Center for Health Care Strategies
Better care where it's needed most

Texas MCO SDOH Learning Collaborative: Reconnecting in 2022 and Deepening Our Impact

In-Person Meeting

April 1, 2022

10:00 AM – 1:00 PM CDT

Texas Medical Association, Thompson Auditorium

Made possible by Episcopal Health Foundation

Agenda

- *10:00* **Welcome and Introductions**
- *10:30* **Plan Perspectives on Addressing Health Disparities**
- *11:30* **Using Data to Inform Care Delivery**
- *12:00* **MCO/Food Bank Partnerships to Address Food Insecurity**
- *12:15* ***In Lieu of*** **Services**
- *12:30* **Small Group Discussions/Working Lunch**
- *12:50* **Wrap Up**

Housekeeping

- Light breakfast items can be found outside
- Water bottles can be found at the back of the room
- Lunch will be provided around 12:30 PM
- There will be no formal restroom breaks – please feel free to get up whenever you need to. Restrooms can be found down the hall to the left
- WiFi: **Thompson-2.4G** or **Thompson 5G**. No password needed.

Welcome & Introductions

Anna Spencer, Senior Program Officer, Center for Health Care Strategies

Center for Health Care Strategies

Opening Remarks

Elena Marks, President and CEO, Episcopal Health Foundation

Kay Ghahremani, President and CEO, Texas Association of Community Health Plans

Jimmy Blanton, Director, Office of Value-Based Initiaitves, Health and Human Services Commission

Aelia Khan Akhtar, Director, Center for Health Policy and Performance, Department of State Health Services

Center for Health Care Strategies

Plan Perspectives on Addressing Health Disparities

Angie Hochhalter, Director of Community and Population Health, Aetna Better Health

Lisa Wright, CEO, Community Health Choice

Salil Deshpande, Chief Medical Officer, UnitedHealthcare

Arnita Burton, Associate Director, Clinical Innovations, Analytics & SDOH, UnitedHealthcare

Center for Health Care Strategies

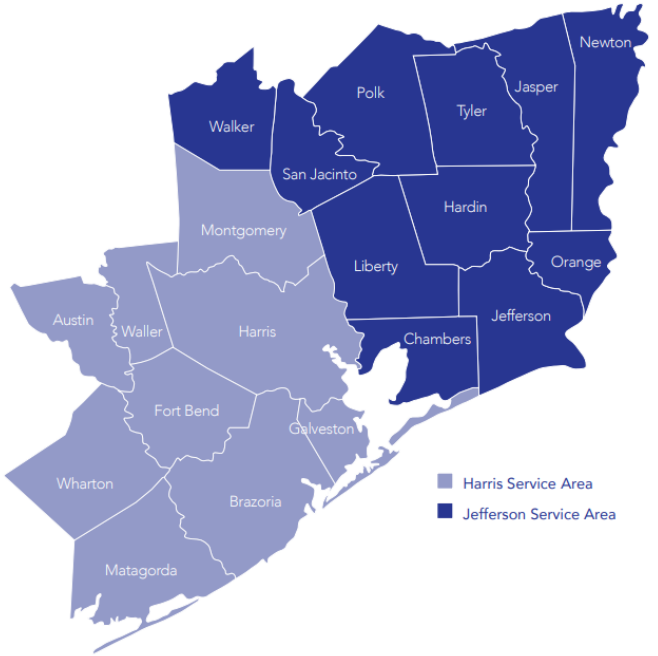
COMMUNITY HEALTH CHOICE

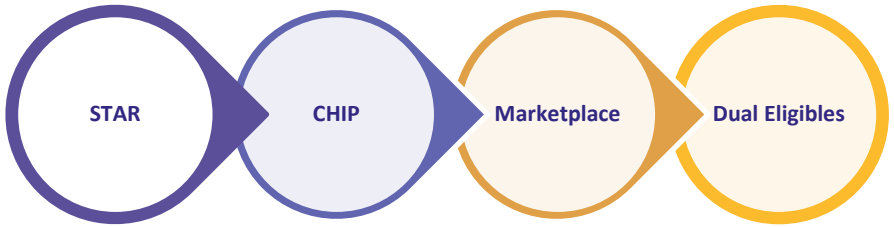
Lisa Wright

COMMUNITY HEALTH CHOICE

Community Health Choice

- A Houston-based, non-profit safety net health plan
- Our mission: Improve the health and well-being of underserved Texans by opening doors to health and health-related social services
- 25-year history of serving low-income populations across SE Texas

