Collaborations in Action: Aligning Initiatives Across a Region

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COMMUNITY INFORMATION EXCHANGE VIRTUAL SUMMIT

Session Reminders

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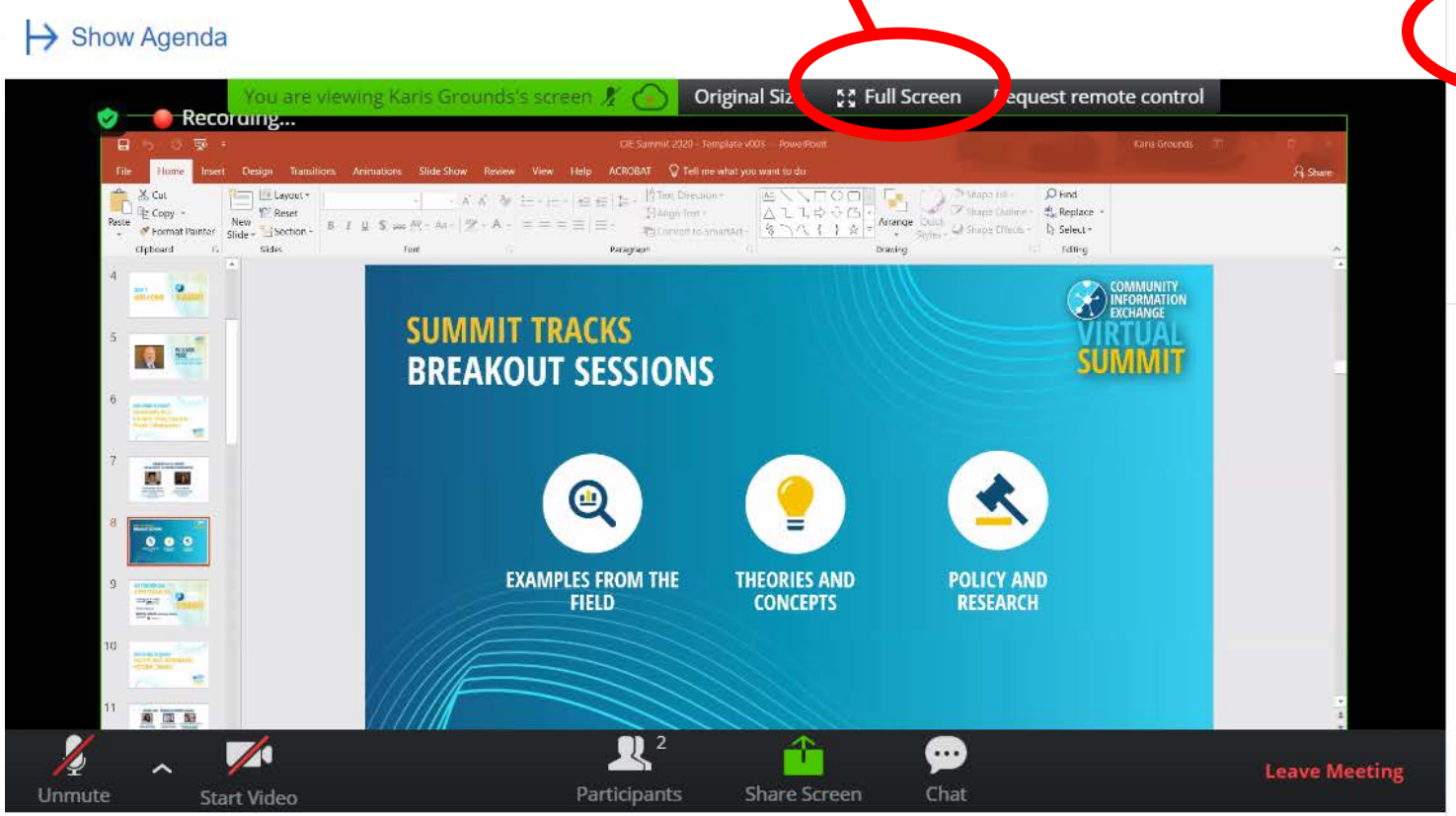
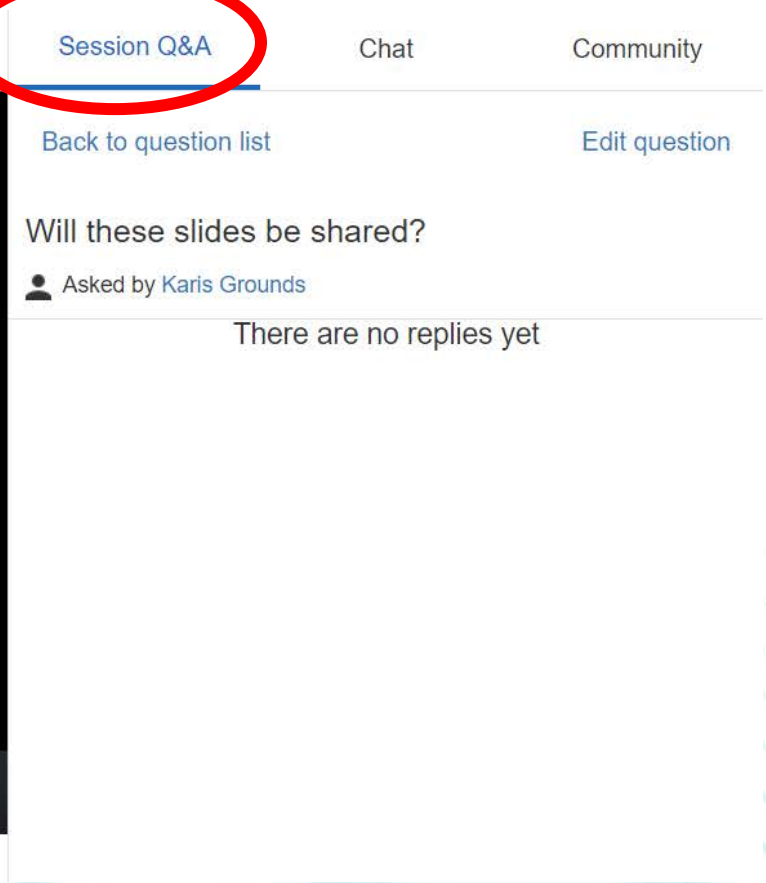
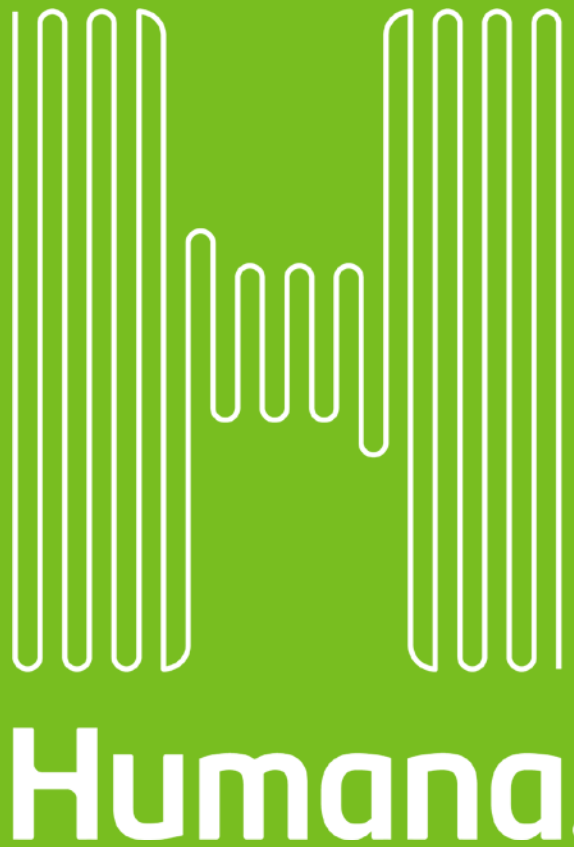






Healthcare system transformation: During and beyond COVID

Caraline Coats, Vice President
Bold Goal and Population Health Strategy, Humana

Today’s discussion

- Humana’s response to COVID-19
- Humana’s perspective addressing health inequities
- What we’ve learned
- Establishing a new normal

Humana’s response to COVID-19

Reaching farther, faster

Access to Care

Care delivery shifted immediately from facilities to the home. We expanded and fast-tracked telehealth services.

Testing & Protection

Safety is number one. With our partners, we made testing more accessible and protecting ourselves easier.

