi disciplinary care teams around children and pregnant women who are at risk for developing significant health needs. And the second is each awardee is developing a state-based alternative payment model to help incentivize for the kind of care delivery that they believe will make a difference for these beneficiaries.

Rivka Friedman: [00:18:11](#) I like to say that as complicated as the AHC model is, the InCK model is arguably even more complicated. There are three goals to InCK. The first is to see broad performance on key priority measures of child health. The second is to reduce avoidable inpatient stays and out of home placements. And then the third is to create sustainable APMs for this community of providers.

Rivka Friedman: [00:18:43](#) InCK works across three main stakeholders. The first is the state Medicaid agency, which will be implementing both, some of the clinical aspects of the model. In other words, the interventions, how those are going to work and also will be building and implementing the alternative payment model. The second is the lead organization, which is the awardee of the model, the one

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that receives the funding and will coordinate across all of the stakeholders in the model and there are cases in which the awardee is actually the state Medicaid agency, others where the real organization is a different organization that will be working closely with the state Medicaid agency.

Rivka Friedman: [00:19:22](#) And then third is the partnership council because at its core this model is an effort in collaboration. The partnership council will have representatives from the state Medicaid agency, the lead organization and many of the providers in play as well as some of the other community stakeholders that need to be represented to help make sure the decisions are made by consensus. Hopefully you can see already why this model is so complex.

Rivka Friedman: [00:19:47](#) I did also just want to note that again, this model touches on a set of core child services that as you can see run across many different settings and this is part of why collaboration really lies at the heart of what we are aiming to do in InCK. So, clinical care, including physical and behavioral health, but also care delivered in schools, in housing, food and nutrition in youth, early care and education, child welfare, mobile crisis response. I think there are some cases where juvenile justice will be involved as well.

Rivka Friedman: [00:20:20](#) I really think that it's early days, we have just started the InCK model and I think our awardees are extremely excited to start, but this model will require even more collaboration across many different sites and settings to try to improve outcomes for kids and pregnant women. Not much to report there because, again, it's still early days, but we are really excited to see how the InCK model shapes up and how we're able to learn lessons from AHC that might apply to InCK and its awardees as well.

Rivka Friedman: [00:20:54](#) And I will just say one more note before I can sink back, which is we at CMMI are paying close attention to both of these models to really hear from our awardees about how things are going, about where they feel they're able to have an impact and where they feel like they're less able to have an impact and are trying to really incorporate those lessons into any future work on social determinants of health. So, thank you again for having me. I'm thrilled to be here and I'm also happy to take any questions.

Kathryn Santoro: [00:21:21](#) Thank you so much Rivka and to your team at CMMI for being with us and for all the great work that you're doing. It was really interesting to hear more about the InCK model and it sounds like a very promising approach and we're excited to continue to

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learn more and to learn more as you continue to implement and evaluate the Accountable Health Communities Model as well.

Kathryn Santoro: [00:21:45](#) Our next speaker is leading innovative, collaborative efforts to improve access to care and reduce barriers from social determinants of health. We're now joined by Dr. Karen DeSalvo, Chief Health Officer at Google Health and co-convenor of the National Alliance to Impact the Social Determinants of Health. She's also Adjunct Professor of Medicine and Population Health at University of Texas at Austin Dell Medical School. Dr. DeSalvo was national coordinator for Health Information Technology and acting assistant secretary for health in the Obama administration.

Kathryn Santoro: [00:22:22](#) Prior to joining HHS, she was the New Orleans health commissioner. Dr. DeSalvo is a physician executive working at the intersection of medicine, public health and information technology to improve the health of all people with a focus on catalyzing pragmatic solutions to address all the social determinants of health and we're so honored that she's here with us today. Karen.

Karen DeSalvo: [00:22:47](#) Well, hi. Thank you very much for having me here today. Can you guys hear me okay?

Kathryn Santoro: [00:22:55](#) You're okay. But there's a little bit of an echo.

Karen DeSalvo: [00:22:59](#) All right. How about now? Can you hear me now? Is that better?

Kathryn Santoro: [00:23:02](#) That's better.

Karen DeSalvo: [00:23:04](#) Perfect. Well, thank you so much. I'm really delighted that I get to follow the theme of my presentation because this is sort of the natural narrative that a lot of the country has been on. The Accountable Health Communities work really sparked some more systemic and national interest in the efforts, but as you'll see from speakers who follow me, there's been a lot of private sector work and great projects that even date back decades frankly and personally did some work in addressing social drivers in our post-Katrina environment in New Orleans. But the information that I'm looking to share with you all today really takes a national perspective.

Karen DeSalvo: [00:23:44](#) Next slide. I'm wearing my hat here as the co-convenor of the National Alliance to Impact the Social Determinants of Health, also what we call NASDOH. This is an effort that I co-convened with former HHS secretary Mike Leavitt to pull together

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stakeholders who are interested in working towards more systematically and pragmatically building a common understanding of the importance of addressing social determinants of health as part of an overall approach to health improvement, not only through the healthcare system but more broadly in communities.

Karen DeSalvo: [00:24:23](#) Our work has been to really move towards creating a pragmatic, not only understanding, but a way to fund sustainably and durably all of the sectors and work that really drive a holistic value based person-centered approaches to successfully impact the social determinants of health beyond demonstrations and projects that we might be engaged in doing. I just want to highlight three big areas that are important to us.

Karen DeSalvo: [00:24:49](#) One is that we do believe that the success of value based care is dependent on attending to all the drivers of health including the social determinants of health in it. Secondly, breaking down silos at the federal, state and local level and encouraging private sector collaboration, innovation and partnership with the federal government is going to be essential to success; and that public private sector collaboration is happening in local communities, but we have an opportunity to think about scaling and sustaining those and I'll talk a bit about the funding of that in my presentation.

Karen DeSalvo: [00:25:23](#) Next slide. The active healthcare environment, as I said, dates back decades but the work of the Accountable Health Communities Model really grew out of a lot of appreciation from the healthcare sector on its value based care journey that there was going to be more to health and health care. Next slide. This idea that to get to health we have to go beyond great medical care, what is reflected in this diagram is 20% of the health outcomes for an individual or a community; and really began to think about addressing the social and environmental and behavioral factors that drive some 60% of health outcomes.

