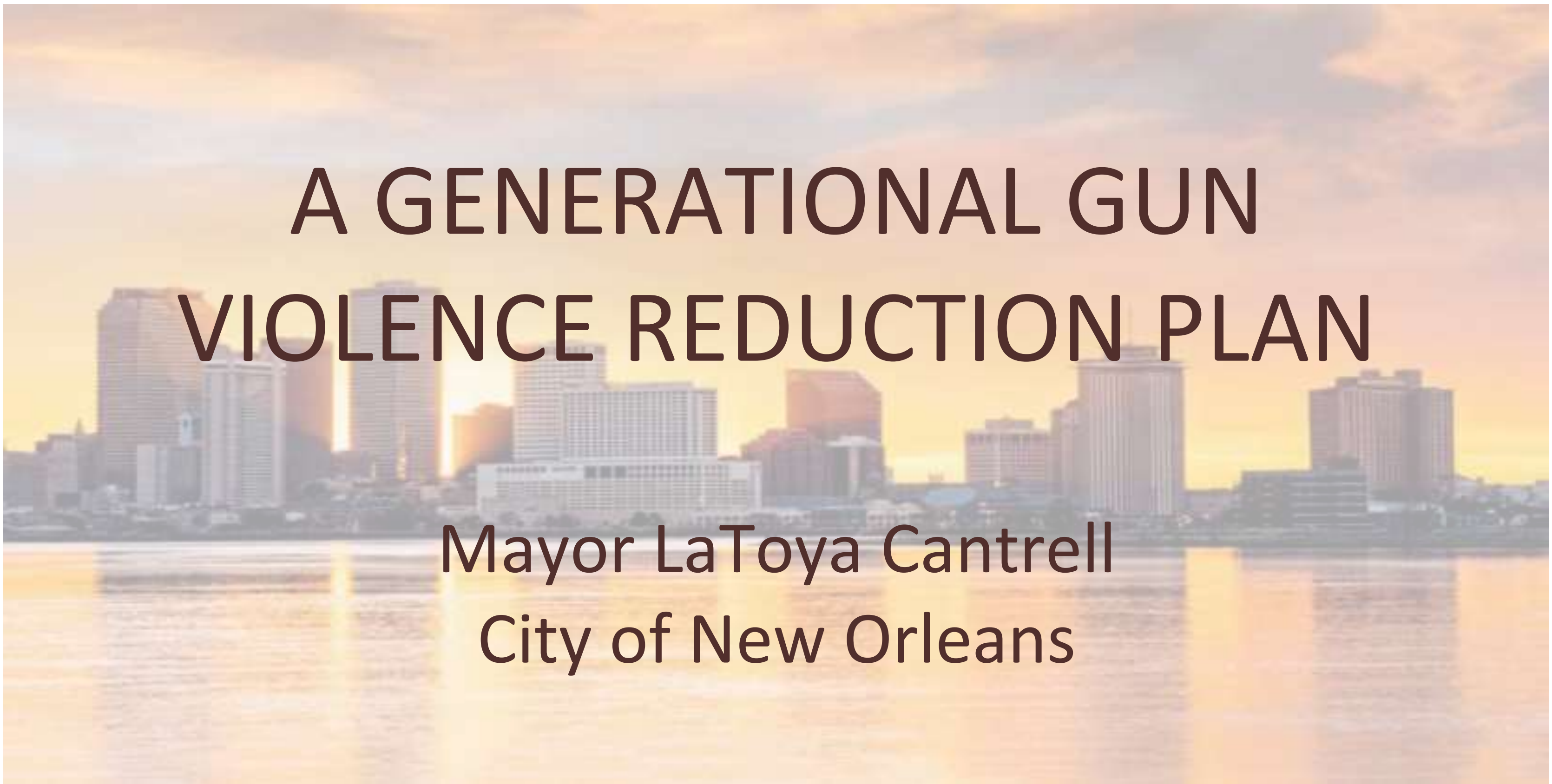


A GENERATIONAL GUN VIOLENCE REDUCTION PLAN

Mayor LaToya Cantrell
City of New Orleans

MAYOR'S GUN VIOLENCE REDUCTION TASK FORCE

August 2019

Letter from Mayor Cantrell

Fellow residents of the City of New Orleans,

When I took office on May 7, 2018, I knew that we faced some tough challenges ahead, and that the only way we could meet them was if we went forward together. One of the most pressing challenges we face as a city is the high number of murders, which has topped 145 every year since 1972. With nearly 90 percent of murder victims being killed by firearms, our homicide problem is a gun violence problem.

To combat this issue, I commissioned the Gun Violence Reduction Task Force, composed of a broad range of community stakeholders, and charged them with developing a comprehensive set of recommendations for helping my administration deal with this epidemic in our city. I wanted a plan that would make a difference – not just in the short term with temporary successes, but one that would outlast my tenure, save lives for many years to come and lead to our city truly being safer.

It is important to remember that this plan is not a cure-all; gun violence in New Orleans will not be eradicated overnight. Determining exactly what works at scale will take years of iteration, trial and error, data analysis and community feedback. That being said, if we remain focused on making long-term, strategic investments in public health interventions that data shows are effective; if we improve our homicide clearance rate; and if we disrupt violence through intentional and sustained community engagement efforts, I know our city's next 50 years will involve far less gun violence than our last 50 years.

I would like to extend my sincerest thanks to the Task Force members who gave their energy, time, passion, and insight to the planning process. I also want to extend my gratitude to my staff, the consultants, community leaders, advocates, and local and national experts who played a role in devising this plan.

Yours for a safer New Orleans,

L. Cantrell

LaToya Cantrell
Mayor of the City of New Orleans

Contents

Executive Summary

I envision a New Orleans where all residents are safe from gun violence and empowered to reach their full potential. There have been at least 145 murders in New Orleans every year for the last 50 years. Gun violence has ravaged our communities and families for generations, and we can no longer just respond to its aftermath; we must strategically work to prevent it. My administration's generational gun violence reduction strategy is grounded in a public health approach that relies on data and collaborative engagement across the public, nonprofit and academic sectors.

There are three core components of our approach:

1. **The Gun Violence Prevention Collective:** Specifically, we believe gun violence will decrease over time by creating an entity called the Gun Violence Prevention Collective (GVPC). The GVPC will be tasked with funding and developing public health interventions, ensuring that programming is effectively delivered, and measuring the outcomes. Data-driven and informed by national best practices, the GVPC will offer individuals likely to be involved in gun violence comprehensive preventative services.
2. **Preventing Homicides by Solving Homicide Cases:** Through solving more homicide cases, law enforcement can play a critical role in removing dangerous individuals from our communities, deterring would-be shooters and increasing community trust in the criminal justice system.
3. **Community Engagement:** Cure Violence New Orleans (Cure Violence) is the local arm of an international violence intervention program based out of Chicago. The program aims to prevent shootings by identifying situations where the likelihood of violence is high and engaging to de-escalate the situations before violence occurs. The current program is rooted in Ceasefire New Orleans, with a similar usage of culturally competent messengers as violence interrupters and case workers who impact at-risk individuals in their neighborhoods and in hospital settings.

> *"I envision a New Orleans where all residents are safe from gun violence and empowered to reach their full potential."*

Sustainably reducing gun violence will be a long and hard road; the number of annual murders in New Orleans will not reverse overnight. Progress will require improving and investing in programs that data shows are working, sunsetting those that are not, and designing and rigorously evaluating new interventions that have the potential to reduce gun violence. We believe this plan will ensure that New Orleans is a city where all residents are safe from gun violence and empowered to reach their full potential.

Vision and Goals

Vision

The Cantrell Administration envisions a New Orleans where all residents are safe from gun violence and empowered to reach their full potential.

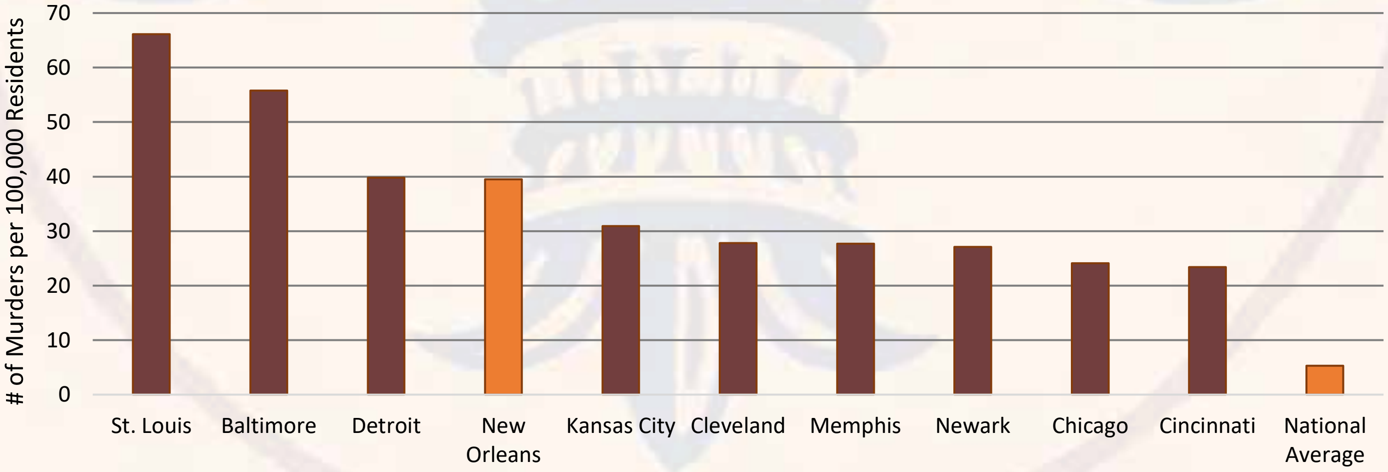
Goals

This plan aims to meaningfully reduce the number of gun-related murders in the city over the next 50 years.

Defining the Challenge: What Gun Violence Looks Like in New Orleans

In 2017, the most recent year for which national statistics are available, there were 157 murders in New Orleans (a rate of 39.5 per 100,000 residents), with 136 of them resulting from gun violence.[1, 2] The national average rate for that same year was 5.3 per 100,000 residents, making New Orleans' rate more than seven times the national average.[3] New Orleans has ranked in the top 5 nationally in murder rate every year since 1987, a streak that is largely driven by gun violence. Figure 1 below shows how New Orleans compares to other major cities in the U.S. when it comes to murders.

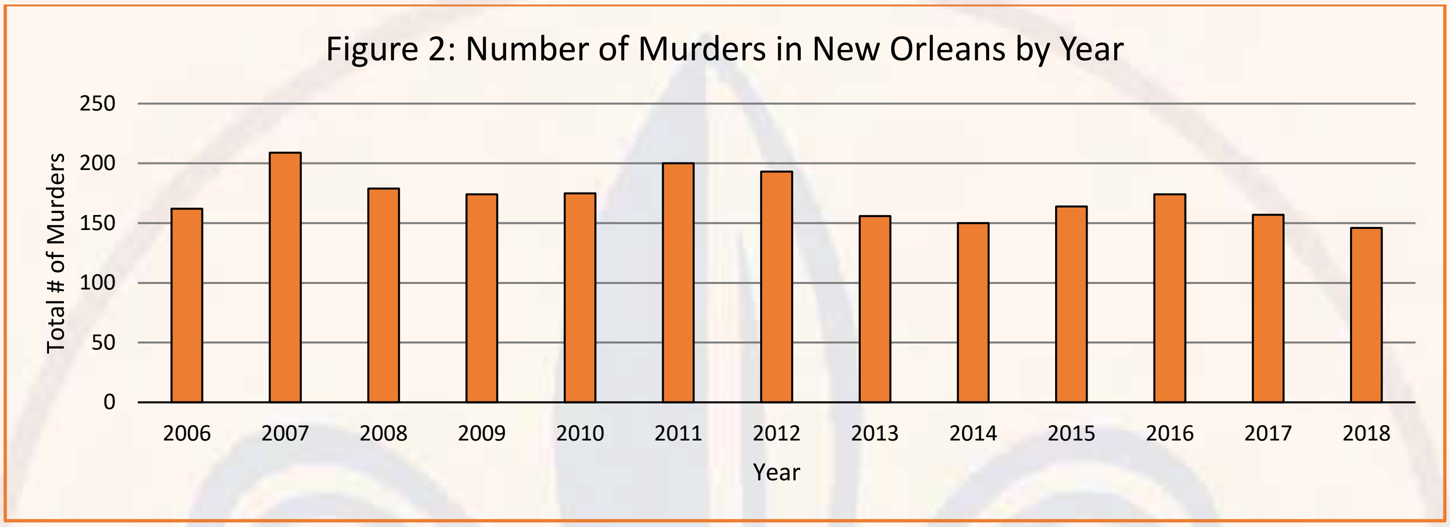
Figure 1: Top 10 Murder Rates in 2017 by City (Per 100,000 Residents)



Source: FBI Uniform Crime Reporting (UCR) Program

At 39.5 murders per 100,000 residents, New Orleans was fourth in the nation in 2017. While this represents an improvement over previous periods when New Orleans had the highest rate in the country, there still remains a lot to be done.

Figure 2 below shows the number of murders for the period from 2006 to 2018. The data shows that the total number ranges from 146 to 207 during this time. In order to reduce these numbers, a new approach is needed.



Source: FBI Uniform Crime Reporting (UCR) Program

> *“At 39.5 murders per 100,000 residents, New Orleans was fourth in the nation in 2017. While this represents an improvement over previous periods when New Orleans had the highest rate in the country, there still remains a lot to be done.”*

Why a Public Health Approach to Gun Violence Reduction?

Public health encompasses any threat to a person's life and wellbeing that can be prevented, contained or treated. For far too long, gun violence has been a leading cause of injury and death in our local community, but it can be prevented through focused interventions for individuals who need them most. This approach is not new; the U.S. successfully eradicated polio and dramatically decreased injury rates from car accidents through dedicated partnerships at every level of the community working towards a common goal.

Science tells us that gun violence concentrates in some communities or social networks.[4] This plan will interrupt the transmission of gun violence by focusing on:

- Upstream factors in a person's life that can be influenced to prevent their involvement in gun violence;
- Delivering appropriate interventions for a person's age and circumstances;
- Evaluating whether interventions are having the intended outcome; and
- Scaling successful prevention strategies.

This public health approach to gun violence reduction does not replace, nor is it at odds with law enforcement. Its focus is simply different: not deterrence, but prevention by addressing the root causes of gun violence. Communities around the country and world integrate public health into public policy challenges, and with respect to gun violence prevention, New Orleans will be no different.

However, my administration's approach will not be successful without community trust, engagement and transparency. As such, we are committing to the following:

1. Data collected pursuant to this plan will NOT be shared with the police and will NEVER be used for predictive policing.
2. The City will hold annual meetings in all five Council districts organized through the Mayor's Office of Neighborhood Engagement to:
    - Educate the public about this plan and its specific elements;
    - Offer an avenue for meaningful community input;
    - Share progress reports on high-level successes/challenges related to the implementation of the plan; and
    - Provide an opportunity for individuals to voice their concerns regarding the plan
3. Annually, there will be a formal opportunity for community partners to have input on programming and interventions;
4. There will be an annual report produced for the public that will detail the GVPC's interventions and evaluate their effectiveness while also detailing the City's progress toward attaining the long-term vision laid out in the plan.

> *"This public health approach to gun violence reduction does not replace, nor is it at odds with law enforcement. Its focus is simply different: not deterrence, but prevention by addressing the root causes of gun violence."*

1. Gun Violence Prevention Collective (GVPC)

Congressional funding for gun violence research stopped in 1996.[5] Since, there has been almost no research on the root causes of gun violence or interventions that prevent it.[6] City agencies, nonprofits and community organizations in New Orleans offer services that address some of the social determinants of health, but these efforts are not coordinated, systematically evaluated for their effectiveness, or based on long-term gun violence reduction research. Therefore, the causes of periodic reductions or increases in gun violence are difficult to understand and explain. To tackle this problem, my administration will create the Gun Violence Prevention Collective (GVPC) to coordinate, fund, and evaluate gun violence reduction interventions and their outcomes.

> *“. . . my administration will create the Gun Violence Prevention Collective (GVPC) to coordinate, fund, and evaluate gun violence reduction interventions and their outcomes.”*

How the GVPC Will Work

One of New Orleans’ greatest strengths is its concentration of institutions of higher learning. The city’s seven universities are an untapped resource that can position New Orleans as a premier research hub for measuring, studying, and combating gun-related violence. The GVPC will function as a consortium of academics from New Orleans and other institutions across the country, and, in keeping with our public health approach, will be led by City Hall.

The GVPC will have three core functions:

1. **Coordinate the Efforts of City Agencies and Nonprofit Service Providers:** City agencies and nonprofits provide services that, if better coordinated, could have an even greater positive impact in our communities. The GVPC will provide this coordination, reduce duplication of efforts and improve the overall effectiveness of programming by directing it to individuals who need it most.
2. **Fund Interventions and Partnerships**: Through various City agencies and funding streams, the City spends millions of dollars on programming and social services. The

GVPC will identify existing City funding sources and strategically align them with key stakeholders in order to ensure that resources are being allocated to provide interventions to our city's youth and adults who are most at risk of being involved in gun violence.

3. **Rigorously Evaluate the Outcomes**: Beyond determining which individuals are most at-risk of being impacted by gun violence, the GVPC will coordinate local and national academics who will study whether specific interventions reduced gun violence and prevented other negative life outcomes. Further, a longer-term goal is to demonstrate that investing in specific, proven interventions reduces the societal costs associated with gun violence (i.e. incarceration costs, court costs, medical costs, etc.).

> "*Investments made at a citywide level will only occur once we are satisfied that the interventions we are investing in will work.*"

GVPC's Guiding Principals

- **Focus:** Research shows that gun violence is incredibly concentrated in American cities with only a small fraction of a city's population involved in the majority of violence.[7] For example, 70% of all victims of non-fatal gunshot injuries in Chicago could be located in a social network comprised of less than 5% of the city's population. Similarly, a study of a high-crime Boston community found that nearly 85% of all victims of fatal and non-fatal gunshot injuries could be located in a network comprised of 763 connected individuals.[8] Gun violence in New Orleans is no different, and the GVPC will focus on coordinating services so that resources are deployed to those who are most at risk.
- **Proof Before Scale:** Cities across the country have struggled to develop and deliver public health interventions that have been proven to sustainably reduce gun violence. Because municipalities are only recently starting to look at the viability of public health strategies to address gun violence, there is no playbook or set of clear strategies that are guaranteed to reduce gun violence over the long term. As my administration develops and delivers targeted interventions to individuals in New Orleans, we will start with small pilots before expanding to citywide implementation of strategies in order to ensure we are investing in proven interventions. This approach will not only allow for the pilot projects to be rigorously measured, but it will also allow for finite resources to be strategically and responsibly deployed. Investments made at a citywide level will only occur once we are satisfied that the interventions we are investing in will work.

- **Making Better Use of Existing Resources:** A review of City programming reveals that the City of New Orleans has resources that can be strategically redeployed to offer services to individuals who are at heightened risk of being involved in gun violence. By reimagining how City resources are used and strategically investing them in expert, local nonprofits that can grow their impact with additional funding, we are confident that more effective programming will reach individuals for whom it would do the most good.