Social Determinants

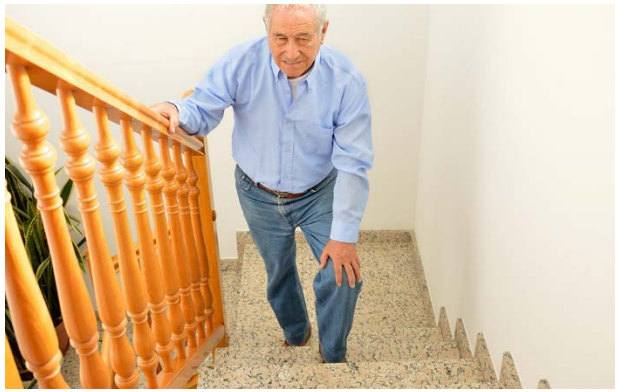
Social distancing has exacerbated health-related social needs. Elevating efforts to address was critical.

Financial & Administrative

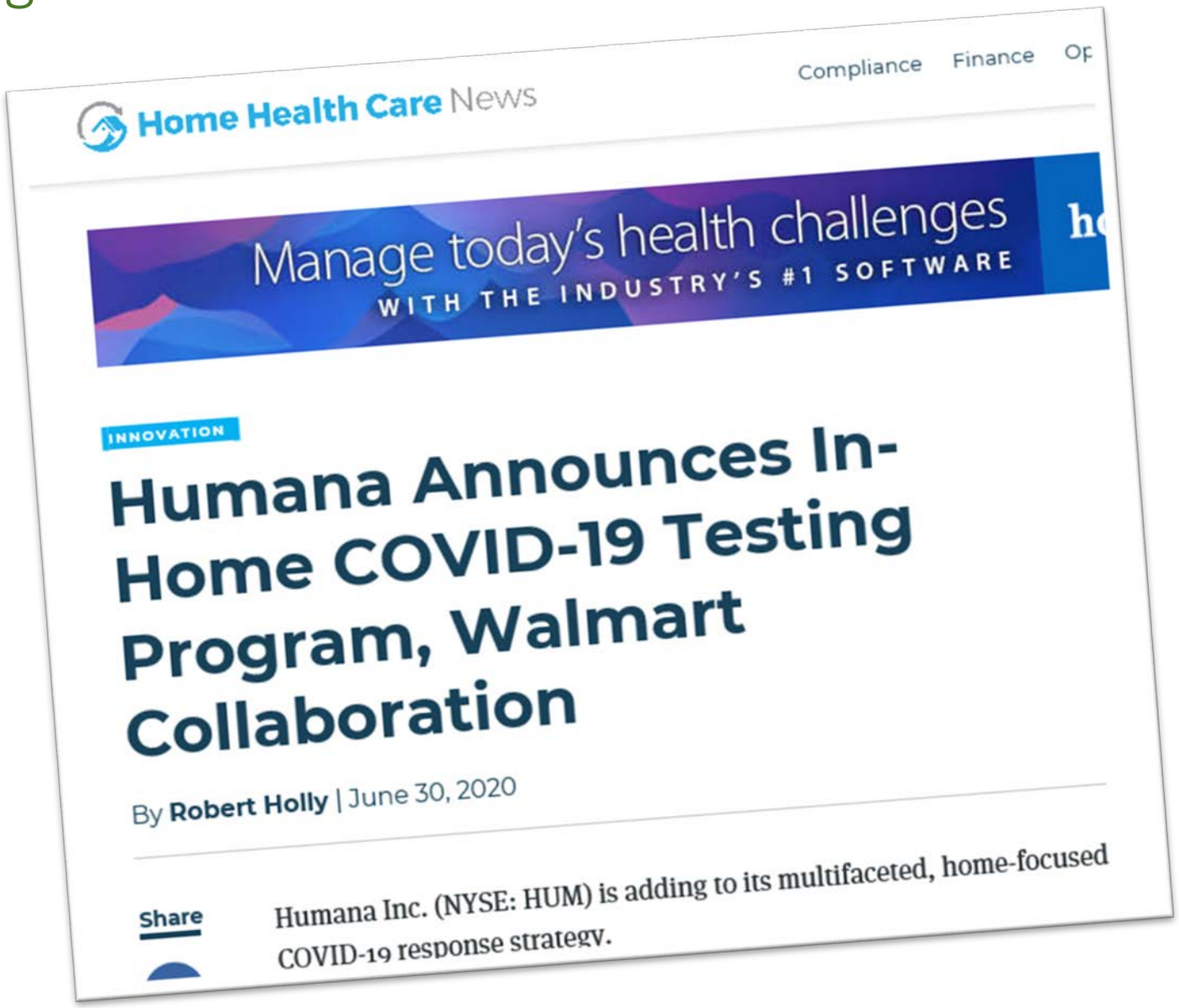
Significant steps were taken to relieve financial pressure and administrative burden for both providers and members. The focus was on care.

All powered by advanced, integrated technology

Assessing first-hand both medical and social needs



Making testing easier



Home Health Care News

Compliance Finance Op

Manage today's health challenges
WITH THE INDUSTRY'S #1 SOFTWARE

INNOVATION

Humana Announces In-Home COVID-19 Testing Program, Walmart Collaboration

By **Robert Holly** | June 30, 2020

Share

Humana Inc. (NYSE: HUM) is adding to its multifaceted, home-focused COVID-19 response strategy.

Our Bold Goal: Improve the health of the communities we serve 20% by 2020 and beyond

THE ROOTCAUSE COALITION

MEALS ON WHEELS AMERICA

LOUISVILLE JEFFERSON COUNTY

CITY OF SAN ANTONIO METROPOLITAN HEALTH DISTRICT

papa

FEEDING AMERICA

American Diabetes Association.

Bold Goal initiatives during COVID-19

Social isolation and loneliness

Papa

- Moved from in home visits to virtual visits
- Added shopping and grocery delivery service
- Expansion of Papa to additional populations

Friendship Line

- Partnered with the Institute on Aging on to establish a Friendship Line
- Repurposed Humana associates to receive inbound calls

Far From Alone campaign

- Campaign provides framework, tools and messaging for our partners to use to alleviate loneliness during COVID
- Designed to go beyond the pandemic and is a new way to conceptualize and message on social isolation and loneliness

Food insecurity

Basic Needs Efforts

- Our outreach calls to members include questions about food insecurity and we act quickly to get help to those who need it.
- Coordinate with national, regional and local partners to expand access to food and meal delivery and connect our members in need.
- Have supported the delivery of 850k meals

Technology

Social health Access Referral Platform (SHARP)

- Expediting processes and creating rapid response work streams

“Our priority during this COVID-19 outbreak is to support the safety of patients. To do this, we have eliminated all cost-sharing for COVID testing and treatment.

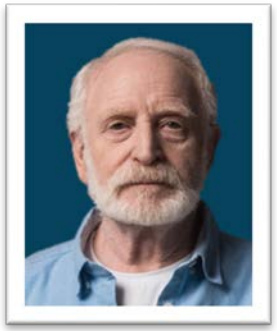
Concerns about costs should never be a barrier to appropriate care during this crisis.”

William Shrank, MD
Chief Medical Officer

Reducing financial and administrative stress

Costs should not be a barrier to patients’ treatment for COVID-19. To ensure this was not a factor, we wanted to support the patient and provider.

Examples of steps we took:

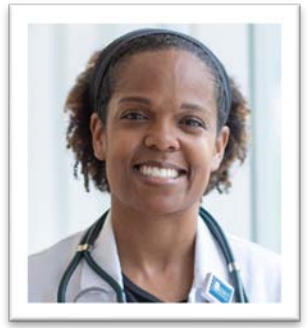


For patients…

Waived COVID out-of-pocket costs

Expanded our telehealth services

Allowed early prescription refills



For providers…

Suspended COVID-related authorizations

Expedited quality recognition bonuses

Suspended medical records requests

Humana's Perspective Addressing Health Inequities

Humana.

What we know about health disparity.

There is a disproportionate impact of health conditions and adverse outcomes on Black, Indigenous and People of Color (BIPOC).

Cardiovascular disease

African Americans are nearly 2x as likely to die from a stroke and their age-adjusted death rates are over 30% higher than for the overall US population.

Cancer

Ethnic minorities are substantially more likely to be diagnosed with cancer at a later stage leading to less successful treatment.

Diabetes

Whites have the lowest rates of diabetes at 7.6% aged 20 and over.

