NAM Leadership Consortium

Collaboration for a Value & Science-Driven Health System

The National Academies of
SCIENCES • ENGINEERING • MEDICINE

Board on Health Care Services
Health and Medicine Division

Financing that Rewards Better Health & Well-Being

May 25, 2021| 2:00 PM – 5:30 PM EST
May 28, 2021| 1:00 PM – 4:30 PM EST
June 2, 2021| 2:00 PM – 5:30 PM ET

Share your thoughts!
@theNAMedicine

NATIONAL ACADEMY OF MEDICINE

Welcome & Introduction

Michael McGinnis
Leonard D. Schaeffer Executive Officer

Financing that Rewards Better Health & Well-Being

Efficiency, effectiveness, equity, and experience implications of integrated payments for health

GOAL OF MEETING SERIES

Facilitate the identification and adoption of health financing that delivers value and optimizes achievement of the fundamental goal of health and health care: assuring that the population, and each individual, reaches their full potential for health and well-being.

OBJECTIVES

- **Understand deficiencies:** Describe the nature and consequences of the failures of our current health delivery and financing systems, so prominently manifest in the nation's experiences during the COVID-19 pandemic.
- **Consider alternatives:** Identify examples of models of payment and delivery for care that are focused on outcomes most important to people and populations, advances equity in outcomes, improves patient and clinician experiences, and reduces per capita costs—highlighting successes from the COVID-19 pandemic.
- **Identify barriers:** Consider barriers and opportunities to scaling effective integrated payment models and approaches, including those that successfully engage social determinants of health.
- **Imagine the strategy:** Discuss specific strategies, levers, and stakeholder responsibilities that represent key elements of a blueprint for transforming health financing approaches from fee-for-service to integrated payment approaches that incentivize person-centered and holistic delivery models to improve equity and individual, community, and population health.

Workshop Series
Co-Chairs

Kisha Davis
Aledade

Hoangmai Pham
Institute for Exceptional Care

NATIONAL ACADEMY OF MEDICINE

Financing that Rewards Better Health & Well-Being: A Workshop Series

Day 2: Levers Underscored during the COVID-19 Pandemic

May 28, 2021 | 1:00 pm - 4:30 pm ET

nam.edu/LeadershipConsortium | #NAMLeadershipConsortium

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Collaboration for a Value & Science-Driven Health System

Agenda

Welcome, Introductions, and Meeting Overview 1:00 – 1:20 PM

Michael McGinnis, National Academy of Medicine
Kisha Davis, Aledade (co-chair) and **Hoangmai Pham**, Institute for Exceptional Care (co-chair)

Panel 1: Elements of Financing and Payment Models that Effectively Reward Health and Well-Being 1:20 – 2:15 PM

Moderator: **Peter Long,** Blue Shield of California
Sharon Lewis, Health Management Associates
Patrick Conway, Care Solutions at Optum
Piyush Gupta, Cityblock Health

Innovation Spotlight 2:15 – 2:25 PM

Fasih Hameed, Petaluma Health Center

Panel 2: Innovative Federal and State Models for Financing Whole Person/Population Health 2:25 – 3:20 PM

Moderator: **Joshua Sharfstein,** Johns Hopkins University
Donna Kinzer, DK Healthcare Consulting
Ena Backus, State of Vermont Agency of Human Services
Cindy Mann, Manatt Health

Panel 3: Innovative Private Models for Financing Whole Person/Population Health 3:20 – 4:15 PM

Moderator: **Margaret Chesney,** University of California San Francisco
David Fogel, CHI Healthcare
Cheryl Pegus, Walmart
Dexter Shurney, Adventist Health

Closing Remarks 4:15 – 4:30 PM

Kisha Davis, Aledade
Michael McGinnis, National Academy of Medicine

Archetypes to Frame Conversations

Jamal:

Jamal is a 10-year-old boy with seasonal allergies, asthma and ADHD. He is really good at soccer, but can't always get his inhalers and has had to miss several games and practices because his allergies and asthma were not well controlled. His primary care provider has recommended counseling, dietary supplements, in addition to medication for his ADHD. His parents are hesitant to start medication and they cannot afford the supplements. They have not been successful in finding a therapist that accepts their insurance and they cannot afford to pay out of pocket. He has health insurance through CHIP.

Margarita:

Margarita is a 45-year-old mother of two. She works full-time as a private duty home care nurse. She usually works nights to be available to her family during the day. She is also the primary caregiver for her parents and her mother was recently diagnosed with Alzheimer's type dementia. Her BMI is 33, she has pre-diabetes and mild hypertension. Her doctor has recommended that she improve her diet, get more exercise and set a goal weight loss of 20 lbs. Her sleep is poor and she rarely finds time to exercise. She has a high deductible insurance plan through her employer.

Mr. Chen:

Mr. Chen is an 85-year-old widower. He lives alone, and his children live in a neighboring county and visit him weekly. He is adamant that he wants to retain his independence. He relies mostly on frozen meals and his daughter worries that he is losing weight. He has peripheral vascular disease and peripheral neuropathy as well as macular degeneration. He has several fall risks in his home. His doctor has recommended a low salt, low fat diet, and gait training. He often has to cancel his appointments for his eye treatments when his children are not able to take him, as he can no longer drive himself. He has a Medicare advantage plan.

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Collaboration for a Value & Science-Driven Health System

Elements of Financing and Payment Models that Effectively Reward Health and Well-Being

Moderator: Peter Long

Blue Shield of California

NATIONAL ACADEMY OF MEDICINE

Sharon Lewis, BA
Principal
Health Management
Associates

Patrick Conway, MD, MSc
Chief Executive Officer
Optum Care Solutions

Piyush Gupta, MD, FACP
Chief Health Officer
Cityblock Health

CITYBLOCK

We’re Cityblock.

The first tech-driven healthcare provider built for underserved communities

The inequity of America's social infrastructure has created disparate health outcomes and our payment systems are leading to unsustainable cost structures.

Our mission is to improve the health of underserved communities, one block at a time.

We built a profitable social enterprise that leans into radical change, breaking down deeply rooted racial and socioeconomic disparities.

We meet our members where they are, bringing care into the home and neighborhoods through our community-based care teams, and virtually through video, phone, and SMS.

Equipped with world-class, custom care delivery technology, we deliver personalized primary care, behavioral health, and social services to deliver a radically better experience of care for every member and community we serve.

Iyah Romm
CEO, Co-founder

Toyin Ajayi, MD
President, Co-founder

Former C-suite partners at *Commonwealth Care Alliance*, an integrated provider with 25,000 Duals and $1B+ revenue. Nationally recognized for novel programming, care outcomes, and cost savings.

Mitch Betses
COO

Acting CEO & COO at Haven

COO at Beacon Health Options

EVP at CVS

Amberly Molosky
COO - Community Care

Market President at CareMore Health

Past experience managing ops for home health, hospice, palliative

Piyush Gupta, MD
CHO - Community Care

VP of population health at BCBSAZ

Regional Medical Officer at CareMore Health

SUPPORTED BY

town hall VENTURES

Alphabet

Maverick

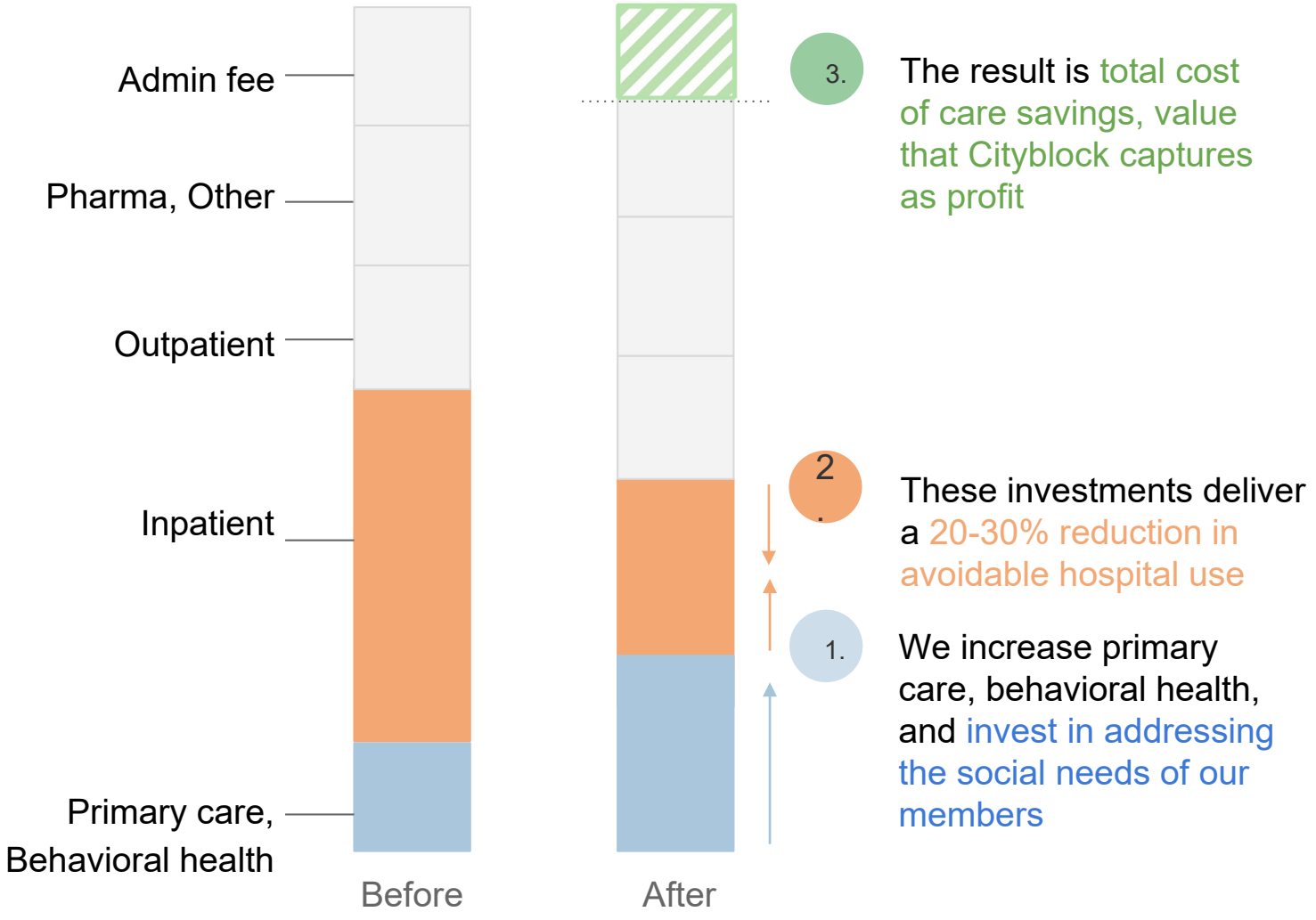
Redpoint

KINNEVIK

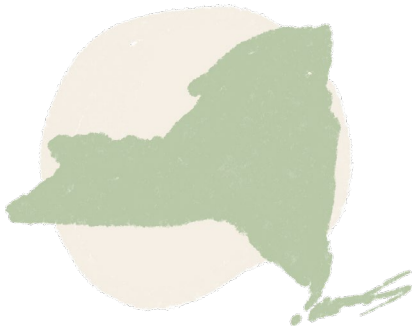
GENERAL CATALYST

WELLINGTON MANAGEMENT®

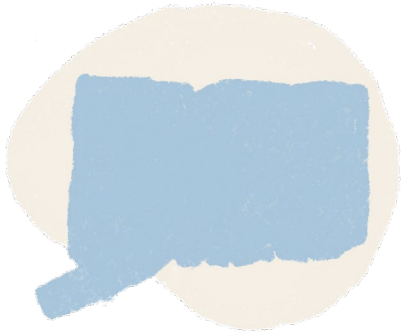
Our model of care delivers better health outcomes and total cost of care savings, which we retain as profit from health plans.



