**Meeting Notes**

The seventh meeting of the Social Justice & Health Disparities Working Group was held on April 22, 2021 from 3:00-4:30pm. Dr. Dora Hughes began the meeting with a brief overview of the agenda. Three speakers presented:

**(1) R.J. Briscione, Aetna, a CVS Health Company**

R.J. Briscione is the Senior Director of Social Determinants of Health Strategy & Execution at Aetna, a CVS Health Company (Aetna).

He began his presentation with an overview of Aetna's efforts to ensure equity in vaccine administration, and its increased focus on data collection. He noted that racial and ethnic data can be difficult to collect. For example, the demographics for the household and other covered members default to the demographics of the primary member. Some of Aetna's self-reported data collection sources include eligibility files from employers, Medicare, navigators, and Aetna paper enrollment forms.

Aetna has a small health equity team; chief medical officers from different parts of the business report to them about any health equity initiatives they are conducting. It has an external health equity advisory council of industry experts and are in the process of forming an internal health equity council.

Briscione shared their five key areas of focus relating to eliminating racial health disparities: 1) social determinants of health, 2) race data collection, 3) targeted interventions, 4) cultural competencies, and 5) health equity advisory council. Aetna is in the process of turning this roadmap into action and Briscione discussed a few key strategies in more detail:

1) Social determinants of health: target activities to address the SDOH needs of African American and other minority populations through enhanced partnerships with third party vendors
2) Improved race data collection: enrich member data collection on race/ethnicity (as well as national origin, language preference, language spoken at home, etc.) to enable targeted member and provider interventions through a combination of activities that include increasing third party administrator capacity for data collection, Aetna navigators, and paper enrollment
3) Targeted interventions: targeted initiatives in maternal and infant health and chronic hypertension to improve clinical and cost outcomes, which include preeclampsia prevention, contraception access, telemedicine support in obstetrical deserts, vaccination completion, and hypertension control
4) Focus on Cultural Competency: cross enterprise cultural competency and implicit bias training through deployment of such training in the medical and service community

5) Leverage Health Equity Council: re-establish a small group of external expert leaders responsible for providing advice and counsel

Briscione also reviewed CVS Health's collaboration with Unite Us, a social care coordination platform, to help Medicaid and dual-eligible members in select locations more easily access social services within their community. At the beginning of the COVID-19 pandemic, they were focused on specific services that were most needed and are tracking those efforts. For example, Unite Us built a network in New Orleans and they identified food access as a key issue. However, many of the existing food programs were neighborhood based and did not have the ability to quickly switch over to an online or covid-safe environment, and so they were transitioned to mass food distribution at a central location. The Aetna Medicaid team on the ground, along with Unite Us, stepped in to help support some of those neighborhood programs function as they were intended to at the local level.

Briscione provided a brief overview of "Close the Care Gap," an initiative to develop a framework and hierarchy of focus for improving health equity across Aetna Black and Hispanic membership and create a culturally responsive Medicare clinical and community program design.

He noted that while much of the work he discussed is heavily Medicare focused, this work is starting to influence their commercial work.

Aetna is rolling out an initiative in 2022 for value-based care providers that will assist them in addressing social determinants. Aetna will initially pay providers to report z-codes and then Aetna will pay for value-based improvements on social determinants. For example, if the provider recorded a food security need, Aetna would track and have the provider report on how they are closing the food security gap. There would be value-based payment associated with the specific z-code and social determinant gap closure.

**Questions**

Dr. Cara James asked for what percentage of consumers does Aetna have z codes, and R.J. replied very few-- single digit percentages. James also asked what they are measuring when they look at return on investment, is it strictly cost or other things as well? Briscione answered that they do look at cost, but for social determinants initiatives they look at other variables as well.

Mila Kofman asked what lessons they have learned from their work in the Medicaid and Medicare space that could be implemented on the commercial side of the business, particularly for the small group market. Briscione responded that they have done some targeted work with employers on building an index for them that is more closely aligned with those specific attributed members and the costs associated with them and gives employers a dashboard of social determinants issues.

Mila Kofman asked, on the commercial side, if they have requirements on the provider side for cultural competency training. Briscione said they do.

**(2) Tonya Vidal Kinlow**

Tonya Vidal Kinlow, VP of Community Engagement, Advocacy & Government Affairs at Children's National Hospital provided an overview of pediatric health disparities in the District. She began with a brief overview of the data on poverty, infant mortality, and life expectancy in the District. At Children's National, in order to determine what some of the drivers are behind childhood health disparities, they are preparing to conduct a new community health needs assessment using the Childhood Opportunity Index which combines 29 neighborhood-level indicators into a single composite measure that focuses on three domains including education, health & environment, and social & economic impact.