Karen DeSalvo: [00:26:04](#) This is true not only because the country needs to advance in the value based care journey but also has become more important because we are responding to a national health crisis, declining life expectancy now for three years in a row, which is related not so much to a single chronic or communicable disease like in the times of Spanish Flu or the HIV epidemic, but more to broad underlying social drivers that are manifesting as the opioid epidemic or suicide and homicide. And so, thinking about broad health generators and doing that in the healthcare environment, in partnership with others, is what really we're seeing happen all across the country.

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- Karen DeSalvo: [00:26:45](#) Next slide. The National Academy of Medicine actually had a report last fall on integrating social care into the delivery of healthcare. I had a chance to sit on this convening group and I wanted to share the framework that we came up with, these five aids. Just as you all are listening to the other presentations today and as you'll hear from models in the field, this is a way of understanding how to maybe organize the work that's happening and then think about in your own organizations how you might approach addressing the challenge of the social determinants of health.
- Karen DeSalvo: [00:27:18](#) The five aids include those that are focused more on individuals and those that are focused more on community level action. It always starts with awareness. You heard a lot of discussions a moment ago about the importance of good screening tools. There's also opportunities around using secondary data to understand the context of the lives of our patients and communities.
- Karen DeSalvo: [00:27:42](#) NASDOH has done a screening brief that you could find on our website and there are many other good resources in this area. But starting with awareness, then drive the idea that we might need to adjust care based upon people, social drivers and contacts that some systems are providing assistance to services for individuals. The work of the Accountable Health Communities Model also brought to light this alignment of sectors like the food sector to identify gaps and also improve synergies and then finally advocacy where necessary to fill gaps.
- Karen DeSalvo: [00:28:15](#) The next slide show some examples in the transportation area in each of these five aids. And so, for example in awareness, the beginning of that would just be to ask people about their access to transportation. Adjustment would involve reducing the need for in person healthcare appointments by using Telehealth, for example. For assistance it might be that some systems began to provide transportation vouchers or rideshare to support access to the healthcare environment and alignment would be really understanding how there can be community ridesharing or time-bank programs. Advocacy would be higher order of community engagement, which would work to promote policies that fundamentally change the transportation infrastructure within the community.
- Karen DeSalvo: [00:29:01](#) Next slide. Some of the reason that I think the social determinants of health work is really taking off now in the minds of healthcare is not just because of the value based care journey or the understanding of the major drivers of health morbidity and mortality in the US but we have better insights

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because of the data infrastructure and an opportunity to really create better appreciation using secondary data of needs but also link people to services.

Karen DeSalvo: [00:29:31](#) Next slide. I would just wanted to highlight two big areas in here. One of which is that in this data landscape there are a lot of tools that have been developed that the SIREN Research Group has a wonderful report out about the community resource referral platforms that are some of the privately developed interoperability platforms that connect health care and community based organizations and sometimes also the consumer.

Karen DeSalvo: [00:30:02](#) Any state level health information exchanges are stepping into this space as well, as well as some of the electronic health record companies are creating these kinds of platforms, but it's also raising some new problems to solve in the space as we add an interoperability layer and want to make sure that we're getting the right information to people, including: the first is appropriate consent, especially stepping outside of a typical HIPAA covered entities. The second is ensuring appropriate digital identity and the last set of problems relate to making sure that we're creating an open interoperability space, leveraging application programming interfaces and standards like fire that are widely available and will be easier to implement.

Karen DeSalvo: [00:30:44](#) Some of that is in streamlining the collection of social determinants of health profiles to prevent people from having to prove poverty multiple times, making it easier for community-based organizations to connect with each other and with the healthcare system and finally to move towards streamlining eligibility and enrollment through better connections with social services, administrative data resources. These are things that NASDOH is again working on in partnership with many others in the public and private sector.

Karen DeSalvo: [00:31:14](#) Next slide. I want to move into the last section which is to talk about financing because during the care models and experimenting is a very active space, and so is this active space of learning the best ways and the most appropriate ways to respect privacy but also share data. But the big hang up has been that we haven't had a sustainable financing model for these projects to move beyond demonstration or pilot days.

Karen DeSalvo: [00:31:40](#) Next slide. I think that the message from the top, from secretary Azar now from the fall of 2018 was a really powerful one where he said that... in his statement which you can read a snippet of his

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speech which would be available on the HHS website, that really there's more than social determinants being abstract and that it's very tangible and frightening for many people on the front lines. He lays out in this speech the idea that it's going to be more than just thinking of payment policy, that there are broader needs to consider policy and support in the human services world, not just in the healthcare world.

Karen DeSalvo: [00:32:23](#)

Next slide. The speech by the secretary and the work that's happening all across HHS really reflects some backstory, including a lot of private sector experimentation and innovation, which you'll hear more about in the presentations that follow me; by part of them congressional action, particularly to provide more flexibility for the Medicare advantage programs to do more to serve seniors who have things like loneliness or transportation or food security challenges. Health and human services beyond center for Medicare and Medicaid innovation, there are a host of projects happening across HHS, some of which started in the Obama administration and have carried forward in the Trump administration, again, reflecting a nonpartisan or bipartisan nature of this work, not only in the value based care agenda but in the human services work.

Karen DeSalvo: [00:33:14](#)

And finally, a lot to learn from the states. The state of North Carolina gets a lot of attention because of really innovative approach to rapid test and learn of what makes a difference in the health and life and cost to people on the front lines. There's a number of other states like Rhode Island or Oregon or New York are far along in this pathway. And I think the more we can learn from those state innovations, I think the better off we're going to be going forward.

Karen DeSalvo: [00:33:44](#)

Next slide. The final thing I wanted to mention in financing is that the important place we are right now as a country is that we've been thinking of how to transfer dollars from the healthcare system or to provide more flexibility in benefits packages in public or private sector insurance, or CEOs are writing checks out of their pocket to buy an air conditioner for somebody's house who's been in now the ER a lot because they have asthma and they need a conditioned space to sleep and live. These kinds of ad hoc models are typically driven from literally the pocket of the healthcare system, but avoiding medicalization of the social determinants of health really means that a person won't be bound to an insurer or a healthcare system to get their social needs addressed, but rather that there is going to need to be a way to address this wrong pocket problem.