- **Partnerships:** New Orleans is fortunate to have a robust nonprofit sector that plays a key role in providing critical social services to many of our community members. Additionally, as mentioned earlier, New Orleans has a wealth of academic experience, as the City has seven postsecondary institutions that can lend support to helping reduce gun violence in New Orleans once and for all. To be successful, partnerships between nonprofit partners, postsecondary institutions and City agencies must be strong, collaborative and mutually beneficial; GVPC will coordinate these relationships.
- **Measuring, Adapting, and Improving:** The GVPC will rely on university and academic partners to measure the outcomes of interventions and determine their effectiveness based on rigorous data analysis. Insights gleaned from this analysis must be used to inform future interventions and programmatic investments.

The GVPC - 2019 Summer Success Pilot

The Mayor's Summer Success Pilot is an example of the type of programming the GVPC will coordinate, fund and evaluate in the future. Research in other cities has shown that summer jobs programs that provide minimum wage summer jobs to at-risk youth reduced arrests for violent crimes, incarceration and premature deaths.[9] Through a partnership with the Office of Youth and Families and JOB1, the Gun Violence Reduction Task Force earmarked 100 summer jobs for youth ages 16-21 who had been arrested three or more times in the last eighteen months and as such were at greater risk of being the victims/perpetrators of gun violence.

Youth were referred to the program through a range of key stakeholders that included Orleans Parish Juvenile Court, Louisiana Center for Children's Rights (LCCR), Welcoming Project and Orleans Parish School Board's (OPSB) Office of Student Support & Attendance. Though senior officials from my administration are still evaluating the Summer Success pilot data, we do know that only 4% of the program's participants were rearrested during the summer. We will look forward to analyzing whether the program had additional positive impacts on participants.

2. Solving More Homicide Cases

The U.S. Department of Justice notes, "The chance of being caught is a vastly more effective deterrent than even draconian punishment."[10] Beyond deterrence, solving homicide cases quickly is also key to preventing future homicides. In 2017, the most recent year for which national figures on homicide clearance rates are available, the City of New Orleans' homicide clearance rate was 50%, which was lower than the national average of 61.6%.[11] However, improvements in training, operations and collaborative case management can increase homicide clearance rates to 55% annually.

My administration will increase the New Orleans Police Department's (NOPD) homicide clearance rate by using the following seven strategies:

1. Constructing the New Orleans Crime Lab

- While ballistics samples, drug identification confirmations and other scientific processes can currently be done in Orleans Parish, DNA processing is analyzed at the Louisiana State Police Crime Lab (LSPCL) in Baton Rouge and gun powder residue is analyzed in St. Tammany Parish. The construction of the new NOPD Crime Laboratory will centralize all of these key crime analysis functions under one roof in our parish and streamline the forensic capabilities of the New Orleans Police Department.

Timeline: The Crime Lab should be completed by 2022.

2. Holistic Case Management

- NOPD will create a Homicide Investigation Process & Procedure Team (HIPP) for each murder case. This will ensure fully integrated communication between the officer who initially arrived on the murder scene and other officers and detectives who subsequently work on a specific case. This team-based approach will optimize information-sharing opportunities while consolidating the responsibility for solving homicide cases with a collaborative investigative body. For every homicide investigation, a HIPP team will consist of:

- Homicide Commander
- Homicide Sergeant(s)
- Homicide Detective(s)
- Street Gang Unit Member(s)
- Intelligence Unit Member(s)

- Major Case Narcotics
- Crime Lab Lieutenant
- Lieutenant(s) or Sergeant(s) from Districts 1-8 (as needed)
- Detectives from Districts 1-8 (as needed)
- Representative from the District Attorney's Office
- Tactical Intelligence Gathering and Enforcement Response (T.I.G.E.R.) team member (for shootings - as needed)
- Community Liaison
- Federal Bureau of Investigation (FBI) - Homicide Liaison
- Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) Agent/Representative
- Drug Enforcement Administration (DEA) Agent/Representative

> *"An updated operations manual will enable a detective at any point in their career to immediately understand each and every step that should happen from the beginning to end of a homicide investigation."*

A HIPP team will meet weekly to ensure critical collaboration and information sharing among the aforementioned members of the homicide investigation process. Specifically, the HIPP team will meet to:

1. Share information on all active homicide cases and related non-fatal shootings;
2. Ensure that all possible avenues for identifying the responsible offender(s) are pursued;
3. Demonstrate transparency by working collectively
4. Give the community a way to engage in the process through the Community Liaison
5. Identify homicide trends, gaps and any deficiencies within the investigation process.

Timeline: HIPP teams will begin regularly meeting by January 2020.

3. Homicide Section Operations Manual - NOPD will create a comprehensive Homicide Section Operations Manual that calls for goals that go beyond clearance rates and include specific best practice requirements for each homicide investigation. While a homicide section operations manual currently exists, it does not lay out in step-by-step detail how a homicide case should be investigated.

An updated operations manual will enable a detective at any point in their career to immediately understand each and every step that should happen from the beginning to end of a homicide investigation. Adherence to the operations manual will be used to track key performance indicators and measure progress towards set department goals.

Timeline: The operations manual will be completed by July 2020

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4. Mentorship - NOPD will create a structured mentorship program for all newly assigned homicide investigators. Currently, new homicide detectives follow a veteran detective for approximately two weeks before being assigned their own homicide cases to investigate. Starting immediately, all new homicide detectives will participate in a minimum of six weeks of homicide training, followed by weeks of shadowing a veteran detective. During the initial six-week training period, each new detective will be given a case to investigate alongside a trained homicide detective, who can offer real-time guidance, support and feedback.

To prepare newer detectives for eventual promotion to the Homicide Section, a district detective from each of the eight police districts will investigate a minimum of one homicide per year alongside a senior homicide detective, as well as attend annual homicide trainings that are recommended by the Louisiana Peace Officers Standards and Training Council (POST).

Timeline: The NOPD's new homicide mentorship program began July 2019.

5. Forensic Training

– NOPD will provide regular and mandatory forensic training to all homicide division and district detectives to ensure an understanding of the types of evidence that are subject to forensic analysis, the types of information that forensic analysis can provide, and best practices in the collection and preservation of forensic evidence. This training should allow for a more integrated work process among investigators, crime scene technicians and forensic scientists. At present, detectives are only given a short briefing on forensics during their week-long detective training. The department will standardize best practices while increasing the efficiency and effectiveness of getting all detectives up to speed.

Timeline: Forensic training for all homicide and district detectives will be established by January 2020.

> *"Starting immediately, all new homicide detectives will participate in a minimum of six weeks of homicide training, followed by weeks of shadowing a veteran detective."*

6. Collaborative Review of Cases Cleared by Exception

– Homicide cases can be cleared either by warrant (a warrant is issued for a suspected perpetrator's arrest); by arrest (a suspected perpetrator is apprehended); or by exception (a homicide was deemed justified or the suspect died before charges were brought forward). Under my administration, before a case is deemed cleared by exception, it must go through a thorough review by the HIPP team and then be presented to the District Attorney for final review.

Timeline: New cleared by exception procedures will be established and implemented by January 2020.

7. Continue and Expand Chaplain Program

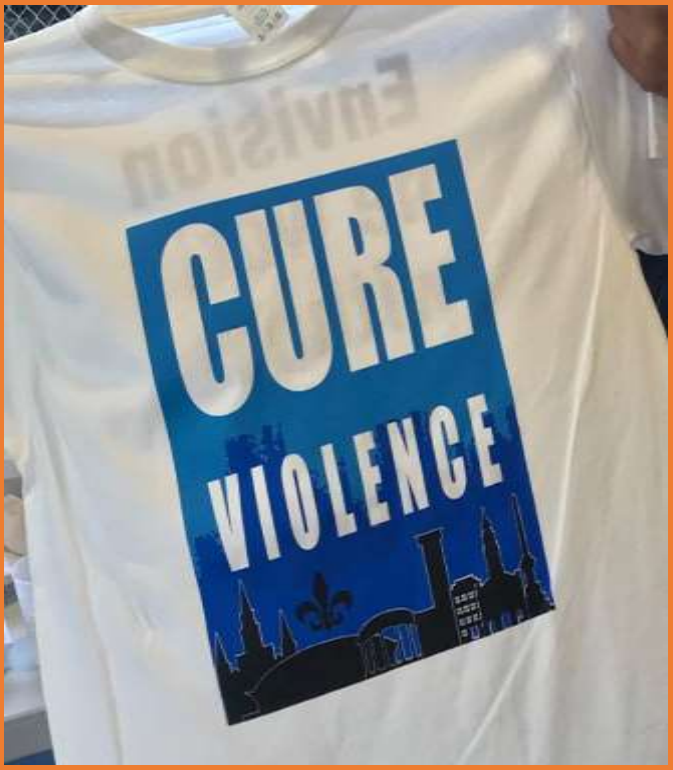
– NOPD employs trained chaplains who offer counseling to victims, families and community members on the scene of a violent crime or murder. Chaplains not only have the ability to comfort those in distress, their counsel could prevent retaliation or increase a community member's willingness to cooperate with the investigation. Moving forward, my administration will continue to support the work of chaplains who offer counseling on crime scenes, and we will look to expand the number of trained members of the faith-based community who can be a part of delivering that service in a volunteer capacity.

Timeline: The expansion of the volunteer part of the chaplain program will begin in January 2020.

> *"Chaplains not only have the ability to comfort those in distress, their counsel could prevent retaliation or increase a community member's willingness to cooperate with the investigation."*

3. Cure Violence New Orleans

Cure Violence New Orleans (Cure Violence) is a community-based intervention that interrupts conflicts before they turn violent. Cure Violence New Orleans is the local arm of an international violence intervention program based out of Chicago, IL, that reduces shootings by identifying situations where the likelihood of violence is high and engages high-risk individuals in order to de-escalate situations before violence occurs. Building upon Ceasefire New Orleans, this intervention uses culturally competent messengers as violence interrupters and case workers who provide support and interventions to vulnerable individuals in their neighborhoods and in hospital settings.



The Cure Violence program under my administration will focus on:

- Connecting groups of individuals at high risk of gun violence to services and resources in order to assist them with making the decision to change their lives and communities. This approach relies heavily on interrupters (adults who previously participated in violent/criminal activities and are thus "credible messengers" on the street) and case managers;
- Mobilizing the larger community to present and reinforce social norms to resolve conflicts peacefully and thus reduce shootings and killings;
- Facilitating mediation sessions with young people and adults who were referred to Cure Violence by community members and partners in order to resolve disputes peacefully, before gun violence occurs; and

> *"Cure Violence New Orleans ... reduces shootings by identifying situations where the likelihood of violence is high and engaging high risk individuals in order to de-escalate situations before violence occurs."*

- Responding immediately to shootings of individuals 25 years old and younger at the hospital in order to diffuse tensions and prevent retaliation by friends and family members and to provide support and resources to victims when they have a great willingness to change their behaviors.

Cure Violence will also work with community partners to insert violence reduction programming into their existing curricula and trainings. Key community partners include the following:

- Schools: Cure Violence will work with schools throughout the City to identify opportunities for Cure Violence staff to discuss the impacts of gun violence, violence prevention and conflict resolution skills
- Healthcare providers: Cure Violence will collaborate with New Orleans Health Department programs, partner agencies, hospital emergency rooms and trauma units to provide support and resources for clients/patients identified as needing additional physical or mental health services
- Workforce training providers/businesses: Cure Violence will connect with workforce development partners and local businesses to provide career opportunities for participants
- Peer support groups: Cure Violence will facilitate peer support groups for participants to regularly discuss conflict resolution, life skills, peer mentoring, problem solving and long-term issues and concerns
- Service providers: Cure Violence will connect family members of those affected by violence (or its threat) to social, legal, faith-based, educational and health services
- Mentoring organizations: Cure Violence will work closely with partners who work with youth and adults engaged with the justice system to ensure there is a continuum of mentoring and supplemental supports provided to individuals who are at risk of ongoing exposure to violence

> *“Cure Violence will also work with community partners to insert violence reduction programming into their existing curricula and trainings.”*

Acknowledgements: The Gun Violence Reduction Task Force

The Public Safety Committee of Mayor Cantrell's Transition Team recommended that she establish the Mayor's Gun Violence Reduction Task Force (Task Force), which she did through executive order as one of her first acts as Mayor. The purpose of the Task Force was to present a data-backed plan to measurably and sustainably reduce gun violence in New Orleans over the next 50 years. Composed of experts in policy, service provision and community engagement, the Task Force focused on developing quantifiable strategies to address gun violence reduction in the City of New Orleans that included a wide array of perspectives, community voices and expertise. This report is the product of the recommendations of this group.

Task Force Membership and Staff Support

The membership of the Task Force consisted of the following:

- Jeff Asher - Crime Data Analyst and Public Safety Consultant for New Orleans City Council
- Dr. Jennifer Avegno - Director of the City of New Orleans Health Department
- Joshua Cox - Director of Strategic Initiatives to Mayor LaToya Cantrell
- Flozell Daniels - Executive Director of Foundation for Louisiana
- Tamara Jackson - Executive Director of Silence is Violence
- Melissa Sawyer - Co-founder and Executive Director of Youth Empowerment Project (YEP)
- Nathalie Simon - Special Counsel to the CEO & President of Laitram, LLC
- Skipper Bond & Jordan Friedman - Bond Moroch

The Task Force received critical support from the following individuals:

- Dr. R. Erich Caulfield - Task Force Meeting Facilitator and Research Coordinator; Founder and President of The Caulfield Consulting Group
- Dr. Neil Kleiman - Public Administration Program, Tulane School of Professional Advancement
- Rayne Pestello - Special Assistant to Mayor LaToya Cantrell

These recommendations would not have been developed without the insight, advice, and dedication of the following groups and individuals:

City and Other Government Agencies

- City of New Orleans Health Department (NOHD)
- City of New Orleans Police Department (NOPD)
- Mayor's Office of Criminal Justice Coordination (OCJC)

Consultants, Service Providers and Other Subject Matter Experts

- Dr. Jonathan M.V. Davis
- Dr. Jennifer L. Doleac
- Dr. Sara Heller
- Dr. Judd B. Kessler
- Dr. Andrew V. Papachristos
- Charles West
- Young people engaged with Youth Empowerment Project (YEP)

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12. Plan Design and Layout Credit: The graphic design and layout of this Plan was based upon prior work produced by Spears Group: https://irp-cdn.multiscreensite.com/a41e72e5/files/uploaded/ForwardTogetherTransitionPlan.pdf
13. Photo Credit: Cover - Nate Hart, Available at: www.natehartstudios.com
14. Photo Credit: Pg. 8 - SkylineScenes.com
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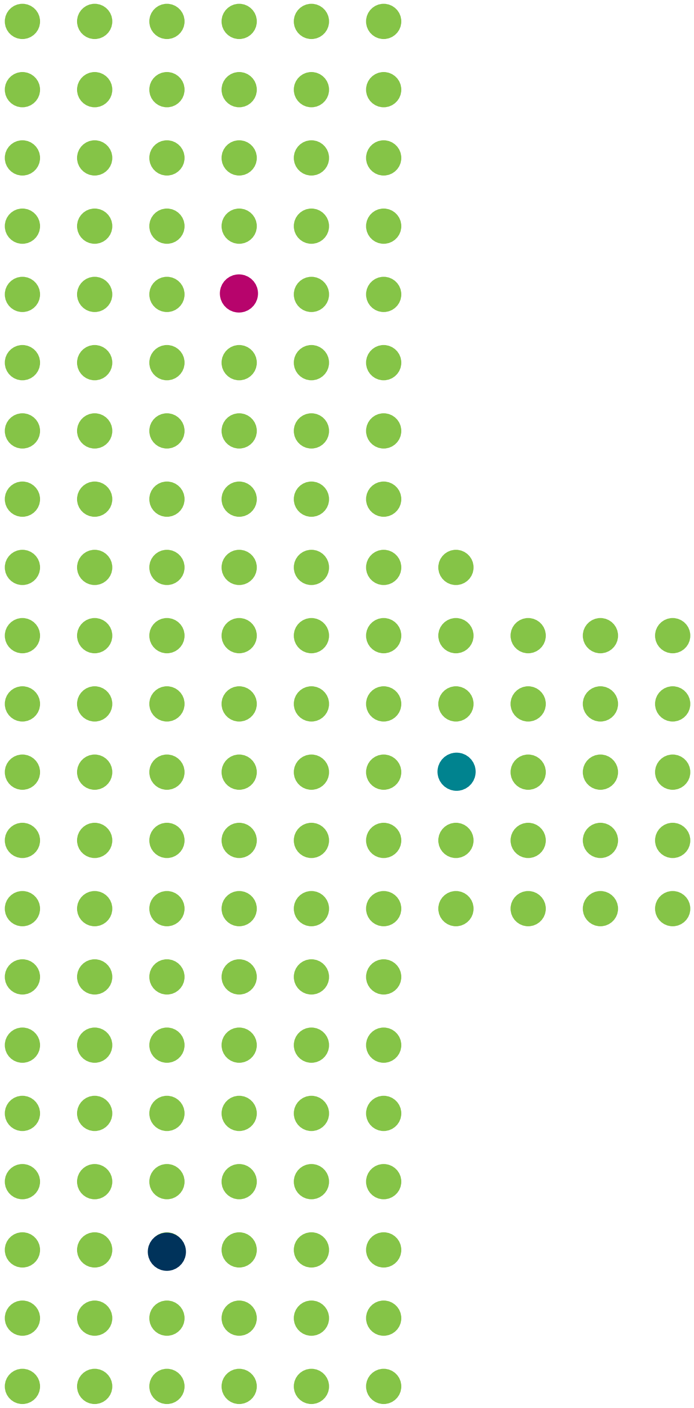
CITY OF NEW ORLEANS

MAYOR LATOYA CANTRELL

April 2021

Access to Healthcare Issue Brief



BOLD GOAL
POPULATION HEALTH STRATEGY
OFFICE OF HEALTH AFFAIRS AND ADVOCACY

The intent of this brief is to increase knowledge and inform our stakeholders of opportunities to address social determinants of health, a core function of Humana's Bold Goal, Population Health Strategy. Our Bold Goal is to improve the health of the people and communities we serve by making it easier for everyone to achieve their best health.