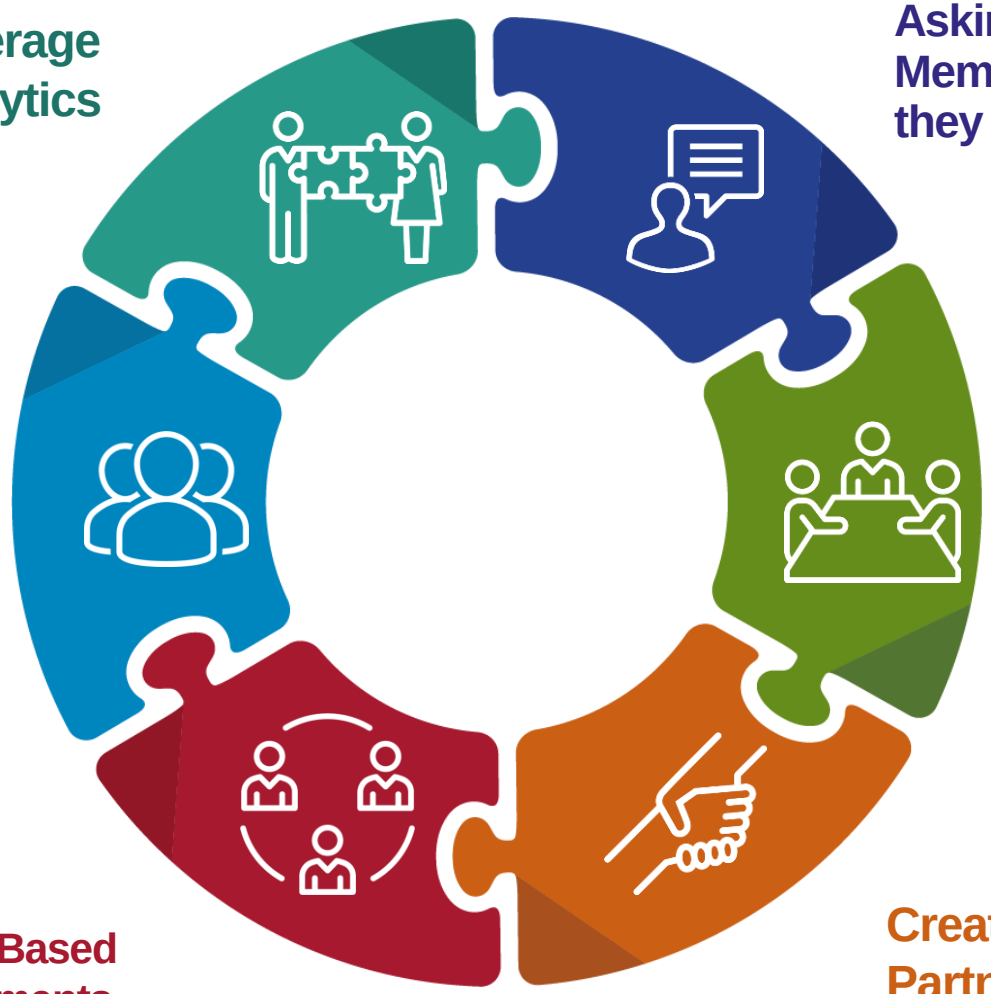




Over 430K Members

Including **370,000** in Medicaid and **over 100,000** in Marketplace (YTD 2022)

How does Community make it happen in Houston?