BIPOC %: Asians 9.0%; Hispanic 12.9%; African Americans 13.2%; American Indian and Alaska Native 15.9%

Kidney Disease

American Indians and Alaska Natives are less likely to receive kidney transplants.

Infant/Maternal Health

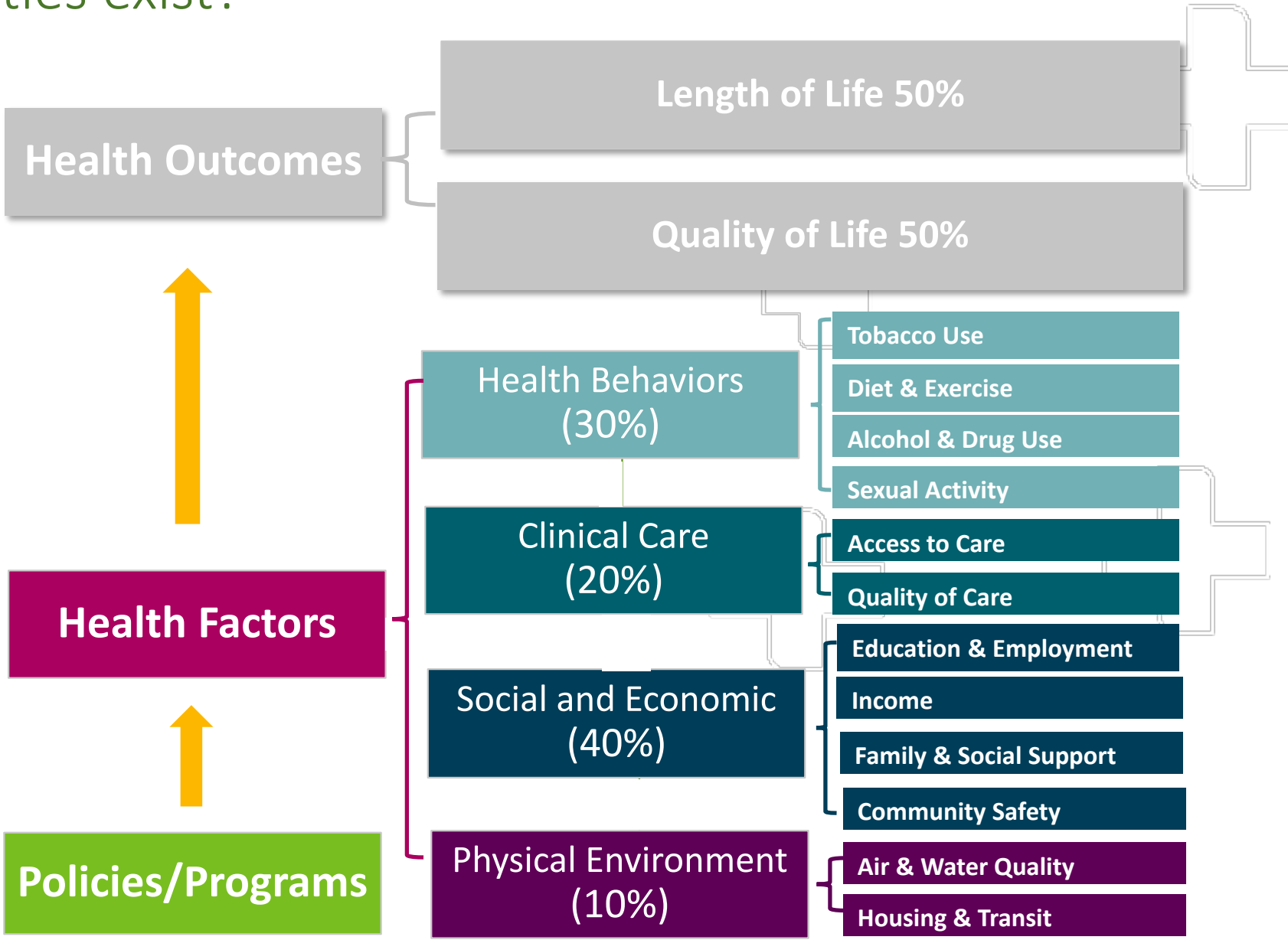
African American women are 2x as likely to give birth prematurely.

Maternal mortality rates are 2-3x higher in Black and Native American mothers

Behavioral Health

Minority children were less likely than whites to be diagnosed with ADHD and those who were diagnosed were less likely to be prescribed medications.

Why do health disparities exist?



Source: County Health Rankings Model 2014

Health sector strategies for reducing health disparities

Medical society advocacy

The American Medical Association created the AMA Center for Health Equity in 2019.

Reduce barriers to meds

When patients experiencing an MI received their medications for free there was an 11% drop in cardiovascular events.

Improve access

When three health systems provided social support, advocacy and navigation patients in low income zip codes experienced 65% less hospitalizations.

Value-based payment

Enhanced patient-provider communication and trust as payments reward for time spent engaging patients, may help overcome cultural barriers.

Success will require a multifactorial approach that addresses many sources of disparities in health.

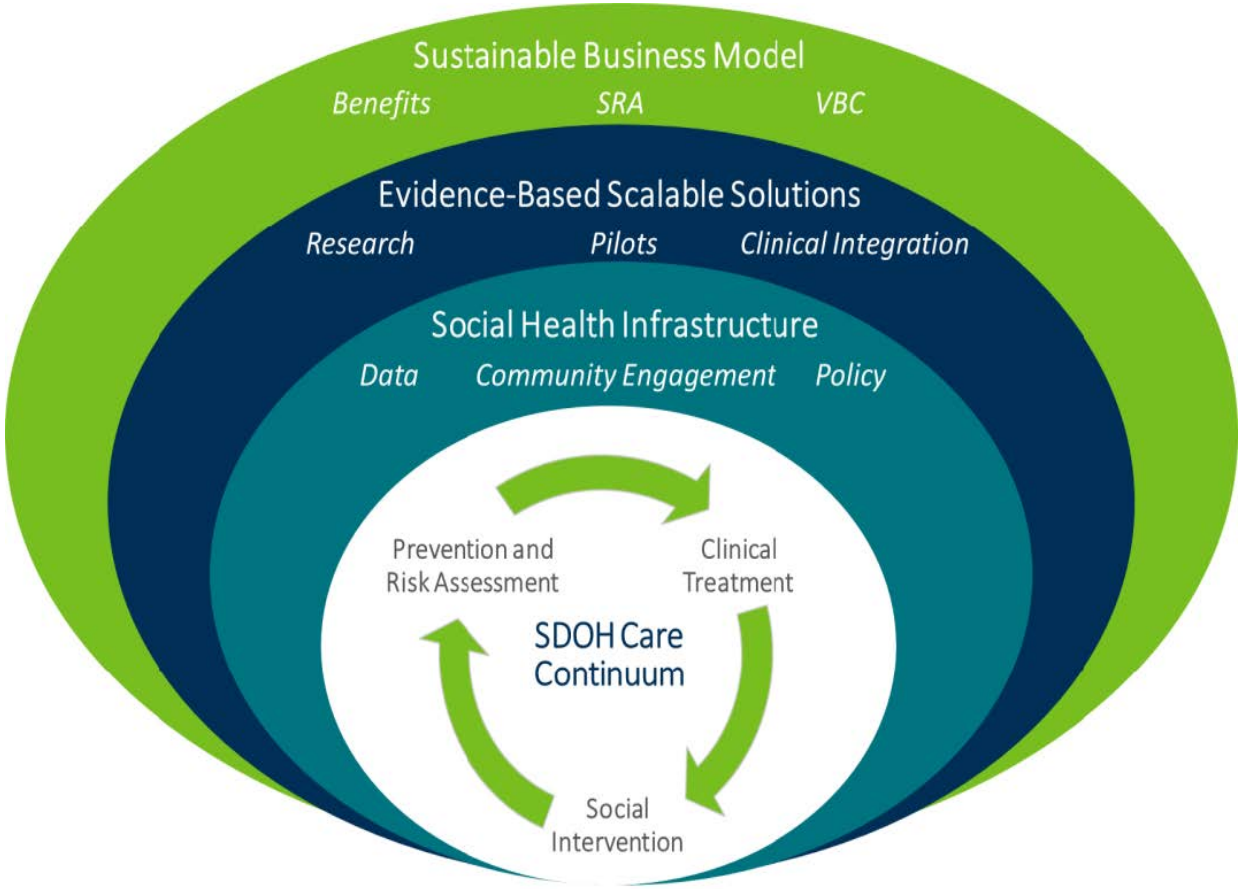
Humana’s approach for our employees

We apply a holistic view and commitment to employee well-being that encompasses multiple dimensions, including SDOHs, and focuses on addressing the varying personal barriers our employees face in achieving their best health.