The Children's National CARE Mission is to excel in Care, Advocacy, Research, and Education. The Child Health Advocacy Institute at Children's National leads its advocacy efforts, and through leadership and collaboration, advances policy and systems change to achieve health equity for all children.

When it comes to child health disparities, top priorities for Children's National include asthma, infant mortality, and mental health. Children's National recognizes that racism is a public health crisis and is the root of many of these disparities, as experiencing racism has been linked to poor physical and mental health outcomes.

Asthma: Asthma is a chronic condition impacting more than 16,000 DC children, and DC's Black children have ~5 times the rate of ED visits for asthma compared to white children. Strategies to reduce these ED visits include: 1) increasing resources to improve equity, 2) implementing institutional approaches, and 3) implementing community-based approaches. Resources to improve equity may include following-up with families and making sure they understand discharge instructions and have the resources they need to care for the child. Children's National is partnering with an organization to identify and address asthma triggers in the home. They are also implementing institutional approaches to address childhood asthma, such as their Impact DC clinic, in partnership with schools, school nurse programs, and community-based organizations.

Infant Mortality: Infant mortality rates (IMR) in Ward 8 is 2 times higher than the citywide rate, and 7 times higher than in Ward 2. Strategies for reducing IMR include 1) increasing resources to improve equity, 2) collaborating with community-based organizations to provide home visits, and 3) providing education to high-risk women. They have a grant from the Clark Foundation, and are looking at upstream approaches to address infant mortality as well, including prebirth activity and postpartum activities.

Mental Health: There is a growing demand for mental health care in DC that far exceeds capacity. Black and Latino/a teens are approximately 3 times more likely to report being depressed compared to white children. Strategies for increasing mental health access: 1) increasing resources to improve equity, 2) increasing integrated mental health services, 3) expanding mental health promotion, and 4) training in trauma informed care models. Kinlow noted that Wards 7 and 8 have high rates of mental health needs but a shortage of mental health services to address these needs. A study done in 2020 found that 48% of DC youth with major depressive episodes did not receive the mental health services they needed. To address the issue of care access, Children's National is working to put psychologists and psychiatrists in primary care environments. Additionally, they are partnering with the Department of Behavioral Health on a program called DC Mental Health Access that allows them to train pediatricians to identify early signs of behavioral and mental health needs and link affected individuals and families to the resources they need. Kinlow also emphasized that mental health parity has yet to be achieved, and network adequacy for behavioral health demands attention and action. The data show that when a child needs mental health care, it is much more likely that it will be an out-of-network visit.

Kinlow closed by discussing the policy and systems actions that Children's National believes will have the largest impact on population health. She said there are gross inequities in non-clinical determinants of health that are best addressed through policy and systems actions. Strategies for policy/systems actions include: 1) engaging in CNHS CHIP, 2) building capacity in advocacy, 3) ensuring community engagement, and 4) advocating for policy/systems changes.

**(3) Colette Chichester on CareFirst's National Health Equity Strategy**

Colette Chichester announced that CareFirst joined other Blue Cross Blue Shield (BCBS) companies and the Blue Cross Blue Shield Association (BCBSA) in announcing a National Health Equity Strategy to confront the nation's crisis in racial health disparities. The National Health Equity Strategy will involve collecting data to measure disparities, scaling effective programs, working with providers to improve outcomes and address unconscious bias, leaning into partnerships at the community level and influencing policy decisions at the state and federal levels. This multi-year effort will focus on four conditions that disproportionately affect communities of color, including maternal health, behavioral health, diabetes, and cardiovascular conditions. CareFirst will first focus on maternal health, followed by behavioral health.

**Review and Discussion of Preliminary Recommendations**

Dr. Hughes ended the meeting with a brief overview of the proposed recommendations.

Allison Mangiaracino noted that the carriers are bound by market rules on actuarial value (AV), and the value-based insurance design proposal may have a significant impact on AV. She asked if at some point the working group could pursue an assessment from Oliver Wyman on the recommendation's potential impact. Mila Kofman thanked Mangiaracino for raising this issue

and agreed that the AV calculator is a major consideration. She stated that HBX staff would ask the Standard Plan Working Group, which works with Wyman, to assist on this issue.

**Attendees**

Dora Hughes
Helen Mittmann
Mila Kofman
Marybeth Senkewicz
Diane Lewis
Anneta Arno
Cara James
Philip Barlow
Howard Liebers
Debra Curtis
Allison Mangiaracino
Ciana Creighton
Yulondra Barlow
Colette Chichester
Purvee Kempf
Jacqueline Bell
Kris Hathaway
Pamela Riley
Karima Woods
Courtney Bragg
Daniel Rutherford Wilson
Janice Davis
Yolette Gray
Maria Prince