Leverage Analytics

Asking our Members what they need & want

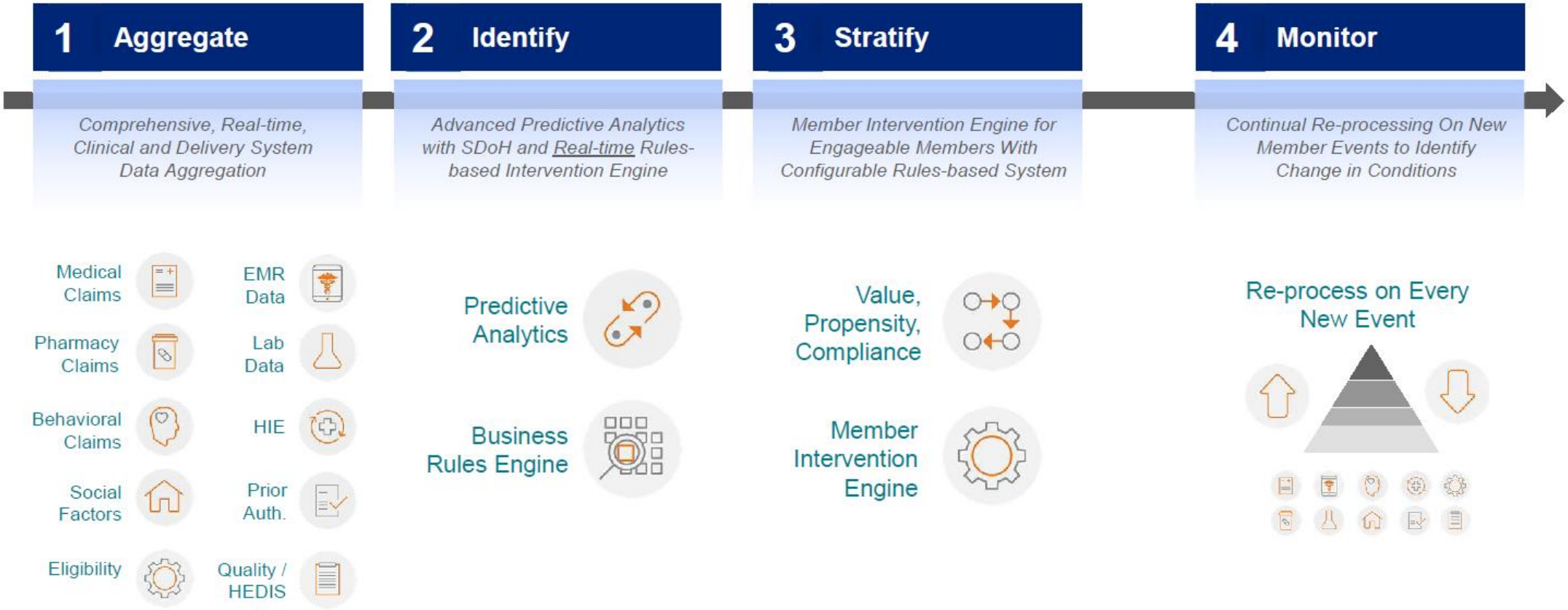
Evaluate

Leadership Buy- In

Value Based Agreements

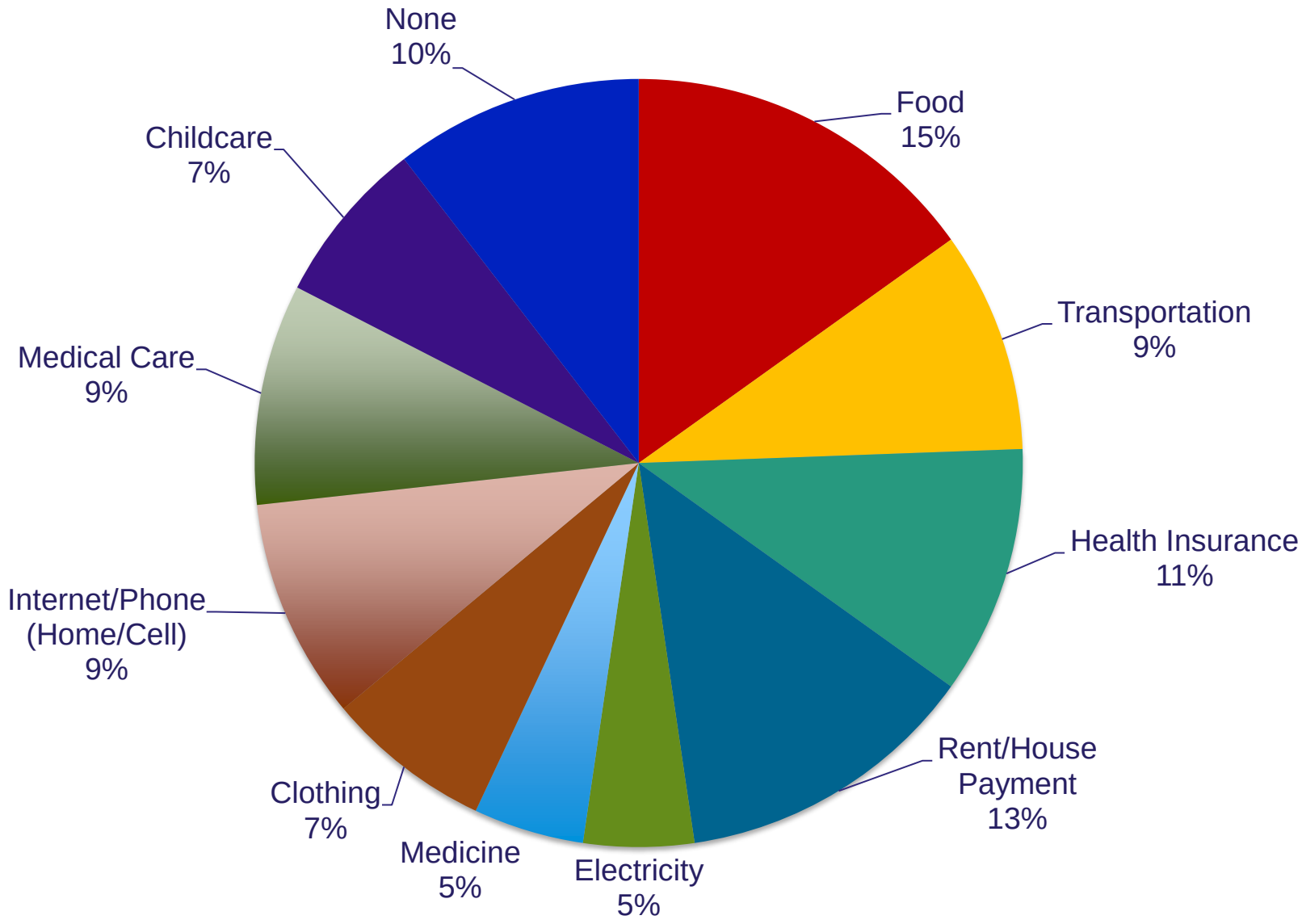
Creative Ideas & Partnerships

Predictive Analytics | *Predictive, Social, Rules-Driven*



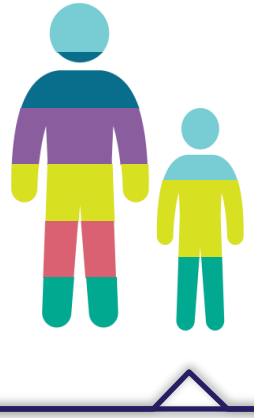
Member Needs

In the past year, have you or your family members you live with been unable to get any of the following when it was really needed?