The Humana Well-being Model

Humana’s approach for our members

Humana has approached health inequity in our health plan membership with what we call Human Care – looking at every facet of a member’s life and working with them to create a plan that works for their unique needs.



Achieving health equity

Short-term

- Assess where your organization is today and set goals for moving forward.
- Integrate the work of health equity in all policies and practices within organizations.
- Create pathways for advancing equitable access to economic opportunity.
- Design employee experiences and benefit programs to address health inequities.

Intermediate

- Implement employee Health Risk Assessments to track progress and adjust to needs.
- Focus on deepening relationships and investments within local communities.
- Participate in public health conversation and planning to foster collective action.
- Create momentum and political will to implement local and national policies.

Long-term

- Lessen barriers to high-value healthcare and reward performance for reducing disparities.
- Clarify accountability and set goals for eliminating disparities in access and outcomes.
- Ensure that new technology does not perpetuate discrimination and disparities.
- Continue to advance other social policies that do, or will, disproportionally impact BIPOC.

How do we get there?

Intentional action, transparency and collaboration.

- ✓ Invest in our employees.
- ✓ Collaborate fairly and ethically with our suppliers.
- ✓ Be a good partner.

Source: Humana’s Perspective on Addressing Health Inequities opinion editorial for Business Round Table.

What we’ve learned

Through conversations with our customers, we heard…

Members

Know us. Understand my unique clinical picture and health-related social needs, so my care is personalized and accessible.

Physicians & Hospital

Trust us. Support me in caring for my patients more efficiently, so I can keep them healthy and safe.

Administrators

Support us. Help me keep my healthcare organization sustainable, so we can continue to deliver high quality care.

Community Partners

Connect with us. Work with us to accelerate interoperability efforts, so we have the best data to serve those in need.

Health department

Help us educate. Put forward materials and tools to support the education of our front-line care staff on staying safe and protecting patients.

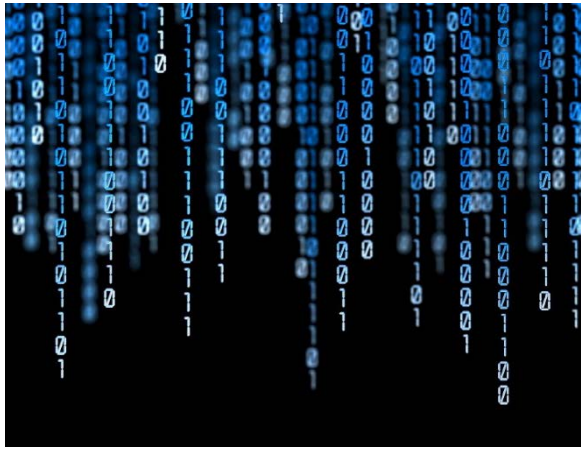
Federal government

Move with us. Provide input and collaborate on new CMS guidelines and policy to ensure we are able to serve those that are the most vulnerable.

Establishing a new *normal*

Think outside the box

It’s difficult to envision the new normal for healthcare, but if we re-imagine it – beginning with the basics and working together as an industry – we will likely wind up in a better place than before the coronavirus pandemic hit.



Tackle inequity

Inequity exists related to access, coverage, health-related social needs, and basics, like food.

Transform pay structure

Our payment models should support our innovative care and incent value-based care.

Mine data

We need to find our most vulnerable and stratify care. Then, we have to share.

Expand partnerships

We can connect across all sectors: community, govt, private, public.

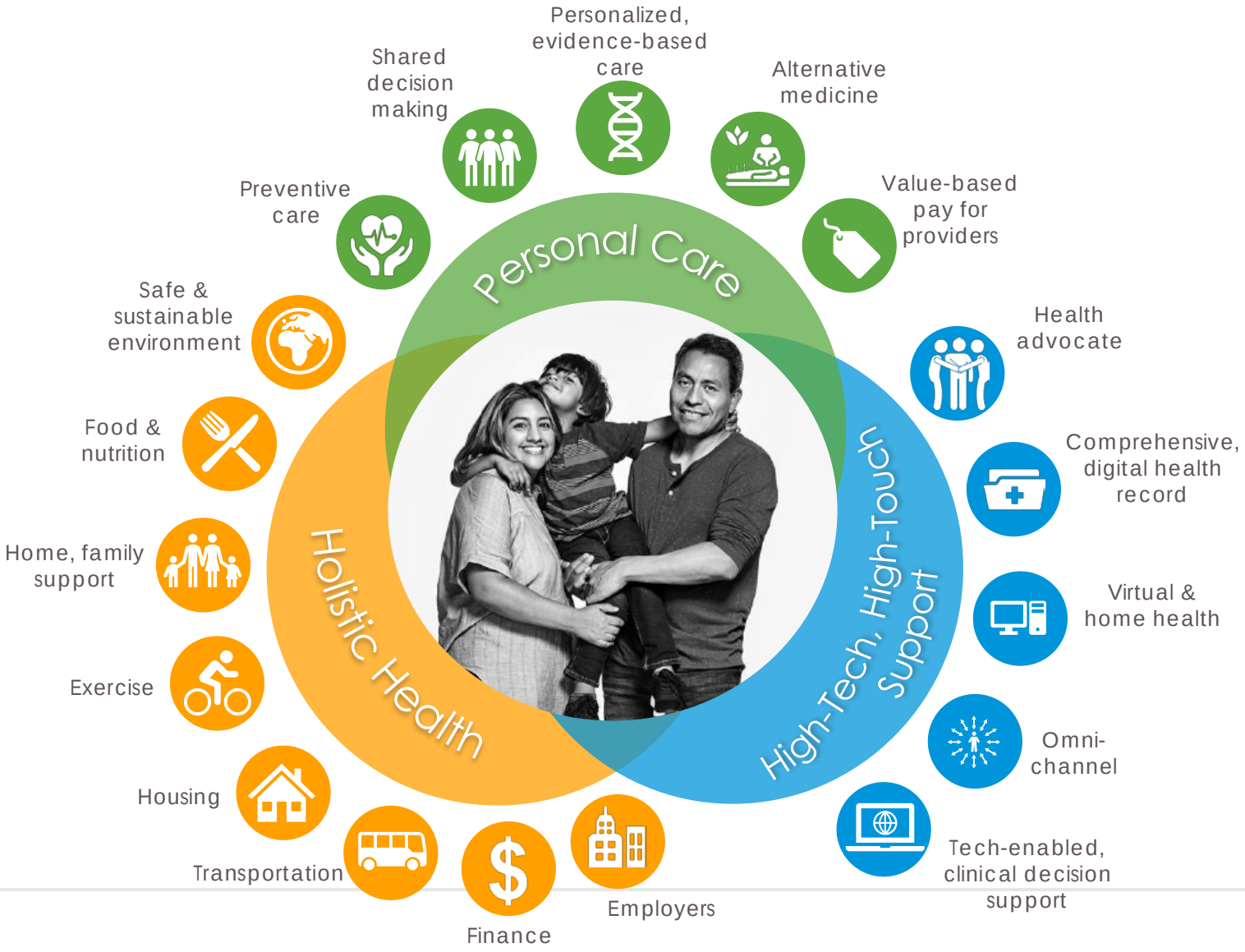
We’re in this together.

