The webinar *Alleviating the Social Drivers of Health During the COVID-19 Crisis: Lessons from Leading SDOH Partnerships* was given on June 17, 2020 as part of M-RCBG's weekly Business & Government Seminar Series.

Alexandra Schweitzer:

Okay, well welcome, everybody. Thank you so much for taking the time this afternoon to join us for, as you heard from our pre show chat, two of the three huge issues that have all converged in our time. Today we're going to talk about alleviating social drivers of health during the COVID crisis. We're going to share lessons from leading SDOH partnerships.

Alexandra Schweitzer:

I'll start with the usual logistics slide, please make sure you're muted. We would like me to use the chat function to ask questions, and we will be monitoring the chat. We'll have time at the end to go through questions and answers. Any questions that we do not get to today, we will answer following the webinar. Finally, I want to let you know that this webinar is being recorded.

Alexandra Schweitzer:

I'm Alexander Schweitzer. I'm the moderator for this panel. I'm a senior fellow at the Center for Business and Government at Harvard Kennedy School. I'm halfway through a two year project, researching the drivers of success in programs to address social determinants of health. I have had the good fortune to make the acquaintance of the people on this panel and many others who are doing really amazing, groundbreaking work. I've asked three of the programs to talk about how they are dealing with, responding to and incorporating the impact of COVID into their program.

Alexandra Schweitzer:

I'm going to ask them each to say a word or two about themselves, and then I'll tell you about today's program. Caraline, can we start with you and Andrew?

Caraline Coats:

Of course, good afternoon, Caraline Coats here with Humana. I lead what we call our whole Bold Goal. I'll speak a little bit to just evolved into our broader population health strategy. I've been at Humana about 13 years. [inaudible 00:01:54] Pleasure to be with you all today.

Andrew Renda:

Hi, everybody, this Andrew Renda, I work with Caraline, work for Caraline. I'm Associate Vice President Population Health at Humana. Physician by training and I've been at Humana for 12 years now.

Alexandra Schweitzer:

Alexandra?

Alexandra De Kesel Lofthus:

Good morning, everybody, and thanks for allowing me to be part of this webinar. I'm Alexander De Kesel Lofthus. I am the director of health care partnerships at Second Harvest Heartland, which is a food bank here in Minnesota. I joined Second Harvest Heartland in 2016, really to focus our work around our health and hunger, understanding that obviously hunger has a big impact on the health of the communities that we serve. I predominantly focus our time and energy on what is called our FOODRx programming that I'll be talking about later today. I'm excited for this conversation, and thanks for having me.

Alexandra Schweitzer:

Thank you, Katherine.

Katherine Keir:

Hi, everyone. Thanks for having me. I'm Katherine Keir and I serve as the Hawaii State Director of Clinical Redesign for UnitedHealthcare Community and State. The clinical redesign team runs several efforts to really try and determine how to most impact social determinants of health and partnerships in healthcare and social services. Happy to be here today.

Alexandra Schweitzer:

Thank you so much. We have four goals for today's meeting. First of all, because coronavirus and SDOH are each of their own so big and moving fast, we wanted to think through and help you think through a framework about how the coronavirus could affect SDOH programs. What are the forces of change, and how is that going to change over time? Thinking about the immediate response, the short term response, and the long term perspectives.

Alexandra Schweitzer:

We're going to spend quite a bit of time on case studies. We're going to talk through, or our panelists are going to talk through how they are addressing the changes that they're seeing. What are some of the best practices from before and lessons learned that they've been able to apply to responding to COVID, and how have those potentially changed as the COVID situation evolves? We'll also pull out some common themes at the end, and with a follow up after this webinar.

Alexandra Schweitzer:

We're going to ask everybody to dust off their crystal balls and talk about how might this crisis become an inflection point to change the trajectory of SDOH programs. Finally, we'd like all of you to help us with questions for future research. My research will be focusing in part on the impact of coronavirus over the next year. It's moving quickly. There's lots of different ways to think about it. Please keep those questions coming, put them in the chat box and we'll be collecting them.

Alexandra Schweitzer:

For those of you who are new to SDOH, which is probably enlightened already, just a really quick refresher. The big idea behind SDOH is it's very well documented that non-medical factors really have a much bigger impact on health and medical care itself. Things like inadequate nutrition, unstable housing, isolation and loneliness, lack of transportation, all of them in their own way and often together affect health outcomes for the worse.

Alexandra Schweitzer:

For this reason, many healthcare organizations have been developing and investing significant amounts of time and energy in SDOH programs, because they believe that with the right kinds of interventions, they can improve health. Obviously, that helps the people whose health is improved, but at the same time, it can also reduce avoidable cost and utilization. If you think about the example of a kid with asthma who lives in a rodent infested apartment, has a flare up all the time and ends up in the emergency room. A small amount of money invested in cleaning up that apartment is not only going to keep the kid out of the ER, but also save all of those ER costs. There's tons of examples like that, which we're not going to go into today, but there's a lot of literature. If anybody's interested in learning more, please put a question in the chat, and we'd be happy to share some good resources.

Alexandra Schweitzer:

How is COVID affecting health in SDOH? We can think about this in a couple of things? First of all, there's the illness itself. The people who are getting the coronavirus, tend to be people who started out with more social barriers, who were crowded together in housing, who can't really social distance. Social distancing itself, particularly among groups that were already isolated, can exacerbate that isolation, which in and of itself, can create health problems down the road.

Alexandra Schweitzer:

Clearly, economic disruptions result in unemployment, will result in housing insecurity and food insecurity. All of that combined, really is going to create a decline in health. It could potentially be averted, at least in part through some of these programs. I think we've all seen the headlines of the lines of cars going around the block for the food banks. We know the unemployment rate is the highest it's been since the Great Depression. Calls to the help lines have doubled and tripled. There's been a huge increase in social isolation and violence. The story can be told in lots of individual people's stories, in lots of communities everywhere around the country. This is a national problem, not a state by state problem.