Providing a Holistic Solution to Health

Community SDOH Programs



Addressing health and well-being means going outside the clinic walls and investing in health-related factors found in one's living and working conditions.

ECONOMIC STABILITY

- CAREERREADY
- WORKTEXAS AT GALLERY FURNITURE
- CAREER KITS

HOUSING & NEIGHBOR-HOODS

- 50/50 PARK PARTNERS WITH CITY OF HOUSTON
- WOMEN'S HOME
- HARRIS HEALTH HEALTH CARE FOR THE HOMELESS

EDUCATION

- HARRIS COUNTY EARLY CHILDHOOD IMPACT FUND
- COLLABORATIVE FOR CHILDREN PRE-K MOBILE PROGRAM
- STUDY LABS

SOCIAL

- VIRTUAL ZOOMBA
- BOOK CLUB
- VIRTUAL COOKING CLASSES

FOOD & NUTRITION

- HOUSTON FOOD BANK FOOD SCHOLARSHIP
- FOOD RX
- COMMUNITY GARDEN

Addressing health disparities through feeding the community

FOODRx

In partnership with the Houston Food Bank

Clients receive Food Rx (food prescriptions) when enrolled by Food For Change (FFC) health partners with the goal of improving their health outcomes

- Health partners identify and enroll eligible patients into Food Rx
- Clients redeem their Food Rx from FFC Markets twice a month
- Each time receiving up to 30 lbs of produce and four additional healthy items

Clients who are food insecure + meet partner's eligibility are enrolled

Clients receive Food Rx card

Clients get nutritious food from FFC Market

Targeted populations are critical to closing care gaps impacted by SDOH

Program Benefits

- Health partners identify and enroll eligible patients into Food Rx
- Clients redeem their Food Rx from FFC Markets twice a month
- Each time receiving up to 30 lbs of produce and four additional healthy items

Target Populations

Community health partners targeted populations must fall into one or more of the categories below:

- Adults with type 2 diabetes, prediabetes, hypertension, and elevated weight and/or BMI
- Children with elevated BMI
- Pregnant women with elevated BMI in the first trimester

Continued program enhancements will impact more communities in the Houston area

- **Performance Improvement Project pilot with Food Rx will reveal other types of chronic conditions among Community's members, which can be addressed through food interventions**
- **Expansion of Food Rx to additional populations with other diagnoses, e.g. dual eligibility members**
- **Build processes for food bank and payor food intervention relationships**
- **Compile evidence of Food Rx on health outcomes**

Building Toward the Future

Create a community information exchange to leverage health information exchange data to coordinate health and social services between providers, community partners, and Community

Expand incorporation of SDOH in value-based contracts to incentivize providers to (1) screen for social risks; (2) partner with social service organizations; and (3) focus on SDOH-associated quality metrics

Utilize predictive analytics to assist efforts in building risk profiles and managing population health initiatives for Community's most vulnerable populations.

THANK YOU

Social Determinants of Health (SDOH) Learning Collaboratives

to leverage Provider Capacity in assessing and addressing Social Determinants of Health