Collaborating to Improve the Social Determinants of Health

Shannon Cosgrove, MHA

Director of Community Health, Blue Shield of California

Health Reimagined



Our Approach

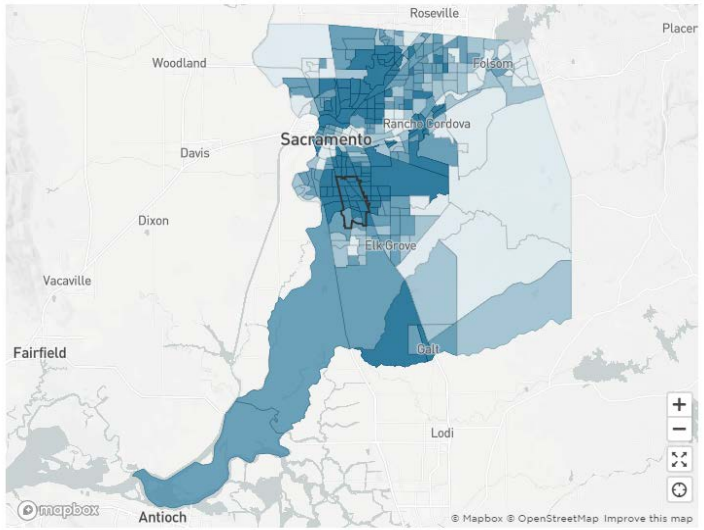
1. Community Health Dashboard
2. Community Connections Partnership
3. Community Health Advocates
4. Applying and re-applying an equity lens

mySidewalk: Telling the story

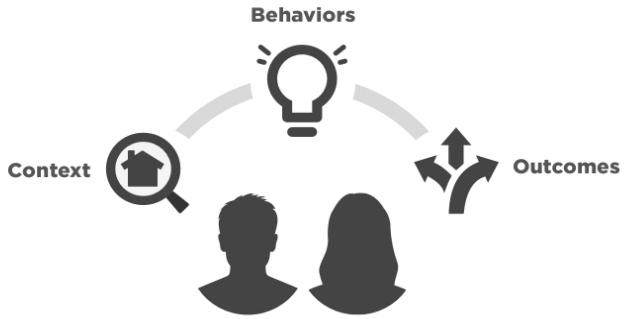
Let's build better opportunity into our communities

Living a long, healthy, and happy life is easier when our communities are safe, schools are high quality, jobs are abundant, and everyone can get the care they need. Some communities face more barriers to this goal than others. Eliminating these barriers makes our communities and all of California stronger.

Social Vulnerability Index



Sources: CDC Social Vulnerability Index within the State of California, 2018. Social Vulnerability Index within the State are percentile rankings on a scale from 0 to 1, where values near 1 indicate high social vulnerability and



Health equity is in our reach

24
out of 58 counties
Health Factors Rank
Sacramento County, CA

28
out of 58 counties
Health Outcomes Rank
Sacramento County, CA

Sources: RWJF County Health Rankings, 2020

Average Physically Unhealthy Days
3.8
Days in past month
Sacramento County, CA

3.5
Days in past month
California

Average Mentally Unhealthy Days
4
Days in past month
Sacramento County, CA

3.5
Days in past month
California

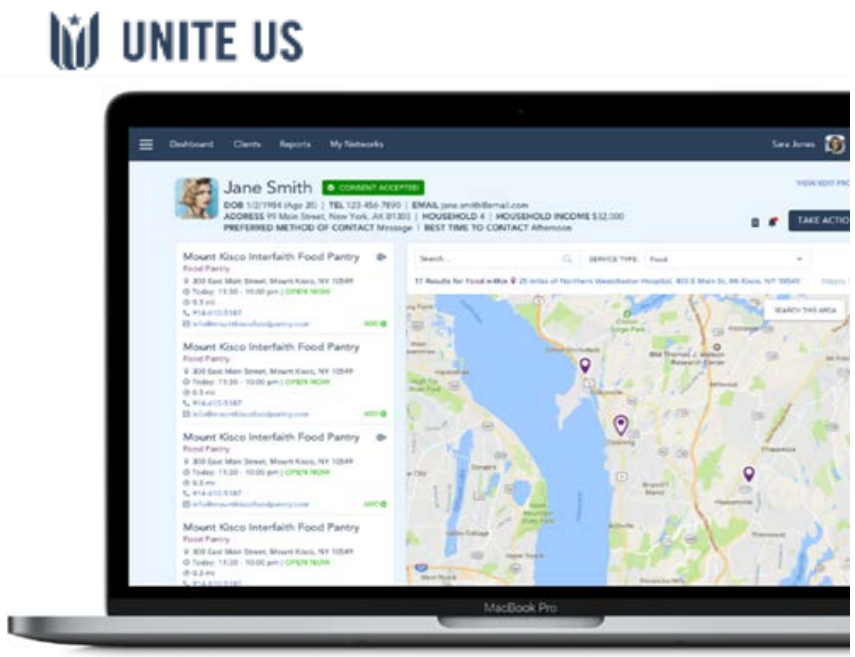
Sources: BRFSS, 2017. Total unhealthy days is the sum of physically unhealthy days in the past 30 days, and mentally unhealthy days in the 30 days.

Community Health Dashboard

- Automated, statewide data story generator allows any Californian to enter an address, choose a comparison zip code, and receive a personalized, interactive, web-based Community Health Dashboard
- The generator will provide essential community data, rooted in equity and framed by the social and economic drivers of health
- Data indicators include CDC Healthy Days, CDC Social Vulnerability Index, Behavioral Risk Factor Surveillance Survey, etc.
- Holistic understanding of communities – from health outcomes, behaviors and social risk factors, to social, environmental, and economic conditions

mySidewalk HEALTH

Unite Us: community-wide coordinated network

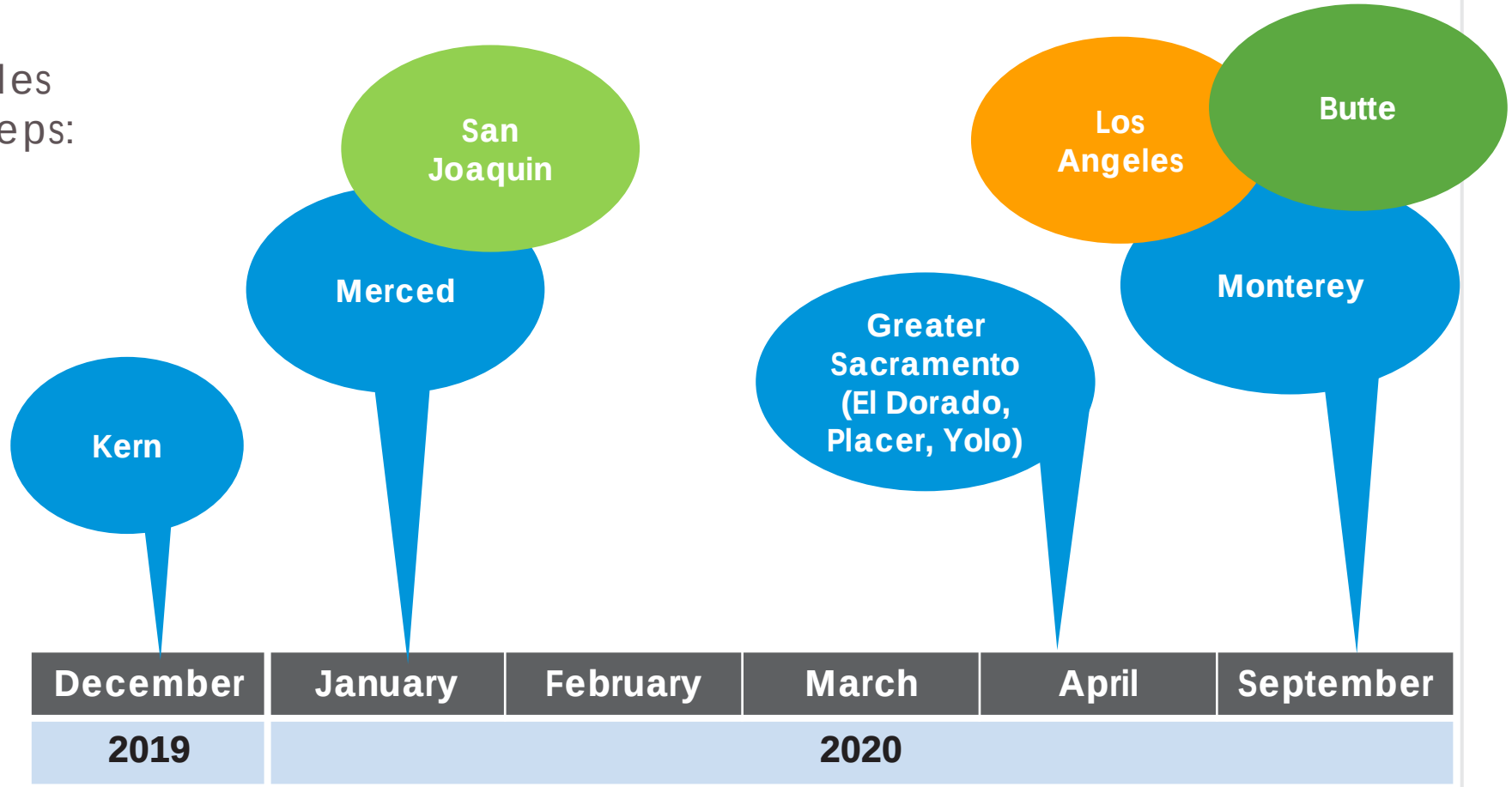


- Powerful closed-loop referral network that matches co-occurring needs to community providers and services
- HIPAA-compliant
- Client information is captures once and shared with community care team
- Support the expansion of social determinants of health best practices
- Implement and support relationship-based referral pathways
- Insight into the entire referral continuum of care
- Access to longitudinal referral record for health and social service providers