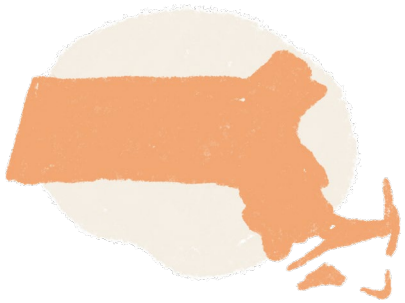
Markets we currently serve:



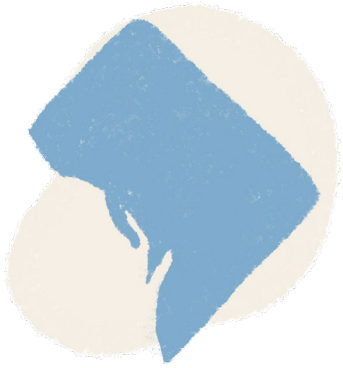
NEW YORK



CONNECTICUT



MASSACHUSETTS



WASHINGTON D.C.

NORTH CAROLINA
(starting june 2021)

Our partners:

MOLINA HEALTHCARE

BlueCross BlueShield of North Carolina

CareFirst

TUFTS Health Plan

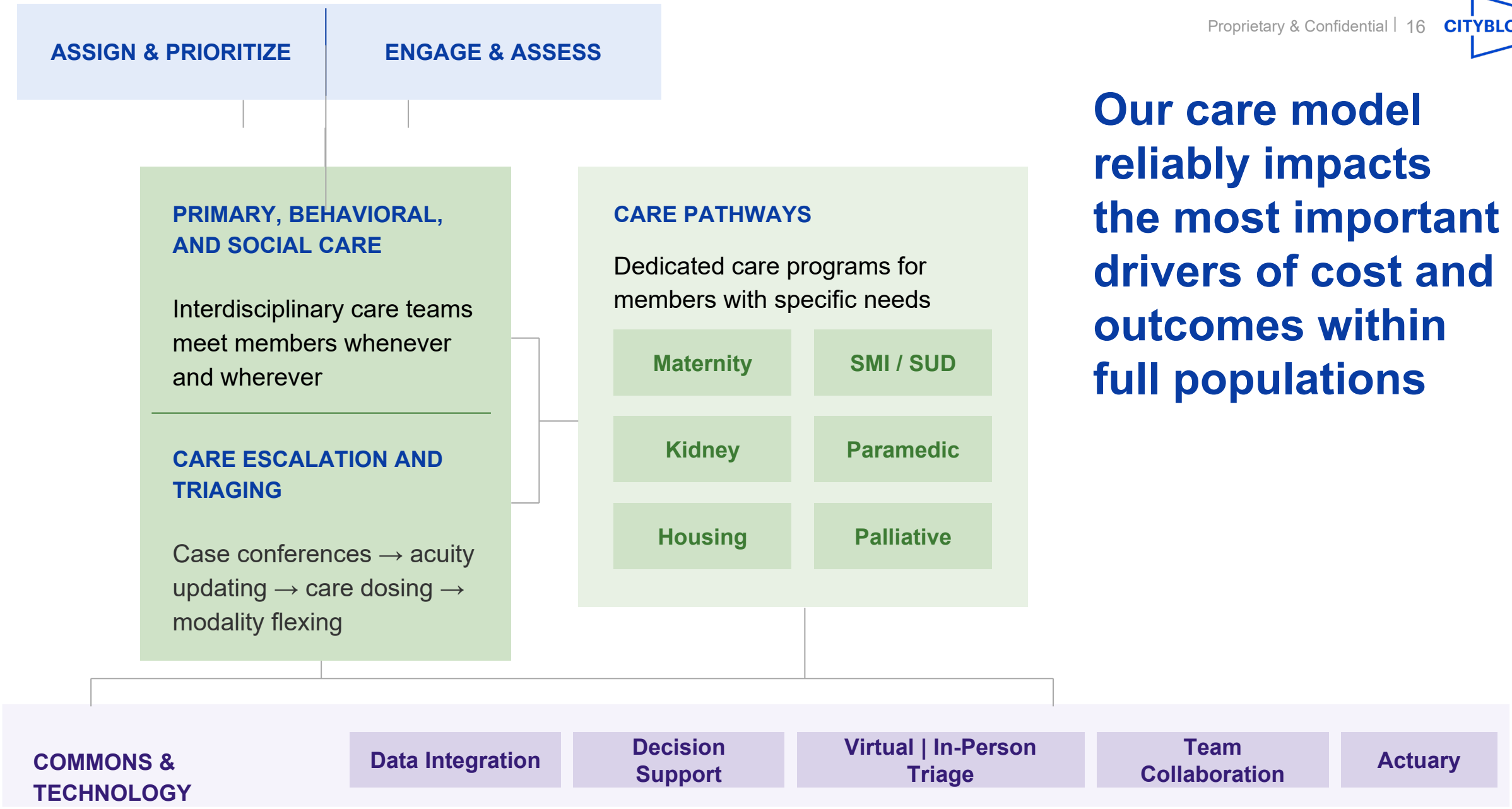
EmblemHealth

ConnectiCare

We deliver outcomes through a deep understanding of the continuum of needs of underserved populations with complex conditions.

Our care model is designed to meet people with the best care — wherever they are.

Our care model reliably impacts the most important drivers of cost and outcomes within full populations



Our tech-driven approach uses data insights and modern design to drive right care, right modality, right time

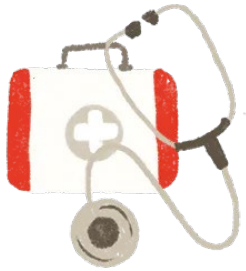
CITYBLOCK

MEMBER FRONT DOOR

Always-available virtual front door (app, SMS, call, video) to both immediate escalated response and true longitudinal primary care relationship with *consistent care teams*

VIRTUAL INTEGRATED CARE

High-quality virtual care led by a longitudinal Cityblock team (CHPs, RNs, BH, MDs), with tight loops to triage escalation to in-home care and link to select specialty care partnerships



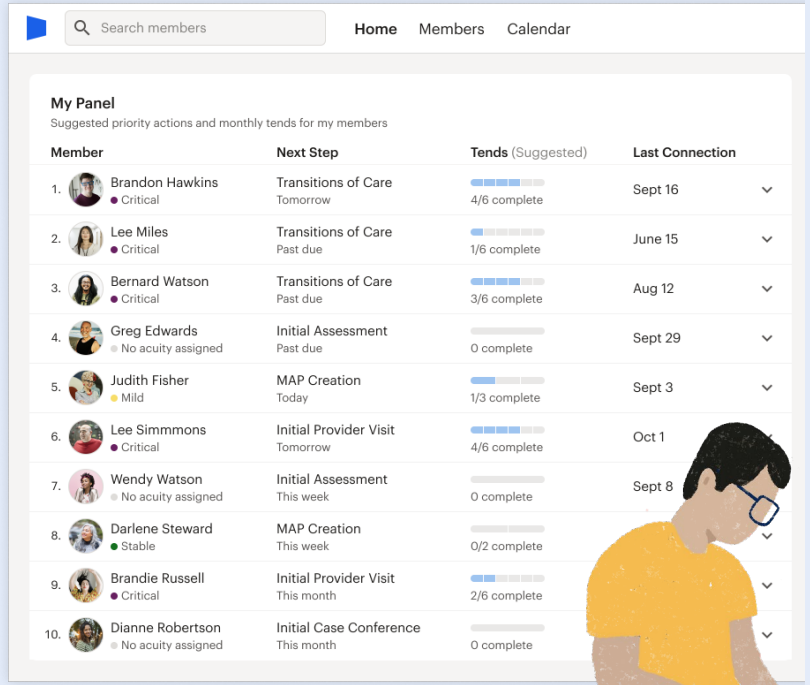
HOME (AND FIELD) INTENSIVE CARE DELIVERY

High-intensity care delivered at the home (CHPs, RNs, NPs), including rapid response for acute needs (MDs, NPs, paramedics) and specialty partnerships (e.g., ESRD); quick transfers back to virtual care upon gap closures

ROUTING & PRIORITIZATION

CENTRALIZED DEPLOYMENT ENGINE

Commons serves as backbone to care delivery triage, allowing seamless scaling up and down different modalities of care based on need.



Our model deeply understand the needs of Medicaid, Dual Eligibles, and low-income Medicare members

CITYBLOCK

Medicaid, Dual Eligibles, low-income Medicare

	What we do:	Desired outcome
 Socially isolated & unmanaged	Create non-clinical & community connection	↓ Social admits to the hospital
 Polychronic & undermanaged	Provide MTM, BH care, and social care	↑ Underlying health ↓ Acute events
 Serious mental illness	High-quality primary care with accessible behavioral health	↓ Inpatient BH-driven admits
 Approaching end-of-life	Advanced care planning with aggressive home-based primary care and palliative care	↓ Unnecessary end-of-life utilization

Case study of an actual Cityblock member

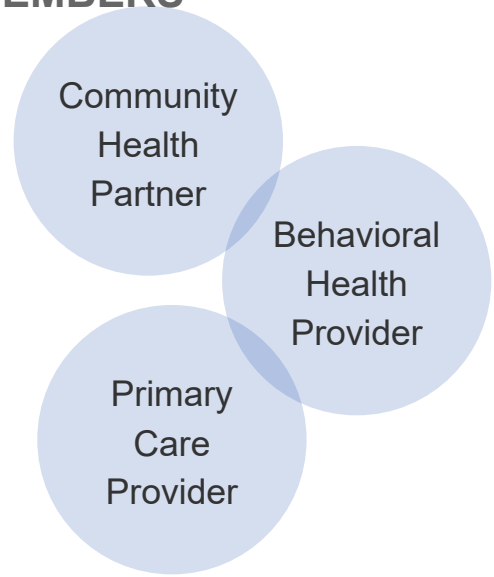
Sonia

*Socially Isolated & Unmanaged

WHAT WE DID:

- Identified underlying behavioral health needs; now engaged in care
- Enrolled in food pantry
- Enrolled in 2 week respite housing program
- Coordinated month long hotel stay during COVID pandemic
- Secured permanent housing during hotel stay

KEY CARE TEAM MEMBERS



SAMPLE MODALITIES

- Phone calls and texts with CHP
- Hybrid visit with primary care provider
- ED diversion with paramedic visit
- Connection with a digital community organization aggregator

ACHIEVED:

21% Reduction in hospital use

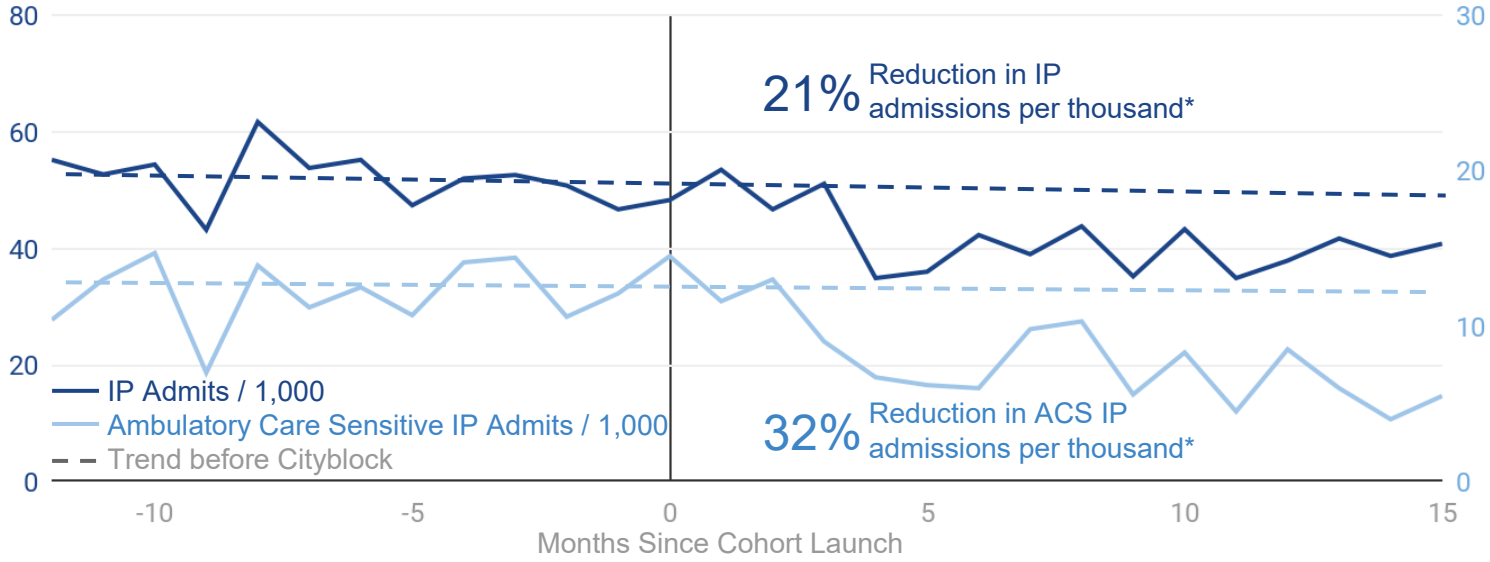
24% Reduction in monthly costs

0 **ED Visits** since April 2020

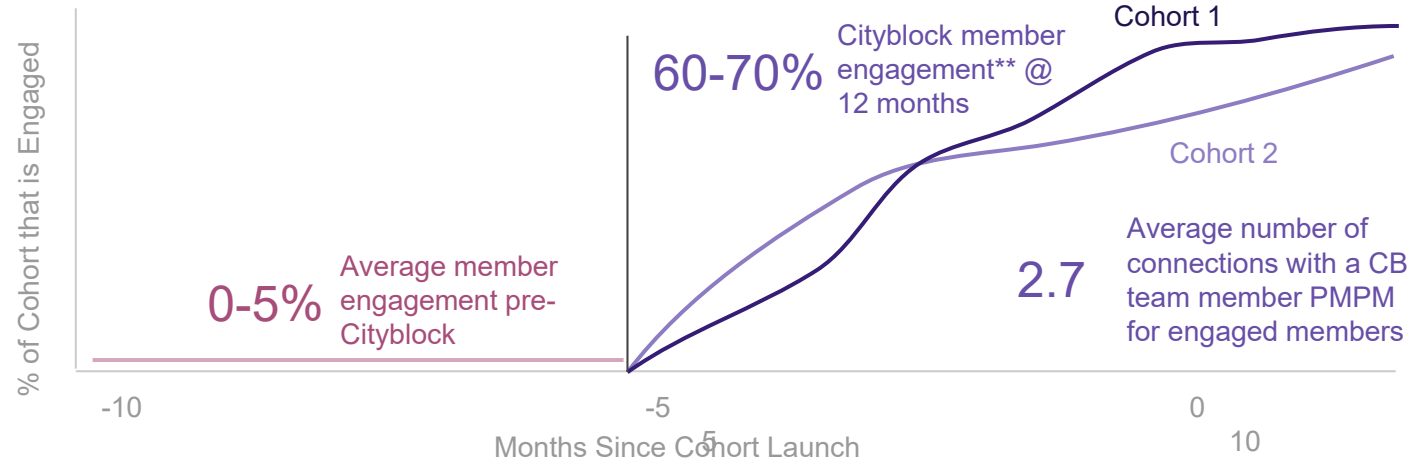
We are delivering strong results today across experience, engagement, utilization, and total cost of care

CITYBLOCK

INPATIENT ADMISSIONS



MEMBER ENGAGEMENT



COST SAVINGS

19% reduction in total cost of care in first year of operations vs. baseline

NY COHORT 1 & 2

Line of Business	
Medicaid / Low Income Commercial	43%
Medicare / Dual Eligibles	57%
Chronic Conditons	
3+ chronic conditions	69%
5+ chronic conditions	33%
Cardiovascular disease	96%
Behavioral health needs	82%
Diabetes	70%
Pulmonary conditions	52%
CHF	37%
Social Challenges	
Social vulnerability	70%
Low social support	36%
Entitlement gaps	22%
Low self-efficacy	18%
Transportation challenges	15%

EXPERIENCE

90 NPS in line with top tech-enabled commercial providers

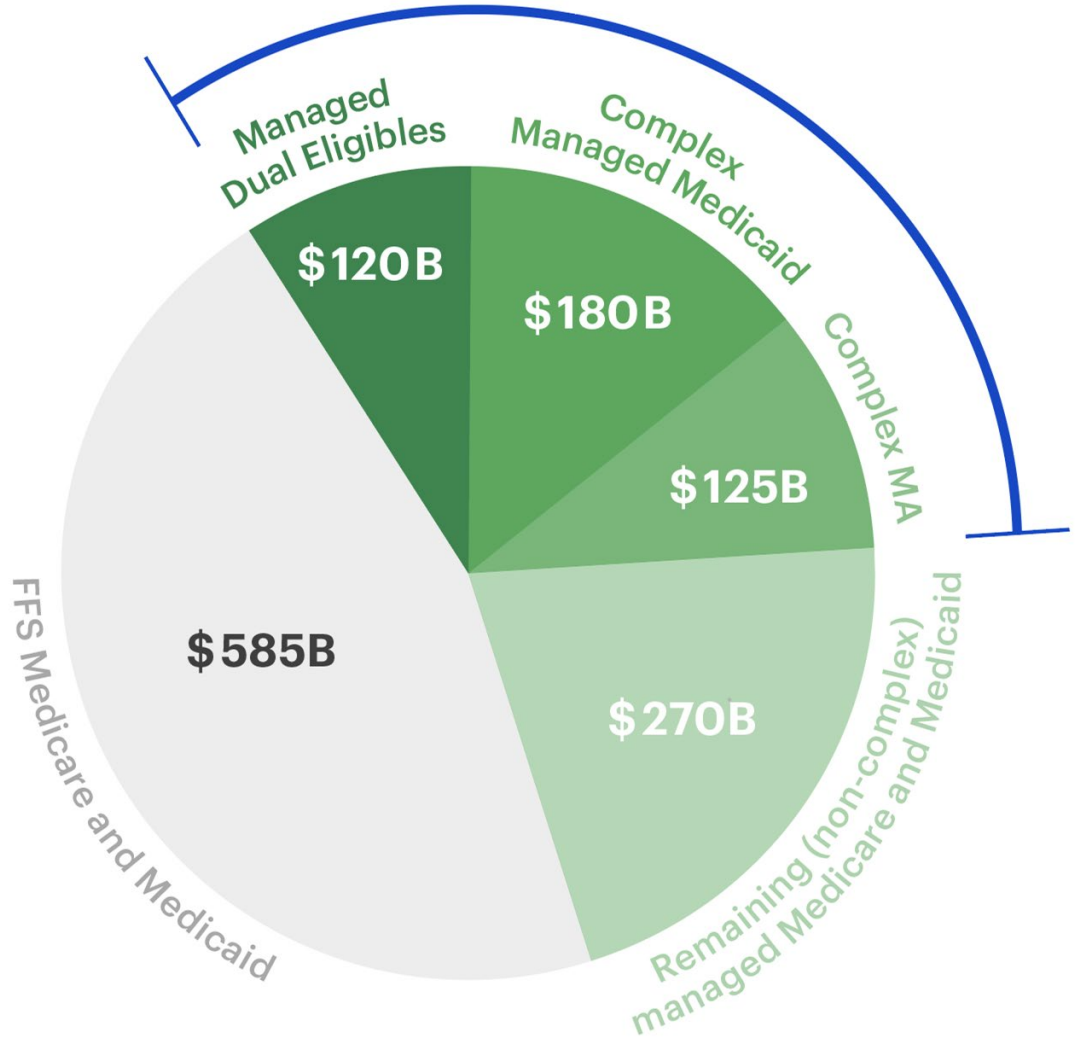
* compared to a 12 month baseline before Cityblock

** standard health plan definition of engagement -- percent of members who are interested in or consented to Cityblock

There are millions of those like Sonia who need better care.

Massive annual spending in Medicaid and Dual Eligibles, with further growth expected to managed care.

The public payer market *(Medicaid, Duals, Medicare)* is a **$1.2T+** market, with **$700B** under managed third-party care.



CITYBLOCK

Thank you.

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Collaboration for a Value & Science-Driven Health System

Innovation Spotlight

Moderator: Sarah Szanton
Johns Hopkins University

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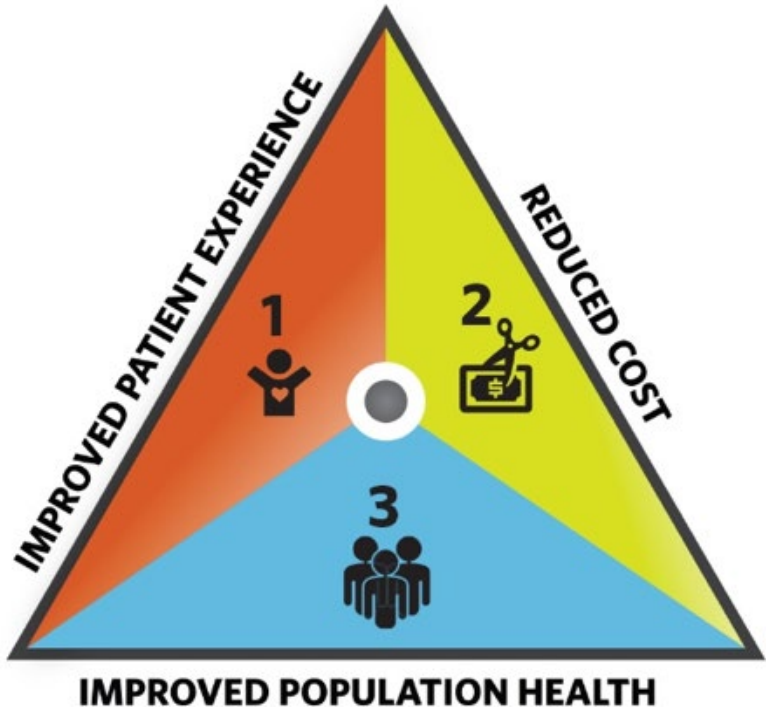
Fasih Hameed, MD
Associate Medical Director Wellness
Petaluma Health Center

Towards Good Health

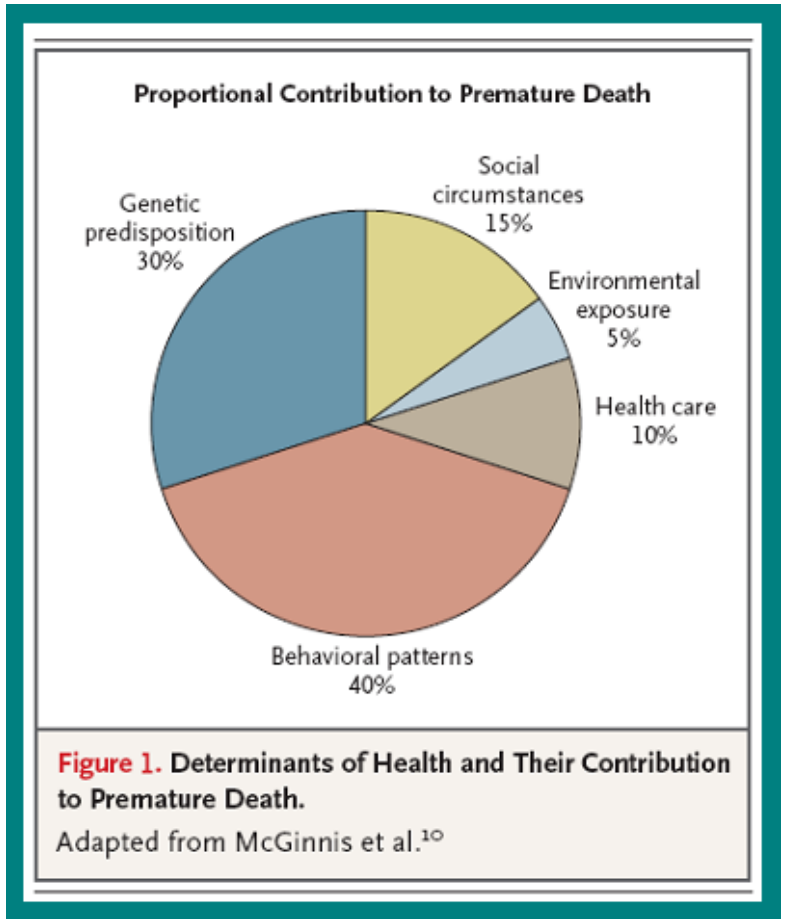
- Northern California, rural to sub-urban, FQHC
- 4+ main clinical sites
- 35,478 unique persons served in 2020
- 31.5% are best served in a language other than English
- 45% medicaid, 25% uninsured,10% Medicare, 20% private.