Salil Deshpande, MD, MBA, FACP

Arnita Burton, MBA

United Healthcare

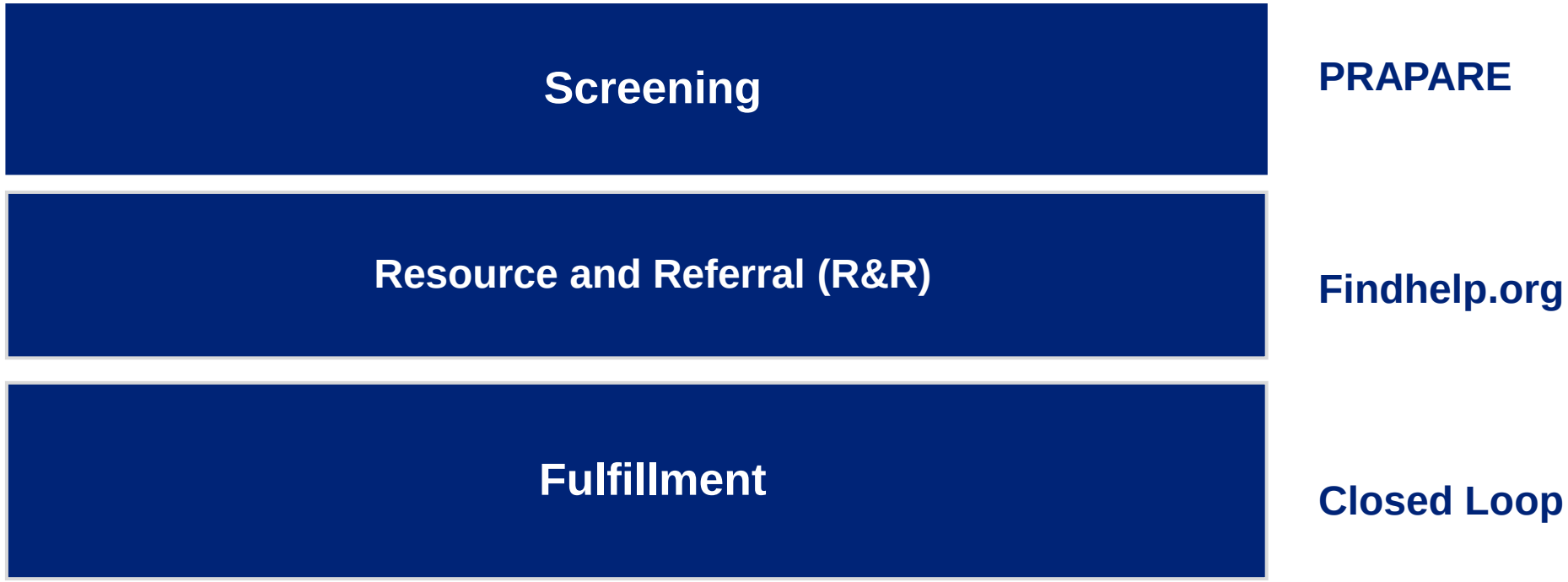
Combined Framework for Addressing SDOH

Health Plan Operational Approach –
Screening, Resource and Referral, Fulfillment

Community-Based Organization Strategy

Provider Alignment & Partnerships

Health Plan Operational Approach



Community-Based Organization Strategy

Goal**: Develop and implement a strategy with CBOs to support **community resource expansion, community partner engagement,** and **community capacity.

Support Navigation Tool

Align with CBO tool of choice to encourage utilization

Value Based Contracting

Assist with a valued resource and confirm that social needs are met

Quantify Value

Quantify work to allow CBOs to socialize work or as a metric to use for grant writing

Identify/Establish CBO Networks

Demonstrates the collective work CBOs do for our members and in the community

Provider Alignment and Partnerships

***Goal**: Develop and implement provider partnerships and health system engagement opportunities focused on the **integration of health equity and SDOH strategies** into the clinical workflow.*

Data Sharing

Share SDOH data through expanded provider screenings with actionable and bidirectional data flow