Alexandra Schweitzer:

We're going to turn now to the programs that are addressing SDOH. I want to just say a couple of words about the programs that we're going to be looking at before we start. First of all, all of the programs that I'm researching and all the programs that are represented here today, are leading programs that have been around for a while. They've learned a lot and they've done a lot. They've been collecting evidence to really understand what they're doing and to demonstrate that the outcomes that they're seeing aren't a result of the work that they're doing.

Alexandra Schweitzer:

They also involve significant contributions from both healthcare and social service organizations, financial, strategic, and other. They all represent partnerships between health care and social services. I'm going to start by asking each panelist to talk about first, what programs did you have in place? Let's just set the baseline. What programs did you have in place to address SDOH, then we're going to talk about how has COVID affected those programs, and how are you modifying your programs? Finally, we'll turn to predictions for the future.

Alexandra Schweitzer:

Let's start with Humana and then go to Katherine and then Alexandra to talk about your programs to address the social determinants of health.

Caraline Coats:

Yeah, hi. Thank you, Alexandra. I'll take this first question. I think Andrew and I will alternate questions to be respectful of time. It's hard to think about what life was like before all of this. But we've been and Humana has been long at the social determinants of health equation, if you will. We started... I mentioned in my introduction, I lead our Bold Goal. That was launched in 2015 with the very aspirational intent of improving the health of the members and communities we serve.

Caraline Coats:

We latched on to the CDC population health tool, Healthy Days, which measures mental and physical health. By studying that and tracking our members' healthy days and unhealthy days, lead us down the path of social determinants of health. We looked at which ones moved that Healthy Days needle the most and saw some correlation with social isolation, loneliness, which you touched on, food insecurity, transportation, housing, and actually in that order.

Caraline Coats:

For the last five years, we've been spending a lot of time in what we call our designated Bold Goal markets and looking at interventions around all those particular social determinants of health, looking at Healthy Days results pre and post, social isolation loneliness index scores pre and post, measuring food insecurity. We've had an enterprise wide effort at screening as many of our members as we possibly can to get data and to understand what's really going on.

Caraline Coats:

Just within the last few years, we've gone from 1,000 screenings to recently about over 2.5 million screenings. That's really because this just through arming every associate who interacts with our members with these questions. We all know talking about our social health needs can be sensitive and complex. We've been long at really trying to meet our members where they are, and trying to study the barriers to achieving good health and what interventions we can place to improve that. Really, again, with that aspirational goal of improving everyone's health.

Caraline Coats:

As you mentioned, it's all certainly been exacerbated. I won't go into how we've had to pivot some of those programs yet. But one thing I think we've learned is that there's not one solution that fits all. While we've been at this, it feels like for several years now, it's really the surface, the first layer of all of this and I anticipate we'll get to the root of the root as all of this work evolves.

Alexandra Schweitzer:

Thank you.

Caraline Coats:

Thank you.

Alexandra Schweitzer:

Katherine.

Katherine Keir:

Thank you. UnitedHealthcare was fortunate to, in 2017, receive an award from CMS, Center for Medicare and Medicaid Innovation to implement the accountable health communities model, which we are implementing here in Hawaii on the island of Oahu. The model really looks at from a bird's eye view if you intentionally screen Medicare and Medicaid beneficiaries at point of care, within clinical settings, for health related social needs, and then connect them with community resources. Can you impact health? Can you impact health outcomes? Can you impact access to care, and can you impact cost of care?

Katherine Keir:

We're fortunate to be implementing that project here. We're in the middle of the five year project period. We are screening all patients, any kind of Medicare or Medicaid, with our partner hospital and [inaudible 00:12:24] clinics for social needs, including housing, food insecurity, utilities, transportation, and interpersonal safety.

Katherine Keir:

For those who have a need, reported need, we're connecting them with community resources. For those who are accessing the health care system more frequently, they're more frequent users of the ER, we're offering them a navigator who really does more of an assessment and warm handoff to those community resources. At more of the system or community level, what we're doing is gathering a lot of data, real time data around the social needs in our communities and whether folks are able to access services to meet those needs.

Katherine Keir:

I like to think of it in terms of a demand versus supply. We're working very closely with both our clinical and social service partners to start to reconcile that, to really ensure that the system of services is meeting the needs that are identified. That is an ongoing feedback loop in terms of identifying the needs, connecting them with services, determining if they're able to access those services, and where there are opportunities for improvement in service delivery.

Katherine Keir:

To date, we have done over 75,000 surveys of individuals here in Hawaii, and we'll be continuing that for another two years.

Alexandra Schweitzer:

Great. Alexandra.

Alexandra De Kesel Lofthus:

Hi. Like I said, I work for Second Harvest Heartland, that's a food bank here in the state of Minnesota. We really focused, and starting in 2016 on really how do we integrate food security solutions with our healthcare partners? Knowing that we were missing quite a few people that were accessing food shelves, but weren't necessarily... The ones that were going to the hospital systems weren't necessarily the ones that were accessing food shelves.

Alexandra De Kesel Lofthus:

We know that folks that are food insecure, have a higher likelihood of having chronic disease as well as just in general, poor health. In 2016, we started the FOODRx program, really looking at how do we work with healthcare partners to not only address the social determinants of food security, but also the health of our patients and the members of their community.

Alexandra De Kesel Lofthus:

One thing that was really unique about our program was, we've had a lot of experience and we had some experience in the past with a screening referral program, electronic referral with one of our health care partners that was going really well. It was time to do more for the community and the health of the members that we serve.