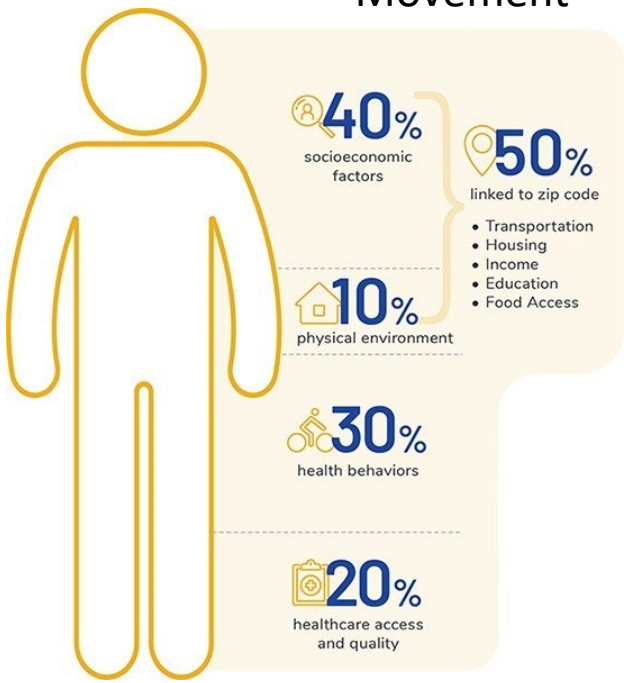
- What is *Good* Medicine?
- Partial-Patient Care Vs. Whole-Person Care

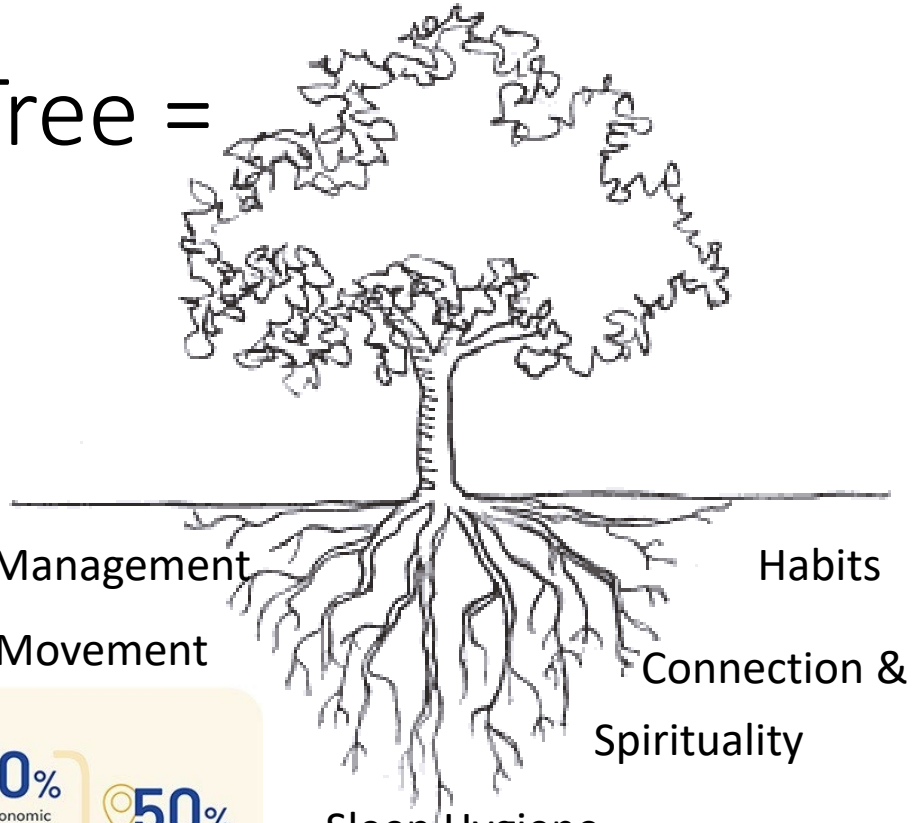
Triple Aim + Therapeutic Order +



DOH + SDOH + Lifestyle Tree =







Stress Management

Habits

Movement

Connection & Relationships

Spirituality

Sleep Hygiene

Food

ex. Whole-Person Good Medicine Pyramid

Petaluma Health Center, Person-Centered by Design

- Patient Advisory Counsels
- Early adopter of PRAPARE SDOH needs assessment
- Early adopter of ACE-IQ and Trauma informed Care
- Wellness is embedded throughout organization
- Patient-Centered Medical Home
- Team-Based Care, physical structure and leverage of technology engenders collaboration to help the patient in real time.
- Active Population & Care Gaps Management, Huddles, Recalls

Food & Nutrition Security

- Nutritionists *
- Certified Diabetic Educators
- Community partners: Ceres, Petaluma Bounty, Center for Wellbeing
- Redwood Empire Food Bank drop site
- Seasonal Farmacy – ebt, sliding scale
- 4000sf Garden on-site, paid garden intern plus volunteers
- Demo kitchen

HOUSING, Transportation, Access to Medical Care

- Lyft codes, Bus tokens, taxi vouchers
- RN Case managers * & Patient navigators
- Shelter clinic *
- Homeless lead clinician
- CEC –certified enrollment counselors
- Free tax preparation assistance
- School Based Health Centers *

Violence, Racism, Loneliness, Trauma

- DEI work
- Trauma-informed Care, ACE's, healing space *
- **Integrated Behavioral Health**
- Shared Medical Visits/Groups *
- **Recovery Services, MAT**
- **Acupuncture**
- **Chiropractic**
- **Osteopathy**
- **Integrative Medicine Consults**

Stress Reduction, Movement

- Free Exercise classes: Yoga, Zumba, Chi Gong, Mindful Movement
- Fall Prevention for Seniors *
- Mental Health groups
- Community Garden
- La Loteria – Social Time

COVID reflections, plus GRATITUDE

- COVID impact, disparities, primary care in vulnerable communities
- Groups/SMVs, need for billing evolution
- FQHC eccentricities
- Tele-Health *Is* amazing
- Capitated/APM for innovative sites vs. PPS billing?
  - Non billable services essential for whole person care
  - Is fee for service still the best model?
- Flexible visit types + Leveraging Technology = happy & healthy people
- Provider Burnout, Compassion training, support
- THANK YOU!

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Collaboration for a Value & Science-Driven Health System

Innovative Federal and State Models for Financing Whole Person/Population Health

Moderator: Joshua Sharfstein

Johns Hopkins University

NATIONAL ACADEMY OF MEDICINE

Donna Kinzer, BS
Principal
DK Health Care Consulting

Ena Backus, MPP
Director of Health Care
Reform State of Vermont

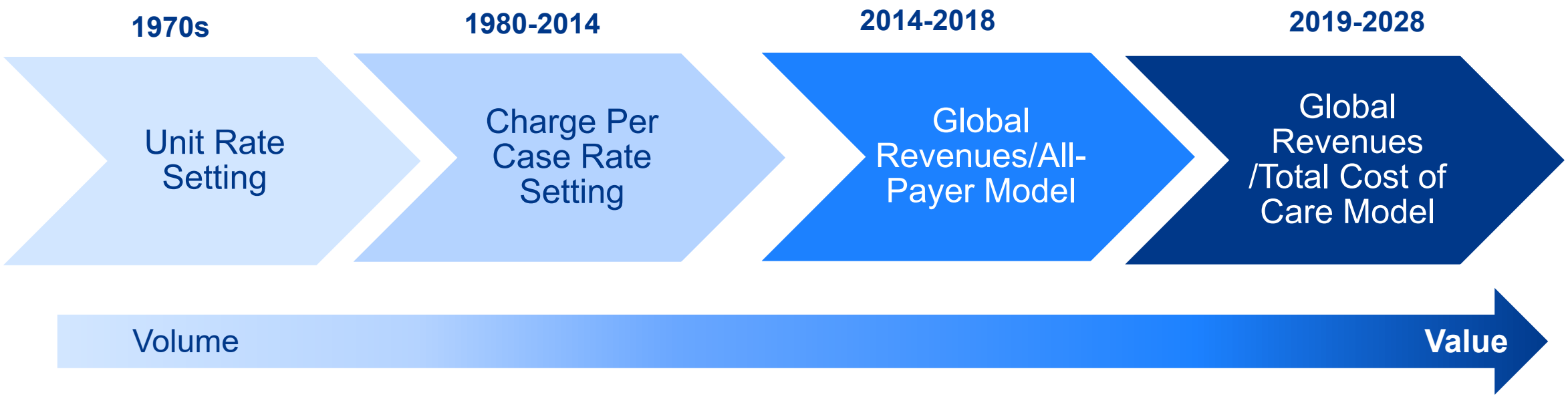
Cindy Mann, JD
Partner
Manatt Health

Financing that Rewards Better Health & Well-Being

Maryland's All-Payer/Total Cost Model

May 28, 2021

Maryland's Unique Hospital Payment Model



Maryland has an independent commission to set all-payer hospital rates. For many years, these were fee-for-service rates. In 2014, Maryland shifted to paying hospitals through global revenues.

Under global revenues, the total amount of revenue to be earned through inpatient and outpatient charges at hospital facilities is preset. This new system incentivizes reducing preventable admissions and controlling the total cost of care, as well as improving outcomes.

Current Components of the Maryland Model

Hospital Global Revenues (All Payers)

Presets total hospital revenues, value-based risk/reward for Medicare TCOC* performance and all-payer quality and outcomes

Care Redesign Programs (Medicare, some other payers)

Fosters transformation across the system

Incentives for hospitals to work with others

Programs for non-hospital providers

Maryland Primary Care Program (Medicare, some other payers)

Enhances chronic care and health management for Medicare enrollees

Incentives tied to population health goals and other performance

All-Payer Population Health

Requires statewide improvement in outcomes and population health

Targets for diabetes, opioid addiction, and maternal and child health

CRISP—Maryland's Robust Health Information Exchange

*TCOC = Total Cost of Care

Outcome and Population Health Components- Statewide Goals Across Three Domains

Domain	Goals/Key Targets
Improve Hospital Outcomes	❑ Reduce avoidable hospital admissions (PQIs reduction targets) ❑ Reduce readmission rates by reducing within-hospital disparities (Disparity reduction targets)
Increase Transformation Process Across the Continuum	❑ Increase beneficiaries under care transformation programs/value-based payments across the continuum (Participation targets) ❑ Improve care coordination for patients with chronic conditions (Post-discharge follow up targets)
Population Health Improvements	❑ Reduce Diabetes: BMI reduction targets for the adult population ❑ Reduce Opioid Use: Overdose mortality reduction targets ❑ Improve Maternal and Child health: Targets ▪ Reduce severe maternal morbidity ▪ Decrease asthma related emergency room use for children

Core components and goals of Vermont's All-Payer ACO Model

A statewide move away from fee-for-service to value-based payment, to moderate growth in health care costs, to improve quality and experience of care, and to improve population health.