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- Karen DeSalvo: [00:34:38](#) Some of that is in looking at how to share gains when cost goes down, not just seeing that those gains accrue to the healthcare system, but that they're shared with the social services and community based organizations that are supporting patients and communities. Oregon is a state that has been doing a lot of thinking of this and working this in Medicaid, so are parts of the New York state Medicaid program. But I think we're just beginning to understand how to respect the partners and not just treat it as a contract, but think about moving towards the shared gains as we reduce costs from addressing social drivers of health.
- Karen DeSalvo: [00:35:15](#) There's also an opportunity to better understand how to pool funding from the public and private sector. This may mean blending and braiding of funds, so not exactly putting it all in one pot that pays out for services. But certainly places like Rhode Island have been already understanding how to maximize the federal rules around where transportation dollars can be aligned with Medicaid dollars as an example. But there's plenty more that I think we can learn and hopefully that the federal government and states will begin to create more flexibility so that services really truly wrap around the person in the community and we are able to make the right investments in social care organizations, which is really the last comment I'll make in this space and that is, many may be aware that, as is shown in this graphic, this bar chart on the right, the US is in the middle of the pack when you combine healthcare and social care spending.
- Karen DeSalvo: [00:36:12](#) We just spend much more on healthcare than on social care. The current movement in social determinants of health funding would sort of push those dollars into healthcare and have them then pass them on to social care. Another approach might be that we would want to invest more in the social care sector, allowing it to modernize, to become more digital, to have a stronger business infrastructure. Very much along the way that we require transformation and modernization of the healthcare infrastructure to develop more value to be able to do that for the social care infrastructure.
- Karen DeSalvo: [00:36:46](#) The last slide really is just a request and maybe particularly a call to action that NASDOH has been keen to begin to lift up. And that is that we have a lot of great patchwork efforts happening all across the country. What we need is a national strategy, given that the morbidity and mortality from the social determinants of health seems on par with prior disasters like the Spanish Flu at the time of World War I or the HIV epidemic. We should be that intentional as we try to create synergies and

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learn to advance the field from lessons learned, including what works and doesn't work to maximize the effectiveness and efficiency of our resource use so we're not repeating things that we already should have known and trying new models that we know work in other areas and not taking the opportunity to scale.

Karen DeSalvo: [00:37:40](#) Clarifying the evidence base systematically by leveraging the talent at the NIH and Procore and other national resource entities and building this with community, not for community as we're thinking of being intentional about reducing disparities and not creating products or care models that might unintentionally drive people out of care or out of services. I look forward to questions when we get to that section and I want now turn it back to the moderator. Thank you very much.

Kathryn Santoro: [00:38:11](#) Thank you so much Karen for your leadership, bringing stakeholders together around this common mission of addressing the social determinants of health and we look forward to continuing to see the work of NASDOH. Our next speaker, Alan Gilbert, is the Vice President for New Business Initiatives at Anthem. Anthem recognizes that there are multiple factors that influence someone's health and it's committed to tackling the social determinants of health by taking a whole person approach.

Kathryn Santoro: [00:38:42](#) This past year, Anthem added social determinants of health related benefits having recognized that interventions like these can help consumers better manage chronic conditions, stay healthy and keep healthcare costs down. Mr. Gilbert previously held executive positions in GE Ventures. In addition, he was domestic policy advisor for health policy to President George W. Bush and served as council in the US Senate.

Kathryn Santoro: [00:39:10](#) We're so fortunate he is here with us today to share a new company-wide effort to address the drivers of health. In his current role, he's creating internal and external partnerships to improve quality of care and member outcomes across all lines of Anthem's business. We're excited to hear more about that today. Alan.

Alan Gilbert: [00:39:33](#) Great. Thank you Kathryn and I am very privileged to be a part of this conversation today. I want to thank you and NIHCM for all the work that you've done in putting together this great panel and I appreciate it so much, and it is an honor and almost intimidating to follow Karen DeSalvo, who is a friend and colleague as an original partner and helped start NASDOH myself several years ago. I am thrilled to be in her company. I

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wanted to start this morning by giving a little information about Anthem. I believe I have the ability to change the slides. I hope that you can see them. Yes. Are you able to see the slide change? Okay.

Kathryn Santoro: [00:40:21](#) Yeah.

Alan Gilbert: [00:40:22](#) I wanted to give you a little bit of base. As Kathryn said, I am new to Anthem, having been here about seven months. I was hired by our CEO Gail to create an enterprise-wide strategy around the social determinants of health and I'm very excited to lead that effort here in this company. Just a little level set at the beginning. Anthem is a large provider of health insurance for over 40 million Americans in the country. We have for example the privilege of being a Medicaid provider in 23 states now and the District of Columbia. And as Karen mentioned, North Carolina, one of the more innovative states, we are partners with Blue Cross Blue Shield of North Carolina in that program when it stands up. So, very excited.

Alan Gilbert: [00:41:10](#) We have one in eight members in the country really provide Anthem insurance and we are thrilled to have this sort of scale and scope; and I know Cathryn and my pal from CMMI talked about scale, we are certainly up the scale to try to test pilots and programs around the social determinants and is one of the reasons that I came to this organization.

Alan Gilbert: [00:41:38](#) I thought I would start out by just giving you the breadth of our portfolio of programs... and I'm having problems changing the slides. Here we go. Since I've been here in the last seven months, I have discovered an incredible amount of opportunity and work that's already going on in the drivers of health across our company, at either the commercial business, our Medicaid business or our Medicare MA business.

Alan Gilbert: [00:42:07](#) I thought I'd just kind of give you an idea that's really soup to nuts here. We are piloting and testing programs around housing, transportation, innovative programs with lifts, the new box. In some of our markets, we are testing food pantries, mobile medically tailored meals. Also trying to identify populations that might be food insecure or populations that have chronic diseases that could be improved by working on food and nutrition. We are looking at non-emergency medical transportation as I said, but also education programs, and this just kind of gives you a flavor and it's certainly not an exclusive list.