Alexandra De Kesel Lofthus:

Based on that previous success, we started our program and our theory behind our program was really around if we are able to offer better food, nutrition and security, would that lead to better health outcomes and engagement, and would that lead to reduction in cost for our partners? Really, having a business model behind the social determinants of health work that we are doing, in order... That was really important to us, for instance, to be able to say, if we are able to show better health outcomes and show better reduction in cost of care for our patients, can we lend an ROI to our healthcare partners, and then from that, be able to have a sustainable program that was not grant based, but then also be able to scale it across the state of Minnesota and across?

Alexandra De Kesel Lofthus:

That was really an important thing for us. We started with some research studies, to prove our program and to see if our program was showing the results that we wanted, which was fantastic. Then as you said, Alexandra, there's a lot of literature out there around food security and health outcomes and cost savings. We wanted to be able to add to that literature as well.

Alexandra De Kesel Lofthus:

The main things that our program do, it's multi-tiered. First of all, we've always offered referrals and assistance around food resources, addressing that in community. Just from anybody in the community, but any kind of partner. Connecting folks to SNAP or other government programs. That was always standard work for Second Harvest Heartland.

Alexandra De Kesel Lofthus:

We then added on food prescription boxes both for acute setting. If you are being discharged from the hospital and you need access to food to go home, that was one way to use our stabilization boxes, but also these larger chronic disease specific boxes. It's a whole program around chronic disease management that we partner with. The boxes also include education and recipes to encourage them to eat the new healthy foods and really driving behavioral change, not just food security. Really driving the nutrition aspect of it.

Alexandra De Kesel Lofthus:

We've got different models that integrate with our partners. That could be anywhere from clinic integration to care coordination, integration, health coaches with some of our health plans. One thing that also sets us unique apart is that we are HIPAA compliant food bank. Meaning, that we're able to collect data from multiple sources, whether it be from our healthcare partners, or other community

organizations plus our data, combine it all together to really have a full view of what's happening with that patient.

Alexandra De Kesel Lofthus:

From that data, we're also able to report back to our healthcare partners, not just A, we got the referral, and we addressed it, but what was the outcome of that referral? Both for your organization, by population level and also at the patient individual level. That's a real close collaboration with our partners to say, what are the impacts of the intervention that we're having? How can you integrate that into their care as a true partnership? When they're going to clinic and when they're seeing us as well.

Alexandra De Kesel Lofthus:

In 2018, we really started to work with healthcare partners and financially contracting with them, which was a big step for us at the food bank. Then in 2019, we expanded our services. Just beyond Second Harvest Heartland service area, we partner with all the food banks in the state of Minnesota, one in western Wisconsin and eastern North Dakota to be able to provide a consistent service for our partners. So they wouldn't have to worry if their patient lived not in the Second Harvest Heartland area, would they get the same service and same level of care?

Alexandra De Kesel Lofthus:

These other food banks have integrated our programming into their work as well. That makes it a lot easier for our healthcare partners to partner with us. Then to date, we have several different contracts, approximately 12 healthcare partners so far. Then that includes anything from individual clinics to health systems, to our pairs. That's where we're at from 2016 to currently 2020.

Alexandra Schweitzer:

That's great. Thank you for that whirlwind tour.

Alexandra De Kesel Lofthus:

It's a lot of work, but great work.

Alexandra Schweitzer:

Well, I think we can see that there is a lot of work and there's some pretty big numbers involved. I've heard 2 million, I've heard 75,000. So, the scale is big. Let's turn to the question of the day, which is how is the pandemic affecting your programs? Some of the questions that you might be thinking about or that you might have observed would include the population needs increasing or changing. Are you seeing different kinds of people who need your services?

Alexandra Schweitzer:

What about your capacity, and generally the social service sector's capacity to address these needs? Because as the needs grow, the capacity has to ramp up as well. Finally, what are you seeing in terms of funding sources and opportunities, or any other drivers that you can see that have really affected how you're responding, which is what we'll talk about next. Why don't we start with Katherine and then turn to Alexandra and then Humana?

Katherine Keir:

Sure, thank you. This is certainly a big question and something that we continue to put a lot of thought into in terms of what we're seeing in the data and what we're hearing from our partners on the ground. I wanted to start by noting that, in general, we're seeing a pretty significant increase in people wanting to talk about their social needs and their situation, from prior to the pandemic, during this pandemic. We're really seeing this as a signal for just a general desire to human connection, but also really a desire to find out about the resources in the community to help them.

Katherine Keir:

That's certainly a good thing because as they share what their needs are, we're able to connect them with services. The data trends that we're seeing do certainly confirm the impact of the pandemic on social needs. Really beyond the physical illness, we continue to see food insecurity coming in as the greatest disparity that was the greatest need prior to the pandemic, and has really been impacted by the pandemic. We're also certainly hearing that from our food distribution partners, including our food bank.

Katherine Keir:

Initially, interestingly, housing, transportation and utilities did all trend downward. We have lots of different ideas about why that is. Certainly, the moratorium on evictions does contribute to that. However, utilities have started to trend back up as a more urgent social need.

Katherine Keir:

We're also seeing really interesting diversified partnerships. Certainly, and Alexandra was sharing about her program and the partnership she has, it's really important for organizations cross sector to come together, and that's what we're seeing. An example of that is the local hospital partnering with our local Meals on Wheels, to ensure patients have ready access to meals on discharge, to be able to free up the hospital beds and prepare for any type of surge.

Katherine Keir:

We're also just seeing a general increase in resources available. Back to our food bank example, or our food bank has significantly scaled the number of their distribution sites, utilizing our local stadiums, to get food to people. Our public schools has set up numerous food distribution sites for children and families who do depend on school meals.