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PopulationHealth.Humana.com
#MoreHealthyDays

Timely and Appropriate Use of Health Services to Achieve the Best Health Outcomes

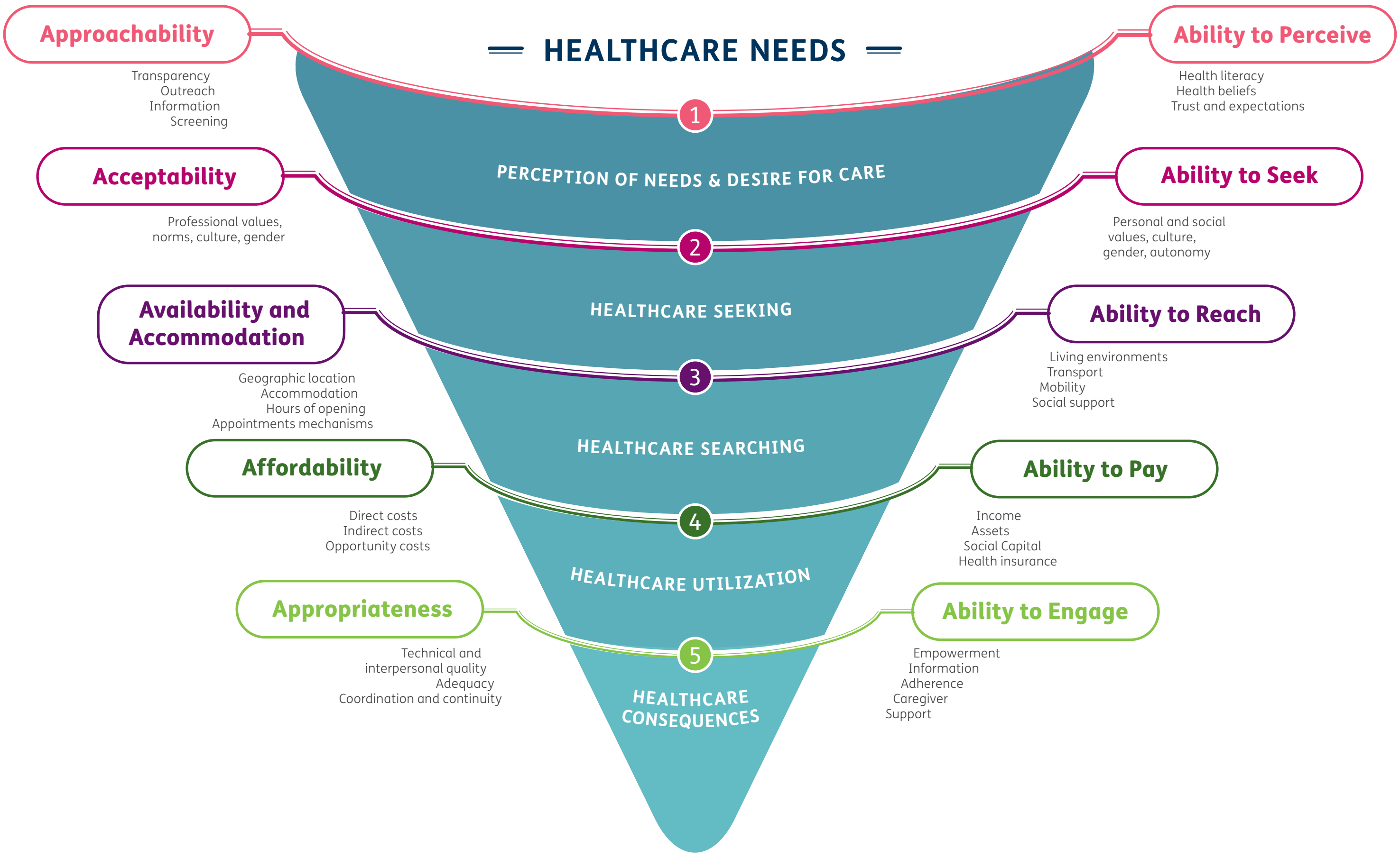
In order for the healthcare system to operate effectively, patients must be able to access health services. However, millions of people in the United States continue to experience tangible and intangible barriers to access. Tangible barriers may include lack of or insufficient insurance coverage, distance and lack of transportation, inconvenient hours of operation, inadequate accommodations for language spoken or functional limitations, as well as pandemic-related "medical distancing." Intangible barriers may include health literacy proficiency, real or perceived bias, different cultural norms, and misinformation.

The following brief provides a review of some of the key factors influencing the complex, multifaceted issue of healthcare access. It also highlights research on interventions and cross-sector efforts to improve access, as well as potential areas of exploration for the healthcare industry.

By the Numbers

23.6%	**Of people in the U.S. lacked a consistent primary care provider primary care provider, which is statistically unchanged over the previous decade**
22 Million	**U.S. seniors lack broadband internet access, according to a report by the Humana Foundation and OATS, limiting their access to telehealth, social connection, and other basic needs**
50%+	**Of U.S. counties do not have a licensed behavioral health provider according to the Health Resources & Services Administration (HRSA). The need is particularly acute for Black, Indigenous, and People of Color (BIPOC)**

Five Dimensions of Accessibility



SOURCE: Levesque, Jean-Frederic & Harris, Mark & Russell, Grant. (2013). Patient-centered access to health care: Conceptualising access at the interface of health systems and populations. International journal for equity in health. 12. 18. 10.1186/1475-9276-12-18.

Access to healthcare may be defined in many ways that capture – to a greater or lesser degree – the complex interaction of supply - and demand-side influences. Exploring the concept using an established framework provides a basis for measurement and evaluation of accessibility, as well identification of potential policies and interventions to promote access.

Levesque et al. define healthcare access as, “the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services and to actually have the need for services fulfilled.” The authors further identify five dimensions of patient-centered access to healthcare – 1) Approachability; 2) Acceptability; 3) Availability and Accommodation; 4) Affordability; 5) Appropriateness – as well as corresponding abilities of healthcare consumers. The degree to which these dimensions are met may produce disparate consequences in terms of health, satisfaction, and financial security.

IN THIS CHAPTER

Approachability
- Perception of Needs and Desire for Care
- Political and Regulatory Response
- Medical Misinformation is Creating New Barriers to Access
- What Humana is Doing
- What Others are Doing

Perception of Needs and Desire for Care

"Approachability relates to the fact that people facing health needs can actually identify that some form of services exists, can be reached, and have an impact on the health of the individual." (Levesque, 2013)

As with any other good or service, consumers must have a demand or desire for healthcare before they seek it out. However, there are many factors that influence demand, including awareness of both personal health needs and services available. There may be significant geographic and socioeconomic variation in awareness and approachability of the healthcare system, so healthcare providers must be intentional in planning and implementing their outreach and marketing strategies to be inclusive and approachable to all cultures and demographics.

Broad, unfettered **access to primary care and the use of community health workers (CHWs)**, also known as navigators or *promotoras(es),* are two evidence-based strategies for improving this dimension of accessibility. Both facilitate person-centered care and navigation across all dimensions – physical, mental, and social – of health. According to the National Quality Forum's **Roadmap for Promoting Health Equity and Eliminating Disparities**, primary care providers (PCPs) are particularly valuable for "people with low health literacy, limited eHealth literacy, limited access to social networks for reliable information, or who are challenged with navigating a fragmented healthcare system," and CHWs facilitate critical clinical-community linkages. Not only has the **Community Preventive Services Task Force** found strong evidence supporting interventions engaging CHWs in diabetes management and prevention, cardiovascular disease prevention, and cancer screenings.

New research from a randomized control trial finds that **every dollar invested by a Medicaid payer in a CHW program posts a return of $2.47 within the fiscal year.**

Political and Regulatory Response

to Enhance Approachability of the Healthcare System

The **Center for Medicare & Medicaid Innovation** (the Innovation Center) supports the development and testing of innovative healthcare payment and service delivery models, and Primary Care Transformation is a key area of focus. **Primary Care First** builds off of the existing Comprehensive Primary Care Plus (CPC+) model to enhance the doctor-patient relationship by reducing administrative burden and rewarding improved outcomes for patients in Medicare Fee-for-Service (FFS). In 2020, **Humana announced** it will offer the model across the 48 contiguous states and the District of Columbia beginning in July 2021 to support the transition of primary care groups from fee-for-service to value-based care.

The Centers for Medicare and Medicaid Services (CMS) has taken steps to expand access to CHW's among vulnerable Medicaid beneficiaries. In 2013, **CMS issued** a final rule to expand the types of providers who are eligible to receive payment for delivering preventive services under Medicaid, giving states the option of allowing non-licensed providers such as CHWs to deliver such services as long as they are recommended by a physician or other licensed practitioner. A number of states currently have **CHW programs** in place, though the financing and certification models varies considerably from state to state. Most state Medicaid programs do not reimburse for CHW services, but several states, such as Florida and Louisiana, encourage their Managed Care Organizations (MCOs) to use CHWs, paid for through administrative costs. Many other state and healthcare organization CHW programs rely on public or private grant funding.

Medical Misinformation is Creating New Barriers to Access

Internet and social media platforms have allowed medical misinformation to proliferate and reach an ever-growing population. This threat became a public health crisis when the coronavirus pandemic struck the United States in 2020 and millions of Americans questioned not only the efficacy of mask wearing but also the severity of the virus itself. Many fear that misinformation will continue to hamstring recovery efforts by preventing Americans from receiving the COVID-19 vaccine. In response, President Joe Biden's Centers for Disease Control and Prevention (CDC) Director, Rochelle P. Walensky, MD, MPH, has stated she will **bolster the agency's presence** on social media to combat vaccine hesitancy and COVID-19 misinformation, and the CDC has awarded millions of dollars in grants to organizations for building trust and countering fear and misinformation.

In March 2021, the chief executive officers of Facebook, Google, and Twitter were called to testify before the House Committee on Energy and Commerce on social media's role in promoting extremism and misinformation. Among other steps, they discussed how their platforms are flagging and removing coronavirus misinformation and blocking chronic offenders. **YouTube** is partnering with reputable healthcare organizations such as Cleveland Clinic, the Mayo Clinic, the National Academy of Health, and Harvard's school of public health to bring more authoritative and accurate health content to its platform.

To coordinate and amplify public health messaging on COVID-19 and increase confidence in guidance from the CDC and public health officials, the CDC Foundation, de Beaumont Foundation, and Trust for America's Health have created the **Public Health Communications Collaborative (PHCC)**. One of the features is a **misinformation tracking and response tool** that provides real-time insights into misinformation that is circulating. In addition, Humana and the Humana Foundation have joined with other large corporations in a **large nationwide campaign**, led by **The Ad Council**, to bring critical vaccine information to the public to increase their confidence in getting the vaccine.

What Humana is Doing

Expanding access to and use of **primary care is a key pillar of Humana's corporate strategy and is integral to providing whole person care.** However, primary care is not a one-size-fits-all solution. Different patients, communities, and providers require different models of primary care to meet their unique needs and preferences. That is why Humana offers multiple primary care models, ranging from a variety of **value-based contracting** models that provide clinical, financial, and analytical services to support physicians to fully-or partially-owned clinics offering "next-generation" primary care. These primary care models also provide the flexibility to, for instance, fund clinic start-up costs for high-quality PCPs to be more accessible to medically under-served areas.

In March 2021, Humana **announced** a new brand – CenterWell – for a range of payer-agnostic healthcare services offerings. The first Humana-owned care services to adopt the new brand will be senior-focused primary care facilities that have operated as "Partners in Primary Care" in several states and as "Family Physicians Group" in the Orlando area. Many of the primary care centers are located in medically under-served areas throughout Florida, Kansas, Louisiana, Missouri, Nevada, North Carolina, South Carolina, and Texas, with plans for rapid growth in the coming months, including new centers in Atlanta, Houston, and New Orleans. All accept patients from many different Medicare Advantage MA plans and utilize multi-disciplinary care teams that include most or all of the following: a nurse practitioner, a physician assistant, a behavioral health specialist, social workers, clinical pharmacist, care coach and support staff.

> **"Humana is committed to leverage our business platforms to support local communities in their efforts to lower social and health disparities. This includes enhancing access to care by continuing to expand and build primary care centers in underserved markets"**
>
> Bruce Broussard, Humana President and CEO, Q4 2020 Results Earnings Call, February 3, 2021

Humana is integrating CHWs and other social health providers into care coordination models to improve approachability and holistically address the whole health needs of members. For Humana Healthy Horizons™ Medicaid beneficiaries in Florida and Kentucky, CHWs provide key clinical-community linkages to improve health management and outcomes. CHWs also serve MA members in certain markets, including those on **Author by Humana** plans. Author is a **new model** that provides tech-enabled personalized care. Initially launched for five MA plans in South Carolina, Author gives both members and providers direct access to a team of navigators who aim to address their needs. In addition, in 2021, Humana began piloting a new, tech-enabled chronic care management platform, Humana Care Support, which harnesses enhanced data analytics to create an integrated, personalized experience for members. **What members may notice most is their access to a multidisciplinary care team to address their individual, whole health needs.** The team includes a nurse, a pharmacist, a social worker, and a behavioral health expert.

Additionally, Humana recently announced the hiring of **Nwando Olayiwola, M.D., MPH, FAAFP, as Senior Vice President and Chief Health Equity Officer,** who began her role in April 2021. Dr. Olayiwola is a longtime advocate for the underserved and brings more than 20 years of experience in clinical and academic medicine, public health, and health systems redesign. In this newly created position, Dr. Olayiwola will set direction and establish strategy to promote health equity across all Humana lines of business, including care delivery assets, to increase access to care for underserved and disenfranchised populations.

IN THIS CHAPTER

Acceptability

- Personal and Social Values, Norms, and Culture
- Political and Regulatory Response
- Native Americans
- What Humana is Doing

Personal and Social Values, Norms, and Culture

"Acceptability relates to cultural and social factors determining the possibility for people to accept the aspects of the service (e.g. the sex or social group of providers, the beliefs associated to systems of medicine) and the judged appropriateness for the persons to seek care." (Levesque, 2013)

Both clinicians and patients enter the healthcare system with their own personal values and beliefs, and these may inhibit access to quality care. This risk may be particularly acute for racial, ethnic, and religious minorities, socioeconomically disadvantaged and vulnerable populations, and women seeking reproductive healthcare services. As discussed in the September 2020 **Health Equity Issue Brief**, cultural competency training for providers, racially concordant clinicians, and integration of community members as CHWs may improve access to and compliance with care.

One area where misalignment of values and cultural norms often hinders access is end-of-life care. Individuals with **serious illness**, defined as "a health condition that carries a high risk of mortality AND either negatively impacts a person's daily function or quality of life, OR excessively strains their caregivers," require patient-centered care that respects patient preferences as they reach end-of-life. However, among the primary **patient-reported barriers** to accessing quality end-of-life care are: doctor behaviors; communication chasm between doctors and patients; family beliefs/behaviors; and cultural/religious barriers. All of these barriers are related to the **difficulty** patients, caregivers, and providers face in discussing such personally-held values and preferences, which are often perceived as "taboo" to discuss in formal settings. Patients and caregivers may view doctors as "insensitive" or "lacking empathy," while doctors may struggle with their oath to "do no harm" and view patients and families as unrealistic or irrational. However, improving the communication and shared decision-making skills of clinicians, as well removing the cultural stigma around end-of-life conversations, may make an impact.

Political and Regulatory Response

to Incorporate Wellness and Health Care Planning

In an effort to improve the quality of end-of-life care, the Innovation Center incorporated mandatory Wellness and Health Care Planning (WHP) into its **Value-Based Insurance Design (VBID) Model**. VBID allows MA organizations to test innovative plan design and cost-sharing structures to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries, particularly those with low incomes, and improve the coordination and efficiency of health services delivery. All MA organizations participating in VBID are required to offer each enrollee access to WHP, including advance care planning (ACP), to improve its effectiveness and impact in avoiding unwanted and unnecessary care.

Beginning in 2021, VBID also offers a **Hospice Benefit Component**, with will test the incorporation of the Medicare Part A Hospice Benefit into MA to assess the impact on care delivery and quality of care, especially for palliative and hospice care, for beneficiaries in MA plans. Currently, when an enrollee in an MA plan elects hospice, Medicare FFS becomes financially responsible for most services, while their MA plan is responsible for others, such as supplemental benefits, often resulting in fragmented care during this sensitive time.

Focus on American Indians and Alaska Natives

In accessing healthcare, American Indians and Alaska Natives (AI/AN) face compounding issues of being historically marginalized minority cultures with unique traditions, languages, and religious practices who often live in isolated, rural communities. In the last 200 years, in exchange for peace and possession of the indigenous lands of AI/AN, the United States government has made a number of promises pertaining to health and wellbeing in the form of treaties and legislation. AI/AN who live on federally-recognized Indian reservations receive care through the **Indian Health Service (IHS)**, which oversees the delivery of health services either directly through an IHS or tribal medical facility or through the Purchased/Referred Care (PRC) Program.

However, a 2018 report by the U.S. Commission on Civil Rights found funding levels for Native American tribes' education, public safety, healthcare, and other services to be **"woefully inadequate."** As a consequence, AI/AN still experience significant **barriers to health**, including discrimination when seeking healthcare, and their life expectancy in some states is 20 years shorter than the national average. The Biden Administration is prioritizing addressing these inequities, including urging Congress to dramatically increase funding for the IHS and invest $900 million in housing, infrastructure, and economic opportunities in its **Fiscal Year 2022 discretionary funding request**. In addition, some tribes have responded by establishing community-based health systems that incorporate physical, mental, emotional and spiritual wellness such as the **Nuka System of Care**. While established by Alaska Natives, this model has been adopted by other Indian health systems such as the **Cherokee Indian Hospital Authority** in North Carolina.

In January 2021, Humana's Medicaid division, Humana Healthy Horizons, **was selected** by the Oklahoma Health Care Authority to deliver healthcare coverage to Medicaid beneficiaries across the state, starting later in 2021. Humana Healthy Horizons is preparing to deliver high-quality, integrated healthcare services in Oklahoma, which is the state with the **highest percentage** of AI/ANs affiliated with federally recognized tribes. Joe Fairbanks, CEO of Humana Healthy Horizons in Oklahoma, belongs to the Leech Lake Band of Ojibwe and has worked with dozens of tribal health systems across the country to improve health quality and access to care. A number of key partnerships are already in place to meet the whole health needs of beneficiaries and communities, including addressing social and behavioral health needs. These include partnerships with March of Dimes Oklahoma to improve maternal and infant health outcomes and **Boys & Girls Club of America** to improve youth food security and support healthy behaviors.

What Humana is Doing

Humana is participating in various VBID models, **offering innovative benefits across a number of plans, all of which include Wellness and Health Care Planning**. Information about one of these VBID benefits, Humana's Healthy Food Card, can be found in the **December 2020 Food Insecurity Issue Brief**. Humana is also participating in the **MA Hospice "carve-in" model** with select plans in select counties in Colorado, Georgia, Indiana, Kentucky, Ohio, and Virginia.

Humana's partnership with the University of Houston to establish a new medical school and the Humana Integrated Health System Sciences Institute, as well as other partnerships to support the development of current and future generations of clinicians, are centered on health equity and ensuring equitable access to high quality healthcare. These programs emphasize inter-professional education – incorporating social workers and behavioral health professionals into medical care – and interpersonal communication skills that help bridge the gap in patient-provider values and preferences. Additional information about how Humana is promoting access through equity can be found in the September 2020 **Health Equity Issue Brief.**

IN THIS CHAPTER

Availability & Accommodation
- Ability to Reach Healthcare
- People with Disabilities
- Political and Regulatory Response
- What Humana is Doing
- Access to Broadband Internet & Digital Literacy
- What Others are Doing
- Mental Healthcare

Ability to Reach Healthcare

“Availability and accommodation refers to the fact that health services (either the physical space or those working in health care roles) can be reached both physically and in a timely manner.” (Levesque, 2013)

Patients must be able to physically access appropriate healthcare services and providers, yet this access is sometimes restricted by characteristics of either the services or the individual seeking care. Those most at risk regarding this dimension of access include:

- Residents of rural areas
- Residents of marginalized, under-resourced urban areas
- Individuals with limited access to transportation
- Individuals with inadequate social support
- Individuals with functional limitations, such as seniors and people with disabilities
- Low-wage and hourly employees who may not be able to access care during traditional operating hours

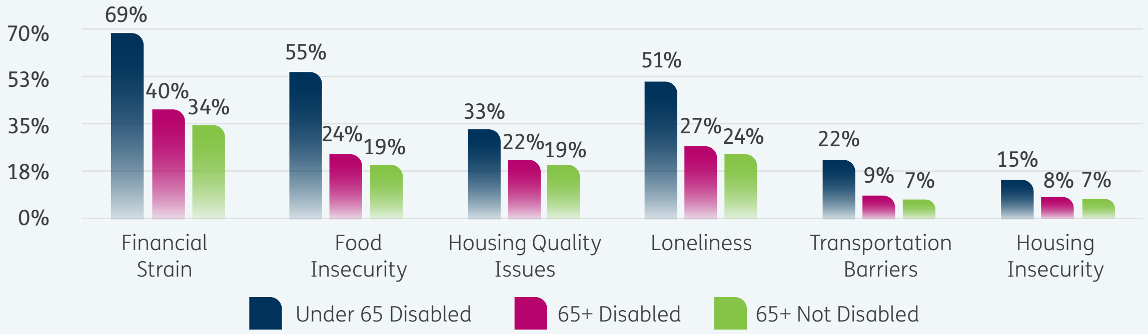
Of course, the coronavirus pandemic added additional barriers, as medical services were restricted or fear of contracting the virus led to “medical distancing.” The Medical Group Management Association (MGMA) and Humana collaborated on a **research report** on deferred care during the pandemic. **It found that 97% of practices reported a drop in patient volumes by early April 2020, with 87% of patients citing safety as the top reason for deferring care.** While outpatient visits rebounded by October due to telehealth and updated facilities, some specialties still lagged behind, including pulmonology, otolaryngology, and cardiology, and months of preventative and diagnostic care were already missed.