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- Alan Gilbert: [00:42:51](#) Since our conversation today was really focused on data and technology, I thought I would spend a moment sort of in the top left corner talking about the challenges that an insurer like Anthem faces in trying to understand the social determinants of health. We are currently working to address many of the issues Karen's raised about individual consent and looking at how we really aggregate and pull into our data fabric external information around the social determinants of health, but also then how we can move that across our system to use that with claims and other electronic health records and the clinical data that we have on many of our individuals to really challenge ourselves to understand in a predictive and also in a prescriptive way how we can find and fund pilots that really impact our members and really try to improve outcomes at the individual and the community level.
- Alan Gilbert: [00:43:49](#) For example, Karen mentioned sort of local resource connections and we certainly are experimenting in many of our markets around the data and technology that's necessary to be able to understand the community based organizations, their capacity and their willingness to work with the broader community to address these issues. And we're really challenged, I think, quite frankly with the right data and technology. And as Karen and others mentioned, this really is a nascent field. Just the idea of how to assess our 44 million members in a standardized and consistent way is a challenge that I'm sure my colleague at Blue Cross Blue Shield of Florida will mention probably.
- Alan Gilbert: [00:44:31](#) I mean, these are all issues that we are really working on and really experimenting on how best to assess them, how best to measure and evaluate. As folks on this call know there really are no standardized measurements and evaluations nationally. I know Karen mentioned SIREN and Karen and there's a lot of groups out there that are really working and Anthem is a member of those groups, to try to make those connections and understand better this space and to be able to work in a really smart data and technology way.
- Alan Gilbert: [00:45:02](#) I'll go to the next slide and start really highlight a couple of programs that I think will really best show that we have been able to harness in a predictive and prescriptive way to really solve some of the problems of our members and their in the communities that they live and work in. I thought I would highlight BLue Triangle, which is a housing program that we instituted a couple of years back in Indiana, which is where Anthem is based in Indianapolis. Back in 2017, we partnered with numerous partners, including the City of Indianapolis and a

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housing authority to really try to identify and understand how we could improve the health and quality of life of individuals in our community who were experiencing homelessness.

Alan Gilbert: [00:45:50](#) And this slide here just really speaks to why we developed this program because Indiana is one of the most insecure states when it comes to food insecurity, but also when it comes to housing in the country. Believe it or not, in Indianapolis, our largest city in the state, over 12,000 individuals are experiencing homelessness in any given time. So we developed this program and structured it with that sort of housing first philosophy, our theory being with working with our provider network, our housing authorities and the city, was that we would first surround in with housing and stability and then show members we support services that are needed.

Alan Gilbert: [00:46:34](#) Our philosophy is to really try to lower the barrier for individuals that are experiencing homelessness and insecure housing to get into secure housing and really then work on their housing and social... their social needs and their health needs. And you can see sort of to this offering what we have done for Anthem members that are in the Blue Triangle program. After it was built, we really have provided them, every individual in there receives private accommodations, they're offered an array of these services in improving health but also including patient education around their prime disease management, but they're also given not only healthcare needs but also surrounded by life skills and they participate in socialization activities, they receive assistance and placement in hopefully into more secure housing.

Alan Gilbert: [00:47:30](#) As you can see and as I mentioned earlier, the program really is a partnership between the city of Indianapolis and our other partners in the community. I'm having a little problem moving the slide. It's probably my own WiFi, speaking of data and technology, but I'll just skip over to the next slide and show you the outcomes which I really wanted to focus on. It's been pretty amazing. My favorite statistic is actually not on this slide, which is that 96% of the individual served in this program are still in secure and stable housing today. And I think that is a testament to the work and the program and the participants and the work that we provide.

Alan Gilbert: [00:48:14](#) But as you can see, the utilization I think is one of the strongest things we've seen. We've seen a reduction in mental health services and physical health. We've seen a reduction in outpatient ER and this is all done by an independent analysis where we reviewed many of the participants and compared it to

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non-participants enrolled in the Medicaid program in our state. But I also like to point out outpatient surgery increased by 90% and it's mostly driven by the fact their primary care docs could not provide a right care coordination plan if they didn't have stable housing for an orthopedic procedure or some other medical procedures.

Alan Gilbert: [00:48:58](#) So, a real win-win for the patients. And then also primary care, you can see drug adherence improving. So just a really great story to tell around the program. All identified, by the way, by harnessing the data and technology that we had available in partnership with the state and our local plan in Indiana to identify individuals that needed housing assistance in the community.

Alan Gilbert: [00:49:25](#) I want to move to a different topic, food, and really talk about a program of ours run by our CareMore business. CareMore is a wholly-owned company of Antheims that's based in numerous states across the country. Started in California in a very unique model, and really an area where we really spent a lot of time digging through our patient population in places like Orange County, California or Arizona or Tennessee in the Medicaid population. The programs that we have designed in CareMore have really shown how we can really change the paradigm and really address folks that have either a chronic need for food assistance or, for example, maybe even tries through data and technology identify individuals that might be in need of food assistance that could be preventing future hospitalization and future healthcare needs.

Alan Gilbert: [00:50:28](#) And so, a couple of the things I really wanted to just run through briefly before I turn it back to Kathryn are the scope and breadth of programs. CareMore is no different than the rest of Anthem. We have these kinds of programs, whether they be prescribed meals or nutrition counseling or food pantry assistance or volunteering in CBO referrals across the CareMore platform, but also across our mini markets in the country.

Alan Gilbert: [00:50:58](#) I thought I would just highlight a couple of key programs that have really, I think, shown some really impressive outcomes. Prescribed Meals is really addressing existing chronic conditions. We targeted our program in California, Arizona with patients that had congestive heart failure or BMI or A1c and really benefited them with 180 days of meals and saw some really impressive results.

Alan Gilbert: [00:51:27](#) If I go to the next slide, I'll show you that, well, we even went a step further and now in this coming year, we'll be addressing

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their needs in the Arizona market for those that have already run out of their previously prescribed meals and really have seen in CareMore and coordinated that we can redesign our benefit design. You notice here that we have zero copays with registered dietitians, which was a pilot to determine the right level of benefit design through data and technology.

Alan Gilbert: [00:52:02](#) The next slide really shows, I'm feel like I'm running out of time, but the next slide really shows a program where we provided food insecure patients with access to healthy food. Again, identified as a population that were really either diabetic patients or in another program, pre-diabetic and really have coordinated through CareMore and our Medicaid program and our Medicare program as well through CareMore, delivered meals and provided assistance that really has shown, you can see here just... and this is over a short period of time, some pretty dramatic reductions in health statistics. And so, we're really proud of the kinds of programs and are expanding those programs across our platforms.

Alan Gilbert: [00:52:52](#) The last slide I'll address is to identify a lot of our work and just highlight one of them in Texas where we're providing food pantries in our CareMore primary care clinics, unlimited use of pantries. We've actually located recently with the pantries inside the primary care and actually use USDA approval to move in refrigeration so we can have fresh vegetables and dairy and meat to add as a supplement to these food pantries in these communities.