Katherine Keir:

The last thing I'll comment on is just our general lessons learned around access to services. As I'm sure in other communities, a lot of our social services partners did move to virtual services to the extent possible. We've seen that have both limiting and expanding impact on access to services. For example, for an individual who doesn't have regular internet or phone access, certainly, the shift to more virtual services can create a significant barrier. However, for other individuals who do have more reliable internet and phones, but struggle with finding reliable transportation, or have mobility restrictions, the shift to non-traditional settings, virtual settings has eliminated that barrier for them, and they can receive care in the comfort of their home.

Katherine Keir:

We're working with our partners to really understand long term, what this may mean for service delivery and the lessons learned around that and how to really continue and enhance access to care as services do start to return at least partially face to face.

Alexandra Schweitzer:

Thank you. Alexandra.

Alexandra De Kesel Lofthus:

I would echo a lot of the similarities that Katherine just stated as far as the work that she's seeing. Some additional things regarding from a food bank perspective, and from the FOODRx program perspective, I would like to say, we're seeing not only a huge increase in demand around food and security, but also as far as folks wanting to engage in government assistance programs, that a lot more folks are saying yes to those resources that in the past would have said no, due to things like public charge or just not wanting to ask for that help or take that help.

Alexandra De Kesel Lofthus:

We're seeing an increase both in the volume of [inaudible 00:23:42] that are food insecure, but also in the conversion rate of those actually accessing the resources to the full extent that we have them. We're also seeing a whole new population that we haven't seen before. These are folks that are newly engaging in the work with our agency partners. It's folks that never needed health systems before. They're learning how to navigate this new world for them on top of all the stress that they're experiencing around COVID and being either unemployed or homebound.

Alexandra De Kesel Lofthus:

We're also doing a lot of work with children program. Child hunger is obviously a big deal as schools are closing and access sites are changing. The biggest thing that we've seen is just again, a huge demand for food resources, government assistance programs. A big one for the FOODRx program that has really made us pivot is an increase in demand for seniors assistance and homebound deliveries. Folks that don't either homebound because they're sick or take care of someone sick or just don't want to leave their home at this time.

Alexandra De Kesel Lofthus:

Also, a high demand for our interest in our chronic disease program. Not only because it allows for access to food, but access to nutritious food, to help these populations manage their chronic disease during this pandemic times as food becomes either hard to find or difficult with transportation, getting to the grocery store, things like that. As far as our capacity, because our program was set up to scale, we were lucky that we are able to meet a lot of these increasing demands already. We have got infrastructure in place, and we have the design thinking methodology already embedded in our programming.

Alexandra De Kesel Lofthus:

As far as implementing new things and pivoting and learning from them, we already did that. It's great to be able to do that now to increase both the need that's out there, but also the diversity of the services that we provide.

Alexandra De Kesel Lofthus:

I would say some of the things that we've learned, some positive things that's really affecting our program is the rapid turnaround in decision making from our partners about implementing program. It seems like we have less hurdles and less bureaucracy to go through. Their willingness to really test out new things and measure them along the way to say, okay, is this working or not working? Then pivoting quickly and really be focused on solutions that work with the communities that we serve, not what we think are the solutions for the community.

Alexandra De Kesel Lofthus:

Really hearing from our patients and our members what they need and then looking for resources in that capacity. I would say one of the challenges from a food bank perspective and from FOODRx is being able to source shelf stable food that is still nutritious, that's culturally appropriate for the clients that we meet, while competing with the big Costcos and Walmarts of the world. Supply chain demand is definitely something that we're keeping an eye on.

Alexandra De Kesel Lofthus:

We also want to make sure that we're still doing it at a cost effective manner. These prices are going up, but so is the need. We're still navigating some of that. We've got some fantastic partners that we work with that are really helping us make sure that there's no disruption in the supply chain, but something that we definitely need to keep an eye on as the demand increases.

Alexandra De Kesel Lofthus:

For our folks that are on SNAP assistance, one of the challenges is, because shelf stable food is so popular right now, by the time they go to the store, sometimes those items that you use your SNAP benefits for, those food stamp benefits aren't available for them, because so many more folks are going to shelf stable foods. Just something to keep in mind that if you're at the grocery store and you see something that's meant for people that have SNAP or food stamps, maybe you pick something else and we use that food for those folks out there. Just something that folks sometimes forget.

Alexandra De Kesel Lofthus:

As far as funding opportunities, we've been really lucky because we have our contracts in place that we continue to receive funding from our healthcare partners to maintain and scale and diversify our programs. It maybe just now shifted from maybe not so much the stabilization boxes, because folks aren't coming into the clinic and don't need that immediate box of food to more focusing on our chronic disease program. The funding is still really the average using is a little bit differently. Meaning there's lots of flexibility around that, which has been much appreciated.

Alexandra De Kesel Lofthus:

Also, like I said, we're seeing an interest specifically on our home delivery, on our chronic disease programs because the population affected by COVID and these comorbidities that are caused by chronic disease, they're impacted at a much deeper level. We want to make sure that they're getting what they need to ensure that they're managing their chronic disease. Also, preventatively addressing that to make sure that the folks that are now needing food assistance or are going to the food shelves, are also able to access nutritious food in that capacity as well, so they don't develop, they don't go from being hypertensive to having a chronic disease. Keeping a close eye on those folks as well on the prevention angle of it.

Alexandra De Kesel Lofthus:

Those are some of the big areas that are affecting us here at our work.

Alexandra Schweitzer:

Great. That's a lot. Humana, how about from you, what's affecting your SDOH programs?

Andrew Renda:

Sure, thanks. Well, first, I echo a lot of the impacts from Katherine and Alexandra, we had some similar things happen in our organization. I think on the one hand, I feel like we were very well prepared for this, because of everything that Caraline alluded to earlier. We've been working in social determinants space for three or four years now and have a pretty good sense of the prevalence of certain social needs within our membership. Things that were mentioned; food insecurity, social isolation, transportation type issues.

