HealthLeaders Virtual Roundtable
SDoH and Health Equity: CFO

SOLVING HEALTHCARE INEQUITIES FROM A FINANCIAL PERSPECTIVE

After a year that exposed long-standing inequities in the U.S. healthcare system, healthcare finance leaders are acutely aware of the vulnerabilities facing patient populations. The focus on addressing the social determinants of health and expanding access to historically disadvantaged patients is now more important than ever.

In this workshop-style roundtable, an executive panel discusses the financial case associated with implementing policies and programs that advance health equity and address bias in the industry, and how that benefits the organization, the employees, and the community at large.

Nick Gates
Interim Chief Financial Officer
Priority Health
Grand Rapids, Michigan

Mitch Perry
Chief Financial Officer
Blue Cross and Blue Shield of North Carolina
Durham, North Carolina

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President, Optum Center for Applied Innovation
Senior Vice President, OptumInsight
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Jack O'Brien (Moderator)
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HIGHLIGHTS

HealthLeaders: *Where do the efforts to address SDOH fit into the larger context surrounding value-based care and access to care?*

Mitch Perry: We've got a number of efforts and we're still evolving here, but at the highest level we're thinking about [SDOH] within the mission of the company. What is it that we need to be doing to address affordability, access, and quality of care for our customers? While that has some challenges, as you can imagine, given how new we are and understanding the impact of drivers of health, it does give us an important lens from which to work.

One thing that we understand, of course, that I think we all appreciate, is how much of our health outcome is impacted by SDOH. Importantly, we understand that access is driven largely by whether or not individuals can afford healthcare and those that have health insurance are more likely to be healthier.

The Affordable Care Act (ACA) is a great example of where there's been an expansion of access to care, and we're proud to say that we've been a participant in all 100 counties in North Carolina from the start. But we all understand that that's not enough, so we're now focusing even more on affordability and what we can do.

One major way [we're addressing SDOH] and how we are linking value-based care is with the driver health approach. We think that the whole-person care approach is important and we think it's important that we are able to support our providers in making the quality decisions, the total cost of care decisions, and therefore access decisions. One of the primary things that we're doing as part of this is putting the primary care physician at the center of our efforts. They're like the individuals, if I can use a sports analogy, who are the quarterbacks of the health system; that allows them to most effectively be able to support and drive care for our members.

Nick Gates: First and foremost, similar to what Mitch said, Priority Health is in all markets. I think it's important to be active in all the communities that we serve. As a nonprofit, community engagements fit within our mission, and even before the pandemic we were doing a lot of analysis on SDOH. The pandemic has certainly highlighted the reasons why it's important to address health inequities.

Priority Health Connect is an example of a resource that we had before the pandemic that helps address SDOH. There are so many free or reduced-cost social programs out there, but it's hard to find what the right local program is for each member. This platform allows our members to seek health services, food-related needs, safety needs, economic needs within their specific ZIP code, and it's free. Priority Health Connect allows individuals to seek the care they need, when they need it.

[This program is] something that we've been building for a few years, and we recently expanded it from just Medicaid to now be available to all of Priority Health's million members.

Mylynn Tufte: As far as impacting SDOH, I think that where I've seen organizations fall down is not having good data or not knowing where to start with the data they have. Some of the technology is not closed-loop technology. We have great case managers, we've made that investment in technology, and we have good partnerships, but [some partners] don't have the measurement in place to know if you've been successful.

I think that there's been a step in the right direction, but we haven't closed the loop and we haven't been able to measure [the success]. I think those are the areas where we still have a ways to go in order to make sure that we're monitoring, measuring, and getting the success so that we can move the mark in health equity.

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—Mitch Perry, Chief Financial Officer, Blue Cross and Blue Shield of North Carolina, Durham, North Carolina

Gates: I'd say jump in on the data because otherwise you might be going in the completely wrong direction or not understanding that what you're doing isn't intervening. That's why we started a partnership with an industry leader to collect data, so we are able to take more of a full life cycle approach. As members are moved into certain programs, we're also able to collect the data and measure it.

Perry: I agree with what Nick and Mylynn said; the pandemic exposed some of the challenges we have around health equity. It became clear quickly that our entire healthcare system was not designed to capture the type of data that is necessary to be able to make a difference.

We are making significant foundational investments here, and we're working with partners to do so. We have the benefit of being affiliated with the BCBS Association; we also are working closely with community agencies, and of course, with our provider partners.

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—Keith Y. Shah, PhD, MBA, FACHE, President, Optum Center for Applied Innovation, enior Vice President, OptumInsight, Eden Prairie, Minnesota

I don't think we're perfect here, but it's not like we don't have anything to work with. The fact that we don't have all the data doesn't stop us from trying to do things. We use national data, state-level data, and industry data where we can create as much confidence that these are the actions we should take.

We don't have shareholders, so every dollar we spend is our customer's. We think seriously about making certain that there is a business case, but we can be creative about how we think about that business case and using whatever data gives us the most confidence possible to support the actions that we think are appropriate and necessary. Then we can monitor and pivot as necessary as we get smarter.

Keith Shah: To Mitch's earlier comment as well about making progress, I think that's such a key point because what we have seen is that there is momentum. These topics that we're talking about are, in some ways, nothing new. We've been challenged with them, but we now have a platform that is both exciting in terms of what it can create if we actively engage with that momentum and not let perfect be the challenge to progress in terms of the data.

So, how do we keep that momentum going? Because my concern is if we don't do some of that, how long will that momentum be sustained in terms of people hitting that reset button more quickly than we want them to?