Value Based Contracting

Drive SDOH collaboration opportunities and deliver better clinical outcomes

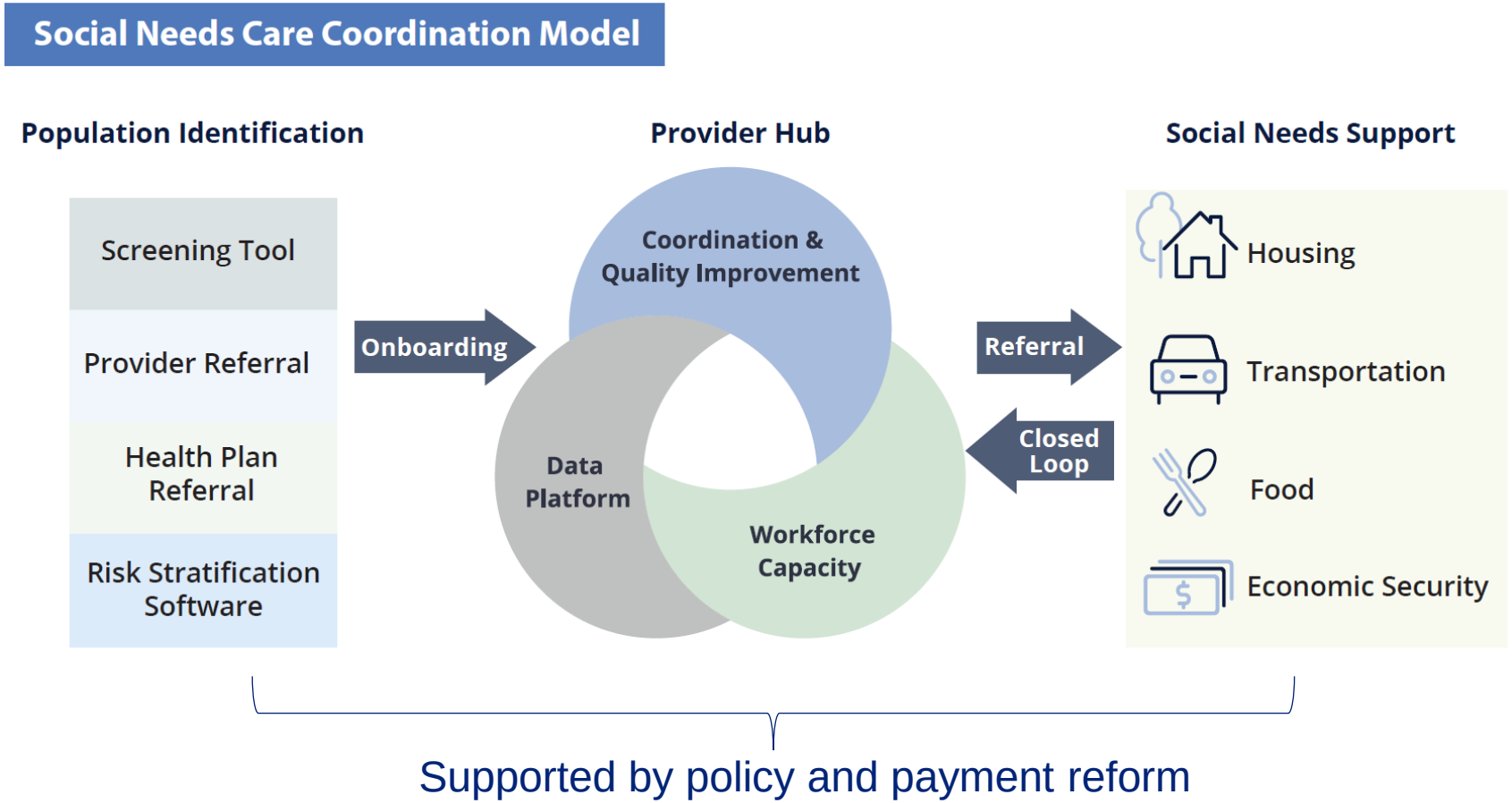
Coding Standardization

Promote the adoption & expansion of ICD-10 SDOH industry standard coding

Health Equity

Implement health equity driven prioritization and outreach strategies using provider screening data

Social Needs Care Coordination Model



Provider Collaborative Sessions Content

Session 1 – Kickoff
- Introductions
- TX SDOH Landscape
- Value Proposition
- Goals Structure and Expectations
- Participant Interests & Needs Poll

Session 2
- Recap
- SDOH Model Presentation
- FQHC SDOH Overview
- Models Among Groups

Session 3
- Social Needs Care Coordination
- Population Identification
- Best Practices

Session 4
- Summary of Discussions
- Example of AZ Pilot
- SDOH Model Presentation
- UHC Sample Data Overview

Session 5
- Cohort Overview
- Workforce Breakout Session
- SDOH Practices Survey

Session 6
- Survey Results
- Diversity in Models
- Buy-in Workshop
- UHC Data Update

Session 7
- Client Populations
- Survey – Learnings
- Partnership Assessment
- UHC Data Update

Session 8
- Data & Digital Solutions
- Survey – Collecting Data
- Screening Tool Considerations
- Technology Literacy
- Vendor Programmed Forms
- Population Health Management Tools

Session 9
- UHC Data Sharing Update
- SDO Referrals

Session 10
- UHC Catalyst Overview
- Food Programs & Partnerships

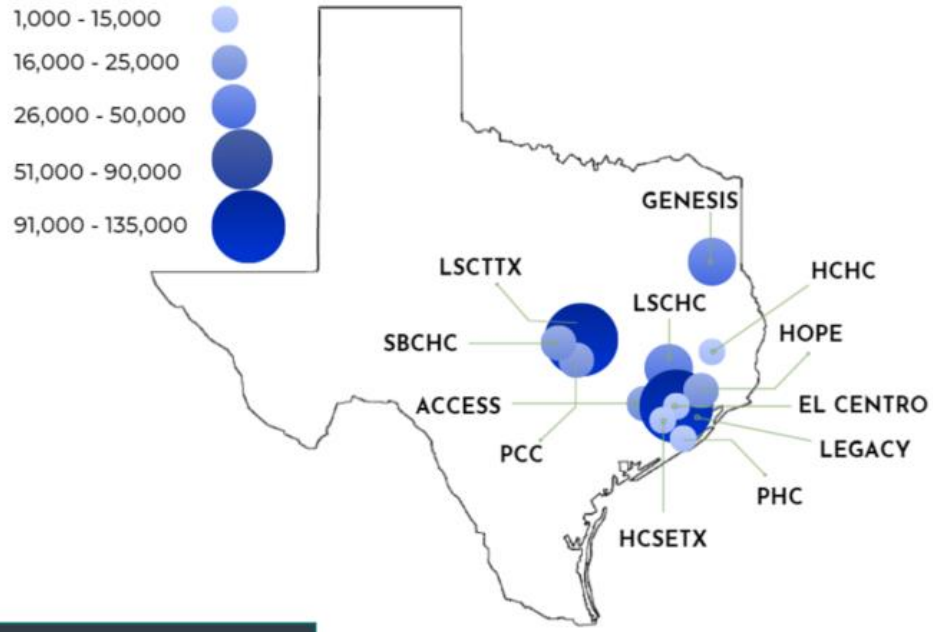
Session 11
- Policy and Payment Implications
- Survey Evaluation

Future Planning

Session 9 – UHC Data Pilot

Our Cohort

SDOH Collaborative Participants 2020 Client Population

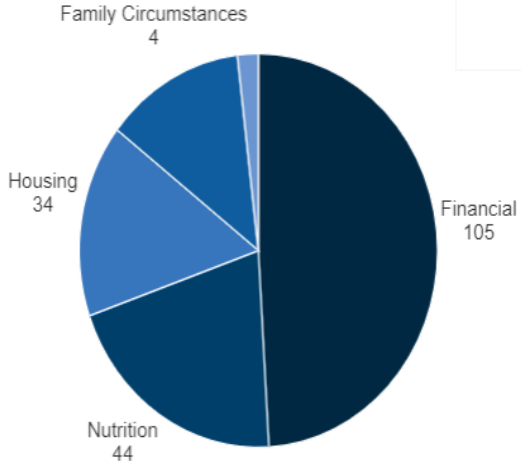


TACHC · ACE · TEXAS Health and Human Services · United Healthcare · JSI · PCCI

TX SDoH Pilot – Identified Needs

Needs Identified via screening by Domain/Subdomain:

Needs by Domain *(Select a Needs Domain)*



Needs by Subdomain

Need Domain	Need Subdomain	
Financial	Necessity Cost	61
Financial	Medical Cost	46
Nutrition	Nutrition	44
Housing	Housing	34
Transportation	Transportation	27
Financial	Prescription Cost	10
Family Circumstan..	Social Isolation	4

Session 11 – Policy and Payment Implications

Existing fee for service structure

Action → Payment → Outcome?