Statewide impact

Each implementation includes the following launch plan steps:

- Resource directory
- Network design
- Socialization
- Provider onboarding
- Training
- Launch



Community Connections Partnership

California Health Care Foundation

blue california

CommonSpirit

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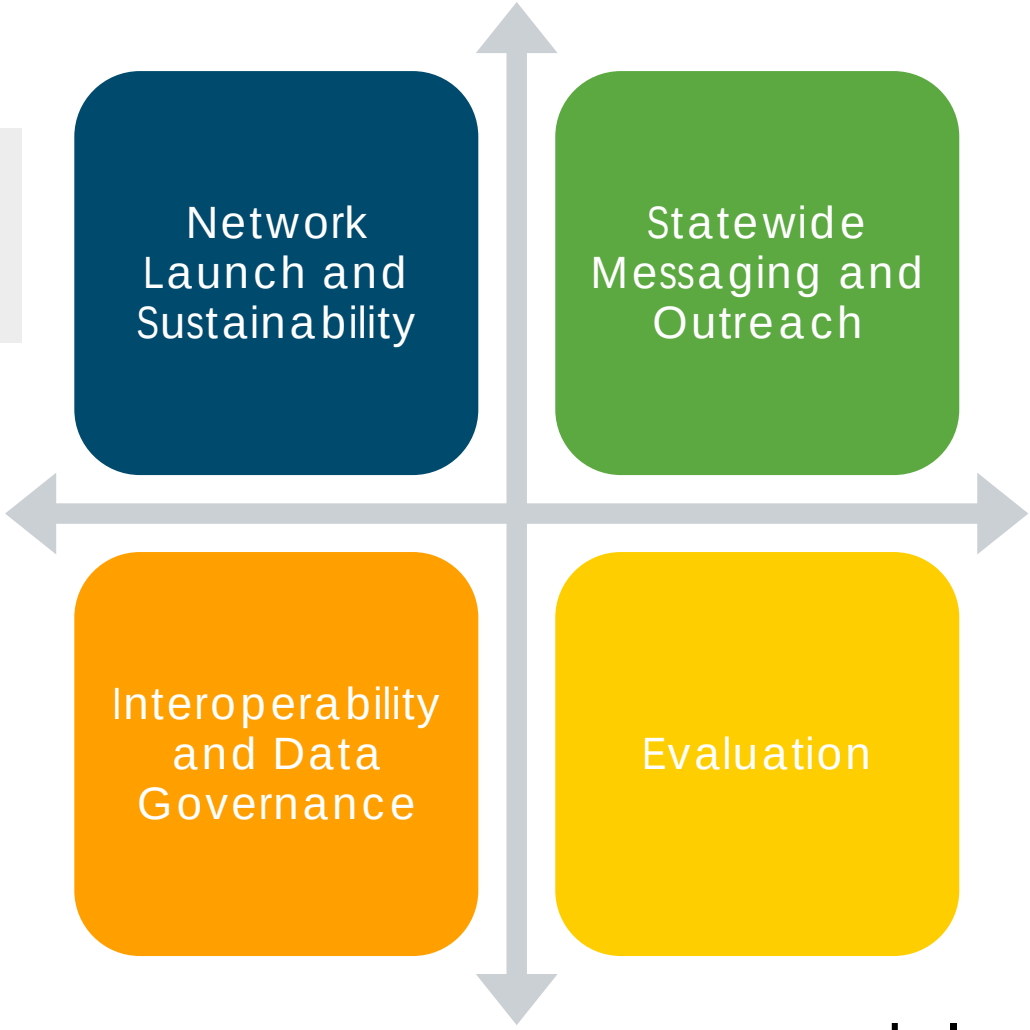


blue

Social Needs Specialists Integrated into Care Teams

Providers

Community Health Advocates

Patients

Streamlined Experience

Personalize Patient Care

Make Health Care Affordable

Holistic health

High-tech, high-touch support

- **Patient satisfaction**
- Provider satisfaction
- **Access to care/ addressing mental, physical and social needs**
- Affordability/improved outcomes

Build whole person care teams

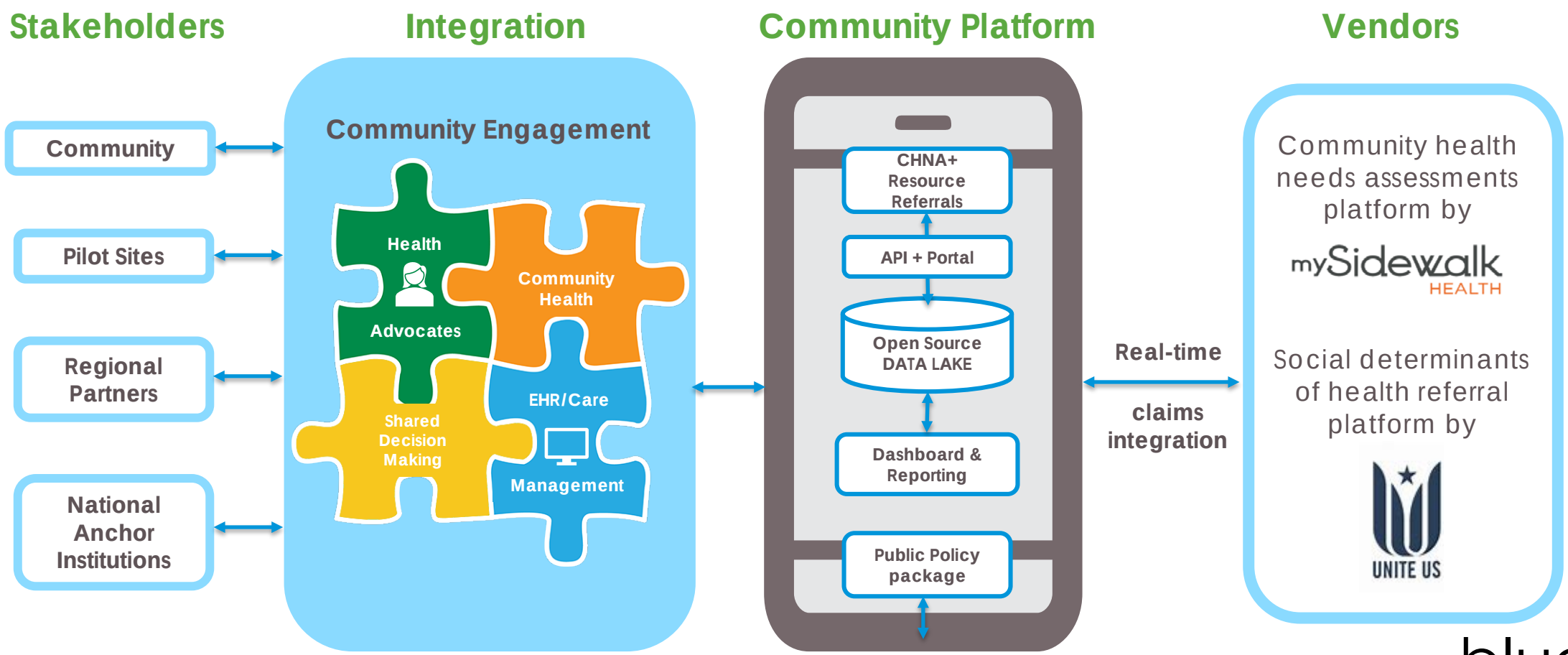
Integrate social health w/MH and BH

Address social determinants of health using a community health platform to track outcomes and payment

Benefit individuals and communities

Holistic Health Platform

Social needs & resource referral system



Patient + Provider + Community

Equality

Equity

Thank you!