The other point that I think is nuanced is the aspect of how little we knew when we thought we knew quite a considerable amount in terms of the measurables. The last 18- to 24-month period has illustrated where we could spend more time and get a little bit more granular. So it's that balance; while that will give us greater precision in terms of the execution, it doesn't slow down. Don't take your foot off the gas in terms of where you're experimenting and leveraging the momentum that we have now.

HealthLeaders: *How do you calculate the cost of inaction?*

Shah: Everything that we're talking about kind of consists of the same conversations that I think we would be normally driving towards in terms of the total cost of care and quality across the board. We talk about the crosswalk—from a health plan perspective—as to what we can be doing for the member in a meaningful way. Our colleagues on the health system side also have the same struggles and are also burdened with a historical cost structure that doesn't necessarily lend itself to the essence of some of the health questions that we're asking.

In the U.S., we work in a healthcare delivery mechanism that some people would cynically say treats sick care and doesn't have great healthcare. But all these organizations, and I think the health plans in particular, are well positioned to go upstream to talk about health in a much more meaningful way. We're trying to figure out the calculus, the equation across the board, for translating health and healthcare in a much more seamless mindset.

My personal belief is that the ACA represented a little bit of a pivot in terms of mindset. I happened to work at a health plan for the three-year runup to the ACA and then witnessed a whole bunch of leadership on both the payer and provider sides say, "Hey, what's going on in our industry and how can we be that much more proactive about challenging some of the norms?" Post-ACA, I think we've seen a continuation of that.

Of course, the events of the last 18 to 24 months only magnify the need to be challenging our thinking here. That cost of inactivity is considerable. I think it will lead to organizations in the coming years being, quite honestly, disintermediated from some of their own goals that they would have had if they didn't try to tackle them head on.

Tufte: Frankly, you're not going to be able to be in the Medicaid space if you're not addressing health equity and SDOH. You're not going to win those bids. It's an expectation that you are doing this work. If you don't address diversity, equity, and inclusion, you're not going to be [competitive]—it's table stakes. You have to have a plan, it's an expectation that you are addressing this, and I think that consumers are savvier. The cost

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is more transparent today with millennials. They're definitely asking. There is a cost the consumers are looking for.

HealthLeaders: *How can payers and providers work together to track SDOH data and make actionable solutions?*

Gates: That's a great question. We can't do it alone. We are part of the [Spectrum Health System], so we know firsthand that to be successful, payers and providers have to work together. There are benefits to being part of an integrated system, and what we've done in moving more to value-based care certainly helps open the doors. For example, we've embedded rewards for our physicians within our incentive programs. One we recently launched is in screening for SDOH data. If a physician supplies more patient data surrounding social factors on at least 5% of their patient base, they'll be rewarded financially. The intent is to start there and then expand that into actionable processes.

Rewarding value-based initiatives are certainly important in this [effort]. As the health plan, we're not seeing the patient every day, our provider partners are. We have to work together on this.

Perry: With value-based care, which is something that we've spoken about the importance of aligning the incentives and which we're still relatively in the early game, the information is positive around how we're impacting cost. Additionally, we're saving lives through this, which produces strong alignment, and that puts us in a better position to succeed with the model over time. We have a lot more open data sharing and we've made investments in capabilities on behalf of our providers so that we can make certain we're getting as much data or the right kind of data to our Blue Premier providers so that they can positively impact total care and quality.

The example that Nick provided is a good one of greater integration of the health system, and it doesn't necessarily mean health plans have to own providers or providers have to own health plans; thinking about integration and partnerships in different ways is an important aspect. There are a couple of things we're doing; one is that we have a partnership with Duke Health System on a Medicare Advantage plan that's in their footprint, and it gives us a good ecosystem to better understand how to improve quality and affect cost if both the provider and the payer are at the table together jointly managing a health plan. We're still early, but so far, good outcomes.

[Finally], we just recently announced a collaboration with a private equity–backed company to invest in physicians in independent primary care with the hope and expectation that we can meaningfully support sustainability in that marketplace and allow for better innovation and cost impact. Again, this is another part of our focus on supporting the primary care physician as the center of supporting care decisions.

Shah: I'm in my third decade of healthcare and yet I still sometimes want to feel naïve, but to say I believe there's a glass half full [perspective] when it comes to some of these conversations when it comes to payer-provider integration. As Mitch and Nick had talked about, I think there's the traditional, vertical kind of alignment that can exist, but I've also seen areas that if there's a little bit of nuance and there are olive branches extended, that you can get meaningful results from folks that have historically sat across the table from each other. Examples of that, to me, include much of what we're talking about in terms of these platforms and the sincere attempt of saying, "What are we looking to do? We're both committed and anchored to these communities. What's the end goal look like? What is success? Where is the rise in tides that floats all boats?"

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Historically, economic development has been one of those areas. If you think about chambers of commerce and the local Blue plan coming together, or a national carrier coming together with the health systems in the region and saying, "Hey, look, what are we trying to do?" We know the employer quotient in all of this is so significant and we know as well that if we attract from a health measure standpoint some of these employers into our region, that that can be a compounding effect and benefit everyone, because it allows them almost a funding ability from a cost standpoint to then take better care of some of our other community stakeholders and whether they're Medicaid or Medicare participants into that.

There are areas, though, that I think we can find that common ground. It comes down to leadership at some level. It comes down to having the right perspectives in the room. They're certainly not short-term conversations. They're longer, from a longitudinal standpoint. I've seen it on both sides—if you get past some of that [acrimony] and create a little bit of a vision, that seems to be the key. But it takes effort and it certainly takes leadership.