Include majority of residents by model end (PY5/2022)

•Limit per capita health care growth to align better with State economic growth

Improve population health outcomes:

1. Increase access to primary care
2. Decrease deaths due to drug overdose and suicide
3. Reduce prevalence and morbidity of chronic disease

Align Significant Payer Programs for ACOs in Value-Based Payment and Care Model

- Medicare
- Medicaid
- Commercial Payers

Build on Advanced Primary Care and Integrated Care Model Foundation

- Patient-Centered Medical Homes
- Community Health Teams
- Care Coordination Model to Integrate Health and Community Services

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Collaboration for a Value & Science-Driven Health System

Innovative Private Models for Financing Whole Person/Population Health

Moderator: Margaret Chesney

University of California San Francisco

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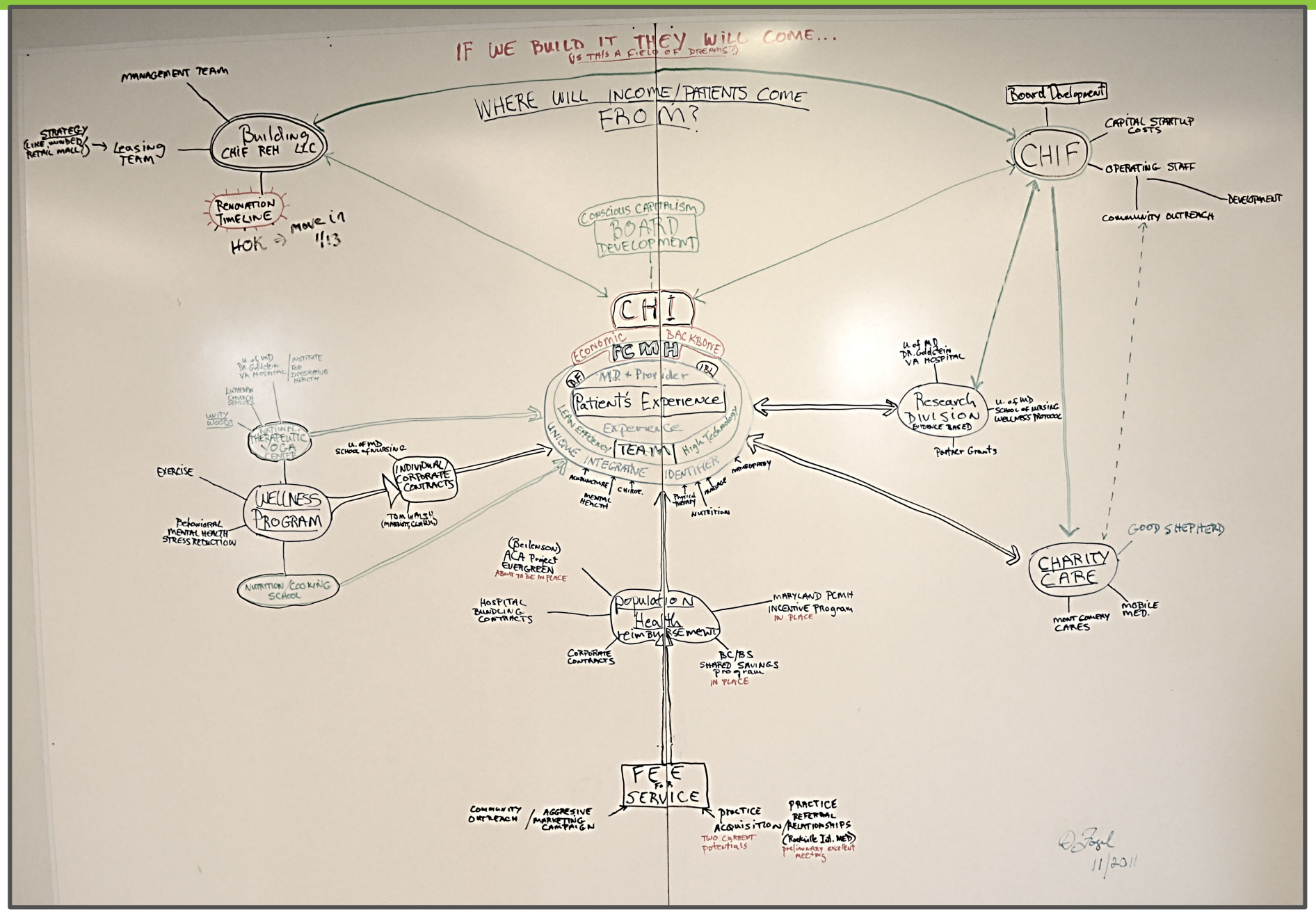
David Fogel, MD
Chief Executive Offer & Co-Founder
Collaborative Holistic Integrative (CHI)
Health Care

Cheryl Pegus, MD, MPH
Executive Vice President Health
& Wellness
Walmart

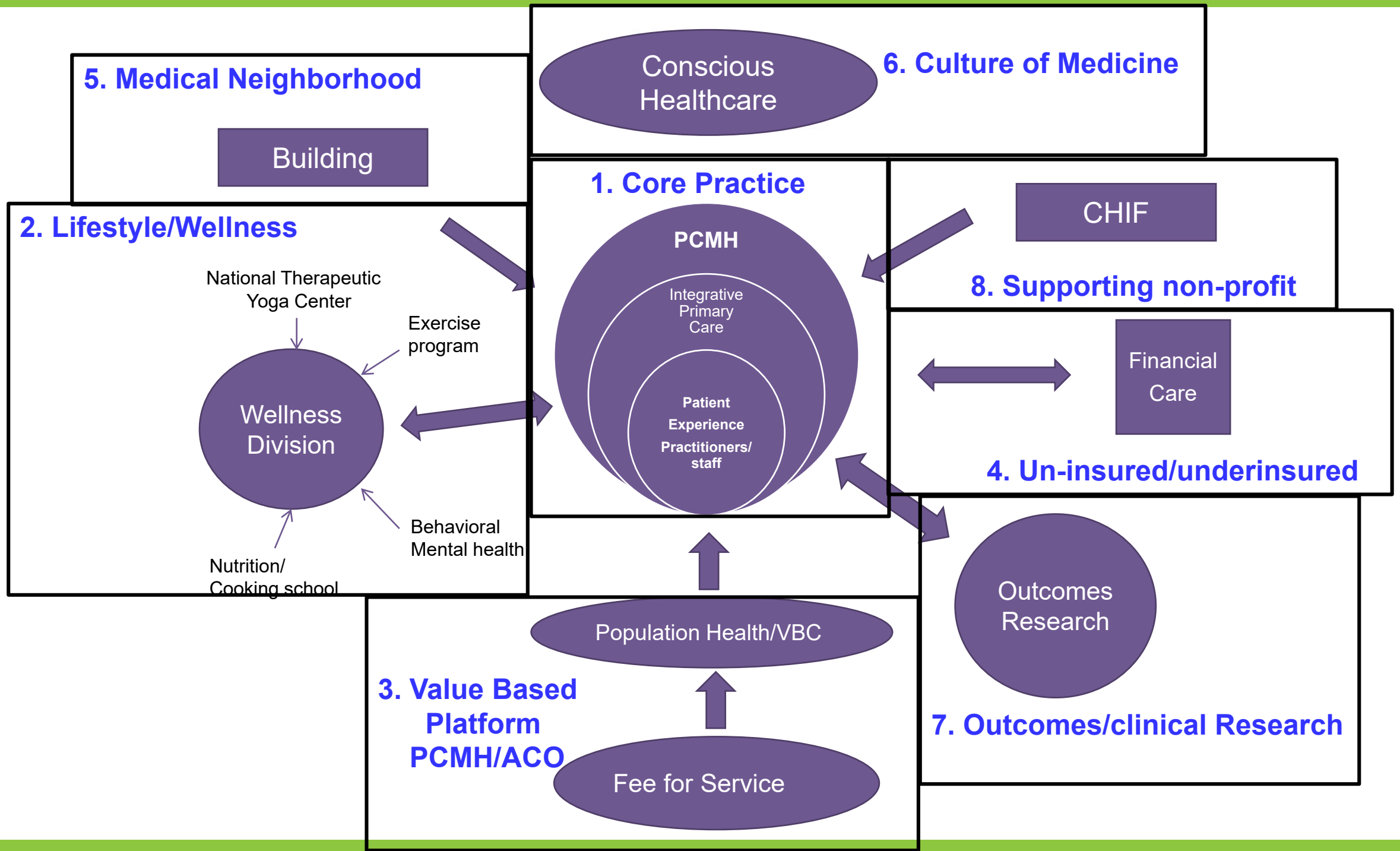
Dexter Shurney, MD, MBA, MPH
Chief Medical Officer and Senior
Vice President
Community Well-Being and the
Blue Zones Institute
Adventist Health

IN 2011, funded by a **$30 million** grant,
CHI Health Care, created an independent, freestanding,
non-profit, community health center by combining:

Integrative Health Staff Model
+
Primary Care PCMH
+
“High Octane” Inter-disciplinary Team Based Collaboration
+
Population Health/Value Based Care Payment Platform

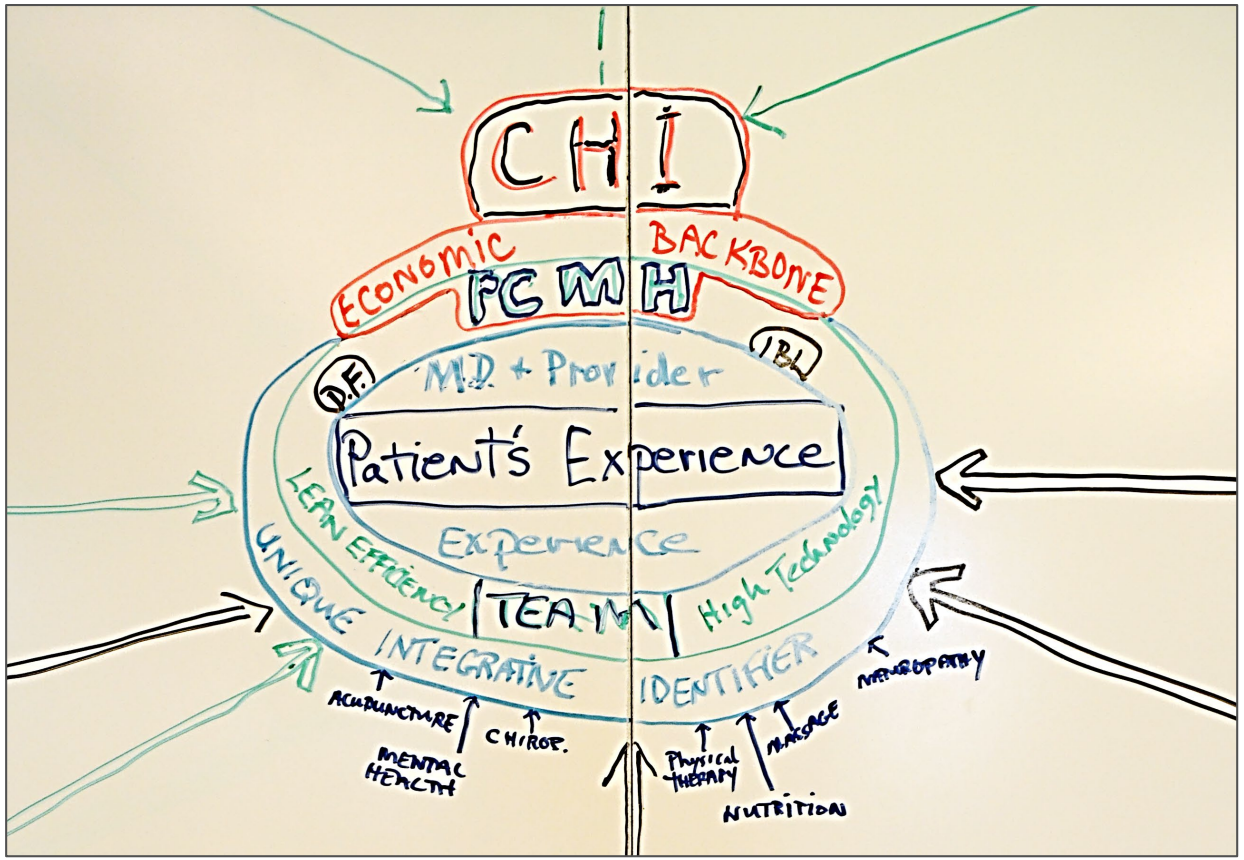


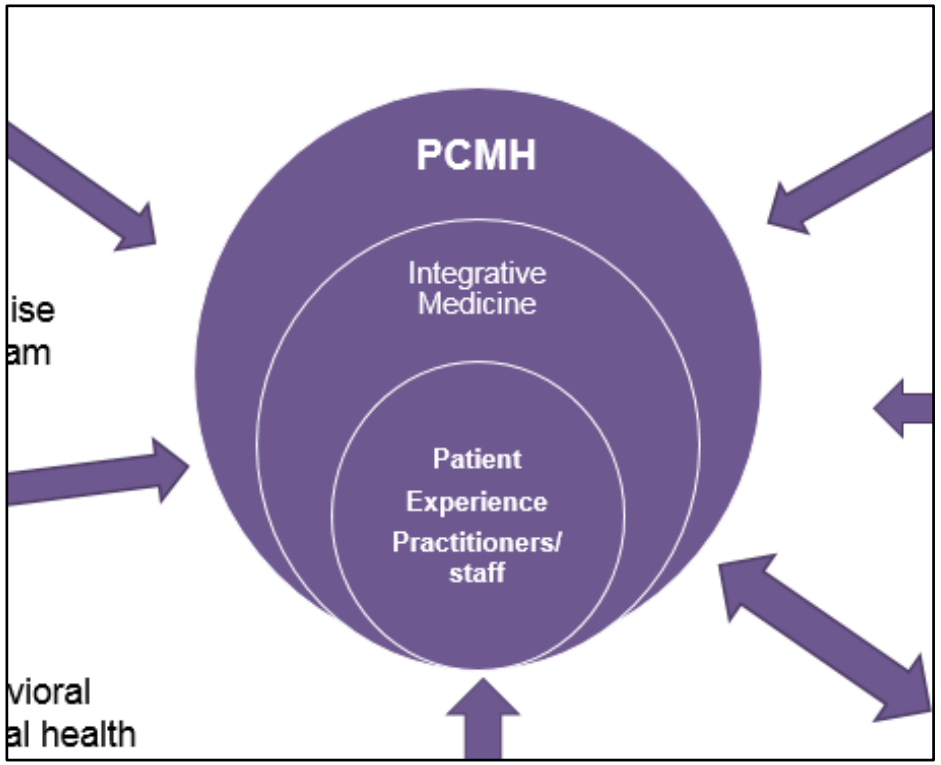
Original Concept Drawing of Business Structure (4'x8' white board nailed to wall)