Alan Gilbert: [00:53:26](#) So, a lot of great things are going on across the ecosystem with not just Anthem but all of the other folks in the payer world. And this is just a quick highlight of a couple of programs that just gives an example of the kinds of things that we're doing in Anthem to try to connect the dots between social and medical and really focus on providing the social needs that our members in the communities are asking for. Thank you, and I look forward to questions at the end of this conversation.

Kathryn Santoro: [00:53:59](#) Thank you so much Alan for sharing your words to address the drivers of health. It was really clear kind of the role by Anthem and the health plan can play, and using technology to provide the linkages that you just mentioned that we know can really address social factors and have an impact on health outcomes.

Kathryn Santoro: [00:54:18](#) Our final speaker today is Dr. Kelli Tice Wells, Senior Medical Director, Medical Affairs at Florida Blue. Florida Blue also recognizes that health goes beyond the traditional boundaries of healthcare. One of the things that makes Florida Blue unique

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as a health plan is that they take a community based approach to achieve better health and Florida blue is taking an innovative approach to social determinants by utilizing social workers to connect patients to housing, transportation, and other social services, where Dr. Wells is the clinical lead for Florida Blue's medical operations work in the areas of public health, social determinants of health, opioid, overused response, and corporate social responsibility. We're so pleased that she is here with us today to share Florida Blue's innovative work.

Kelli T. Wells: [00:55:12](#) Good afternoon everyone. It is a pleasure to have the opportunity to participate in this conversation. As a family physician, I can tell you that during my years of practice, I can attest to the impact of the social determinants of health and the desire that all clinicians had to address them as well as the frustration we experienced as we made futile attempt to try to solve them. GuideWell as the parent company of Florida Blue has actually leveraged a number of its enterprise resources in order to holistically address the needs of Floridians and its members.

Kelli T. Wells: [00:55:48](#) Incidentally, Florida Blue is actually a fairly physician rich environment that chooses to apply clinical expertise to building health solutions as well. And I'm one such physician who has the opportunity to apply my years of providing care to underserved populations to this work and really affect change.

Kelli T. Wells: [00:56:09](#) Many of you I'm sure recognize this graphic with the Robert Wood Johnson Foundation's representation of the various factors that impact health and the relatively small impact of clinical services in this area, right? Only 20% of what determines health actually happens behind the closed door of an office exam room. GuideWell and Florida Blue has created an approach to care in response to an understanding of this concept. In addition to that, we listened to our members when they said to us that they want us to know them and they want us to know what their needs are. Our goal is to know enough about our members and the communities in which they live to be able to move upstream of poor health outcomes and affect change.

Kelli T. Wells: [00:56:53](#) We also strive to hear our members when they tell us what their goals are, even if those needs might be different from what our data has led us to prioritize. GuideWell is a health solutions company and there simply is not a way to solve health issues without addressing the factors that have 80% of the influence. As you see here, that is social and economic factors, health behaviors and physical environment.

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- Kelli T. Wells: [00:57:16](#) You will see, as I highlight a few of our existing strategies, that our solutions are collaborative and locally targeted. I'll discuss programs in our health services and care management areas, our Florida Blue retail centers, and I'll also discuss some work supported by our Florida Blue Foundation. I want to lay as the foundation this Maslow concept, the hierarchy of needs. Often we in healthcare are standing at the top of this pyramid; formulating treatment plans, but doing so without addressing basic needs or assessing whether or not they are addressed.
- Kelli T. Wells: [00:57:47](#) How often have we done this? There have been documents of noncompliance in our charts and records when the member actually fails to perform because they lack the capacity to do so. The suggestion here is that those consumers of healthcare who are at the greatest risk of poor or disparate outcomes are there because of unmet basic needs and do not have the capacity to affect changes in terms of self actualization.
- Kelli T. Wells: [00:58:10](#) In previous systems, we've essentially documented this lack of capacity with our no show stamps in our chart, our patient dismissal protocols and our failure to support necessary services. In my subsequent slides, we'll discuss how interdisciplinary teams deployed at numerous GuideWell and Florida Blue touchpoints serve to increase the capacity of health consumers in our community.
- Kelli T. Wells: [00:58:34](#) Case or care management as we call it, is what I like to think of as following the member home from the doctor's office. Post physician visit, our health consumers return to the places of greatest health impact: their neighborhoods, their homes, schools, work place, places of worship and recreation facilities if they have access to such.
- Kelli T. Wells: [00:58:54](#) Our care management program is constructed in a place of delivery model or pie, emphasizing the local structure and the local focus. The state is divided into 11 PODs and five regions of the state. They work with families and communities where they live. We actually broaden our case management teams to include beyond nurse case managers, but the other expertise that we rapidly identified was needed. We've added for instance pharmacists, registered dieticians, social workers. 80% of those that support our PODs delivery system are deployed locally. Each addition of each member of this multidisciplinary team was made in response to information that our nurse care managers were gathering through motivational interviewing techniques and through the ongoing support they were providing some members as they moved toward achieving their health goals.

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- Kelli T. Wells: [00:59:50](#) Again, if you're familiar with Maslow's hierarchy of needs, we learned over and over and over again that care gaps we set as targets were not going to be prioritized by members who had unmet basic needs. Information which is gathered by our nurse case managers are translated into action and they're tracked in our care management system. Consultations from any member of this multidisciplinary team can be obtained by any participant at any time. The social work team leverages their deep knowledge of the community, partners and resources that exist in the region that they serve. Each member of that social work team has resource list for the top social determinants of health domain: transportation, food insecurity, financial strain, housing insecurity, safety, childcare, isolation, and by virtue of their professional training are equipped to assist members in overcoming the social and environmental barriers impacting their health.
- Kelli T. Wells: [01:00:47](#) Next, I'd like to share a bit about another way we have embedded social work expertise into our strategies to address social determinants of health. We have Florida Blue retail centers throughout the state, and these centers have a variety of functions. The initial functions for these centers were business-related, such as sales, responding to enrollment questions, providing plan information, et cetera. But these are deployed strategically throughout the state, and at a number of flagship centers, we quickly realized that there was a need to shift these functions to include access to things like onsite wellness program, personal health assessment, and preventative health services such as immunizations. We partner locally, in fact, to provide flu vaccines and other indicated vaccines to members at the site.
- Kelli T. Wells: [01:01:39](#) We have retail centers that are even designated as centers for innovation where we did our health related technology. Our retail centers have foot traffic that really amounts to almost half a million members annually. Therefore, it would make sense that these sites would continue to evolve and now serve as a hub for identifying and addressing the needs of the communities they serve.
- Kelli T. Wells: [01:02:02](#) Trained social workers, called community specialists, were placed in our centers beginning July 1st, 2019. The goal was to connect consumers to necessary resources and to provide coaching toward achieving health goal. This funnel gives an impact summary of this work. But understand that in the first 60 days of deployment, this team exceeded \$1 million in estimated annual assistance for members and community visitors. This is money a member or visitor would have had to pay on their own