People with Disabilities

One in four adults in the U.S. have some type of disability, the most common of which are mobility disabilities. Disability is especially common among older adults, women, and minorities, particularly American Indians/Alaska Natives, and compared to adults without a disability, individuals with disabilities are more likely to be obese, smoke, and have heart disease and diabetes.

Despite numerous protections guaranteed by federal and state laws, people with disabilities still face a myriad of barriers to accessing healthcare and frequently have unmet healthcare needs. Exam tables and chairs, imaging equipment, and weight scales are some of the most basic pieces of medical equipment, and yet these frequently present **accessibility and safety issues** for patients with disabilities. As a result, for example, women with disability are 30% less likely to receive **breast cancer** screening services and have a higher breast cancer mortality rate than other women. Due to inadequate equipment and professional training, accessibility can be even more limited for specialty care such as **obstetrics-gynecology** and **dental care**. (Access to dental care is also be limited due to gaps in Medicare and Medicaid **coverage** for oral healthcare.) Under the Affordable Care Act (ACA), the **U.S. Access Board** issued medical diagnostic equipment (MDE) accessibility standards in 2017. However, there is **no enforcement authority** for these standards, and they are not mandatory, though this could be addressed by the Biden Administration. Therefore, it is up to healthcare providers to adopt and adhere to them voluntarily.

Health-Related Social needs of Humana MA Members by Disability Status



SOURCE: Survey of Humana Medicare Advantage Individual members, November 2019-February 2020.

Individuals with disabilities may also face a number of less tangible barriers to health, including conscious or unconscious bias of clinicians and health-related social needs. An analysis recently published in ***Health Affairs*** found that 82% of U.S. physicians surveyed reported that people with significant disability have worse quality of life than non disabled people, and only 41% were very confident about their ability to provide the same quality of care to patients with disability. These potentially biased views may help health disparities to persist. When compared to Medicare FFS, **MA beneficiaries** are 64% more likely to enroll in Medicare due to disability. As such, the care coordination and non-medical benefits and services provided by MA plans may be key tools to address inequities.

Political and Regulatory Response

Emphasizes Ease of Use and Technology Innovation

Recruiting and retaining quality providers in underserved areas

The **Bureau of Health Workforce (BHW)**, located within the U.S. Department of Health and Human Services (HHS), is charged with strengthening the health workforce and connecting skilled healthcare providers to communities in need. This is accomplished through identifying geographic Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/Ps) for primary, dental, and mental healthcare to focus resources. BHW offers scholarship, loan, and loan repayment programs to individuals and schools to not only increase the supply of quality healthcare workers but also ensure equitable distribution.

President Biden's **Fiscal Year 2022 discretionary funding request** to Congress includes a number of investments in the healthcare workforce. These include:

- **Expanding the behavioral health provider workforce** to combat the opioid crisis
- **Promoting health equity by increasing the diversity of the healthcare workforce** and expanding access to culturally competent care
- **Preparing for future public health crises by training a new epidemiologists** and other public health experts who can deploy and support state and local public health efforts

Accelerating telehealth adoption

When the pandemic hit, many in the healthcare community were optimistic about the use of telemedicine and other types of virtual care to replace canceled healthcare visits. However, with only **11%** of U.S. consumers having used telehealth in 2019, there were a number of obstacles to overcome to rapidly increase utilization as necessary. First, not all healthcare providers were already offering telehealth services, particularly small practices, specialists, and Medicaid providers. Telehealth services were reimbursed at lower rates than in-person services, and there were limitations on the health services that could be provided via telehealth for Medicare and Medicaid beneficiaries, as well as the type of provider and site of service for them (e.g. in many cases, a patient had to live in a designated rural area in order to receive the service, and a patient's home could not be the originating site of service). In addition, telehealth services are required to be provided with both audio and visual communication, which presents a challenge to patients and providers without broadband internet access or with low digital literacy. Finally, state-by-state variation in licensure and credentialing requirements limit the opportunity to leverage telehealth to address workforce shortages.

For Medicare beneficiaries, under authority granted by the public health emergency declaration, **CMS expanded** eligible services and providers and allowed flexibility for payers and providers to reduce or waive cost-sharing for telehealth visits. While these flexibilities will only be in effect during the public health emergency, an August 2020 **Executive Order** made permanent some of these policies for Medicare beneficiaries living in rural areas. In addition, CMS is permitting MA organizations and other organizations that submit **diagnoses for risk adjusted payment** to submit diagnoses for risk adjustment that are from telehealth visits; however, the telehealth services must be provided using an interactive audio and video telecommunications system.

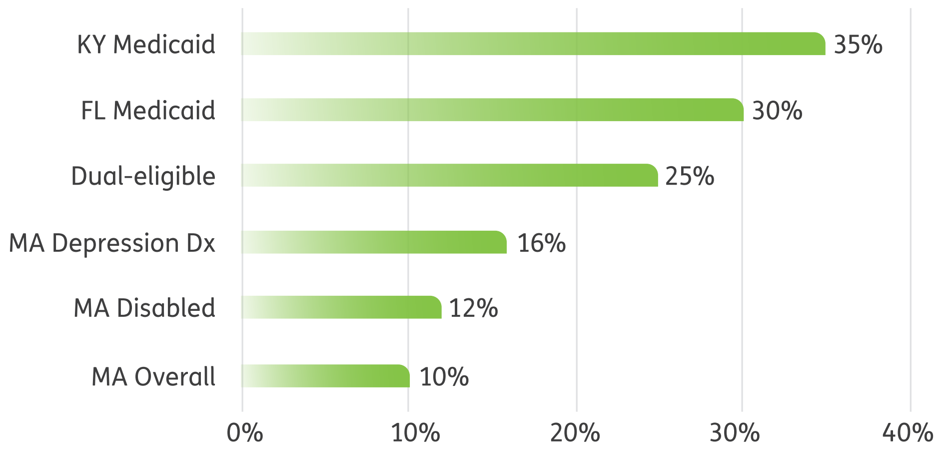
Expanding access to telehealth for Medicaid beneficiaries is more complex, as each state has unique telehealth laws and reimbursement policies. The Center for Connected Health Policy releases an **annual report** summarizing these policies across the country. However, all states, **supported by CMS**, are responding the pandemic by **waiving certain restrictions** on distant and originating sites, modalities, and prior, in-person provider-patient relationships to enable the use of telehealth. As with Medicare, the majority of these flexibilities will expire at the end of the public health emergency declaration.

America's Health Insurance Plans (AHIP) has compiled a list of **policy recommendations** for federal and state policy-makers to strengthen and improve telehealth services after the pandemic. These and other policy changes will be necessary to expand access to care in more cost-effective, patient-centered settings through telehealth and home-based care, including reimbursement and financing models to support the transition and sustainability of services. However, as Congress considers making the pandemic telehealth expansion permanent, they will be **balancing concerns** about potential fraud and abuse, particularly targeting vulnerable seniors.

What Humana is Doing

Providing customers multiple ways to interact – on their terms – with healthcare is critical to personalized and holistic care. Transportation is a key barrier to health and health-related services access, particularly for the Medicaid population. In 2021, strategies to address transportation barriers includes non-emergency medical transportation (NEMT) benefits for MA and Medicaid members, as well as non-medical transportation benefits for MA members. More information about how Humana is addressing access barriers related to transportation can be found in the June 2019 **Transportation Issue Brief.**

Humana Member Reported Transportation Barriers



SOURCE: Surveys of Humana Medicare Advantage Individual members (November 2019-February 2020), Humana Healthy Horizons (Medicaid) beneficiaries in Florida (January-February 2020) and Kentucky (November 2020-January 2021).

Prior to the COVID-19 pandemic, Humana was already investing heavily in virtual and **home-based care** – including **acquisitions** of Kindred at Home and Curo Health Services – as mechanisms to reduce access barriers, but consumer adoption and industry innovation have accelerated. **To combat "medical distancing" due to the pandemic, Humana expanded access to existing telehealth resources** by waiving cost-sharing for all telehealth visits for in-network providers – PCP and specialty, including behavioral health, as well as for telehealth services delivered through MDLive (for MA members and commercial members in Puerto Rico) and Doctor on Demand (for commercial members).

Humana is exploring new ways to deliver care to alleviate barriers for specific populations. For example, Humana has teamed up with telehealth company Doctor on Demand to launch a **new virtual primary care model**. Called On Hand, the plan gives commercial enrollees' access to a dedicated PCP, as well as urgent care and behavioral health, through video visits. Not only will this option provide schedule flexibility and ease for working adults, they are incentivized to engage in this integrated care model with lower monthly premiums.

Humana is expanding access to high-quality digital solutions to Medicaid beneficiaries, who frequently **miss out on** technological innovations in remote patient monitoring, telemedicine, virtual diabetes care, and behavioral health due to provider adequacy issues, state and beneficiary financial barriers, and variations in state regulations and credentialing that make it difficult to scale products. Humana Healthy Horizons in Kentucky offers virtual diabetes management through **Vida Health**. Vida's mobile-first platform gives eligible beneficiaries access to group coaching, in-app peer group support, digital therapeutics for diabetes and co-occurring chronic conditions, and more to help them manage their diabetes and whole health needs.

Humana is also taking steps to alleviate the burden on MA members living with multiple chronic conditions – such as cellulitis, kidney and urinary tract infections, chronic obstructive pulmonary disease (COPD), and heart failure – and their caregivers. Through a partnership with **DispatchHealth**, Humana will be able to provide hospital-level care in the home. When a member is experiencing an acute episode, DispatchHealth may be able to treat the member in their home, thereby avoiding emergency department visits, which frequently lead to inpatient hospitalizations for seniors and people with chronic conditions.

Emerging SDOH

Access to Broadband Internet & Digital Literacy

The COVID-19 pandemic highlighted the emerging social determinants of health (SDOH) of broadband internet access and digital literacy, as patients, students, workers, and isolated people of all demographics were forced to stay inside their homes. It is estimated that up to **half of the U.S. population** lacks broadband internet. This problem is especially pronounced in rural areas, where the cost of building the infrastructure has disincentivized private telecommunications companies from expanding service. In many low-income communities, families may have access but the internet service plans are cost-prohibitive.

While the federal government, through the Federal Communications Commission (FCC), has long recognized the importance of **telephone access**, financial assistance for broadband internet access is still limited and often reliant upon service providers to offer low-cost plans. However, the situation is improving. Healthy People 2030 has establish an **objective** to increase the proportion of people in the U.S. with broadband internet, and Congress included $7 billion to increase broadband internet access in the December 2020 COVID-19 **relief package**, including a new Emergency Broadband Benefit to help students' families and unemployed workers afford the broadband during the pandemic. Funding is also available for state and local governments to invest in broadband infrastructure under the **American Rescue Plan Act of 2021**. The Biden Administration has requested further investments in its **American Jobs Plan**, as well as the **Fiscal Year 2022 discretionary funding** request to Congress, with a focus on rural communities.

Beyond internet access, low digital literacy and design barriers in patient portals and health apps, issues that **disproportionately affect older adults**, especially those in poor health and living in underserved communities, can be additional barriers to health. Prior to the pandemic, 38% of adults over age 65 **reported difficulties** with telemedicine visits, and 72% of individuals 85 and older either lacked the technical experience necessary to participate in video visits or had issues due to physical disability. Frequently, health IT solutions are not designed with seniors or people with disabilities in mind, nor are they involved with user experience testing. The burden of connecting patients with low digital literacy often falls on their clinicians and caregivers. The consequences of this situation can be seen in the **disparity in access to COVID-19** vaccines between seniors with social support to help them navigate the online appointment portals versus who lack such support from digitally savvy family and friends.

To help bridge the digital divide, Humana's **San Antonio Bold Goal** and the Humana Foundation have collaborated with **Older Adults Technology Services (OATS)** to help seniors use technology to improve their health, finances, social engagement, learning, and creative expression. In 2020, the Foundation **invested** an additional $3 million in OATS to establish and lead **Aging Connected**, a consortium for accessible internet connections for older adults. Aging Connected will focus on getting at least one million disconnected seniors online, particularly those in marginalized communities, and will support equitable access to technology.

IN THIS CHAPTER

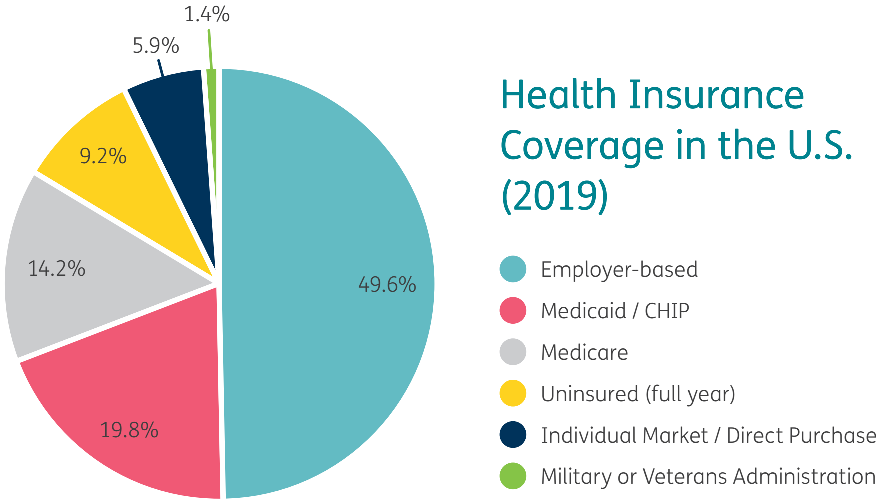
Affordability

- Cost of Healthcare Utilization
- Political and Regulatory Response
- What Humana is Doing
- What Others are Doing

Cost of Healthcare Utilization

“Affordability reflects the economic capacity for people to spend resources and time to use appropriate services. It results from direct prices of services and related expenses in addition to opportunity costs related to loss of income.” (Levesque, 2013)

While people without health insurance can receive some degree of medical treatment in emergency departments, as mandated by the Emergency Medical Treatment and Labor Act (EMTALA), and federally qualified health centers (FQHCs), health insurance is required to access most types of healthcare in the U.S. Research links insurance coverage to **improvements** in financial security, health, and longevity. When the provisions of the Affordable Care Act (ACA) creating the individual marketplace, premium subsidies, and Medicaid Expansion went into effect in 2014, the uninsured rate dropped from 16.7% in 2013 to a low of 10.3% in 2016, according to the National Health Interview Survey.


Health Insurance Coverage in the U.S. (2019)

SOURCE: **Kaiser Family Foundation**, with data from American Community Survey, 1-Year Estimates.
NOTES: For the purposes of this analysis, beneficiaries who are dual-enrolled in Medicare and Medicaid are included in the Medicaid/CHIP category.

Furthermore, many people in the U.S. with health insurance struggle with managing healthcare costs and being underinsured, meaning their out-of-pocket costs constitute an unaffordable share of their household income. For the nearly half of the U.S. population with employer-based health insurance, their **premiums and deductibles** are taking up an increasing portion of their incomes. Premium contributions and deductibles among enrollees in employer plans increased from 9.1% of incomes in 2010 to 11.5% of incomes in 2019. Further, according to research conducted by the **Commonwealth Fund**, in 2018, of U.S. adults ages 19 to 64:

- **45% are inadequately insured**, nearly the same as in 2010
- **37% reported having difficulty** paying their medical bills in the past year.
- **35% reported** at least one of the following cost-related access problems in the past year.
    - **Had a medical problem** but did not visit doctor or clinic
    - **Did not** fill a prescription
    - **Skipped** recommended test, treatment, or follow-up
    - **Did not get** needed specialist care

For example, many working-age U.S. adults with diabetes, one of the most common chronic conditions, **struggle to pay their medical bills**, including 60% of those without health insurance and 40% of those with insurance. People who are low-income, Black, or dealing with multiple chronic diseases were more likely to struggle with medical bills. This research found that, compared to people without diabetes, adults with the disease were 27% more likely to have trouble affording food, 30% more likely to skip or delay checkups due to costs, and 43% more likely to skip or delay medication refills. This missed or delayed care puts patients at higher risk for dangerously elevated blood sugar and complications like kidney failure, blindness, and amputations.

The simple intervention of reducing out-of-pocket costs for desirable health services and behaviors, such as **breast cancer screenings** and **cardiovascular disease management**, has proven effective. The Community Preventive Services Task Force found strong scientific evidence that lowering out-of-pocket medication costs for patients with high blood pressure and high cholesterol can help control both conditions. Particularly when combined with interventions aimed at improving patient-provider interactions and patient knowledge, this is effective in improving medication adherence and blood pressure and cholesterol outcomes.

Political and Regulatory Response

to Improving Affordability of Healthcare

Driving value over volume

One important avenue for reducing the cost of healthcare is improving the quality and efficiency of healthcare via **value-based payment models** and managed care. These models are accessible to patients often through MA plan or when states expand the use of value-based contracting through their managed care organizations and Section 1115 waivers. I**n 2018, Humana MA members cared for by physicians in value-based care arrangements had 27% fewer hospital admissions and 14.6% fewer emergency rooms visits, compared with fee-for-service Medicare.**

Not only have MA organizations driven the adoption of advanced value-based models, but plans must also **deliver value** by providing high quality, coordinated care while keeping costs low for **beneficiaries who are increasingly more likely to be low-income, a racial or ethnic minority, and have a disability or serious mental illness.** These savings enable MA plans to reinvest in improved coverage, lower premiums, and innovative services, programs, and benefits. For example, 80% of MA plans offer vision, hearing, wellness, or dental coverage, none of which are covered under Medicare FFS.

Importantly, MA plans deliver cost savings to members. With cost of prescription drugs being a key burden on seniors, according to one recent study, between 2015 and 2017 MA beneficiaries' costs for Part D drugs were approximately **44% lower** compared to those with FFS Medicare. MA members also spend less when **admitted to the hospital**, with seniors on FFS plans spending an average of seven times more out-of-pocket on inpatient hospital costs than their peers on MA. Further, MA plans protect seniors from catastrophic healthcare costs by limiting out-of-pocket costs.

In response to the coronavirus pandemic, CMS granted a number of regulatory waivers to ensure beneficiaries are able to access healthcare and other health-related basic needs. In an April 21, 2020 **memorandum** to MA organizations, CMS stated it would use its statutory discretion in 2020 to "adopt a temporary policy of relaxed enforcement in connection with the prohibition on mid-year benefit enhancements." These enhancements may include expanded or additional benefits or more generous cost-sharing as long as they "are provided in connection with the COVID-19 outbreak, are beneficial to enrollees, and are provided uniformly to all similarly situated enrollees." The more generous cost-sharing was embraced by plans, who were able to use this flexibility to help reconnect members to healthcare.