5. Medical Neighborhood
Building
Conscious Healthcare
6. Culture of Medicine
1. Core Practice
PCMH
Integrative Primary Care
Patient Experience Practitioners/ staff
CHIF
8. Supporting non-profit
2. Lifestyle/Wellness
National Therapeutic Yoga Center
Exercise program
Wellness Division
Behavioral Mental health
Nutrition/ Cooking school
Financial Care
4. Un-insured/underinsured
Outcomes Research
7. Outcomes/clinical Research
Population Health/VBC
3. Value Based Platform PCMH/ACO
Fee for Service

Core Practice:

Integrative Primary Care
Patient Centered Medical Home (PCMH)



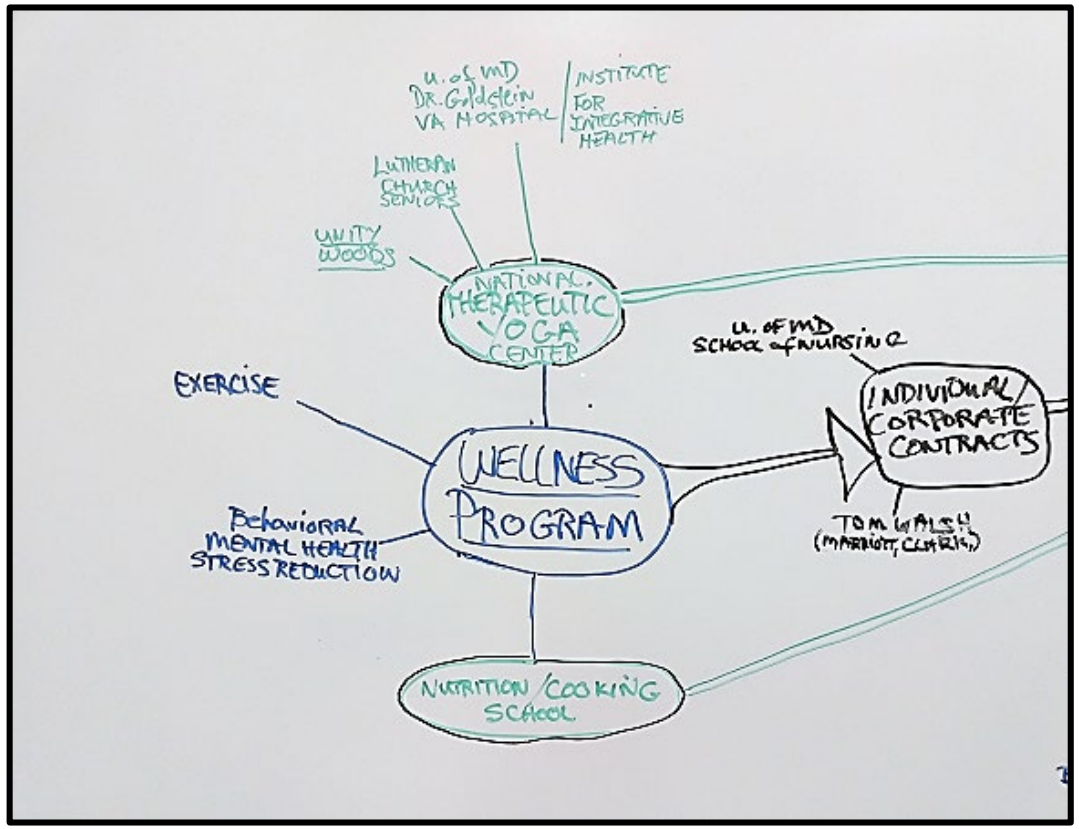


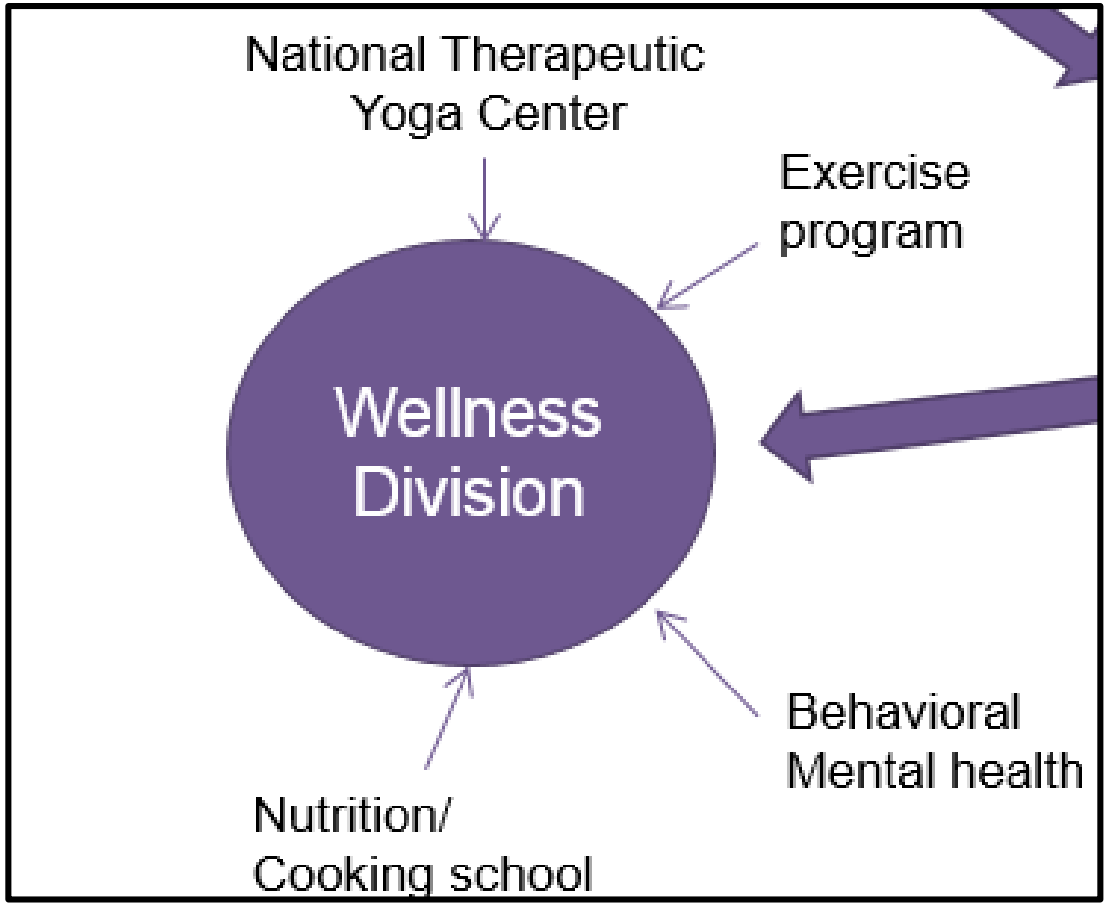
In an Integrative PCMH the team consists of:

- Front Desk (2)
- Nurse Coordinator (1)
- Medical Assistants (5)
- Population Health coord(1)
- Practice Manager (1)
- Billing Manager (1)

- Family Physicians (5)
- Doctor of Chiropractic (2)
- Nurse Practitioner (1)
- Acupuncturist (2)
- Health Psychologist (2)
- Naturopathic Doctor (1)
- Nutrition/Registered Diet. (1)
- Massage Therapist (1)
- Energy Medicine (1)
- Yoga Therapist (1)
- Health Coach (1)

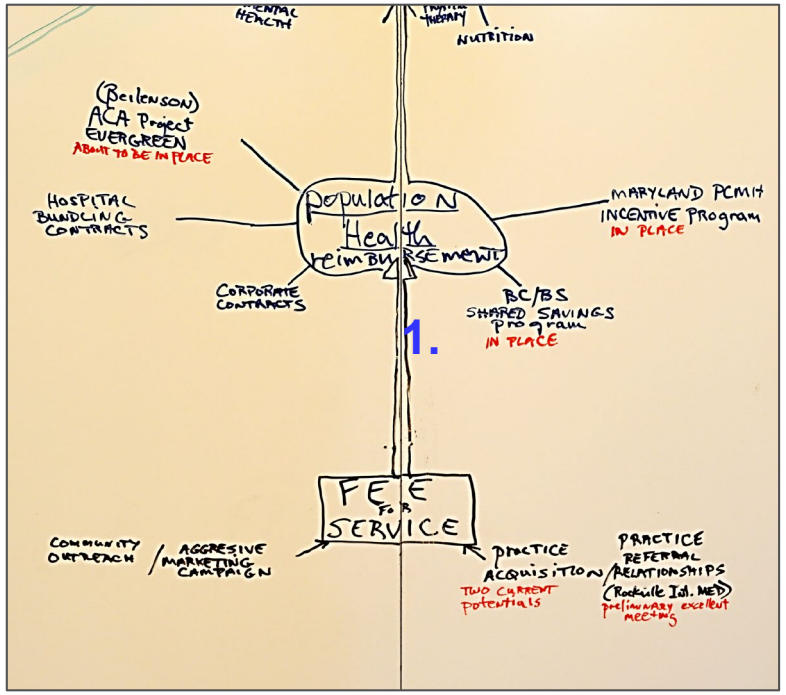
Lifestyle/Wellness

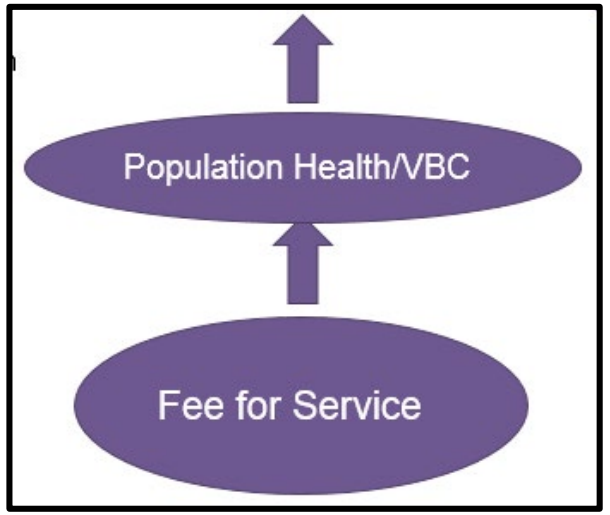




Value Based Platform

Population Health
+
Value Based Care





CHI prioritized participation in both PCMH and ACO programs as building blocks to Value Based Care (VBC) and Population Health Management (PHM)

Collaboration is not intuitive and needs to be highly operationalized

Formal

Informal

Group case presentations
Speed Dating
Experiential learning
Inter-practitioner in-service education
Electronic Health Record

PCMH SearchLight

Patient-Centered Medical Home

PCMH Data
January - December 2016

X. Ranking of Overall Performance

PCMH SearchLight Report for Panel MP06150356

F. Year Over Year Measures That Matter - Key Metrics and Comparisons

In our 4th year, we were outperforming our conventional primary care peers

		Panel					Provider Type Peers	Panel % Change		
	Metrics	2013	2014	2015	3 Year Weighted	2016	2016	2013-2014	2014-2015	2015-2016
1.	Medical Member Months			3,346		10,883	29,177			225.3%
2.	Average Members			669		906	2,495			35.4%
3.	Average IB Score			1.42		1.44	1.40			1.4%
4.	Total PMPM			$470.42		$428.37	$462.20			-8.9%
5.	Medical PMPM			$405.57		$375.14	$390.12			-7.5%
6.	IB Adjusted PMPM (Medical)			$284.81		$259.79	$279.30			-8.8%
7.	Pharmacy PMPM			$64.84		$53.23	$72.08			-17.9%
8.	Pharmacy PMPM w Rx Benefit			$120.80		$105.54	$137.48			-18.2%
9.	Inpatient Admissions per 1,000			61.8		55.1	69.0			-14.6%
10.	ALOS			3.8		6.8	4.8			76.9%
11.	Inpatient Days per 1,000			247.5		373.8	337.1			51.1%
12.	Cost per Admission			$12,896		$16,032	$16,380			24.3%
13.	Admission PMPM			$69.37		$73.66	$95.50			6.2%
14.	30 Day Readmission Rate			8.8%		10.0%	12.5%			NA
15.	Cost per 30 Day Readmission			$0		$11,475	$11,912			NA
16.	ER Visits per 1,000			190.1		180.8	213.4			-4.9%