Andrew Renda:

Yet, despite that, when COVID first happened, our first principles and first response were to ensure continuity of care and having medications on hand for our members. That's probably the right way to approach. But what we found in reality was what our members were calling in about was not care, and it was not medications, it was about meeting their basic needs. It was about, they have a new financial strain issue that's causing them to be food insecure, or they're even afraid to go to a grocery store, because they're worried about contracting the virus. So, they're food insecure, really from an access standpoint.

Andrew Renda:

Very quickly, we had to pivot our response a little bit from focusing on that clinical aspect to understanding that our members, what they really needed in this moment was having their basic needs met. That in fact, it affected a lot of what we did overall. Now, specifically within our social determinant programs and projects, we did have to pivot a lot of what we did.

Andrew Renda:

On the one hand, we had interventions in flight already in the field, pilots that had really rigorous study designs, because a big piece of what we're trying to accomplish with our strategy is to justify further investment and scaling. We do that by getting proof points so that there's a return on health and a return on investment. We've been really intentional with putting things in the field with good study designs, with randomization and control groups and so forth.

Andrew Renda:

When something like COVID happens, because the way people use health care changes dramatically in a pandemic, are all elective procedures are canceled and everything, it really messes up a little bit our ability to measure the impact of addressing a social need on healthcare resource utilization, admissions and service and all that stuff has changed dramatically.

Andrew Renda:

We've had to pivot our study designs a little bit and reassess our strategies and understanding what we can and can't measure. Putting that up against the idea that we want to do the right thing by our

members and our patients in this moment. That's point one, I would make. Point two is that of some of the pilots that we had in the field, many of them were in person. An example that I would give is to address loneliness, I work with an organization called Papa. Their tagline is, Grandkids on demand.

Andrew Renda:

The idea of matching college kids with seniors, these college kids will go into a senior's house, not to provide home health, but really to provide companionship. Obviously, when COVID hit, we all got these stay at home orders, we couldn't do those in person visits. Very quickly, we had to say, well, do we shut the program down, or do we pivot what we're offering?

Andrew Renda:

What we were able to do is actually create, in almost real time, virtual visits to address social isolation and loneliness through virtual visits was one way, but we also, after a while, were able to enable those Papa pals to actually do grocery delivery. With a mask and with distancing, and all that stuff, they could actually meet some basic needs, in addition to just the loneliness.

Andrew Renda:

That's point two, is adopting interventions in the field so that we can still address social needs, but in the new context with all the new constraints that we have going on. The third point that I would make is that we actually have created some new programs. Probably the most prominent is something we call our basic needs program because as I said, when people were calling in that it wasn't about continuity of care or medications, it was about me helping to meet their basic needs.

Andrew Renda:

We quickly had to cobble together with bended relationships and developing new community partnerships, actually shipping out meal kits to address food insecurity. Prior to when COVID hit, we had about a 25% food insecurity rate within our Medicare Advantage population, that got worse once COVID hit. At the peak we were sending out 2,000 meal kits a day, right now we're still running at about 500 meal kits a day. There's really a significant need.

Andrew Renda:

That basic needs program has helped us, in the near term, sending out meal kits for now, adding on different capabilities, different bended solutions, and also looking to address additional social needs. It's just an example of, very quickly, all hands on deck approach, bringing our organization together to cut through some red tape, like I think Alexandra alluded to, in order to get some things off the ground and get, in this case, meals in people's homes as quickly as possible.

Alexandra Schweitzer:

Great. Okay, thank you. We've started to morph into this, but I'd like to ask you each to say a little bit more about how are you modifying the programs? I've heard the word pivot and flexible a lot. But could you go a little bit deeper into specifically as COVID hit and you were getting together virtually to think about okay, now what do we do? How did you frame that set of decisions as you thought about, what do we do now? What do we do when things settle down? Then we'll talk a little bit more about the longer term. What are you thinking about in terms of the stages of response, and what are some of the drivers of your response? What motivated you to make the changes that you made, and how are they working out so far? Let's start with, Alexandra.

Alexandra De Kesel Lofthus:

Great. I think, of course, it's always emergency response goes quickly. We quickly address what's going on and pivot from there, love that word. Around some of our programming, we really changed how we're doing our screening and access and support to our partners. We've really leveraged our partnership with our case managers and health coaches, where they're doing now tele health screening, for instance, and are sending referrals that way.

Alexandra De Kesel Lofthus:

Instead of being embedded into an EMR system where the screening can take a while to do we've developed an online form where they can immediately be screening patients and then those referrals come to us automatically so that we can just really quickly loop back with that person. There's no gap in response to that patient or that member that we work with. That's really, really been really helpful in our work with our senior population.

Alexandra De Kesel Lofthus:

As far as the immediate need, again, we are very data driven, metrics driven part of our programming. Now, one of the biggest pivots we have to do is because our clinics aren't to see patients at the same level, patients aren't coming in to do their screening there. We've modified kind our measurement and how we talk about our screening referral program, for instance. It is more important to get the information out to your patients and your members about the resources that are available to them, than to be able to necessarily tie it back to that particular health care provider.

Alexandra De Kesel Lofthus:

We're looking at the impact on our screening and our work around SNAP assistance more in the community level. Then if a patient remember, does tell us that they were referred by or they heard it through one or their healthcare providers, then we do track it that way. But we're modifying some of those requirements and being nimble about that, knowing that it's more important to give people the resources that they need to manage their difficult situations that they're in.

Alexandra De Kesel Lofthus:

One of the biggest things that we've done is... A real thing that's been really helpful for our healthcare partners is because we have so many departments here at the food bank, one that works with child hunger. One that works for senior hunger, one that works with SNAP and government programs. Is we're collecting all those changes, all the waivers, all the exceptions, all that stuff that's happening at the government and advocacy level, compiling it, putting it into short format and spreading it out to all healthcare partners, so they have the most up to date information that they can share with their members and their patients.