Supporting access and affordability

Expanding health insurance coverage and improving healthcare affordability are high priorities for the Biden Administration. In fact, one of President Biden's first **executive actions** upon taking office was on strengthening Medicaid and the ACA and to announce a Special Enrollment Period for uninsured and under-insured Americans to seek coverage through the Federally Facilitated Marketplace. With a Democratic majority in Congress, albeit slim, it is likely that some related legislation will be enacted. Some proposals under consideration include:

- **Stabilizing** the ACA Individual Marketplace
- **Extending the Medicaid coverage period for women after giving birth** (the state of **Illinois** recently received a waiver to extend postpartum coverage to one year) and inmates being released from prison
- **Boosting Medicaid funding to states to shore-up budgets** and expand covered services, particularly for behavioral health and substance use disorders
- **Numerous measures to improve the affordability of prescription drugs** such as reducing barriers to generic and biosimilar development and market entry to increase competition and access

Congress enacted the Families First Coronavirus Response Act in March 2020 to respond to the public health emergency. Among numerous other provisions, this legislation puts a freeze on **Medicaid disenrollment** during the public health emergency, essentially providing continuous eligibility to all current beneficiaries and new enrollees in Medicaid unless they move out-of-state or request voluntary termination. However, this freeze does not apply to CHIP.

The most recent COVID-19 stimulus package, the **American Rescue Plan**, enacted into law on March 2021, included a number of provisions to expand healthcare access enhancing premium subsidies for lower- and middle-income families enrolled in health insurance marketplaces, subsidizing premiums for continuation health coverage (COBRA), and providing incentives for states who have yet to expand Medicaid eligibility to cover their “expansion” population. The legislation also sought to alleviate financial strain on individuals and families through additional relief payments, extending enhanced unemployment and Supplemental Nutrition Assistance Program (SNAP) benefits, and increasing and making refundable the Child Tax Credit.

Some states are also taking action to curb the cost of healthcare. For example, **Kentucky** recently enacted legislation to make insulin more affordable for people residents with diabetes. The bill limits the cost of insulin to $30 per 30-day supply for Kentuckians with state-regulated healthcare plans or plans purchased on the marketplace exchange, state employees, and people under group plans.

What Humana is Doing

Humana’s **2021 Medicare Advantage and Prescription Drug plans** with member access to care and affordability in mind. Benefits may include:

- **$0 telehealth copays for PCP visits,** urgent care, and outpatient behavioral health, $0 copays for COVID-19 testing, and a Health Essentials Kit that includes useful items for preventing the spread of COVID-19 and other viruses like the flu
- **$0 copay for COVID-19 treatment** and 14 days of home-delivered meals
- **Insulin Savings Program (ISP)** to help members save on their diabetes medications; members will pay no more than $35 for a 30-day supply of select insulins
- **Healthy Foods Card, which was first offered in 2020**, providing qualifying members a monthly allowance, depending on location, of up to $75 to purchase approved food and beverages at a variety of national chains
- **Extra benefits like dental, vision, over-the-counter (OTC) allowance**, fitness program memberships, and home-delivered meals following an inpatient hospital stay
- **Access to preferred mail-order cost sharing at Humana Pharmacy**, where they may enjoy additional savings and the ease of prescriptions being delivered right to their door

In addition, Humana is participating in CMS’s Part D Senior Savings Model, which Humana calls the **Insulin Savings Program**. The program offers low-cost, predictable copayments – a maximum of just $35 per month for select insulins – for diabetic members with certain Medicare Advantage Prescription Drug (MAPD) plans and all Humana Premier Rx Plan prescription drug plans. Further, covered insulin prescriptions will not be subject to a deductible or any coverage gap cost increases throughout the plan year.

IN THIS CHAPTER

Appropriateness

- Opportunity and Capacity for Quality Care
- Political and Regulatory Response
- What Humana is Doing
- What Others are Doing

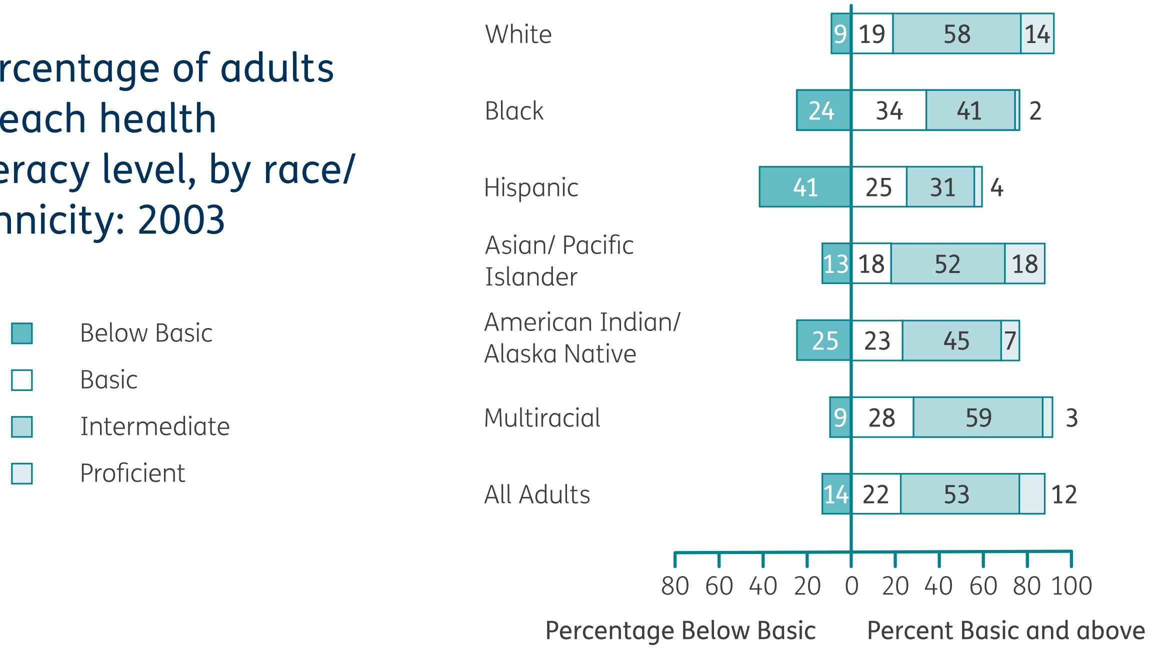
Opportunity and Capacity for Quality Care

"Appropriateness denotes the fit between services and clients need, its timeliness, the amount of care spent in assessing health problems and determining the correct treatment and the technical and interpersonal quality of the services provided." (Levesque, 2013)

The final dimension of access **requires that patients receive the right care, in the right place, at the right time.** In order for this to happen, patients must have access to good quality health services and be fully engaged in their own care through shared decision-making and disease self-management. As such, effective patient-provider communication and patient health literacy are key, as they allow patients to receive the care they need that is in accordance with their values and preferences and to adhere to their treatment regimen. Medicare recipients with higher health-literacy levels are more likely to receive preventive care such as flu shots and visited the hospital less than those at a lower health-literacy level, according to a **research report**, and seniors living in counties with the highest health literacy experience **better health outcomes**.

The only **comprehensive assessment of health literacy** the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions was conducted in 2003. It found that 14% of adults in the U.S. had "below basic" health literacy, while only 12% qualified as "proficient." Hispanics had the lowest health literacy of any race/ethnic group measured, and 49% of people with less than a high school diploma had "below basic" health literacy.

Percentage of adults in each health literacy level, by race/ethnicity: 2003



SOURCE: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, **2003 National Assessment of Adult Literacy**.

NOTES: Detail may not sum to totals because of rounding. Adults are defined as people 16 years of age and older living in households or prisons. Adults who could not be interviewed because of language spoken or cognitive or mental disabilities (3% in 2003) are excluded from this figure.

Political and Regulatory Response

Focusing on Quality Measures Drives Appropriate Care

There is a broad array of quality measures that may be used to assess and compare the quality of care provided by healthcare organizations. One of the most widely used quality measure sets is the Agency for Healthcare Research and Quality's (AHRQ) **Healthcare Effectiveness Data and Information Set (HEDIS)**, which are predominantly process measures, but there are many quality measures available. A good practice in evaluating whether a measure is good is to confirm that the **National Quality Forum (NQF)**, which checks each measure it endorses against a list of criteria, has endorsed it.

Classifications of Healthcare Quality Measures

Type of Measure	Description	Examples
Structure	Healthcare provider's capacity, systems, and processes for providing high-quality care	Ratio of providers to patients Whether a healthcare organization uses electronic health records
Process	What a provider does to maintain or improve health Clinical best practices Most common, publically reported quality measures	Percentage of people receiving preventive services (such as mammograms or immunizations) The percentage of people with diabetes who had their blood glucose tested and controlled
Outcome	Reflect the impact of the healthcare service or intervention on the health status of patients May require risk-adjustment methods to account for factors beyond the provider's control	Surgical complications and mortality rates Preterm birth rate

SOURCE: Agency for Healthcare Research and Quality (AHRQ)

To participate in the Medicare, Medicaid, and ACA Individual Market programs, healthcare organizations – plans and facilities – must meet minimum quality and safety criteria, as well as report on how they are meeting HEDIS and other quality measures to CMS. However, CMS and many states also use quality measures to incentivize higher quality (or penalize low quality) in managed care programs and to inform consumers about the quality of care to anticipate from various providers and payers. While quality performance is important in Medicaid, it is often challenging to assess. Medicaid data are less accessible, slower to get, and often incomplete. Beneficiaries may also be auto-assigned to plans and only be eligible for short time periods and intermittently. Some states, such as **Washington**, are investing in health information exchanges (HIEs) and a Master Person Index to better track and share data between stakeholders.

CMS uses a variety of quality measures that are updated annually for Medicare Parts C (MA) and D Stars Ratings and Quality Bonus Payments (QBPs). Increasingly, CMS is incorporating and increasing the weights of certain patient experience and access measures, and in bonus year 2024, these measures – a combination of certain patient-reported measures from the **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** and the **Health Outcomes Survey (HOS)** and measurements using administrative data – will account for 53% of the overall Stars Rating and bonus potential. **These measures emphasize this final dimension of access, assessing if patients are treated with respect, get appropriate support understanding their treatment and health plan, and receive effective care coordination.**

Bonus Year 2024 Star Ratings and Quality Bonus Payment Patient Experience Measures (all 4x weighted)

CAHPS	• Getting Needed Care • Getting Appointments (Care Quickly) • Customer Service • Rating of Health Care Quality • Rating of Health Plan	• Rating of Drug Plan • Core Coordination • Getting Needed Drugs
CMS Administrative Data	• Call Center TTY/FL Part C • Call Center TTY/FY Part D	• Complaints • Members Choosing to Leave the Plan
Independent Review Entity (IRE)	• Timely Decisions About Appeals	• Review Appeal Decisions

While “increasing the health literacy of the population” is an **objective** of Healthy People 2030, it is currently only in “research” status, meaning that no evidence-based interventions have been identified to address it, and there is limited data available. Patient-reported measures such as those in the CAHPS survey may be indicators of health literacy and effective patient-provider communication, but more research is necessary to understand how to improve and measure these critical facets of healthcare access.

What Humana is Doing

Humana is deeply invested in providing the highest quality of care for our members. This not only includes **striving for the highest possible plan quality ratings, but also working across the industry to identify and promote innovative ways to advance quality.** Humana’s Chief Medical & Corporate Affairs Officer William Shrank, MD, is help guiding healthcare organizations as a member of the NCQA Board of Directors. Dr. Shrank and other clinical leaders have collaborated with NQF on advocating for incorporating **social risk** into population health models and establishing quality measures for addressing health-related social needs such as **food insecurity**. Humana clinical quality leaders have also documented our corporate journey to streamline and **prioritize quality measures** to better support value-based payments by reducing complexity and helping physicians focus on meaningful measures.

Humana supports the health literacy of members in a number of ways. We provide all member materials in plain language to help them better understand the terms and provisions of their insurance plan and screen members for health literacy and other communications barriers during care management programs to ensure they receive appropriate assistance. Humana Healthy Horizons has also incorporated the national culturally and linguistically appropriate services (CLAS) standards into our overall Medicaid Population Health Strategy.

IN THIS CHAPTER

Recommendations
- Humana's Priorities to Pursue in the Future

Humana's Priorities to Pursue in the Future

With five dimensions of access, there are many opportunities for Humana to make it easier for our members to achieve their best health by improving access to care.

Routinely screen members for access barriers such as health literacy, broadband internet access, digital literacy, transportation, and financial strain and connect them with services and supports.

Expand use of CHWs, patient advocates, and other non-clinical professionals assist with care navigation, particularly those members low health literacy or facing other systemic barriers to access

Root out bias – by race, ethnicity, culture, age, disability, income – in healthcare through broad cultural competency and implicit bias training, eliminating any bias in clinical algorithms, and incorporating health equity into quality measurement.

Incentivize or require contracted providers to install medical diagnostic equipment that meet accessibility standards, and use the Provider Finder tool to highlight disability-friendly providers.

Identify more opportunities to hear the voice of our consumers such as through patient advisory councils evaluating new digital solutions.

Support the development of interpersonal communication and shared decision-making skills among healthcare providers, including providers in value-based relationships with Humana, those employed by Humana, and the next generation of clinicians in medical school.

Contact

Stephanie Franklin, MPS, PMP
Population Health Strategy Lead
Bold Goal, Population Health Strategy | Office of Health Affairs and Advocacy
O 502.476.1770
C 502.295.5605
sfranklin20@humana.com

PopulationHealth.Humana.com

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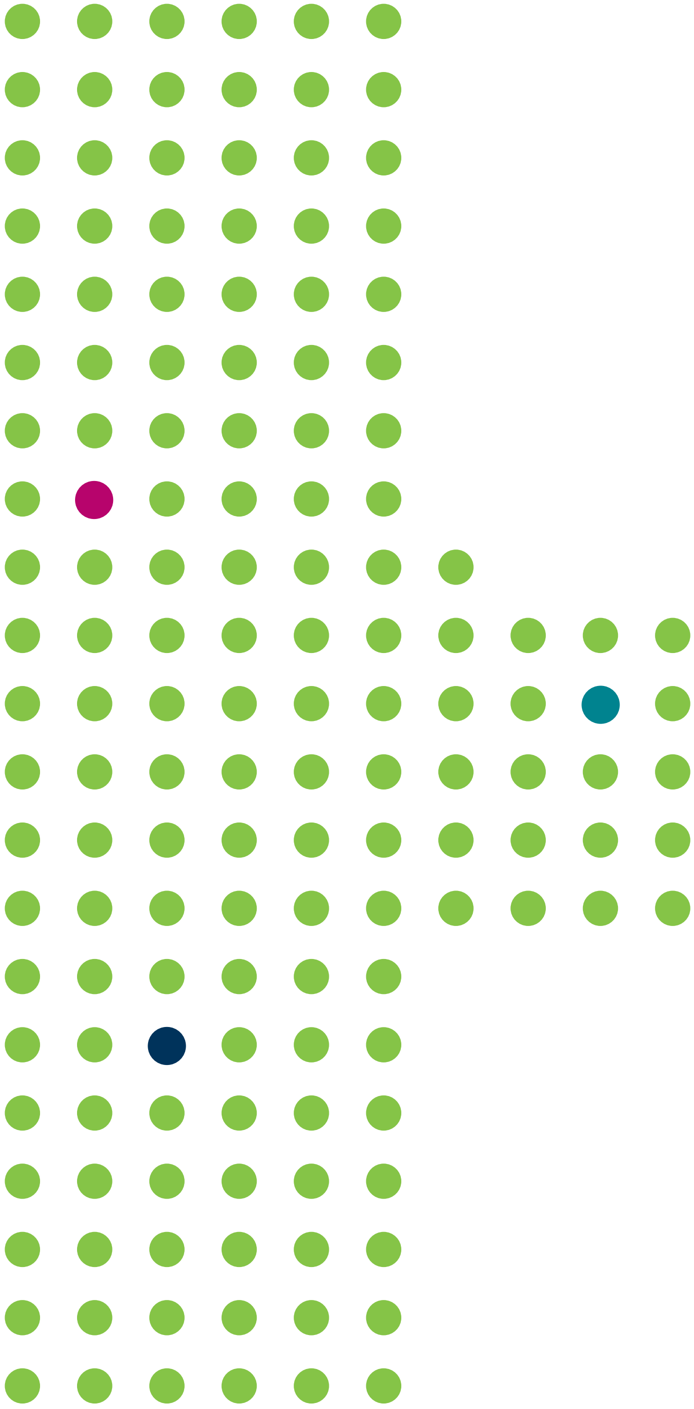
September 2020

Health Equity Issue Brief

BOLD GOAL,
POPULATION HEALTH STRATEGY
OFFICE OF HEALTH AFFAIRS AND ADVOCACY



The intent of this policy brief is to inform and update stakeholders on health equity, including current research and public policy. It's meant to spark conversations over opportunities to affect change. Humana's Bold Goal is dedicated to improving the health of the communities we serve 20% by 2020 and beyond by addressing the health of the whole person.

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PopulationHealth.Humana.com
#MoreHealthyDays

The impact of health equity

With each news cycle comes additional evidence that the coronavirus pandemic is having different consequences for Black, Indigenous, and People of Color (BIPOC) versus White people living in the U.S. Tragically, the disproportionate impact of the COVID-19 pandemic on BIPOC only underscores existing health inequities, which result in shorter lifespans and more chronic illness for BIPOC. These inequities span from cradle to grave and are a burden not only on individuals but also on our economy through lost productivity and higher healthcare costs.[1]

The following brief discusses some of the root causes and effects of racial and ethnic health inequity, as well as opportunities for the healthcare sector to advance equity. While it focuses on one type of inequity, we acknowledge there are other minority groups experiencing inequities such as sexual and gender minorities and people with disabilities. In this brief, we are using the acronym BIPOC, which stands for "Black, Indigenous, and People of Color," a term that originated around 2013 to be more inclusive of historically marginalized groups, when speaking collectively about non-White people in the U.S. who may identify as Black, African American, Hispanic, Latinx, Indigenous, Native, multi-racial, or other ethnic origins.[2] When citing research on inequities facing individual groups, we will use more specific terminology.

> “
>
> **Health equity means that everyone has a fair and just opportunity to be as healthy as possible**. This requires removing obstacles to health, such as poverty, discrimination, powerlessness, and their consequences, including lack of access to good jobs with fair pay, safe environments, and quality education, housing, and health care.
>
> ”

- Robert Wood Johnson Foundation, What Can the Health Care Sector Do to Advance Health Equity? (2019)

By the numbers

16.08 average

Unhealthy Days reported by Black Humana Medicare Advantage (MA) Members in the 2019 Annual Healthy Days Survey, compared to 12.62 Unhealthy Days reported by White members.