Collaborations in Action – Aligning Initiatives Across a Region

Community Information Exchange (CIE) Summit

August 12, 2020

Sarita A. Mohanty, MD, MPH
VP, Care Coordination, Medicaid and Vulnerable Populations
Accountable Executive, Thrive Local

KAISER PERMANENTE®

Kaiser Permanente

At a Glance

KAISER PERMANENTE

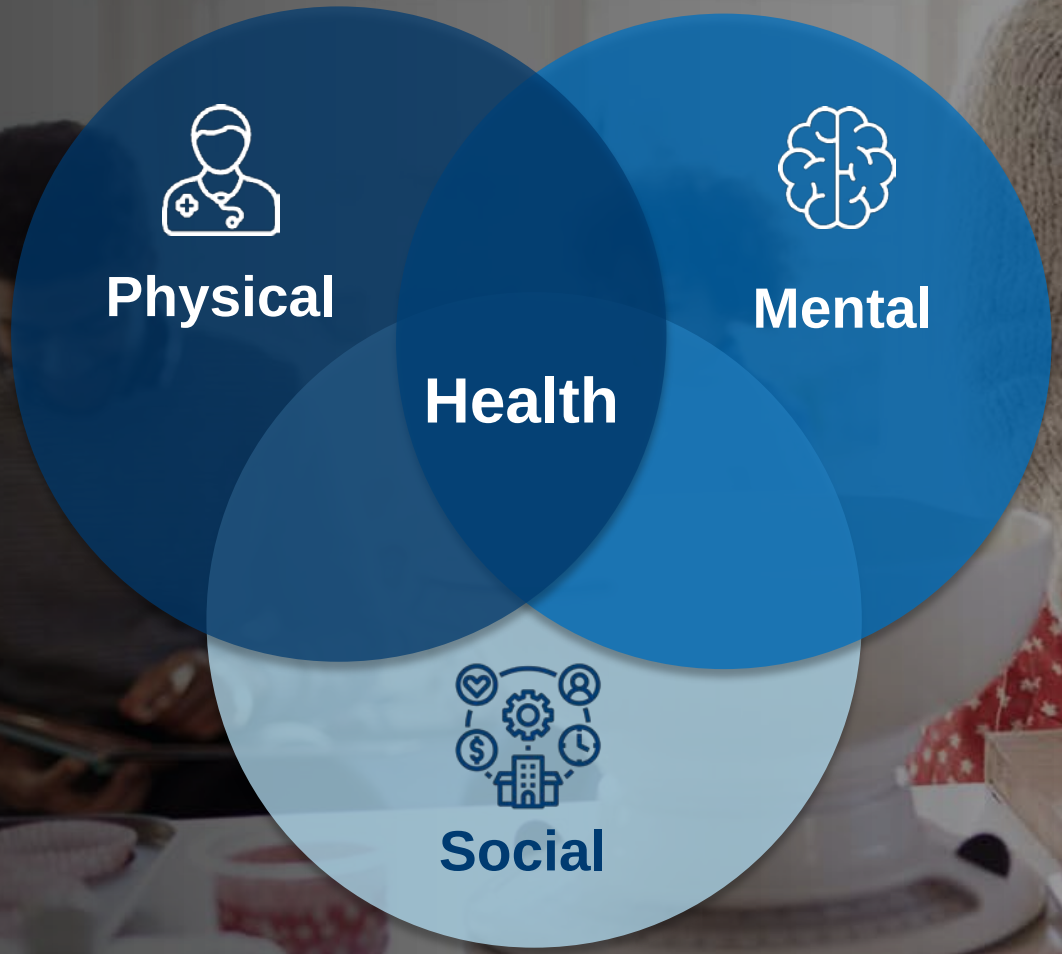
Our Mission

To provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Our Vision

We are trusted partners in total health, collaborating with people to help them thrive, creating communities that are among the healthiest in the nation, and inspiring greater health for America and the world.

Social health is equally important as physical and mental health



Even before COVID-19, people struggled with unmet social needs

68%

Had at least one unmet social need in the past year.

People reporting unmet social needs are

2x

As likely to rate their health as fair or poor.

97%

Of respondents want medical providers to ask about social needs during care visits.

UNMET SOCIAL NEEDS ARE A BARRIER TO HEALTH.

1 in **4** Americans

Have had an unmet social need they say was a barrier to health in the past year.

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Social Health Analytics: Tracking Social Needs Among Our KP Members

Preliminary Findings as of June 26, 2020 (n=8,801 out of planned 10,000)*

63%
of survey responders have at least **1 social need**

21%
have **3 or more** social needs
.

Top 2 prevalent social needs:

42%
Financial strain

35%
Social Isolation

35%
would **seek assistance** for their social needs

Responders **desired** assistance with **financial assistance** more than other programs

COVID-19 Impact on Social Needs

Interim Results
- **47%** of those with identified social needs reported a negative mental health impact of COVID-19.
- **19%** of survey responders feel that COVID has had a negative impact on their ability to keep a job.

COVID-19 and its long-term impacts threatens to deepen the social health crisis

Social Health **Playbook** Overview

- Guide for caring for COVID-19 patients who have social needs and **can be applied broadly for all members**
- **3 core steps** to support patients with social needs:

Screen
for needs

Connect
to resources

Follow Up
to make sure needs are met

Addressing COVID-19 patients' social needs not only ensures appropriate care is provided to our vulnerable patients but **can also prevent further transmission of the virus.**

Guidance for Patients with Specific Social Needs

The playbook suggests steps for screening patients for social needs, offers abundant resources to connect them to, and provides guidance for following up and documenting care and service.

Homelessness & housing insecure
Example resources: United Way, community action agencies, legal services and housing assistance, local public housing authorities, etc.

Food insecurity
Example resources: SNAP. Food banks, medically tailored meals, USDA Find Meals for Kids site, etc.

Social isolation
Example resources: myStrengh, Friendship Line, Village to Village Network etc.

Financial strain
Example resources: Medicaid, CHIP, health benefits exchanges, MFA, CARES Act, etc.

Seniors & those with **behavioral health needs**
Example resources: Friendship Line, Village to Village Network, Eldercare Locator, KP digital health offerings, regional behavioral health access centers, etc.

Questions: Please email us at socialhealthplaybook@kp.org

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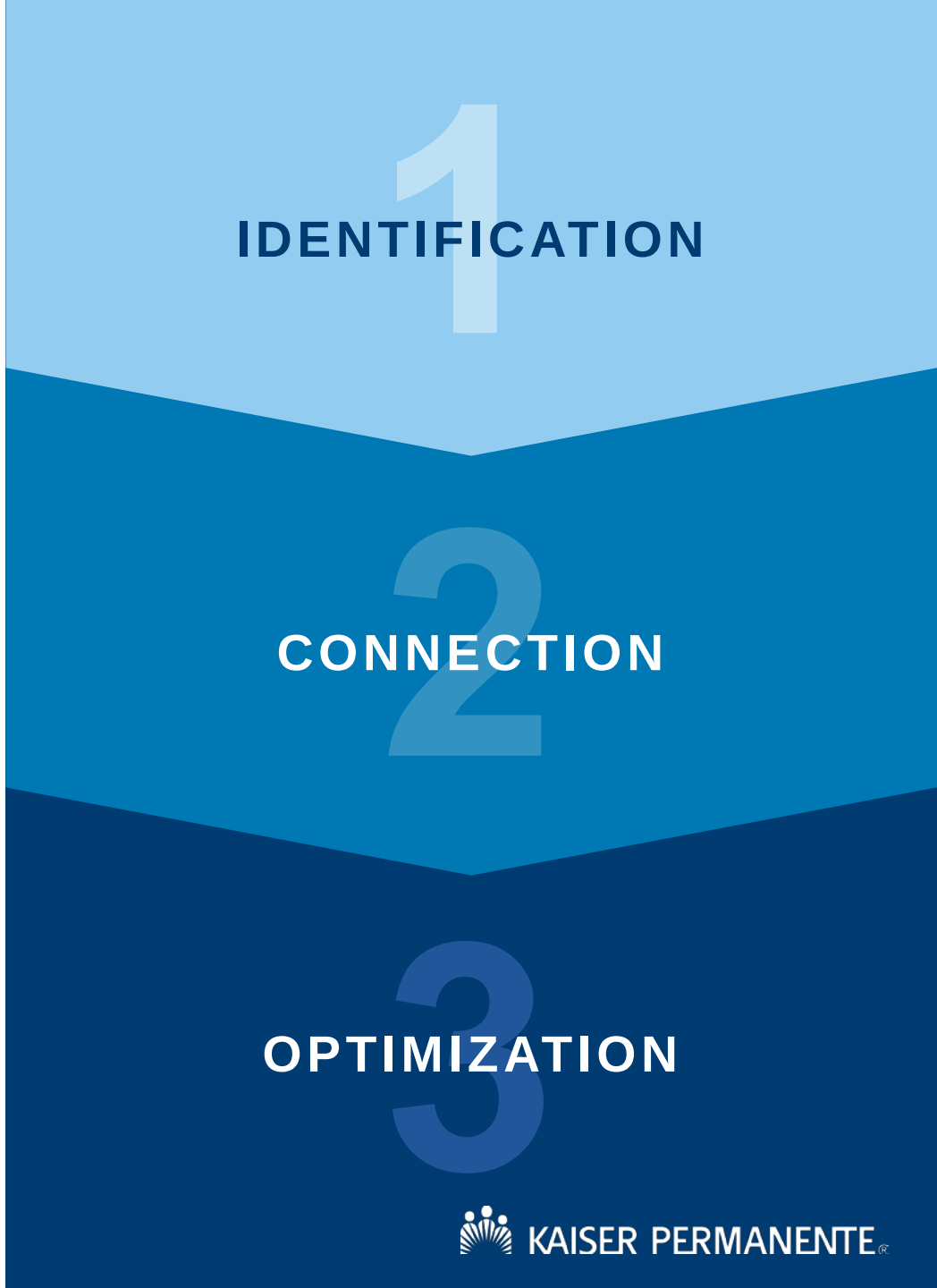
Updated as of 05.22.20