Alexandra De Kesel Lofthus:

For instance, pandemic EBT or changes around child hunger, things like that. Some of the things around our chronic disease program that we was initially emergency but it's, I think going to become our longer term solution is home delivery. Initially, patients were going to the clinic to pick up their FOODRx boxes. Now, we're either home delivering the community paramedics, or third party couriers, things like that. We also opened up our food channels to some of our patients where they can go there. Then when they're there, they can pick up protein and produce. A lot of our agency partners also offer assistance with utilities, legal aid, really having a one stop shop not just to meet their basic needs, but maximize

amount of resources they can access in one setting. Is something that I think we're going to continue to do and expand in our partnership with them like that.

Alexandra De Kesel Lofthus:

Same thing with a partnership with Lyft. They are able to give the patients and our members an option to go to the grocery store, go to the clinic, go to the food shelf, and then we pick up that cost with our Lyft partners. I think that's something that we will explore further as well as the patients that are enrolling that program are really enjoying that flexibility and not having to worry about transportation on top of food security, on top of trying to make it somewhere within a limited timeframe as they're navigating all the other conflicts that they have in their lives.

Alexandra De Kesel Lofthus:

One thing as far as rebuilding our future growth, we are exploring right now a couple different partnerships. One is seriously around behavioral health and mental health, knowing the impacts that COVID is having on all the populations that we serve. How do we work with healthcare partners and our behavioral mental health partners and FOODRx to really again, provide these wraparound services for the patients. Then also, somebody had mentioned prepared meals. We also have a partnership right now with an organization that does create prepared meals and meal kits. Also, we really focus on chronic disease management and behavioral change.

Alexandra De Kesel Lofthus:

Being able to expand our services, not just a FOODRx, shelf table, but offering prepared meals, a meal kit, and then our boxes and letting the patients choose where they are in the spectrum, what level of care that they need is something that we're really exploring very intimately as well.

Alexandra De Kesel Lofthus:

One other service that we're exploring through the FOODRx program, I think because of the increase availability or accessibility of telehealth, is we have a registered dietician on staff that is going to be... We're looking at her providing medical nutrition therapy to help our partners with that caseload that they're experiencing as well. Contracting with partners around that. That's also going to be as an emergency need, because we're hearing a lot from our partners that they need that, but also a longer term, because once it's established and the program is set up, I think it's going to be really great value add to our partners.

Alexandra De Kesel Lofthus:

I think some of the lessons learned real quickly, I would say, the test and learn model, like you said, it's very, very important in times like this, and then also the data sharing to say, what is working, what isn't and what do we want to move forward as the timetable changes? There's really great needs right now, but as the needs change, can we continue to update the model?

Alexandra De Kesel Lofthus:

We have a couple different scenario planning that we're doing, that we're testing against, to see, how will the program develop over time? How does that partnership develop over time, in the short term, medium term, and of course, the long term? Hopefully, COVID will eventually hopefully, settle down a little bit.

Alexandra De Kesel Lofthus:

I think the last thing I'd like to end on that I think that we're learning a lot about, it's just integrating with the care coordinators, and how do we, again, provide them support so they can support their patients, or we can take that caseload for them to expand services through our healthcare partners. Because especially around the Medicaid population, that's a population we're very familiar with, and we really know how to manage and talk with and talk to and gather information from. Expanding that service line to our partners and to make sure that we're meeting the needs of the communities as they're telling us what they are.

Alexandra Schweitzer:

Great. Thank you. Caraline?

Caraline Coats:

I'm going to give my colleague, Dr. Renda here a hard time because he stole a lot of my answers. It's hard to talk about how our programs have been affected without getting into some of the solutions. I'm going to share a personal story because I think it's really representative of what we are doing. My dad's 81 with CHF, and my mom has Alzheimer's. There's all sorts of issues going on here to meet his health related social needs at home.

Caraline Coats:

What we personally immediately pivoted to do was to one, make sure that he had low salt meals being delivered because he couldn't go out to eat anymore and my mom doesn't know how to use the kitchen anymore. That we do a weekly Zoom call with the 17 grandkids. This is not a panacea, but it was this immediate... I have four sisters. The five of us are like this is immediate, how do we pivot to use this panel's theme word of the day here, how do we pivot to meet his needs?

Caraline Coats:

I share that because I don't think he's a minority in the senior population and some of the issues that have been experienced. From a Humana perspective, I'll just tell you even culturally, it was this immediate, doesn't matter what your job description is, doesn't matter what team or department you're on, it was just this all hands on deck.

Caraline Coats:

We stood up this proactive outreach team and identified, put members in different cohorts based on are they homebound? Do they have chronic conditions? How vulnerable are they based on certain criteria? Prioritize making calls out to them to proactively meet their needs, which in some cases were easier to assess and intervene than others. Our pilots, Andrew touched on. Those that required in person visits were changed to virtual. The delivery of food and meals and then realizing well gosh, some of these meals aren't the right types of meals. You can't give someone like my father isn't getting low salt meals and so continuously evolving, those with chronic conditions, are they getting the right kind of meals?

Caraline Coats:

Understanding, are they food insecure now because of a transportation issue, they can't get to it? Or is this an issue they had even before COVID? I think a lot of this triggered us to stop a little bit and

understand our members' needs more. We did launch in partnership with Uber and Papa Health, Far from Alone Campaign, and that is in collaboration with them. That is something I'm excited that will really continue to live on. It's really an awareness campaign around social isolation and loneliness, which is a harder nut to crack than some other social determinants.

Caraline Coats:

It's a place to go for resources. Frankly, just to start talking about it. To your point, I think Alexandra, mental health. I don't think we've even started to get into the downstream impacts of what loneliness and some of the social isolation will do on mental health. We're trying to double down and be laser focused on that.