6x higher

COVID-19 mortality rate in predominantly Black U.S. counties than in predominantly White counties.[3]

40% greater

Likelihood a Black adult is to have **high blood pressure** than a non-Hispanic White adult, putting them at greater risk for heart disease and stroke. For women, this increases to 60 percent.[4]

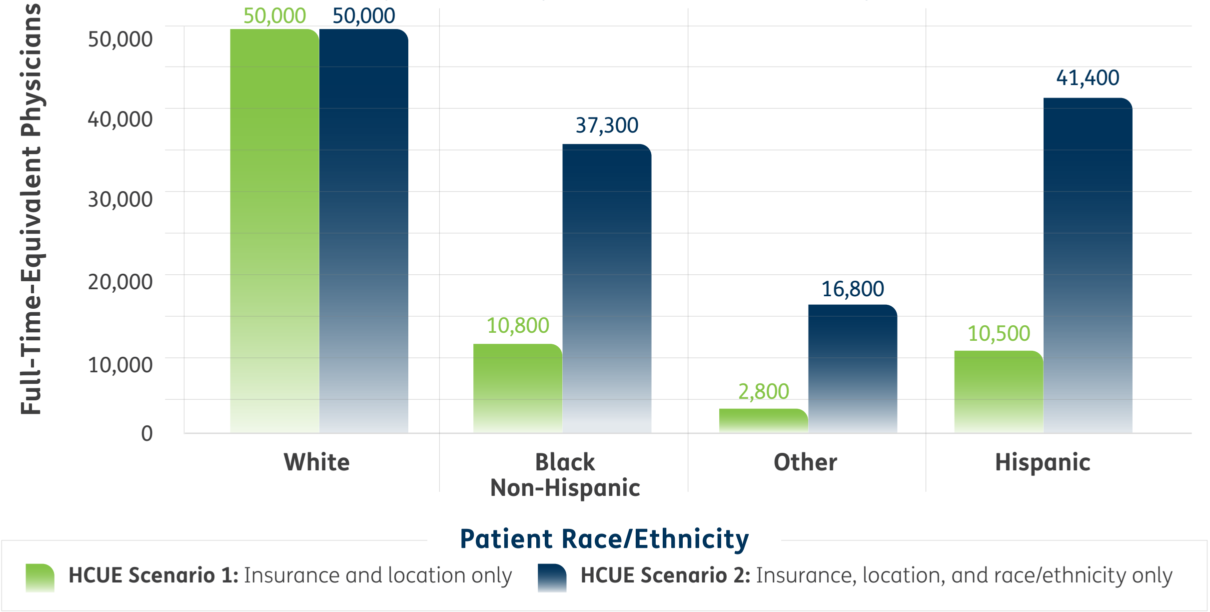
Causes of health inequity

Racial and ethnic health inequities are the result of individual and institutional, or systemic, biases and discrimination in the healthcare system and the U.S. more broadly. What we often perceive as health differences by race and ethnicity are, in actuality, differences in how people are able to experience and benefit from the environmental, economic, or social factors that influence health outcomes. The social determinants of health (SDOH) – including access to healthcare, healthy food, safety, social support, and economic opportunity – and structural determinants of health – such as systemic racism in public policies, labor/employment policies, and cultural values – dictate the choices available to individuals, which, in turn, influence their behavior and their health.

Bias, disparate treatment and trust

On the individual level, most healthcare providers appear to have implicit bias in terms of positive attitudes toward Whites and negative attitudes toward BIPOC. This influences care recommendations in a variety of settings, including acute care and advanced illness.[5] This may be partially explained by the fact that BIPOC are underrepresented among physicians relative to both U.S. and patient demographics. In 2019, 2.6 percent of physicians were Black or African American, 3.8 percent were Hispanic, Latino, or of Spanish origin, 23.3 percent were Asian, and 68.2 percent were of White origin. While the demand for physicians is projected to grow proportionately faster for minority populations in the coming years, the medical school pipeline is not adequate to meet this growing demand for BIPOC physicians.[6] As a result, Black patients have a much lower chance than White or Asian-American patients of finding a racially concordant physician. Black patients are more likely to trust, and heed the advice of, Black physicians.[7] This lack of trust in non-racially concordant physicians impairs access to and compliance with quality care and, therefore, health outcomes.

Additional Physicians Required to Achieve Health Care Utilization Equity in 2018 by Patient Race/Ethnicity[8]



The lack of trust that BIPOC have in White medical professionals and the healthcare systems itself is due not just to individual instances of bias, but also to generations of discrimination and outright medical exploitation. Among the most well-known examples is the Tuskegee Study, an experiment launched in 1932 by the U.S. Public Health Service to study the effect of untreated syphilis on Black men in rural Alabama. In the 1940s, penicillin became the recommended treatment syphilis, but researchers and local physicians recruited to participate in the study withheld treatment without informed consent, causing these men and their loved ones to experience unnecessary suffering and death.[9]

After 40 years, a whistle-blower finally helped bring an end to the experiment in 1972. In subsequent years, Congress established the Tuskegee Health Benefit Program to provide lifetime medical benefits to all living study subjects and the widows and offspring of deceased study participants and enacted the National Research Act to institute basic principles of research conduct. However, it was not until 25 years after the end of the Tuskegee Study that the men, their families, and the Black community received a formal apology from the President of the United States. Of the 600 original study subjects, eight survived to hear President Bill Clinton's apology on May 16, 1997.[10]

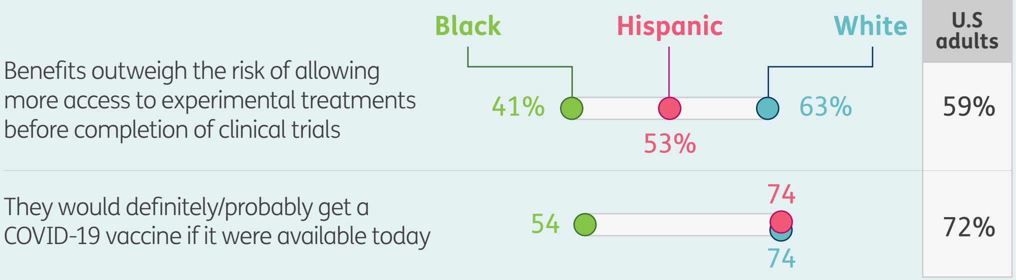
Although the Tuskegee Study is emblematic of the inequity in healthcare and medical research (see also numerous examples of experimentation on enslaved African men and women and Native Americans, Alaskans, and Hawaiians, as well as prisoners, people in psychiatric institutions, and orphans), there is also evidence that the public revelation of the study itself led to deepening of medical mistrust and changes in medical behavior among Black males.

Researchers estimate that life expectancy for Black men fell by up to 1.4 years by 1980 due to lower healthcare utilization in direct response to the 1972 disclosure.[11]

> **Without building rapport and trust in these communities, there is no guarantee that the highest risk populations will get the vaccine or that they will even want the vaccine.**
>
> Mercedes Carnethon, PhD, Professor Of Epidemiology And Vice Chair Of The Department Of Preventive Medicine, Northwestern University Opening statement, The COVID-19 Pandemic and Seniors: A Look at Racial Health Disparities, July 21, 2020

This real and immediate impact underscores the crucial role of trust in improving health outcomes – and how ingrained medical mistrust may be for BIPOC. This barrier is particularly acute as the world races to develop a coronavirus vaccine. In order to ensure the efficacy and safety of a potential vaccine, a diversity of individuals, including BIPOC, older adults, and people with underlying medical conditions, will need to participate in clinical trials, and then all these individuals must be willing to get the vaccine when one is available to be protected.

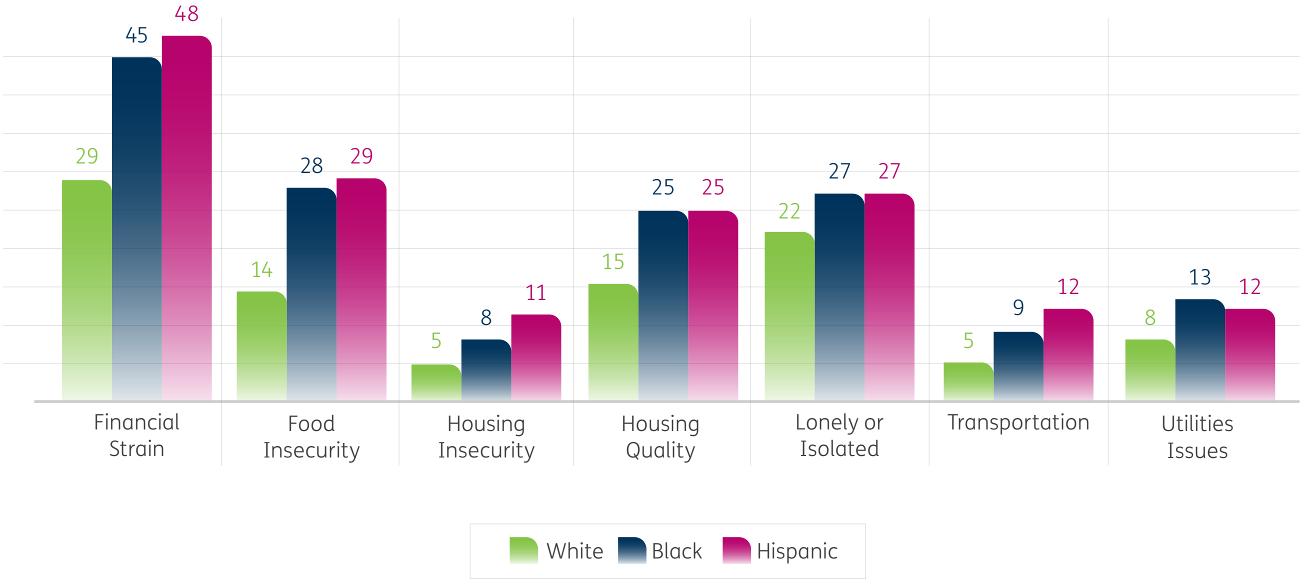
In a Pew Research Center survey conducted in April and May 2020, Black Americans were far less likely to say they would definitely or probably get a coronavirus vaccine if one were available than White or Hispanic Americans.[12]



Health related social needs and policy associations

We must also look to institutions other than healthcare to understand health inequity, as studies that define the drivers of health outcomes consistently indicate social context and healthy behaviors have a much greater impact on health than the delivery of healthcare services. Humana recently conducted a survey to assess the health-related social needs of our MA members (November 2019-February 2020). We learned that Black and Hispanic members have a higher prevalence of all social needs measured. These disparities persist even when looking at only those members who do not qualify for the Part D low-income subsidy (LIS), presumably controlling for the greater number of low-income Black and Hispanic beneficiaries.

Health Related Social Needs by
Race Non-LIS Members (%)



BIPOC experience a greater burden of social needs because of systemic racial exclusion and discrimination embedded within our housing, banking, employment, education, and criminal justice policies and institutions that create inequities in both health and economic opportunity. There is considerable research into each of these areas. We will look at housing policy and how it has contributed to the wealth gap between Black and White people living in the U.S. and racial segregation that relegates BIPOC to neighborhoods with poorer opportunities for health and prosperity.

A Deeper Look
Housing policy

In the 1930s, the Home Owners' Loan Corporation was created to stabilize struggling cities and prevent foreclosures during the Great Depression. However, its most enduring legacy is codifying the practice of denying access to credit and homeownership to Black Americans. Government surveyors created color-coded "residential security" maps to rate the desirability of certain neighborhoods for mortgage lending, with the least-desirable neighborhoods colored red. This practice became known as "redlining," and it disproportionately affected communities of color, withholding capital investment for decades. (The term, "redlining," is now more generally applied to the discriminatory practice of withholding access to services or investment based on community demographics.)

While redlining in mortgage lending was officially prohibited by the Fair Housing Act of 1968, in three decades the practice had already made a lasting impact both on the built environment of American cities and on the wealth-building and economic stability of generations of Black families.

> **Formerly redlined neighborhoods are still largely racially segregated and lag behind in access to mortgage credit, homeownership rate, and housing value.[13]**

Due to this lack of investment (including from public sources, which, on a local level, rely heavily on property taxes for revenue[14]), BIPOC are more likely to live in neighborhoods that limit their ability to choose healthy behaviors, such as those without sidewalks, bicycling infrastructure, and other opportunities for physical activity.[15] [16] They are also more likely to live in "food deserts," which have limited access to affordable and nutritious food, and "food swamps," where there is an over-abundance of fast food, junk food outlets, convenience stores, and liquor stores.[17] These neighborhoods are also likely to have high levels of air pollution and poor tree canopy coverage, which can help mitigate air pollution.[18] As a result, residents are at a higher risk for a number of respiratory and cardiovascular conditions and cancers.[19]

Today, city zoning laws perpetuate the legacy of redlining by restricting where affordable, multi-family housing can be built, confining it to under-resourced neighborhoods and frequently near industrial zones.[20] For families unable to buy homes, build capital, and pass accumulated wealth on to their children, the lasting impact of redlining can be seen in limited mobility, as homes in better resourced and less polluted communities are out of reach. Families also have limited opportunity to invest in healthy behaviors, such as better nutrition and physical activity, as well as in health-related factors such as education. These conditions perpetuate ongoing differences in health outcomes between BIPOC and White people living in the U.S.

Disproportionate impact of health conditions and adverse outcomes on BIPOC (non-exhaustive list)

Cardiovascular disease (CVD)

- African Americans are nearly twice as likely to die from a stroke.[21]
- CVD age-adjusted death rates are over 30 percent higher for African Americans than for the overall U.S. population[22] and studies have shown they receive less lifesaving treatment (e.g., 30 percent less coronary revascularization) than Whites.[23]

Cancer

- African Americans have the highest mortality rate and shortest survival of any racial or ethnic group for most cancers.[24]
- African American men have the highest incidence of prostate cancer and have higher mortality than White men have.[25]
- Ethnic minorities are substantially more likely to be diagnosed with cancer at a later stage of the disease, which often leads to less successful treatment.[26]
- Hispanics and African-Americans have lower colon cancer screening rates and higher mortality rates than Whites.[27] [28]
- African Americans with colorectal cancer received less aggressive treatment than Whites, even after adjusting for comorbidities, hospital type, and insurance coverage status.[29]

Diabetes

- Whites have the lowest rates of diabetes, with 7.6 percent of adults aged 20 years or older diagnosed with diabetes. Comparatively, 9.0 percent of Asian American, 12.9 percent of Hispanic, 13.2 percent of African American, and 15.9 percent of American Indian and Alaska Native adults have been diagnosed with diabetes.[30]
- Non-Hispanic Blacks are 2.3 times more likely to be hospitalized for lower limb amputations as compared to non-Hispanic Whites.[31]

Kidney Disease

- Non-Hispanic Blacks are 3.5 times more likely to be diagnosed with end stage renal disease as compared to non-Hispanic Whites.[32]
- American Indians and Alaska Natives are less likely to receive kidney transplants.[33]

Infant/Maternal Health

- African American women are twice as likely to give birth prematurely.[34]
- Maternal mortality rates are 2-3 times higher in Black and Native American mothers.[35]
- A Black infant born in the U.S. is more than twice as likely to die before his or her first birthday than a White infant does.[36]

Behavioral Health

- Minority children were less likely than white children to be diagnosed with attention-deficit/hyperactivity disorder (ADHD), and among those who were diagnosed, racial and ethnic minorities were less likely than Whites to be prescribed medication for the disorder were.[37]

Political and regulatory landscape

COVID-19: An inflection point for health equity?

According to the Centers for Disease Control and Prevention (CDC), racial and ethnic minority groups are at a higher risk of COVID-19 for a number of reasons, all related to economic and health inequities that predate the current crisis. The living and working conditions of BIPOC are more likely to put them in close contact with many people and contribute to health circumstances that make it less likely they will seek and receive appropriate care and experience positive outcomes.[38] BIPOC are also more likely to have underlying medical conditions that put them at higher risk for severe complications from COVID-19 infection.[39]

While awareness of health inequity is not new to the healthcare community, since early in the COVID-19 public health crisis, advocates have pressured the CDC and others to collect and report data stratified by patient race and ethnicity to help more clearly measure disparities.

Centers for Medicare and Medicaid Services (CMS) claims data show gaping racial disparities in the burden of coronavirus.

Black individuals who are Medicare beneficiaries have been hospitalized four times (465 per 100k) more than White beneficiaries (123 per 100k) and have contracted the virus nearly three times as often. Hispanic and Asian beneficiaries were also more likely to become infected and hospitalized than White people.[40]

The stark differences in coronavirus infection rate and outcomes between BIPOC and White people have ignited calls for immediate action to address inequities. In Washington, DC, several congressional committees have held hearings, including the House Education and Labor Committee,[41] House Committee on the Budget,[42] and Senate Special Committee on Aging.[43] Advocates, including prominent professional associations, have called on Congress and the Trump Administration to do more for BIPOC during this crisis. In July, the American Hospital Association, American Medical Association, and American Nurses Association called on Senate leaders to tackle health inequities in a future COVID-19 relief package and recommended specific actions to address the health and social needs of BIPOC and marginalized communities.[44]

Patient Protection and Affordable Care Act

The Affordable Care Act (ACA), enacted in 2010, made the most significant changes to the American healthcare system – and most targeted action toward health equity – since the creation of Medicare and Medicaid in 1965. While not all ACA provisions have been fully implemented due to court challenges, relevant ACA provisions include:

- Increasing health insurance coverage via the individual and employer mandates, Medicaid eligibility expansion, and increasing the age of dependent coverage
- Prohibiting annual and lifetime benefit limits
- Providing specific preventative health services without cost-sharing
- Encouraging the shift toward value- or outcomes-based contracting through delivery system reforms and demonstrations, including providing MA plans bonus payments based on quality ratings (Star Ratings).[45] [46]

The ACA also elevated the issue of health equity within the U.S. Department of Health and Human Services (HHS) by reauthorizing and funding the HHS Office of Minority Health (OMH), establishing individual offices of minority health within the Agency for Healthcare Research and Quality (AHRQ), CDC, CMS, Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration (SAMHSA), and by elevating the National Center on Minority Health and Health Disparities to an institute within the National Institutes of Health (NIH). Collectively, these offices have goals to:

- ↓ **Reduce disparities** in population health
- ↑ **Increase the availability** of data to track and monitor progress in reducing disparities
- ↓ **Reduce disparities** in health insurance coverage and access to care
- ↓ **Reduce disparities** in the quality of healthcare
- ↑ **Increase healthcare workforce diversity** and cultural competency.[47]

OMH funds a number of grants and initiatives each year to further these goals. In 2020, these include a specific focus on disparities related to COVID-19. It launched the National Infrastructure for Mitigating the Impact of COVID-19 (NIMIC) Initiative, which is a three-year cooperative agreement between the OMH and the Morehouse School of Medicine in Atlanta, Georgia, to develop and disseminate culturally and linguistically diverse information on COVID-19.[48]

Promoting equity through quality measurement and accountability

A number of thought leaders, including the Institute of Medicine in its landmark 2003 assessment of health inequity, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* have recommended the promotion of and alignment of incentives to evidence-based guidelines to advance equity.[49]

Some progress has been made to this end, particularly in the process of healthcare delivery for which there are quality measures and clear disease-specific best practices. Research suggests there is minimal difference in the chronic condition management recommended by clinicians for Black, Hispanic, and White patients,[50] and a recent systematic review conducted by researchers at CMS and William H. Shrank, M.D., M.S.H.S., Humana's Chief Medical and Corporate Affairs Officer, have affirmed these conclusions.[51]

Despite the reduction in racial disparities in process measures, stark inequities persist in health outcomes. Quality research and accreditation organizations have already provided considerable guidance on how to measure and reduce disparities, and medical societies, such as the American Medical Association (AMA), which created the AMA Center for Health Equity in 2019 and published a health disparities toolkit for physicians, are helping their members implement these standards and best practices.[52] The American Hospital Association also established the Institute for Diversity and Health Equity to advance equity and expand leadership opportunities for BIPOC in health management.[53]

The National Quality Forum (NQF) has endorsed a number of disparity-sensitive measures and a framework for measuring cultural competency. NQF has also been exploring social risk adjustment of performance measures and has been commissioned by CMS to develop new methods for social risk adjustment in accountable care organizations and in MA. [54] **The National Committee for Quality Assurance (NCQA)** was contracted by the CMS Office of Minority Health to develop a toolkit to help healthcare providers reduce inequities among BIPOC, people with limited English proficiency, sexual and gender minorities, and people with disabilities by providing culturally and linguistically appropriate services (CLAS).[55] NCQA also offers a Distinction in Multicultural Health Care.[56] In addition, CMS has contracted with NCQA and RAND to develop a new Health Equity Summary Score to characterize the quality-of-care delivered my MA plans to people with social risk factors.[57] At this time, CMS intends this to be a quality-improvement tool rather than a public report.