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for food, prescriptions, transportation, housing, et cetera. End of the year data confirms our savings to members of more than \$5 million at this point. Community specialists provide services which include linkage to community and social resources, health plan literacy and advocacy, care access and coordination, coaching and decision support and much more.

Kelli T. Wells: [01:02:52](#) Again, as we look at this funnel that depicts the impact of this work, I call your attention again to the impact being made in a number of areas: food, clothing, shelter, medication costs, et cetera. But I also draw your attention to the other valuable information that we gained from it. Alan spoke about the difficulty in assessing and gathering social determinants of health information and landing it somewhere so that we can act upon it. But here we see that there's valuable information about the needs that our members have but there's valuable information about what doesn't show up on this list.

Kelli T. Wells: [01:03:26](#) For example, we know that food security is a prominent issue in many of the communities that we serve. Why aren't we seeing more of this in our centers? We learn about member behavior through this work. Were members likely to seek and accept help? Do members understand the connection between food and health? Are they not asking for these services because they don't recognize the value of the retail center in terms of applying healthy food to their health outcome? Can we be prepared to provide what members need no matter what front door they walk through, be it a retail center, a funding community partner or the office of a provider partner?

Kelli T. Wells: [01:04:03](#) In addition, in doing this work, our social services team of community specialists has found that many of the members they served have some level of awareness about the resources available to meet their needs, but did not know how to access them. They didn't know how to apply or the offices were located, what information they needed to provide, et cetera. That's a gap in the system that can be closed by the community partners. This funnel gives you some perspective of the depth of needs at our community and informs us about the depth of needs of our own members. This is invaluable information as we continue to build out our program. We're not currently using any available software products and services that exist to complete and track referrals related to social service needs and as those resources continue to mature and our own data matures, that is certainly something that we will consider.

Kelli T. Wells: [01:04:52](#) Thus far, I've discussed the addition of social work professionals to our multidisciplinary teams in care management and the

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statewide deployment of social workers or community specialists in our retail centers. I'll close my discussion with a description of the work being supported by the Florida Blue Foundation, which is a collaborative and partner component. Florida Blue Foundation is a separate philanthropic affiliate of GuideWell, but a visible and supportive arm to our care team's retail centers as they serve as a resource to enable the growth and development of community partners to whom we refer.

Kelli T. Wells: [01:05:24](#) The foundation approaches its investments in the community with the corporate social responsibility perspective. They serve to address targeted drivers that impact the wellbeing of families and community. They'll encourage and support employee engagement and they support partners in the communities that are positioned to impact the community's needs. Currently, Florida Blue Foundation goals are to impact food security, improve health equity and advance mental wellbeing through grant supportive partners in the communities served. Linkages do exist between foundation grantees, our care teams and our retail center teams. Information from each source contribute to the environmental assessments done annually at a minimum to assess gaps in service delivery. Again, these are assessments that are done from a local perspective.

Kelli T. Wells: [01:06:15](#) The foundation supports a large number of programs, but for the purpose of today's discussion, I want to focus on one strategy in particular that I think dovetails nicely with what we've done in the area of social work expertise, and that is the use of community health workers. What you see here is a summary of one funded project using community health workers. Community health workers are trained and certified community workers that work with families in community and they become invaluable experts in how to navigate the health, transportation, social services, and other systems in the community.

Kelli T. Wells: [01:06:50](#) I liken this valuable asset to that knowledgeable clinic intake person in a physician's office or a local shelter manager involved in active members of the same community or even elders in the community. These assets are the go to people in the community and they can, with specified training, be leveraged to improve medication adherence for instance, attendance at primary care visits, clinical followup, improve blood sugar control and more. While this is one example of foundation supportive of community health worker strategies, community promotoras is another example.

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- Kelli T. Wells: [01:07:26](#) The promotoras provides social and health needs assessments, nutrition and wellness classes and navigation assistance to get members enrolled in health insurance. Their primary language is Spanish and they are well-respected in the communities they serve. This model is crucial to the members of our state. We're typically forced to navigate their health care and social needs using a translator, that's in and of itself a contributor to disparate outcome. One additional point worth noting in this model is the financial impact to the community that is attained simply by providing jobs. This is another important way to impact communities, employment.
- Kelli T. Wells: [01:08:06](#) As a payer, we have worked not only to identify the needs of the member population we serve, but to impact the environment those members are born, live, work, learn and play in. In order to do that, we have built systems which allow us to gather information from members and respond to their identified needs. Our focus on maintaining a local presence in each area of the state allows us to know community partners who may need structured referral funding, technical assistance, or even just publicity in order to meet the needs of our community and its members.
- Kelli T. Wells: [01:08:40](#) In order to use multidisciplinary efforts to solve social determinants of health problems, you must be willing to incorporate social work expertise into your model. You must know who it is you're trying to serve and what their needs are. You must know the community partners who are already doing great work on issues of importance. You must identify gaps to avoid duplication and waste of resources and you must empower community members to self advocate. You must collaborate to problem solve and then reassess what may well be changing community needs. Thank you for the opportunity to contribute to this conversation. I will return it to our host to lead us into the question and answer period.
- Kathryn Santoro: [01:09:22](#) Thank you so much Dr. Wells for sharing Florida Blue leadership and commitment to implementing this comprehensive approach. I know our audience is eager to continue to learn from you all and we have a lot of questions coming in, so I'm going to try to start to go through them, but please continue to submit them and we'll get to as many as we can. I wanted to start by going back to Rivka. We had a lot of questions about how people can find out more information about the InCK model and program. Where can they turn to to find out more and can you talk a little bit more kind of about your plans for implementing and evaluating that model?