Alternative Payment Models

Goal → Success → Payment

Alternative Payment Models - Examples

CP-PCPi

- PCPs and OBGYNs assigned as PCPs
- Payment for completion of P4Q measures

Home Health Agency

- PAS and PDN Providers
- Reduction in potentially preventable emergency room visits

Pharmacy Medication Adherence Program

- Walgreens, HEB and Kroger
- Incentivizes pharmacies for medication adherence (diabetes & hypertension)

Integrated Behavioral Health Home

- Providers who can perform the 6 health home core services
- Shared savings opportunity based on total cost of care and quality measures

What We All Can Do – Together

Salil Deshpande, MD, MBA, FACP
Chief Medical Officer
sdeshpande@uhc.com

Arnita Burton, MBA
Associate Director
Clinical Innovations, Analytics & Social Determinants of Health
arnita_burton@uhc.com

Questions?

Center for Health Care Strategies

Using Data to Inform Care Delivery

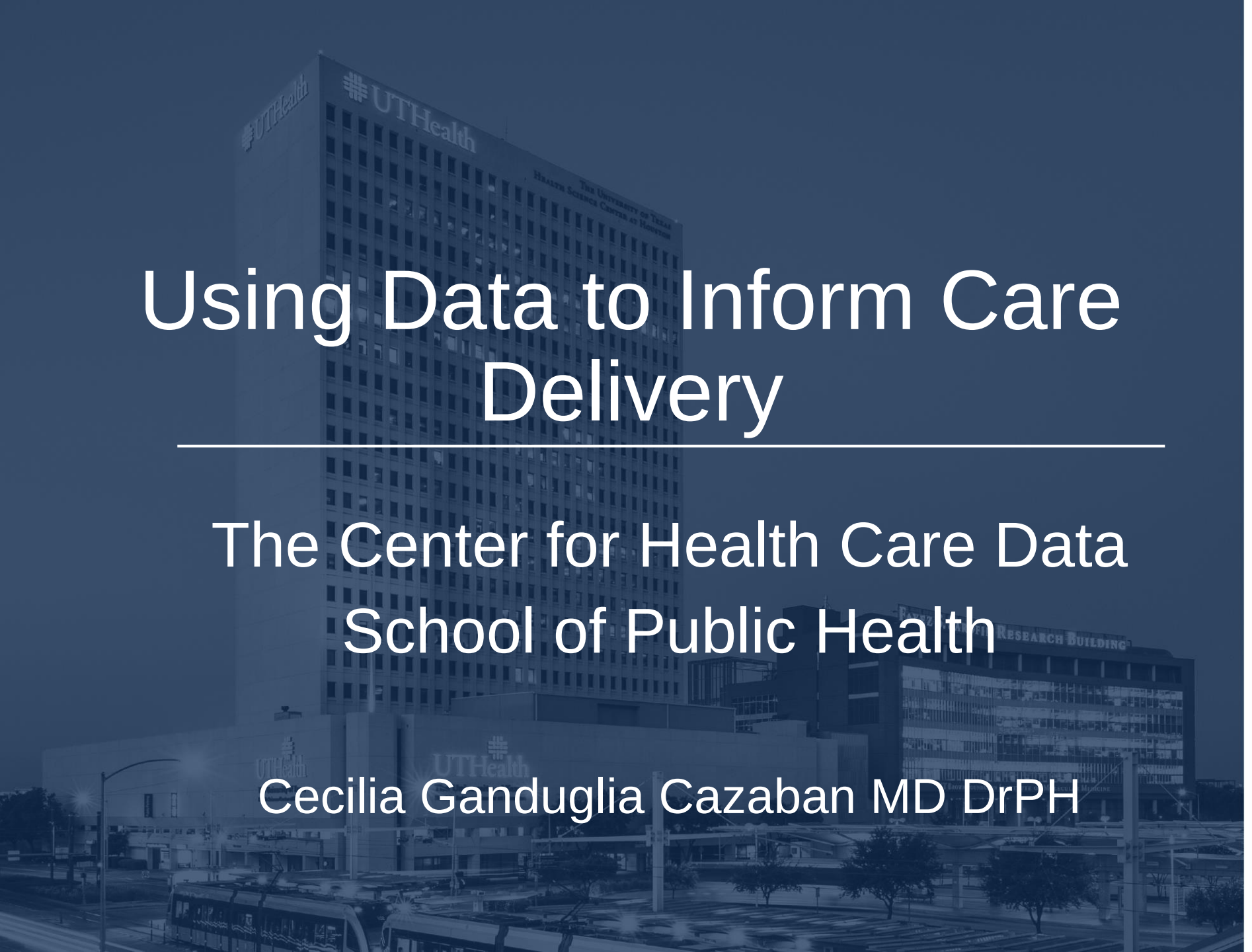
Cecilia Ganduglia Cazaban, Co-Director of the Center for Health Care Data and Assistance Professor of Management, Policy, & Community Health, UT School of Public Health