The **Institute of Medicine** also highlighted value-based contracting as an opportunity to promote equity. It recommended structuring healthcare payment systems to ensure adequate access for minority patients, limit provider incentives to promote disparities, and link payment to favorable clinical outcomes. This includes incentives not only to adhere to evidence-based protocols but also for high scores on patient satisfaction measures.[58] Many states, due to the vulnerable population served, have already incorporated equity and SDOH into their Medicaid managed care contracts and demonstration projects. In recent years, CMS has increasingly emphasized patient experience in payment models. On May 22, 2020, CMS issued a final rule for the MA and Part D programs for 2021 and 2022 that increased the weight of patient experience and access measures, as measured through Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and related surveys, in the Star Ratings methodology.[59] CMS uses CAHPS patient experience surveys in other areas as well, including some value-based purchasing programs such as hospitals, home health, and the Merit-based Incentive Payment System (MIPS).[60]

What Humana is doing

Addressing the upstream causes of poor health through Medicare Advantage

Key to Humana's efforts to reduce inequity in our members' health is a focus on upstream determinants of health. For our MA members, we are addressing these factors by treating health-related social needs – specific needs of individual patients such as food insecurity, transportation access, housing instability, and loneliness – as true "gaps in care." We have instituted broad screening of our members for social needs. In 2019, we completed over 2.6 million social need screenings with referral to appropriate Humana benefits or programs or community resources.[61]

We are also working closely with physicians, community partners, and national leaders in this space – such as Feeding America and Meals on Wheels – to test and scale interventions to "treat" social needs. Many of these involve deep community collaborations, such as establishing the process to screen patients for food insecurity in their doctor's office and immediately connect them to the local food bank for benefit enrollment and emergency food provision. Others are interventions that we are incorporating into the health plan benefits we provide to members. We are leveraging new flexibility from CMS to offer non-medical benefits to MA beneficiaries to address social needs, including:

Value Based Insurance Design (VBID): An example of this is the Healthy Food Grocery Card. In 2020, we began offering a Healthy Food Grocery Card providing a monthly grocery stipend to low socioeconomic status (SES) members on certain plans under VBID, a CMS Innovation Center demonstration project. With this benefit, we are testing, for the first time, the ability to lower cost and improve quality by targeting benefits based on SES/income. We hope this benefit will alleviate some of the economic impacts of COVID-19 for our members.

Special Supplemental Benefit for the Chronically Ill (SSBCI): SSBCI, which is also new in 2020, allows health plans to better tailor benefits to a member's individual needs, including clinical and social health needs. We are offering benefits to address the financial strain on members and to provide them with services and supports to help them remain safely in their homes. In 2021, Humana – and others – will be expanding these offerings, with a focus on addressing financial strain, loneliness and social isolation, and food insecurity.

Advancing equity for Medicaid beneficiaries

For our Medicaid beneficiaries, many of whom are BIPOC, issues of health equity are particularly resonant, so we have intentionally built our health plan benefits and programs with this in mind. Steps taken include:

Incorporation of the National CLAS standards into our overall Medicaid Population Health Strategy

Assessing social needs and integrating social factors into our core clinical model through Health Risk Assessments, Social Needs Assessments, comprehensive assessments, all of which feed into risk stratification for enrollment in case management

Employing specialized staff dedicated to addressing unmet social needs and members at high risk for being adversely impacted by SDOH (e.g. community health workers, social determinants of health coordinators, housing specialists, peer support specialists)

Utilizing plan level community engagement teams to solidify community partnerships and relationships with community-based organizations (CBOs) that are addressing unmet health related social needs

Exploring innovative payment models (value-based care, outcomes-based financing) to better align incentives of the plan, CBOs, physicians and clinicians, and others to better address unmet social needs and the determinants of health in our membership

Building off of Bold Goal national relationships and doubling down with local pilots such as medical respite and eviction diversion (medical legal partnership) in our newest markets

To advance Humana's whole person care strategy, in July 2020, Humana CEO Bruce Broussard announced the creation of a new role, a Chief Equity Officer. This leader will provide strategic direction in developing clinical programs, education, and communications that address underlying drivers of disparities in healthcare, with the express goal of fostering more equitable care and health outcomes.

Leading healthcare transformation

We are also working to transform healthcare so that physical, mental, and social health are treated as equal dimensions of health. This includes paying physicians to screen, document, and treat or refer for social needs through our Social Determinants of Health Value Based Care Program.[62] A feature of value-based care is enhanced patient-provider communication and trust by rewarding for time spent engaging patients and their families, which may help to overcome barriers of culture, communication, and empathy.[63] This will only be strengthened by incorporating SDOH.

Further, Humana's Chief Medical and Corporate Affairs Officer William H. Shrank, M.D., M.S.H.S. and NQF President and CEO Shantanu K. Agrawal, M.D., MPhil co-authored a paper in the ***New England Journal of Medicine*** calling for exploring the impact of incorporating social risk factors, along with physical and mental health, into payment models. They argue that social risk adjustment in population-based payment models would provide incentives for addressing health-related social needs to improve health outcomes, rather than lowering the standards for their care.[64]

Humana is leading efforts to standardize benchmark measurements and expectations to help physicians address food insecurity by working with NQF to define quality measures around food insecurity.

As part of this work, in February 2020, we released an implementations guide for healthcare organizations to effectively intervene and assist individuals who may experience negative health outcomes from unstable access to food.[65]

Planning for the next generation of clinicians, in 2018, Humana invested $15 million into a new medical school at the University of Houston that is focused on integrating interdisciplinary training, focused population health, into medical education. The Humana Integrated Health System Sciences Institute aims to be a leader in health systems science that produces high impact research to inform policy, innovative inter-professional educational programs that prepare the next generation of healthcare providers and practitioners, and novel programs that support population health and community transformation, with emphasis on Houston's Third Ward and East End. Collaborative programs have tested a community health worker (CHW) intervention and a partnership with the Patient Care Intervention Center to understand and analyze our members' use of community resources, enabling us to expand and target partnerships with community-based organizations (CBOs).

Advancing health equity in the community

As we reflect on the progress our country and we have made toward health equity, we know that we need to go further upstream than just the social needs of individuals to improving the systemic and social conditions in communities. That is why the Humana Foundation announced in 2018 a commitment to address SDOH, with the key aim of promoting health equity. With this new focus came a recognition that long-term, larger investments would be needed to support strategies addressing upstream determinants of health. The Foundation also recognized the need to co-create processes with communities to understand how to provide essential holistic supports. The Foundation focuses on data in the local context of the community, recognizing that is specific culturally and historically driven and designed and that it is more than healthcare.

The Humana Foundation's Strategic Community Investment Program (SCIP) addresses SDOH by funding initiatives that are working to close systemic gaps in eight communities that also parallel with some of the Bold Goal communities. Currently, 12 programs receive a Humana Foundation investment, with a specific focus on organizations that address food security, postsecondary attainment, financial asset security, and social connectedness with an intentional focus on historically marginalized populations.

Some of the SCIP initiatives that are sustainably impacting communities while also influencing individual changes include:

Growing Local Food Collaborative (New Orleans, Louisiana) | Advocates to make shifts in local policy that prohibits people, especially Black people and other communities of color, from engaging in farming because of land access and other barriers.

Healthy BR (Baton Rouge, Louisiana) | Intentionally focuses on North Baton Rouge, an area that is predominantly Black, and ensures that the dollars are going to organizations led by people who live in that community and serve that community.

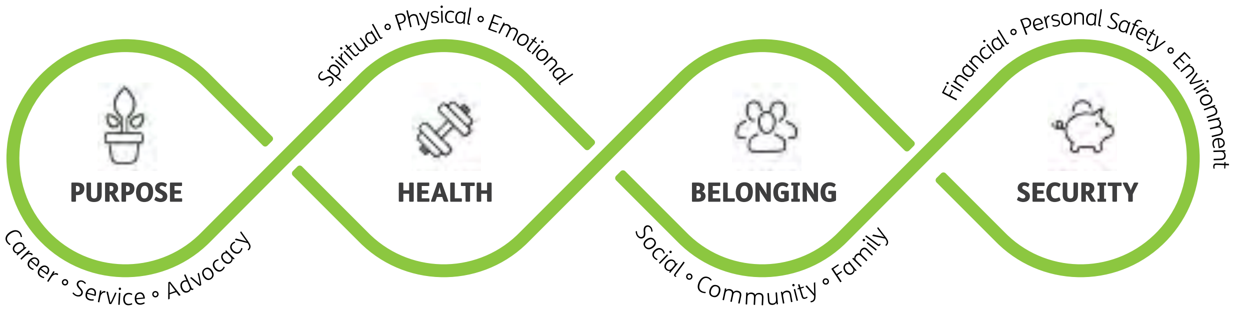
University of Florida (Jacksonville, Florida) | With an emphasis on cultural sensitivity and partnerships with trusted organizations such as African Methodist Episcopal (AME) churches, focuses on Health Zone 1, a geography that is predominantly Black and experiencing concentrated poverty.[66]

The Humana Foundation's Community Partners Program addresses SDOH by funding initiatives that provide critical safety net services that make Louisville a more appealing place to live for all. Through August 2020, the program provided $2.2 million to community organizations, with a specific focus on addressing root causes of health inequities in historically marginalized populations. One example is the Parent Advocates High Road Program led by 2not1 Fatherhood & Families. This initiative promotes family stability through parental leadership development to create effective co-parenting relationships, improve interaction with children, and build community.[67]

Supporting whole person health of Humana associates

Humana applies a holistic view and commitment to employee well-being that encompasses multiple dimensions, including SDOH, and focuses on addressing the varying and very personal barriers employees face in achieving their best health. Humana's goal is to systematically embrace the diverse cultural backgrounds of associates so that the workplace can become a venue for solutions that improve health outcomes by fostering well-being both while at work and when at home. Associate well-being is measured and reported in four domains (purpose, health, belonging, and security) applying approximately 70 metrics, with results and insights delivered to drive action plans for improvement at the team, unit, and enterprise levels. While this serves well-being advancement for the associate population at large, this analysis also forms the basis for uncovering unmet needs impacting sub-communities vulnerable to health inequity.

The Humana Well-being Model



Through this well-being measurement, social isolation was identified as a barrier to engagement and health-related quality of life for BIPOC associates. Among the efforts to improve social connectedness, was the development of Network Resource Groups, nine experience-based forums for exchanging ideas, building community, and bringing a diverse lens to business decisions. Measured levels of belonging have increased for these groups, as well as Humana overall, in the last five years. Network Resource Groups are also advancing inclusion in the workplace by facilitating open discussion and education about equity issues. For example, the Pride LGBTQ (lesbian, gay, bisexual, transgender, and queer) Associates & Allies Network Resource Group developed an Ally Playbook that provides education, tools, and resources on how to foster ally growth and inclusive behaviors around the LGBTQ community.[68]

To realize our customer-centric strategy, Humana is transforming the way we work as well as accelerating the focus on the associate experience. Underpinning these efforts is building an inclusive culture and diverse workforce that drives collaboration and represents the communities we serve. The Office of Inclusion and Diversity (I&D) supports enterprise initiatives such as the creation of a robust Inclusion Toolbox of training and workshops available to all associates and leaders and Local I&D Councils that foster a sense of belonging through cultural awareness, a celebration of diversity, and community partnerships. In addition, to accelerate progress, in 2020, leaders will also be held accountable for I&D goals around hiring, promotion, and retention, as well as mentoring talent and other measures. In recognition of this work, Humana was honored on the 2020 DiversityInc list of Top 50 Companies for Diversity, making the list for the third year in a row and jumping 17 spots to number 25 on the list.[69]

Humana priorities to pursue

Humana's Values

Achieving health equity requires intentionality, specifically targeting the sources of inequity, setting outcome-driven goals, and using data to track progress and course-correct when needed. Sometimes this will necessitate approaching what we do with equity – giving people what they need to achieve their best health – rather than equality – giving everyone the same thing – in mind.

Inspire health

- Scale or implement evidence-based interventions to improve access to care. The County Health Rankings and Roadmaps, a program of the Robert Wood Johnson Foundation, has identified a number of strategies that are likely to decrease disparities, including the medical home model of care,[70] telemedicine,[71] community health workers,[72] and health literacy interventions.[73]
- Include incentives for reducing health disparities in value-based payment models to promote better data collection and measurement, as well as an intentional focus on equity.
- As we shift more healthcare into the home, safeguard the health of frontline workers during and after the COVID-19 pandemic, who are more likely to be female, BIPOC, and low-wage hourly employees. Research on the early months of the COVID-19 crisis in New York City found that home health workers were at heightened risk for contracting and transmitting COVID-19 due to these vulnerabilities.[74]

Cultivate uniqueness

- Embrace whole person health by considering medical, social, and mental health needs in all our member interactions, programs, and benefits.

Rethink routine

- Disaggregate data by race, ethnicity, and other key sub-populations such as disability status and language preference when tracking and reporting clinical, utilization, and quality metrics to make disparities evident and measure progress.
- Seek out diverse, underrepresented companies through the procurement process who may be able to deliver as well or better than existing vendors may. Similarly, when forming national or community partnerships, ensure they are representative of the population and diverse voices are included.

Pioneer simplicity

- Build equity into quality assurance processes so it becomes part of the way we do business. This may include building additional reviews into workflow for new analytic models, clinical products, and marketing materials to ensure diverse perspectives are considered.
- Make it easy for members to self-report their race, ethnicity, written and verbal language preferences, sexual orientation, and gender identity upon enrollment.

Thrive together

- Participate in local public health conversations and planning to foster shared funding, services, governance, and collective action. This perspective may provide insight into how business decisions – such as capital investments and advocacy – may affect public health, as well as how policy decisions may promote equity. There are a number of resources for identifying evidence-based policy, such as County Health Rankings and Roadmaps[75] and CityHealth.[76]

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Contact

Stephanie Franklin, MPS, PMP
Population Health Strategy Lead
Bold Goal, Population Health Strategy | Office of Health Affairs and Advocacy
O 502.476.1770
C 502.295.5605
sfranklin20@humana.com

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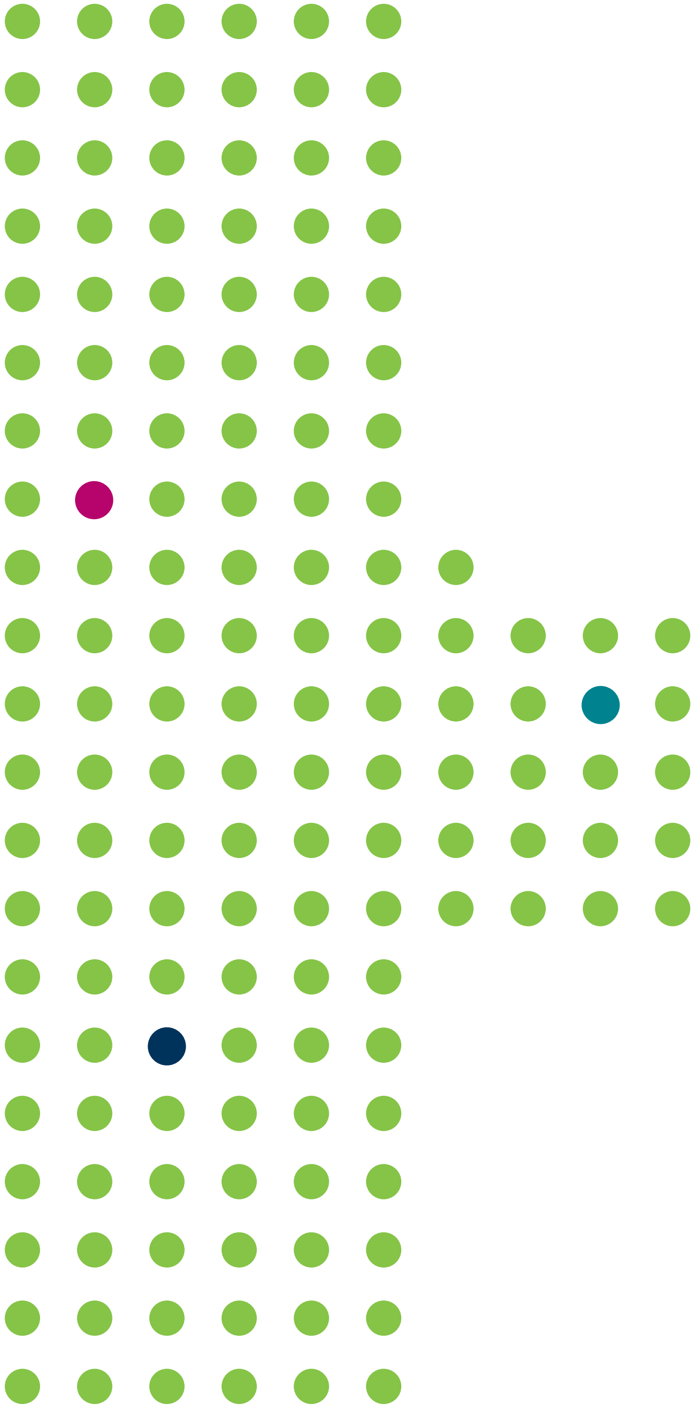
March 2020

Loneliness & Social Isolation

BOLD GOAL,
POPULATION HEALTH STRATEGY
OFFICE OF HEALTH AFFAIRS AND ADVOCACY



The intent of this policy brief is to inform stakeholders on loneliness and social isolation as social determinants of health, including research and legislation. It's meant to spark conversations over opportunities to affect change. Humana's Bold Goal is dedicated to improving the health of the communities we serve 20 percent by 2020 and beyond by addressing the health of the whole person.

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The role of healthcare

Loneliness and social isolation are two social determinants of health (SDOH) that have negative health impacts on people of all ages. Loneliness refers to the quality of relationships within a person's social network. Social isolation refers to the quantity and structure of a person's social network and participation in social activities.

In February 2020, the National Academies of Sciences, Engineering, and Medicine (NASEM) published a consensus study report on **Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System**. The committee concluded that the healthcare sector is uniquely positioned to play a key role for seniors because interactions with the healthcare system may be the only opportunity to identify affected individuals.

The following brief provides an update on industry-wide efforts to address loneliness and social isolation. It also highlights research on interventions and health impact, and includes considerations for areas of exploration.

> “
>
> **Human beings are social by nature, and high-quality social relationships are vital for health and well-being.**
>
> ”
>
> – NASEM, Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System, 2020

By the numbers

2–5x **increase**	Likelihood of socially isolated individuals to die prematurely than those with strong social ties
57% **increase**	Risk of emergency department visits among heart failure patients who are lonely
64% **increase**	Risk for seniors developing clinical dementia and **doubled** the risk of Alzheimer's disease

Political and regulatory landscape

Older Americans Act Reauthorization

Policymakers and advocates are succeeding in raising the awareness of loneliness and social isolation as public health issues. In March 2020, Congress voted to reauthorize the Older Americans Act with its passage of the **Supporting Older Americans Act of 2020 (H.R. 4334)**. OAA authorizes key programs and services to help seniors maintain independence, such as nutritional services, health promotion activities, abuse and neglect prevention, and caregiving services.