Closing The Gap in Social Needs to Improve Total Health – Mind, Body, Community

Thrive Local aims to address unmet social needs. Our social health network will:

- ✓ Provide an **online Resource Directory** with up-to-date, searchable information on a wide range of social services and public benefits
- ✓ Engage Geographic **Community Networks**, including community-based organizations and public agencies that health care providers can refer to.
- ✓ Partner with Unite Us to establish a **technology platform** that allows for **two-way, closed-loop referrals**.



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Thrive Local: Tools to connect people to needed resources

We accelerated development of Thrive Local resource directories and we have launched a national call center to match members to social assistance.

In response to COVID-19, KP expedited work to connect members with social needs to community resources.

2 pivotal resources to support members with social needs

Thrive Local Resource Directories
connect members to resources

Thrive Local Connections (TLC)
member call center
800-443-6328

COVID-19 Related Thrive Local Resources

KP partnered with Unite Us to add COVID-19-related programs and services to the resource directories, including local organizations helping with these and other needs:

Housing & shelter: There is an increased need for services related to *emergency housing, housing mediation and eviction-prevention services, housing applications and recertification, and rent and mortgage payment assistance.*

Food: Hunger and food insecurity are increasing as a result of COVID-19. Services addressing urgent food needs, such as *emergency food, prepared meals, SNAP, WIC, and other nutrition and grocery benefits* have been added to the resource directories.

Childcare: With schools and camps closed, *families need help with childcare during this time.*

Financial & employment assistance: Services in the resource directories include help with *emergency, one-time financial assistance, social security and disability benefits, cash assistance, veterans' pension and disability benefits, job-search, placement services, and job training*

Social isolation: Over the next few months, we will expand the range and volume of services to include *family support and education programs, clothing and household goods, utilities assistance, and programs addressing social isolation and domestic violence, etc.*

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Social Health in Action:

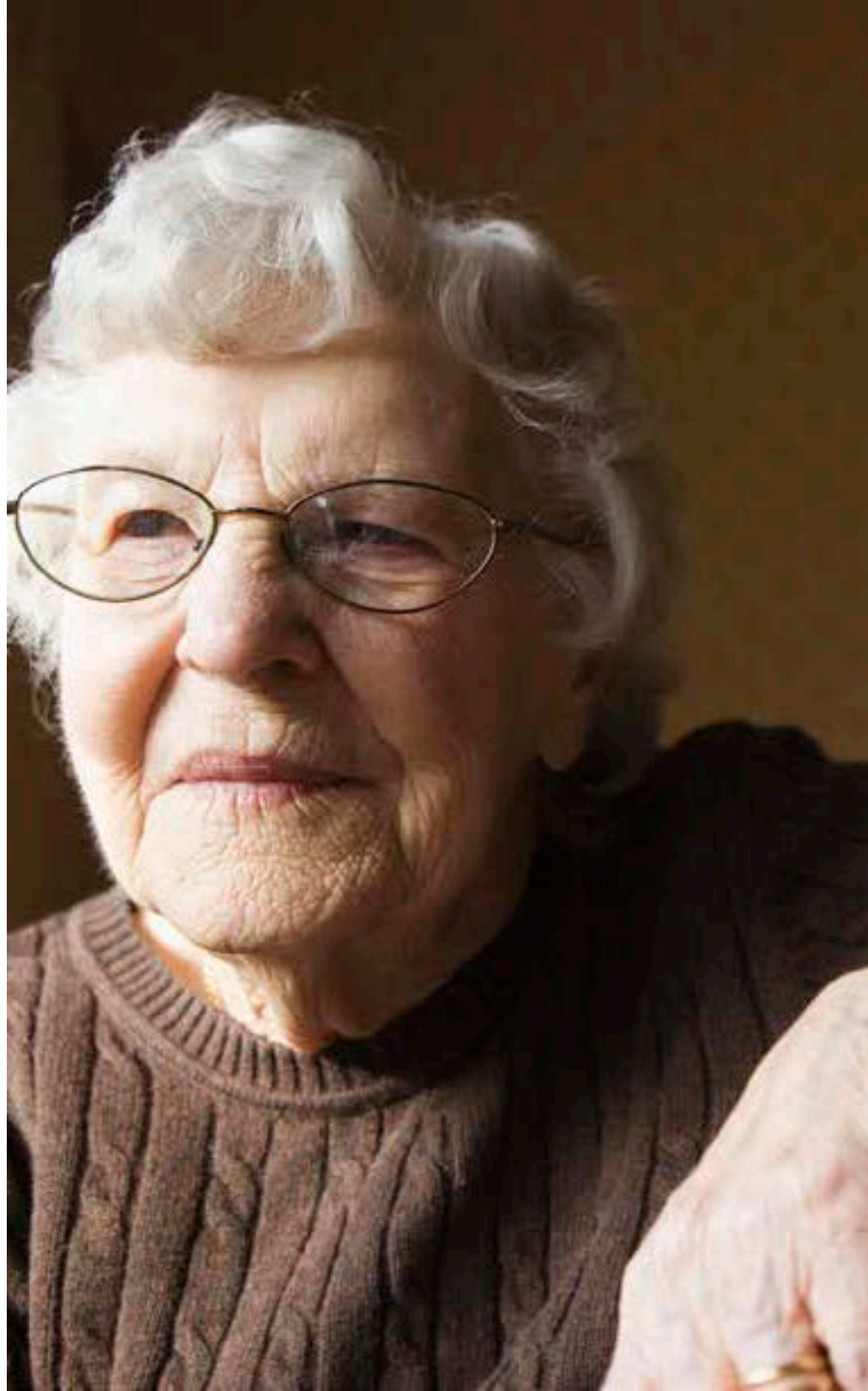
Portland man avoids eviction when his clinician refers him to Society of St. Vincent de Paul for emergency rent assistance

Husband and wife awaiting surgery connected to agency providing prepared meals

Caller connected to family services support for husband receiving dialysis

Mom worried about her homeless son is directed to emergency food and housing resources in son's area

Sacramento-area woman finds housing and completes a substance abuse program after her KP clinician refers her to Covered Sacramento



STATEWIDE COLLABORATIONS

Partnering with other organizations to build community networks and **statewide connections**.

California

blue california

CommonSpirit

California Healthcare Foundation

Oregon

LEGACY HEALTH

Samaritan Health Services

Providence

PacificSource HEALTH PLANS

PeaceHealth

health share Health Share of Oregon

OREGON HEALTH LEADERSHIP COUNCIL

St. Charles HEALTH SYSTEM

CareOregon

allcare health

Washington

HealthierHere

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Thank You
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QUESTIONS?

COMMUNITY INFORMATION EXCHANGE
VIRTUAL SUMMIT

THANK YOU!

What's Next:

1:15 PM - 2:15 PM

More Breakout Sessions! Check the Agenda!

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