Caraline Coats:

I'd say, not that we weren't before, but I would say this pandemic certainly expedited those efforts. From a Humana foundation perspective, I'll just summarize that we allocated some funds to some areas. There's a lot of discussion that went around that, that would have definitely been different before the pandemic. We prioritized some areas to support that included workforce development, the frontline, not just clinicians, but frontline. Folks who are out there delivering packages or what have you. Mental health and food insecurity. Those came in a couple different waves; immediate needs and then more middle and long term.

Caraline Coats:

Then a lot of different pivots with our home care division. We can't send a bunch of people into homes. So, understanding what we need to do virtually. And telehealth. Don't quote me on this, I think our telehealth visits went from under 10% to over 80%. We've seen an explosion in that. I think similar with telehealth with what how we're pivoting our pilots with home care, I think we've gone from one extreme to another to meet these needs.

Caraline Coats:

I won't get into the next question, because I won't steal from my colleague. But I think we're going to find the new normal. There's something in there. It's somewhere from where we went and where we are going. The last thing I'll say that I don't think we yet fully know yet is I think there's a research opportunity here. I think we've had this unintended and not in any ways to say we're trying to take advantage of this situation, but we have an unintended experience of data, delivering thousands of meal kits to members. What has that done in a long term impact to their physical health, clinical health, social health and obviously studying more the impacts of loneliness and social isolation/

Caraline Coats:

Trying to find some of the silver linings in this. I'll just end with that, we've had to change a lot of our programs. I don't think anything will go completely back to the way it was, and we'll find that new normal and hopefully this has shaved a little bit of time off of our industry's movement to balance, clinical and social a little bit more.

Alexandra Schweitzer:

Great. Katherine.

Katherine Keir:

Hi, can you hear me okay?

Alexandra Schweitzer:

Yes, we can.

Katherine Keir:

Okay, great. I apologize, I'm having some connectivity issues. I lost my video. Just wanted to thank the other panelist for sharing their thoughts and their stories. I think the dialogue around this is so important. Certainly, just from an overall perspective, UnitedHealthcare continues to strengthen its focus on assisting people with health related social needs, and specifically homelessness and food insecurity and deploying supports around that.

Katherine Keir:

With respect to our local programming here in Hawaii, just wanted to address on a couple of things. We've definitely seen, as I know everyone has, that increased flexibility and innovation in service delivery, both on our end and definitely with our partners has increased their search capacity, so to speak. Both on the healthcare and social service side.

Katherine Keir:

On the healthcare side for our project, specifically, the ability to move staff out of the clinical settings, out of the ERs, out of the clinics where they were screening patients, to more of a phone based model, certainly has its pros and cons, but was able to keep staff safe, reduce the footprint in the clinical settings and continue to connect patients to the resources they need.

Katherine Keir:

On the social service side, I touched on, in my earlier comments how a lot of service delivery is now virtual, like expanding ways to submit a SNAP application, for example, opening an online portal. That has really allowed for critical access to services while maintaining public health distancing recommendations. Another thing around community services that we've seen here is this idea of community resilience. We've really seen a wide variety of community driven resource development. Community members coming together who weren't necessarily in the service delivery sector prior, to really address very localized needs.

Katherine Keir:

I don't say that to minimize the importance of the established organizations, but they really complement them and have been partnering with them to ensure that food delivery is happening to our senior members. That folks are connecting with each other to address potential social isolation. Just this idea of community resilience, I think is a huge learning for us locally here and certainly something that we want to continue and to integrate into the overall service sector and safety net.

Katherine Keir:

Our work was well positioned prior to the pandemic, to identify health related social needs and connect patients with available services. That was the premise of the work, is when someone is coming into access care, can you ask them about these other needs, which we know affect their care and affect their overall health in a very large way, and connect them with resources. Taking advantage of the

opportunity that they're here, they're seeing a provider, and that we have these established partnerships.

Katherine Keir:

What we were able to do, to borrow the word, pivot, is to make adjustments and additions to our surveys to incorporate specific COVID-19 questions. For example, in the vein of asking the questions around food security, we really drill down to their availability of food, do they have two weeks or less of food available? Specifically regarding prescriptions, do they have two weeks or less of their prescription medicine available?

Katherine Keir:

If they rely on caregiver, do they have a backup caregiver identified as their primary caregiver becomes unavailable to provide that care. Then we lined up resources for all of those additional needs as well. That, we put into play immediately and got resounding positive response from the patients on those. For this work, we sit in this bridge position. We are bridging our clinical partners with our social service provider partners.

Katherine Keir:

We were really able to leverage that position as a bridge entity, if you will, across these multiple stakeholder groups to be able to ensure information was flowing between health care and social services. Where are services being expanded? Where are there changes in eligibility criteria, which offices are closed and services are now virtual? Get that very quickly over to the clinical side and vice versa. Really, a lot of clinical information and recommendations out to the social service sector.

Katherine Keir:

I think just facilitating that communication has been really important. We're using that currently to capture additional lessons learned from our partners, to be able to identify best practices that have come about because of this rapid surge in activities, and how do we leverage some of those? With respect to partnerships, new and innovative, and different partnerships that have been effective, really effective at providing services and connecting people on how they're delivering services.

Katherine Keir:

That's really what we're working on now, is to gather that information and to be able to relay it. Again, because we serve as the facilitator and convener, relay it across our local network, while just day in and day out working to continuing to work to collect information on resources available and deploying it across our state so that everyone has the most up to date as those change quickly. Those are just a few of our learnings.