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- Rivka Friedman: [01:10:06](#) Sure. So the first answer to the first question. We have websites dedicated to both the Accountable Health Communities Model and the Integrated Care for Kids Model on the CMS website. You can find them by navigating to the innovation center webpage, but it's easiest to just type in Accountable Health Communities or Integrated Care for Kids into your search browser and it'll probably pull up the relevant websites. That is where we post all information about these models including the awardees which have now been announced for InCK, background on the model, and then any publicly aware documents and resources which include things like our fact sheets and press releases but also for the Accountable Health Communities Model two case studies that we've been able to publish and we hope to publish more of those going forward.
- Rivka Friedman: [01:10:49](#) Second on the implementation, frankly I think this is especially true for InCK, we do have a list serve that's open to any interested party. You can find a link to that also on the webpage and that's the easiest way to get information as soon as we post it because we'll blast the list serve as soon as we have more information on the website. In terms of implementation and evaluation for both of these models, same as true. We post the evaluation results on website as soon as they're available. So that's the easiest place to find information as soon as it comes out.
- Rivka Friedman: [01:11:19](#) I know I mentioned randomization when I was talking about the Accountable Health Communities Model and saw a couple of questions about why we're doing that and why it's important. Randomization is critical to our evaluation. We really felt strongly about creating a randomized design where possible to be able to evaluate the sort of differential impact of this work. I think there are some obvious complications to randomizing beneficiaries when you know that a beneficiary has a need and you're not providing services and there's plenty of information available on the sort of decision making process there, some of which has been published in the two articles that I linked in my presentation. One of the two tracks is randomized, and that again is for evaluation purposes. So any available information that we have that's publicly available will be posted on the websites. Definitely recommend checking both of those for more.
- Kathryn Santoro: [01:12:11](#) Great, thank you. This question is for Alan. Could you talk about how you're partnering with any existing seed agencies to fund or provide services? And just more broadly for any of the speakers, we had a couple of questions coming in just about any

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lessons learned or advice for partnering with local and state government agencies.

Alan Gilbert: [01:12:37](#) Sure. Absolutely. I'll use the Blue Triangle as an example just to give you an idea. In that context, we partnered with the city of Indianapolis and they provide basically what amounts to a form of rent for the individuals that are identified to be in the housing that we provide. And then we provide a lot of the resources for the wraparound services. That kind of gives you an example. And then one of the housing authorities help to do the renovations for the project at the beginning. So we have a sort of a public private partnership. But this is absolutely, and Karen might be able to comment on this too. I mean, financial sustainability is a key issue in these communities.

Alan Gilbert: [01:13:30](#) In many of our states where we are a Medicaid plan, we partner with our states. But in the community level, we'll partner with food banks or with housing authorities and other places where we are providing services. And it can take the form of... Karen mentioned her foundation, and the Anthem Foundation does an incredible job across the country in not only just our markets but in other places where we're really looking at sort of food as medicine pilots in places that are not even related to... are not specifically for the members that we serve in those communities, to really try to test and pilot.

Alan Gilbert: [01:14:16](#) You asked about what recommendations... This is really hard. It's really hard. Cross sector collaboration in the community is something that when you think about it initially you think it should be intrinsic and easy. But I've worked in communities across the country where the public health department doesn't know, the employer community doesn't know the public safety in the community and everyone's scared of the public health system, I mean, of the health system. So, it's really hard. And what I would suggest is you need to have a catalyzer or convener in a community. Anthem is for example trying to serve that role here in Indianapolis, our own town, around food insecurity. Bringing together other employers in the community. All the incredible work of that. A lot of the groups that have been focused on food for many years are already doing.

Alan Gilbert: [01:15:16](#) Many times you'll see in communities where there are five different well-intended groups that are doing work in a community, all in the same population targeting different strategies. And if they work together... and you need a real strong convener in those communities. It doesn't always have to be someone like an Anthem. It can be... if you know one community, you only know one community, right? But you

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really do have to link to this cross sector notion to really have sustainable change that can really take hold. And I guess in our places, and again I've only been here for seven months, but I've been impressed by the work that we're doing, but we have a long way to go to really build sustainable community and individual outcome change by harnessing and connecting social and medical. A lot of work still left to do, but I hope that helped answer your question, and happy to take some more after this call if you need.

Kathryn Santoro: [01:16:23](#) Did anyone else want to add anything about partnering with state and local government?

Karen DeSalvo: [01:16:31](#) Hey this is Karen. Alan, thank you for going through some detail about how you all are doing it and for your leadership in the area. I think one of the important challenges that I mentioned in my remarks was that sometimes states aren't clear what is allowable, what current flexibilities there are without any statutory or regulatory change to the rules. And so, I mentioned the state of Rhode Island, which has done a lot of great work in thinking about how it can take advantage of the existing resources to make them more effective for the existing environment.

Karen DeSalvo: [01:17:09](#) I think the reality going forward though is... what the country is going to need to do is make sure that we're aligning resources and hopefully moving to a direction of being able to pool. Some folks like Len Nichols and Stuart Butler have done some good writing on this to think about how not just pooling public sector dollars, but the private sector dollars seems like community health needs assessments or other investments the private sector might already be making in housing or the food sector and get away from kind of a Byzantine one-off patchwork approach that we've been doing. This is... I think we're learning a lot from what communities are doing together to create tables where everyone's got an equal place. But I think it just gets to be frankly more... need to be more clear that it's not about always more money. It's about the right application of the resources we have.

Kathryn Santoro: [01:18:07](#) Great. Thank you. A question for Dr Wells. From your experience working in community settings as a provider, what role can providers play in addressing social determinants of how it's taking things like burnout and limited resources, especially in underserved areas into account? And also how do we think about the voice of the patients and partnering with patients and just making sure that we are addressing their needs in the best way?