To address loneliness and social isolation, H.R. 4334 will:

- Support screening for the prevention of social isolation and the coordination of supportive services and healthcare to address social isolation and loneliness;
- Increase the Assistant Secretary on Health's focus on social isolation through the development of a long-term plan for supporting efforts to detect, prevent and raise awareness of the negative health effects; and
- Promote research on interventions to address social isolation and loneliness by directing the Secretary of Health and Human Services to develop a report on recommendations to reduce the negative health effects caused by the issues.

Medicare Advantage Policy

On Feb. 5, 2020, the Centers for Medicare & Medicaid Services (CMS) released the Proposed Rule for *Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly*. This proposed rule would revise a number of regulations for MA, the Medicare Prescription Drug Benefit (Part D), Medicaid, and a number of other programs. This year, the Rate Notice did not include a Call Letter, so all policy changes for these programs will go through a formal rule-making process. The Proposed Rule would codify the authority of MA plans to offer Special Supplemental Benefits for the Chronically Ill (SSBCI) as well as make a few technical changes from 2020.

The Coalition to End Social Isolation and Loneliness

A key advocate for these policies is the **Coalition to End Social Isolation and Loneliness**. Humana is one of the inaugural members of the coalition, which launched in 2019 and consists of organizations in both the public and private sectors. The Coalition's five strategic goals are:

1. Increase public awareness of social isolation and loneliness and its effect on health and well-being.
2. Enhance social services and supports to address social isolation and loneliness.
3. Advance health services and supports that address social isolation and loneliness.
4. Leverage innovative solutions that foster connection and social integration.
5. Advance research to continue to develop the evidence base necessary to design effective programs and policies.

Special Supplemental Benefits for the Chronically Ill

Who is eligible for SSBCI?

A chronically ill enrollee is defined as an individual who:

1. Has one or more comorbid and medically complex chronic condition that is life threatening or significantly limits the overall health or function of the enrollee;
2. Has a high risk of hospitalization or other adverse health outcome; and
3. Requires intensive care coordination.

MA plans may also consider an individual's social determinants of health when determining eligibility.

What types of benefits are permitted?

An SSBCI can be in the form of:

1. Reduced cost sharing for Medicare covered benefits;
2. Reduced cost sharing for primarily health-related supplemental benefits;
3. Additional primarily health-related supplemental benefits; or
4. Additional non-primarily health-related supplemental benefits to address an individual's SDOH.

What about uniformity requirements?

SSBCI is intended to relate to an individual enrollee's specific medical condition and needs. Therefore, plans may offer non-uniform SSBCI so long as the benefit has a reasonable expectation of improving or maintaining the health or overall function of that chronically ill enrollee.

National Service Programs

While not always explicitly discussed, ensuring seniors have a sense of purpose and social connections is not a new policy objective. For instance, **Senior Corps** is an agency under the Corporation for National and Community Service (CNCS), and its programs date to the 1960s.

These three national service programs for Americans 55 and older are:

- **Foster Grandparents:** Volunteers stay active by serving children and youth in their communities as role models, mentors and friends to children with exceptional needs.
- **Senior Companions:** Volunteers provide assistance and friendship to older adults who have difficulty with daily living tasks, such as shopping or paying bills. They help these adults remain independent in their homes rather than moving to institutional care and provide some relief to caregivers.
- **RSVP:** Volunteers may connect with diverse and flexible opportunities in their communities through one of the largest volunteer networks in the nation for people age 55 and older.

Not only are these volunteers helping people in their community, but research also shows that the Senior Corps volunteers also benefit. A **study** published in 2019 found that, after two years of volunteering, volunteers were less socially isolated (88% reported fewer feelings of isolation), less depressed (78% reported fewer symptoms of depression), and in better health (84% reported stable or improving health).

Transportation impacts on loneliness

More than **100 million Americans** do not drive—which is one-third of the U.S. population. While transportation is important for accessing medical care, it is also essential to being socially engaged with people and activities. With new flexibility granted by CMS, it is now permissible for health plans to provide transportation for nonmedical or health-related social needs to MA members, in certain circumstances.

For a detailed look at transportation as a social determinant of health, see Humana's **2019 Transportation Issue Brief**.

In 2019, the Humana's Bold Goal team began evaluating the desirability of a nonmedical transportation benefit, and the findings so far have been encouraging. Transportation is a significant barrier to seniors living more fulfilling, independent lives. Having access to transportation (i.e. via a ride-sharing service such as Lyft or Uber) would empower members by giving them freedom to do things, such as shopping and socializing, as well as exploring new interests and activities.

For the first time, Humana surveyed a representative sample of our MA membership for a comprehensive set of social needs, including transportation (see the **2019 SDOH Data Issue Brief** for details). Of the responders, **10.3% answered "yes" to the question below on transportation access:**

> *In the past 12 months, has a lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?*

Further, 32.7% of responders who expressed feeling "lonely or isolated" reported also having transportation barriers. However, this may not capture the full need. In consumer research, members who do have transportation resources still expressed frustration with pre-scheduling requirements and wait times, and they feared becoming a burden on their family and friends.

New Resource from Humana

Transportation Consumer Flyer (updated October 2019) | A helpful guide for those struggling with transportation barriers to provide them with helpful tips, resources and information that help to alleviate concerns about transportation services.

What Humana is doing

Papa "Grandkids On-demand" Pilot

Papa Inc. connects college students, known as Papa Pals, to older adults who need companionship, assistance with house chores, technology lessons and other senior services. In October 2018, Humana launched a proof-of-concept pilot with Medicare Advantage (MA) members in Tampa, Florida, offering lonely MA members up to 10 hours per month of service for four months. Papa enrolled 189 members, with 158 members completing at least one visit.

Pilot results for Tampa participants

21% Reduction in loneliness (measured using UCLA 3-Item Loneliness Scale)

54.7% of participants were less lonely after the intervention

3 days Average increase in Physically Healthy Days

5 days Average increase in Mentally Healthy Days

> *"This program has helped me lift my spirits. I just recently had a stroke and I was not able to travel to see my grandkids graduate from high school. I was really sad about that. The Papa Pals have been there for me in my time of need, even helped me with my phone so I can at least Facetime® them and congratulate them."* – Trudy, age 72, pilot participant

Pilot expansion

With the success of the proof-of-concept phase, Humana is expanding our testing of the Papa program. In late 2019, we launched in Louisville, Kansas City metro, New Orleans, Atlanta and Richmond, Va. Papa Pals will provide assistance to members for up to two hours per week or a maximum of eight hours per month for 6 months. With the extended intervention period and increased enrollment, we will have the opportunity to measure the impact on hospital admissions and readmissions, cost, utilization, health outcomes and quality outcomes.

Other ways Humana is helping

Loneliness Health Navigator pilot

Social needs, such as loneliness, can be difficult for doctors to address in the clinical setting. Humana is committed to using our analytical models and care management programs to support the doctor-patient relationship.

In 2019, Humana collaborated with Atrium Health in Charlotte, N.C., to test this model. The primary objective of the Loneliness Health Navigator proof-of-concept pilot is to determine if we can improve MA members' health-related quality of life (as measured by Healthy Days) and thereby reduce utilization through a one-on-one telephonic outreach intervention, conducted by the Humana Wellness team, over 4 months. This pilot is on-going, with outcomes expected in 2020.

The Public Good Projects | Communication about loneliness

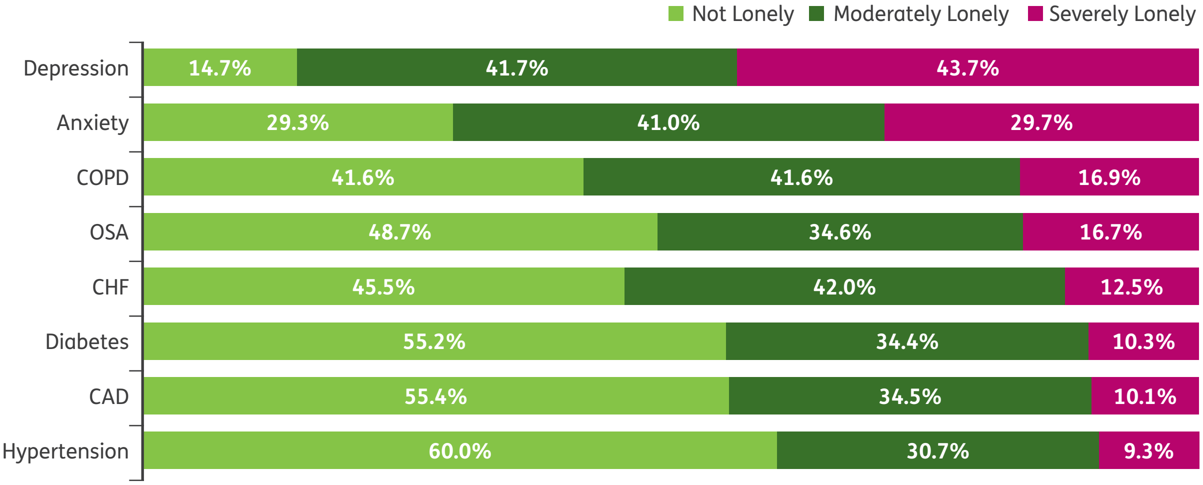
In 2019, Humana partnered with The Public Good Projects (PGP), a public health nonprofit composed of experts in public health, media and marketing. The goal was to study how to strengthen programs that intervene with older adults who are isolated or lonely. The research found that efforts should be made to use terminology that will best resonate with the target audience, as some terminology may be unfamiliar or carry social stigma. Future research should examine innovative and sustainable ways to meet older adults where they are by using specific, tailored messaging. This research is pending publication.

Prevalence of loneliness in older adults with chronic conditions

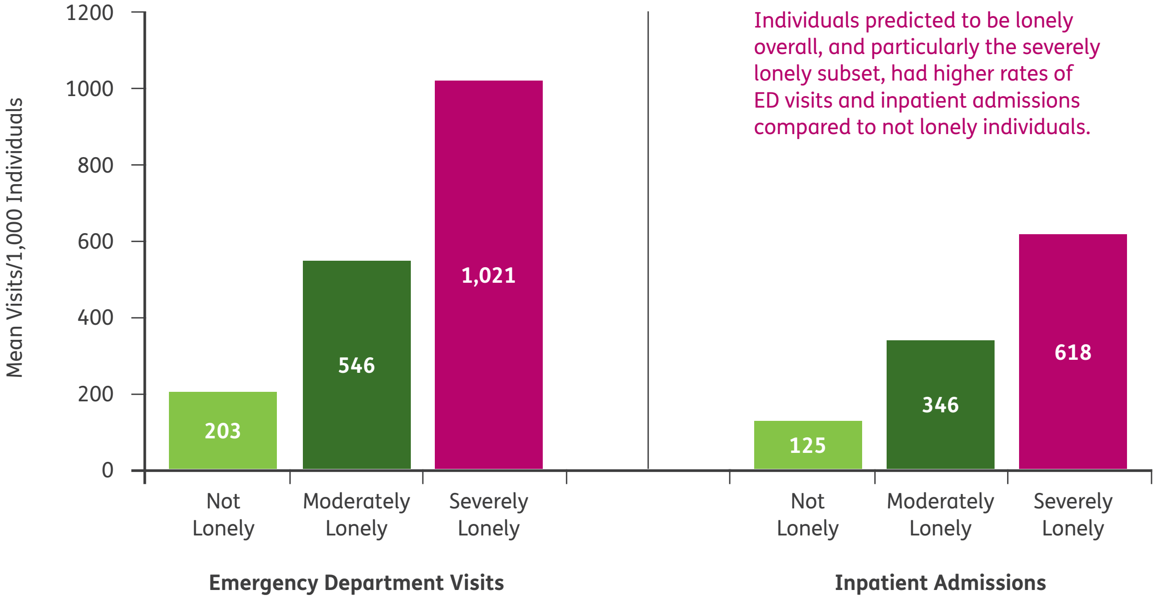
It is important for Humana to understand the emotional and mental needs of chronically ill patients to help us provide the most useful support possible. In October 2019, Humana presented **new research** on this topic at the American Academy of Family Physicians 2019 Global Health Summit. Some of the findings are below. Future research should explore the association between risk of loneliness and higher rates of healthcare utilization.

COPD, chronic obstructive pulmonary disease
OSA, obstructive sleep apnea
CHF, congestive heart failure
CAD, coronary artery disease

Loneliness Prevalence by Condition



Healthcare Utilization by Loneliness Segment



Individuals predicted to be lonely overall, and particularly the severely lonely subset, had higher rates of ED visits and inpatient admissions compared to not lonely individuals.

Plan Benefit: Meals on Wheels™ Friendly Visitor Program

As noted in Humana's **2019 Food Insecurity Issue Brief**, beginning in plan year 2019, specific MA plans offered a meal benefit with Meals on Wheels™ for post-acute and chronic condition members. This benefit not only addresses food insecurity and transportation by delivering healthy meals to members' homes, but also addresses loneliness and social isolation by including a Friendly Visitor benefit to those who screen positive for loneliness.

New Resources from Humana

Loneliness & Social Isolation Resource Toolkit (updated December 2019) | A toolkit to help seniors and caregivers learn about the causes of loneliness, find new ways to connect with others and see what resources are available.

Loneliness Consumer Flyer (updated November 2019) | A helpful guide for seniors on loneliness and social isolation that provides tips and resources to build social connections.

Loneliness Veterans Flyer (developed February 2020) | A helpful guide for veterans on military-related loneliness and social isolation that provides tips and resources to build social connections.

Humana priorities to pursue

- **MA Benefits** | With the benefit flexibility granted by CMS in recent years, Humana has the opportunity to explore benefits to meet the unique needs of individuals. Solutions addressing loneliness may:
  1. Strengthen existing relationships,
  2. Form new connections, and/or
  3. Change thinking (i.e. cognitive behavioral therapy), and they may be delivered in-home, telephonically, virtually or in the community.

  There are also opportunities to add nonmedical transportation as a stand-alone benefit or as a component of another SSBCI (i.e. as part of the services that could be provided by a Papa Pal) or of care coordination. The Bold Goal team is actively vetting and testing these interventions as benefits in future plan years.

- **Papa** | There are numerous opportunities to leverage our deep, collaborative relationship with Papa not only as a desirable Special Supplemental Benefits for the Chronically Ill (SSBCI) in Plan Year 2021, but also as a lower cost in-home, nonmedical service for step-down care, closing gaps in care, addressing health-related social needs, virtual care activation for telehealth or remote monitoring, and encouragement to engage in chronic condition management.

  In 2020, Papa will also be **expanding into new channels**, opening opportunities in Employer Group and Medicaid. Papa Pals could provide assistance not only to seniors, but to family caregivers or postpartum mothers. With this, Papa is also moving away from the "grandkids-on-demand" slogan to "family on-demand."

- **Hospice** | Humana's acquisitions of a number of large hospice providers (**Kindred Healthcare, Curo Health Services** and **Enclara Healthcare**) highlight another population at high risk of loneliness and social isolation. In addition, beginning in 2021, MA plans have the opportunity to participate in a **new Value-Based Insurance Design (VBID)** program to "carve in" hospice benefits. As Humana plans for how to integrate this line of business, it will be important to consider loneliness and social isolation among both hospice patients, to improve their quality of life, and their caregivers, both before and after their loved one's death to prevent their own health from deteriorating.

- **Veterans** | As noted in the Health Affairs article, **The Social Determinants of Suicide in the Military**, co-written by Humana's Kristin Russell, Chris Hunter and Dr. William Shrank, loneliness appears to be particularly prevalent among veterans. Humana serves tens of thousands of veterans—as well as 6 million TRICARE beneficiaries—and we are committed to meeting their total health needs. In 2020, we launched the **Humana Honor Medicare Advantage plans**, which are designed to complement healthcare provided through Veterans Affairs (VA) and with a holistic focus on health and well-being for veterans and their families. Going forward, we should continue to build the programs and benefits to address the unique loneliness and other social needs of veterans.

Contact

Stephanie Franklin, MPS, PMP
Population Health Strategy Lead
Bold Goal, Population Health Strategy | Office of Health Affairs and Advocacy
O 502.476.1770
C 502.295.5605
sfranklin20@humana.com

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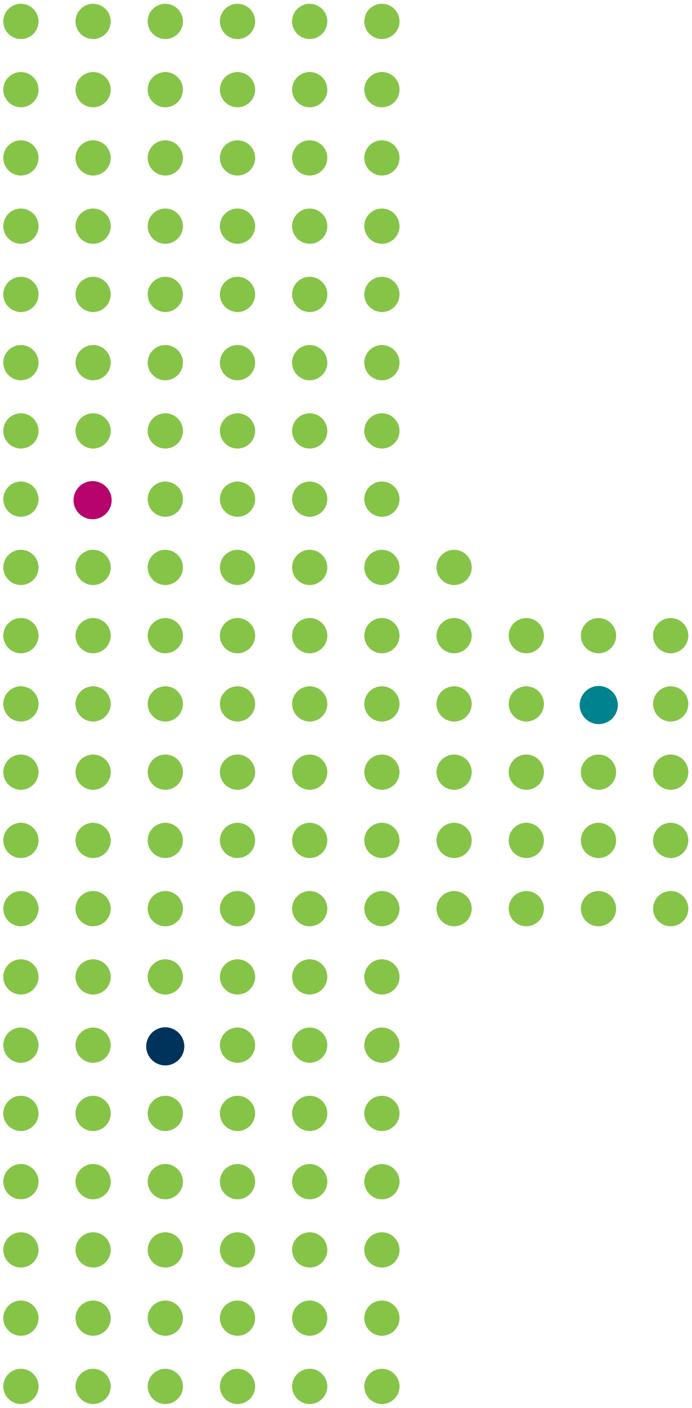

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Humana’s Bold Goal: Addressing the needs of the whole person

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https://www.youtube.com/watch?v=9OObcO6HjzE

Humana’s health equity trailblazer Dr. Nwando Olayiwola’s personal journey to understanding inequity

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The Public Good Projects (PGP)
From Neighborhoods to nations, PGP advances health communication for the public good.

https://publicgoodprojects.org/about