Alexandra Schweitzer:

Wow. It's going to be tough to summarize all of this, and we are getting close to five o'clock. What I'm going to suggest is that we reserved the key takeaways and lessons I hear in so many things. We will summarize those and send those out rather than me trying to do it now verbally. But if you can assume the word pivot will figure in there somewhere. What I'd like to do is ask one question and ask for... This is not very fair, a one sentence response from each panelist, and then we'll turn to a couple of audience questions.

Alexandra Schweitzer:

Please do keep putting those questions in the chat. It's really super important to hear what all of you out there are thinking and we will definitely work that to the ongoing research. Okay, the question is, if you think about the crystal ball, do we think that as a result of the COVID crisis, this will be an inflection point that will lead us to more investment in SDOH because people appreciate how important it is, less because people are worried about just basic survival, or something in between? We're going to go Humana, Alexandra, Katherine. One sentence.

Andrew Renda:

We have one sentence for that? What I would say is that the needs will persist, but the visibility may not. It's really incumbent upon us to prove the value of addressing social determinants. The value is both in terms of improving health outcomes, and also lowering costs.

Alexandra Schweitzer:

Thank you, Alexandra, sentence.

Alexandra De Kesel Lofthus:

Sentence. I would agree with that past statement and add that there's value also in collecting the data for policy advocacy work around this, especially around how we address some of the other things, to really not have the whole burden only be on healthcare or only be on social services. There's a lot of policy work that we're doing right now with the data that we're collecting, especially during these times.

Alexandra Schweitzer:

Perfect. Katherine, sentence.

Katherine Keir:

Sure. Just to follow up with my previous panelists, I think this certainly has shone a light on the importance of social needs and its impact on health outcomes. I think it's important for all of us to continue to highlight that and further support the integration and coordination across the sector's and make data driven decisions on where there are opportunities to support that even more. But certainly has highlighted the importance of those as well as the social service providers that are working so hard to address them.

Alexandra Schweitzer:

Perfect. The question that we have from the audience actually really follows on nicely. I think we're going to, again ask you for shorter responses so that we can stick within the time frame. The question is, "How are your organization's addressing SDOH from a policy perspective?" Why don't we start with Alexandra, you've mentioned it, and then we'll go to Katherine and end with Humana.

Alexandra De Kesel Lofthus:

This is not necessarily the department I work in, but some of the things that we're doing is by collecting the data that we have, were able to, as part of a coalition we work with like the Minnesota Department of Education, MDH, and being able to provide that information back to them about the needs that their community is feeling and where the need is increasing or decreasing until we are able to help them figure out where to better utilize the resources that exist, where the gaps are.

Alexandra De Kesel Lofthus:

I think this is really helping us really show that there's an increased need, but there's always going to be a consistent. Hunger has always has been a problem in our communities, even though we have more than enough food.

Alexandra De Kesel Lofthus:

By collecting all this data and advocating within our coalition, we are grabbing policy change as far as the benefits that are offered to Minnesota. I can't say [inaudible 00:56:12] on the federal level, but we also build a coalition, especially with our healthcare partners to say, look, if folks are accessing SNAP consistently and have school meals, it's reducing the cost of care for those patients. There's literature out there for that.

Alexandra De Kesel Lofthus:

Having our healthcare partners join us in some of the work that we're doing and sending on letters and advocating and lobbying with us, both on health care, but also with the breakfast after the bell for schools for kids. Insecurity within school, same thing with the housing in seniors. Building a coalition around that has made the voice a lot stronger around how do we make some permanent changes around support around social determinants of health?

Alexandra Schweitzer:

Okay, thank you so much.

Alexandra De Kesel Lofthus:

[inaudible 00:56:53]

Alexandra Schweitzer:

I know, it's a lot. Katherine, policy responses?

Katherine Keir:

Sure. If I can just speak to our local work here in Hawaii in implementing the model. We are very fortunate to work with a great advisory board that consists of leaders from healthcare, social services, as well as work with our local and state partners to really identify opportunities for improvement in screening and providing social services to address social needs.

Katherine Keir:

We think of the levels of impact for those opportunities for improvement. Some of them are certainly at the policy level. What we're really doing is using the data we're collecting to identify what folks needs are, where they're able to access services, do those services really meet the needs? There may be services available, but are they really meeting the needs of those individuals and communities? Where those gaps are and then looking at a spectrum of interventions from individual organizational community policy and environment in working... This is our advisory board doing this work is really looking for solutions at those levels to address those gaps. We're right in the middle of that work here in Hawaii.

Alexandra Schweitzer:

All right, Caraline, I'm going to give you the last word.

Caraline Coats:

Quickly, I think a lot of what we do, all these pilots, all the work that we're doing to study social determinants of health, health related social needs, the core of it is really to influence policy, to be this engine for benefit reform, for payment reform, to take these pilots and turn them into more scalable solutions for our members. To look at all these 2.5 plus million screenings we're doing, to use that data to influence policy to apply social risk adjustment and not just medical right to start to tip that scale of balancing more clinical and social.

Caraline Coats:

I could go on that question for a long time. For the spirit of time, I will end with a very close to work with policy ultimately to change the way we deliver health care.

Alexandra Schweitzer:

Fantastic, that's a great way to end. I would like to thank all the panelists so much for great insights. You have provided us with so much information and so much food for thought. It really does reflect the maturity and the depth of the programs and the commitment that all of you have to really meeting the needs of the members that came up over and over and over again, and using data to do so in a thoughtful way.

Alexandra Schweitzer:

We really appreciate the work that you're doing, and the fact that you came and shared some of it with us today. But I'm sure these are still pretty busy times for you. To follow up, we will be answering any questions that we didn't have a chance to get to today. We will be sending out some kind of a summary or a synthesis. If people want the slides, we're happy to send those out as well.

Alexandra Schweitzer:

We have our contact information up on the screen. Please feel free to contact us directly. If you have questions for specific panelists, we can get them to those panelists as well. Thank you all very much.