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- Kelli T. Wells: [01:18:39](#) That's a great question and I appreciate the opportunity to address it even briefly. There isn't a simple answer but I will say that one of the things I think is really important is that we flex the muscle that we have. And what I mean by that is that everyone, every part of the collaboration needs to be working in their scope. When I was... as a practicing clinician, I worked in federally qualified health centers and often my lunch hour, if you could call it that, was filled with calls to social service agencies in deal making to try to get folks seen or evaluated by specialists and those sorts of things.
- Kelli T. Wells: [01:19:22](#) What we recognized is that there was an opportunity for payers or other private or public organizations to actually fund expertise in problem solving related to social barriers that can be co-located in provider offices. The physician can be the physician and identify, do the difficult work of establishing the rapport with a patient and gathering the information that needs to be acted upon. But then those problems can actually be solved by having access to resources to address some of those issues. We are working to expand our partnerships. One of the speakers talked about the importance of that work in the value based setting.
- Kelli T. Wells: [01:20:08](#) In order to be sure that our providers feel supported to that end, it is also very necessary that any partner, any community organization: private, public or otherwise, that has the opportunity to contribute to improving the health literacy of the community that we serve, meaning making our members better health care consumers, actually advance that work a good bit. I talked a little bit about how folks walk through whatever front door they walk through seeking services without understanding always the connection of the services to their health and their health outcome.
- Kelli T. Wells: [01:20:47](#) I can tell you that, having cared for underserved folks for years and years, if you can make clear to them the impact of today's decision or the absence of a particular resource to a longterm outcome, like in stage renal disease, blindness or other chronic disease impact, that becomes actionable information for them and they then become empowered to begin to advocate for themselves. Plus the month you have, look for a collaborative partner that can hold up the ends of the things that you're not able to do in clinical settings. And with particular attention to our primary care providers, we've looked to explore some co-location models where we can actually support having those resources at your fingertips in your office settings.

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- Kathryn Santoro: [01:21:39](#) Great. Thank you. Question for Alan. With such a vast geographic footprint, how do you prioritize which communities that you're working with and how do you evaluate these community-based organizations for partnership?
- Alan Gilbert: [01:21:57](#) Yeah, great question. Karen mentioned earlier around the the states... many of the states in the Medicaid program for example are requiring as part of our work that we do some of these activities with community based organizations. We've been doing them before, but I do think to some extent we prioritize around... the reality is we prioritize around the activity and the requests we're getting from our partners at the state and at the local level as well. In fact I'd say the same thing goes even with our scope and scale even with our commercial business, right?
- Alan Gilbert: [01:22:40](#) I mean, Karen just joined Google and we now, I think, the life we provides insurance for Google employees. So we prioritize when our customers ask us for work. And I can tell you from conversations in my short time here that there are a lot of national employers that we provide insurance for their employees and their families. You got to really beginning to talk about these issues and wanting to prioritize this, and many of them are wanting to prioritize issues around things that you noted across this conversation today: housing, food insecurity and other issues that are really popping up and rising as high on the issues of social needs. So you're seeing it that way.
- Alan Gilbert: [01:23:30](#) How do we evaluate the community based organizations? Well, a lot of it's on the ground. I mean, we have really armies of partners in these communities. We have incredible networks of providers. A lot of these social needs are coming in from individuals who work with their primary care doctor and they know a lot of folks in the community. We get a lot of information around maybe our individuals from the community based organizations. I think Karen mentioned this earlier or someone else did about the burden there is of constantly multiple times rechecking eligibility.
- Alan Gilbert: [01:24:17](#) There's a lot of information in the system from the very beginning, whether it be the Medicaid program or seniors enrolled in Medicare managed care around their social needs and really it should be bi-directional anytime a state during enrollment of eligibility or a community based organization as opposed by an individual that happens to be an Anthem member, we want to know their social need. And so, we're really actively working in partnership in the local and community level and at the state level to really identify the

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needs of our members and being able to have actionable data to work on their behalf.

Alan Gilbert: [01:24:59](#) And so, there are also some great technology platforms out there that are really helping to close the loop and we're experimenting with the... close the loop, by that I mean be able to provide a resource referral network in a community and many are in North Carolina which was mentioned earlier. The state of North Carolina has been incredibly innovative and it's literally going county by county with the roadmap and connecting the social care network together so that we all have access to it, and so that we all will assess in the same way, in a standardized way and then be able to really understand the capacity of these community based organizations.

Alan Gilbert: [01:25:43](#) In the old days, if a community based organization was given a referral from whether it be a care manager from Anthem or from a primary care doc, we had no way of really seeing whether, did the individual received a service if they go to the housing authority that was given to them by the primary care doc or by an Anthem care manager. Did they get the services that they need? Do they still have stable housing? And it's even further to think about, are we following that member's journey and understanding whether not only their social needs met, but are we seeing, for example, a diabetic patient now have more stable care, not in the emergency room as much, not using... utilization down and their health outcomes improved.

Alan Gilbert: [01:26:33](#) And that's the state we want to all get to. But likely none of us are there yet. And so, we're really working to test and pilot and we need to understand if a community based organization has the capacity to take on a new person. And that's all being developed today. And there's a lot of experimentation, which is not bad at all in the space being done to really understand and being able to participate in a very actionable way in communities.

Karen DeSalvo: [01:27:02](#) Alan, this is Karen. I just want to underscore the importance of all of us recognizing that the community based organizations, the food banks, the meal on wheels, the transportation support companies, the housing support agencies are really significantly under-resourced and stretched to do the added work that is being layered on. And so, not just understanding that this isn't a terrible effort and we should do contractual services and pay for the services, but also thinking more broadly about how to help support their infrastructure so they can really help participate as true partners in meeting the health needs of patients in communities. That's incumbent on us in healthcare to raise this

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to help be an amplification for their voice in this really important space.

Alan Gilbert: [01:27:45](#) That's a really good point Karen and we'll just go back and forth here and say that we're experimenting with new payment models to do that, right? And so, we can dream of the day in the future where we have a totally different risk model and then we're supporting them. We are supporting many of the community based organizations with added resources and capacity and infrastructure in many of our places. But there are experimentations and pilots and so what we need to really understand is which one of them... what works, what doesn't, what can we scale, what is scalable, what's not? But you're absolutely right.

Kathryn Santoro: [01:28:24](#) Thank you all so much. I know we could keep going for a couple more hours talking about this really interesting discussion, all your interesting work and perspective. I think we've all learned so much. I know we didn't get to all the questions, but we can share them with the speakers if they're able to try to answer a few offline. It's really just great to learn about all this exciting work and we'll definitely continue to share information and continue that really important conversation.

Kathryn Santoro: [01:28:57](#) Thank you to our excellent panel of speakers and to our audience. Your feedback is really important to us. If you could take a moment to complete a brief survey. We also invite you to check out NIHCM infographic in our resources, and recording of this event will be available as well as the slides so you can catch anything that you missed. Thank you all again so much for joining us today.