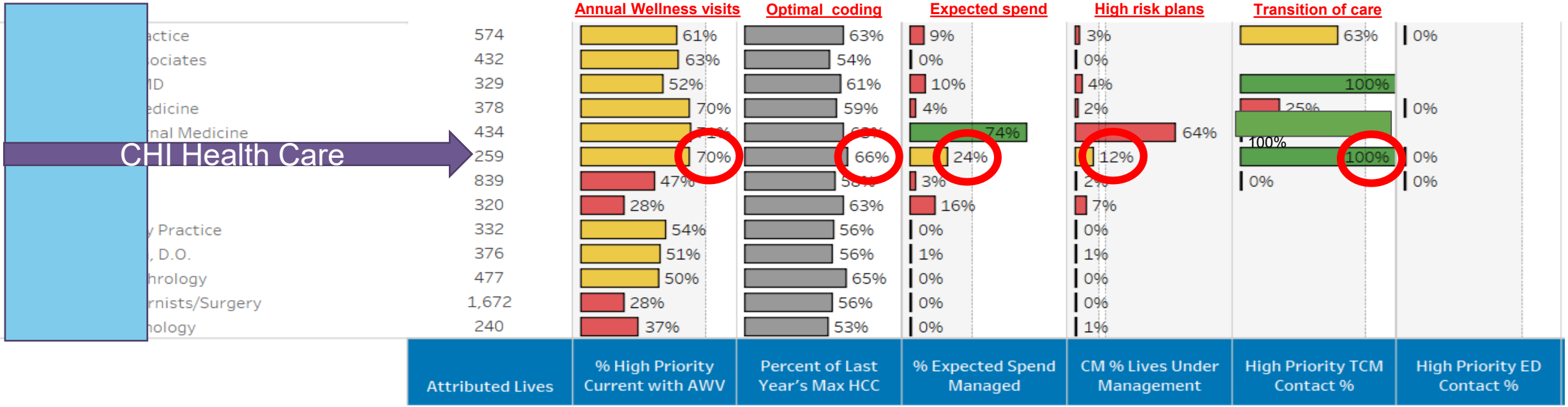
2018 Snapshot- Practice Detail

As of May 7, 2018

Population	YTD Performance Year	Exclude Hidden Pati..	ACO	Practice / Site
MSSP Attributed	2018	Yes	Primary Care ACO (MD, NY)	Multiple values

EWEP Key Practice Process Performance Indicators

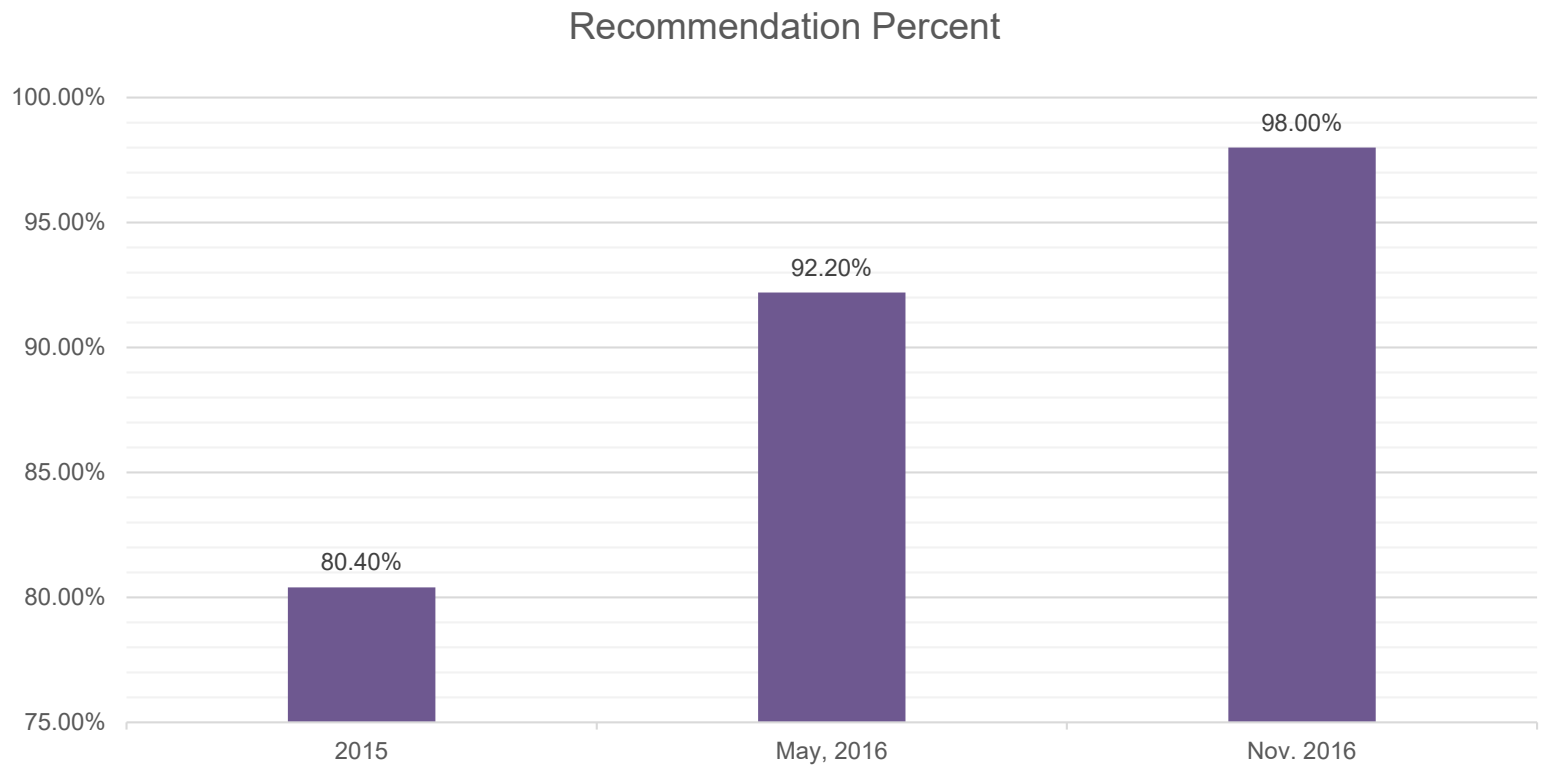
Current snapshot metrics on key Aledade initiatives. Data last updated 5/7/2018 5:02:25 AM (GMT -5).



2018 year end benchmarks	>80% by 12/31/18	>100% by 12/31/18	the lower the better	>50% by 12/31/18	100% by 12/31/18

Focus on care coordination, care plans, and optimal illness coding

Would you recommend CHI Health Care to your family and friends?



CHI HEALTH CARE

$30 Million Was Not Enough

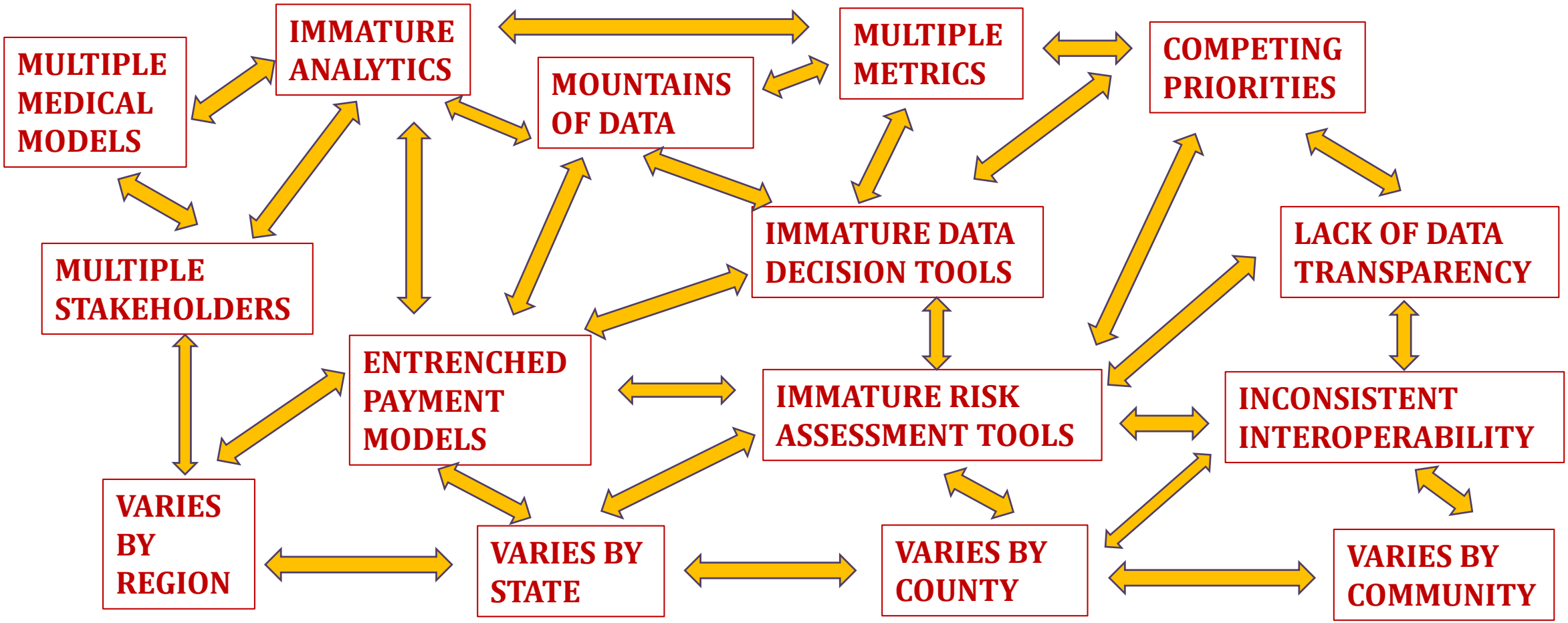
Why Not?

CHI Health Care created the Value in Value Based Care?

…but Value turns out to be only one gear in a highly complex system of gears that we call healthcare

CHI HEALTH CARE

HIGH COMPLEXITY HEALTH NETWORK WITH NO CENTRAL DECISION-MAKING BODY



I've spent many years beating my head against the wall…

…playing whack a mole trying to fix each malfunctioning gear

My head got very sore and I discovered there may be a better, or at least parallel approach

We Need to Focus on the System, Not Each Gear

- Randomly organized, highly complex systems like U.S. healthcare evolve organically and are always in evolution.
- There is a science behind how the relationships between a complex **system's** parts (i.e.the gears) give rise to its collective behavior.
- The question is, can we intentionally influence how a complex system like the U.S. healthcare system, evolves?
- I believe the answer is yes.

- This explicit kind of systems change…

"never happens as a result of top-down, preconceived strategic plans, or from the mandate of any single individual or boss. Change begins as local actions spring up simultaneously in many different areas." ***Margaret Wheatley and Deborah Frieze***

Lifecycle of Emergence: Using Emergence to Take Social Innovation to Scale

- If these changes remain disconnected, nothing happens beyond each locale.

- However, when they become connected, the system begins to move in a direction aligned with shared goals and the collective consciousness of the whole.


SORRY FOR
THE INCONVENIENCE
WE ARE TRYING
TO CHANGE THE WORLD
JVC
Perfect Exp
from JVC
STARBUCKS
COFFEE
NOVOTEL

Employer Supported Innovative Health Models

Cheryl Pegus, MD, MPH
EVP H&W Walmart

Caring for our associates

During COVID-19

- COVID leave policies Enhanced cleaning procedures
- FAQs
- Daily screening process
- Access to free PPE
- Sneeze guards
- Social distancing markers
- One-way aisles
- Free COVID-19 testing
- Time off + incentive for vaccines

Outside of COVID-19

- Walmart Cares
  - Thrive
  - Counseling
  - Weight loss/healthy eating
  - Smoking cessation
- Education/Training
  - Live Better U
  - Academies
  - Teaming
- Leading by example
  - Road shows
  - Normalizing feelings
  - Variety of leaders

Addressing health inequity through vaccines work

We are scaling as eligibility for vaccines widens and partnering with multiple stakeholders while maintaining our focus on community engagement.

Humana CENTENE Corporation BlueCross BlueShield

Get Out The Vaccine

Payors

- Partnering on events for members in underserved communities
- Humana, Centene, UNH, BCBS AR, Cambia

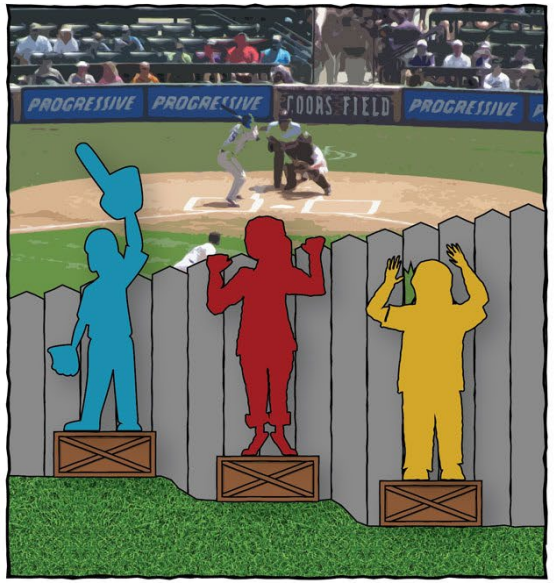
Employer program

- We intake requests from employers and provide account management
  - Education; FAQs; Updates as CDC guidelines change
  - Coordinating onsite events/pharmacy hours for their employees
  - Reporting of Total # of employees receiving vaccine

Expanding Community engagement

- In addition to continuing community events, we will expand our focus on vaccine education and combating hesitancy
  - This will be executed through a national "**Get Out The Vote"-style national education** campaign and community-targeted outreach

Healthcare occurs outside of clinician's offices & has effects on health outcomes



EQUALITY

EQUITY

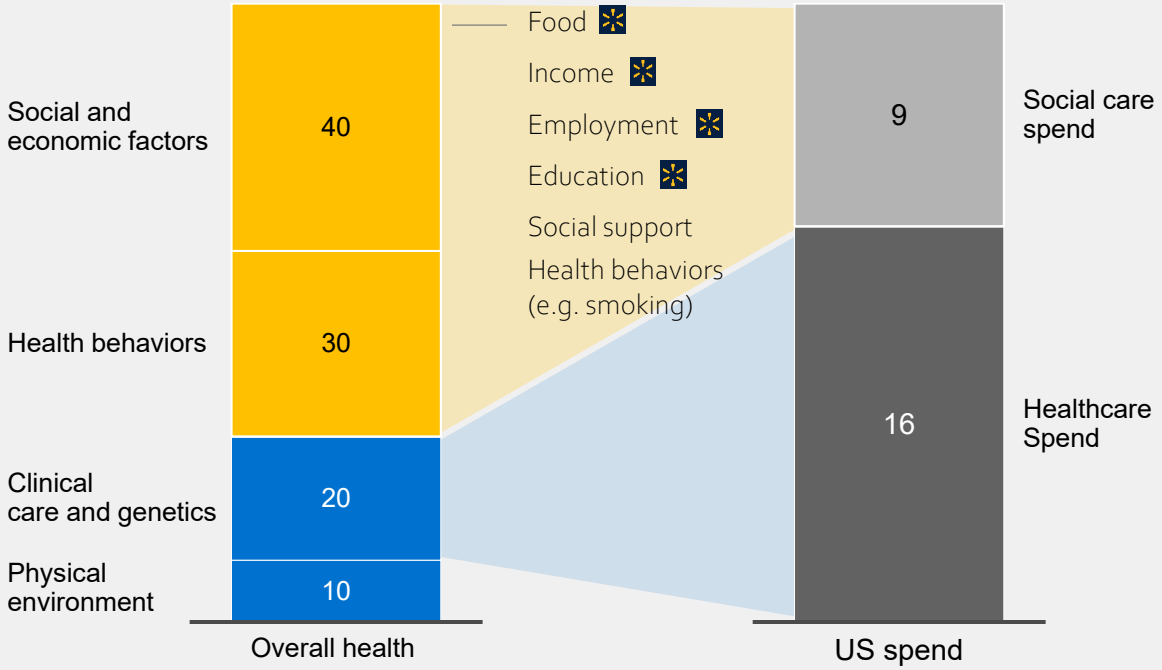
Healthcare Commitment

1. Make Equity a Strategic Priority
2. Build infrastructure to support Health Equity
3. Address the multiple Determinants of Health
4. Partner with community to improve Health Equity

SDoH drive 70% of health outcomes, and addressing SDoH lowers cost & improves outcomes – focus on Whole Health

Walmart SVNs

Contributing effect of SDOH status[1], %

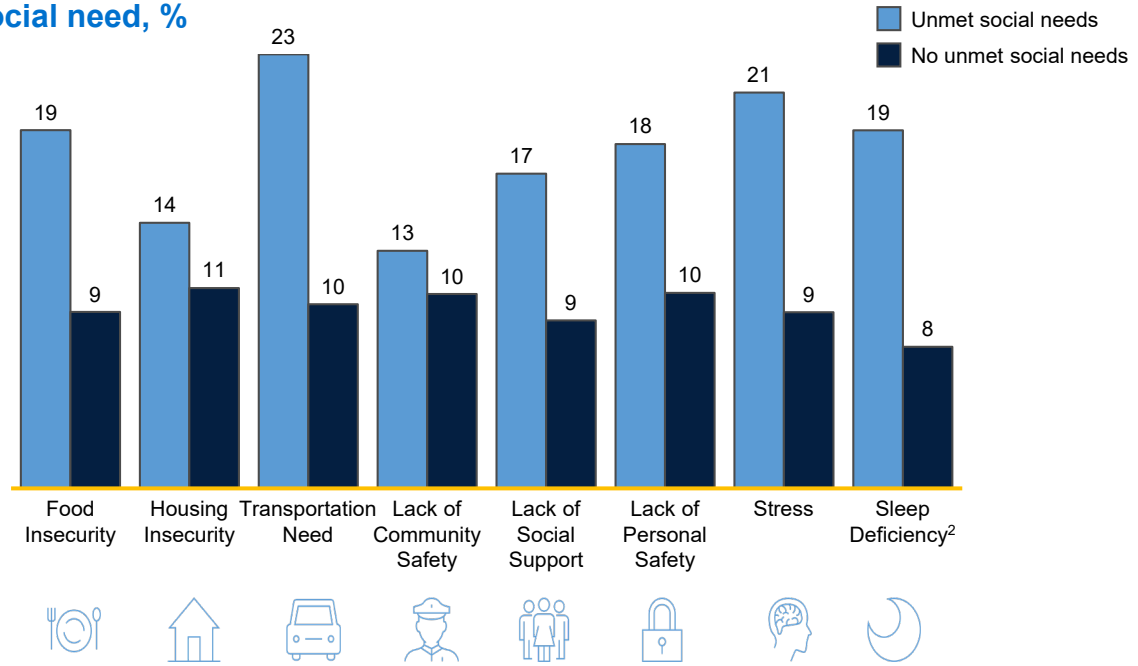


US health and social care spending, % GDP

70% of health outcomes are based on underlying social factors or influenceable behaviors, but social care spend remains disproportionally low

Addressing SDoH is important to delivering best in class care and reduces high acuity, high cost care

Percentage of respondents who went to the ER 1+ times based on unmet social need, %



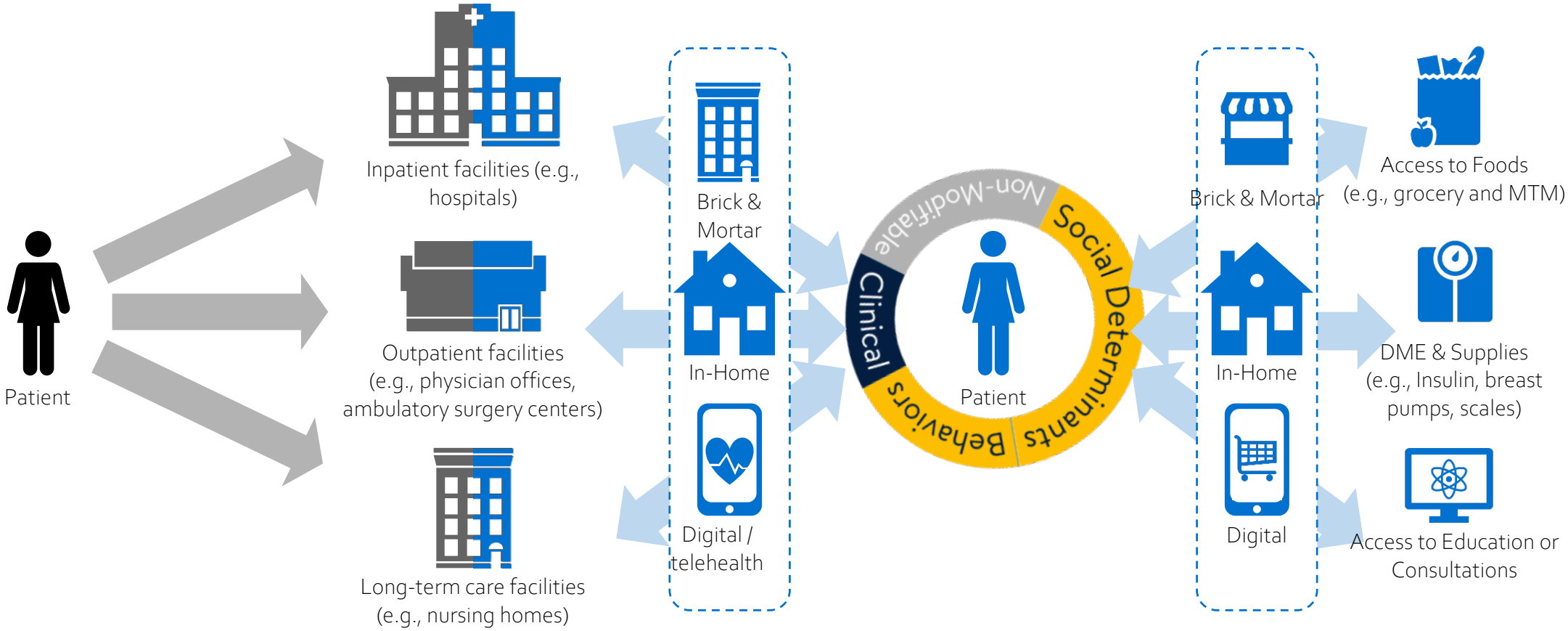
Respondents with high social needs, stress, or sleep deficiency were more likely to report visiting the ER in the past 12 months

1. County health rankings, McKinsey Consumer Health Insights Survey, McKinsey COVID-19 Consumer Survey, 04/27/2020, Bradley, E., et al (2016). Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, and healthcare, 2000-09, Health Affairs 35(5), 760-768.
2. High sleep deficiency defined as having below average hours of sleep a night and feeling tired; low sleep deficiency defined as having above average hours of sleep a night and feeling well-rested

Omnichannel healthcare meets the patient where they are: in-person, via virtual care, and in-home

Traditional Healthcare
Patients always **travel to brick-and-mortar facilities** to access the clinical care they need

Omnichannel Healthcare Future
Care is brought to patients in the most effective setting, be it brick-and-mortar, virtually, or in the patient's home AND addresses all determinants of outcomes



Concluding Remarks

Thank you for joining!
We hope to see you on Day 3

Day 1: *The Vision* | **May 25, 2021, 2:00—5:30pm ET**
Day 2: *The Levers* | **May 28, 2021, 1:00—4:30pm ET**
Day 3: *The Strategic Action* | **June 2, 2021, 2:00—5:30pm ET**

NAM Leadership Consortium
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For more information about the workshop series or to share opportunities to address and advance this work, please contact:

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