Center for Health Care Strategies

Using Data to Inform Care Delivery

The Center for Health Care Data
School of Public Health

Cecilia Ganduglia Cazaban MD DrPH



UTHealth®
The University of Texas
Health Science Center at Houston

UTHealth Center for Health Care Data (CHCD)

Largest, research accessible, healthcare data repository in Texas

Applying expertise from a broad range of disciplines in analytics, clinical medicine, public health, management, and public policy

Supporting Research, Education, and Public Service to improve the health of our communities

Comprehensive, Diverse Datasets to Answer Research Questions

Poverty Education
Crime Air Pollution
Hunger And more…

- Behavioral Risk Factor Surveillance System (BRFSS)
- American Community Survey
- And more

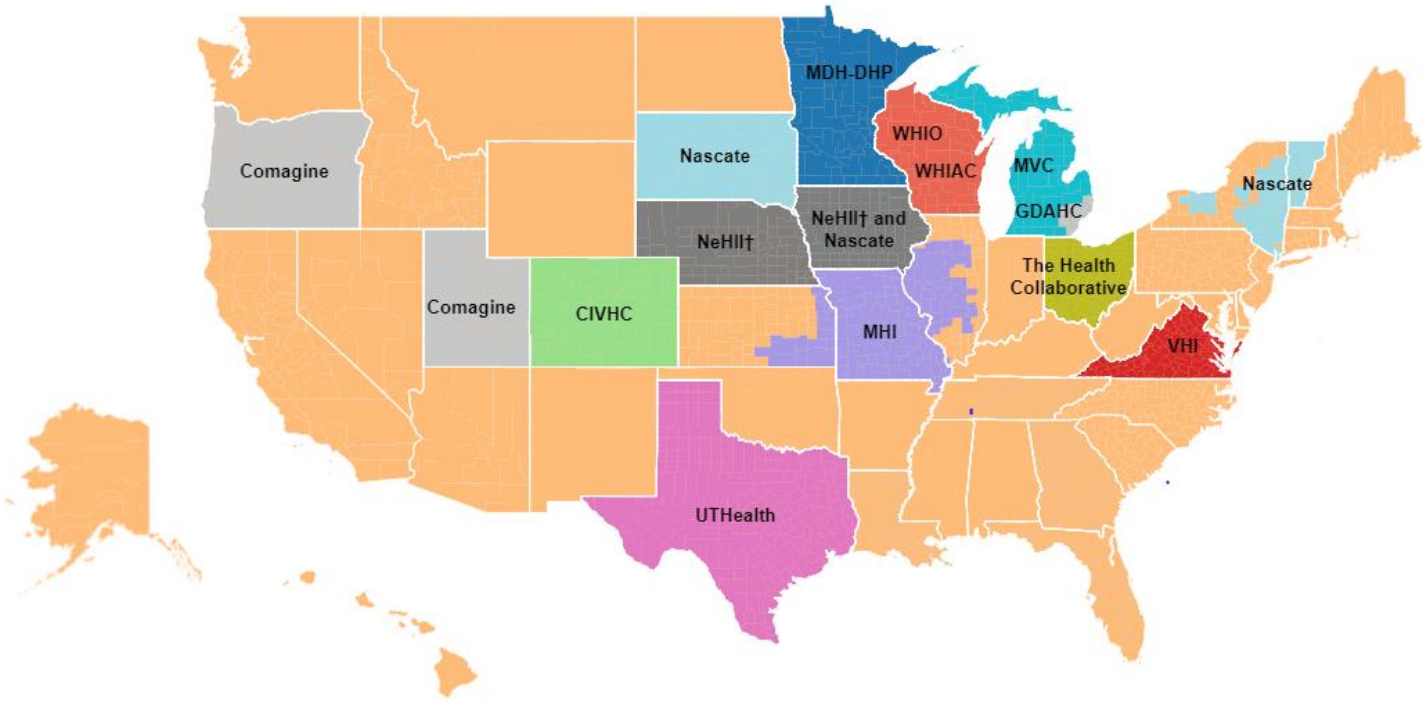
CHCD Datasets

- Social Determinants of Health
- Claims data on 80% of insured Texans
- National Health Care Administrative Claims
- COVID-19 Electronic Medical Record Database
- Texas Hospital Discharge, Workers Comp, & Labor Data
- Survey datasets

- Optum Clinformatic© Datamart
- IBM Marketscan®
- Medicare
- And more

QUALIFIED ENTITY CERTIFICATION PROGRAM
FOR MEDICARE DATA

CHCD has attained certification as a CMS Qualified Entity (QE)



Allows use of Medicare Parts A and B claims data and Part D prescription drug event data for evaluating healthcare outcomes.

Promotes transparency in healthcare delivery

Requires rigorous data privacy and security systems

The Value of Healthcare Administrative Claims Data for Population Health

Year
2017

Select Category
Prevalence Chronic Disease
Prevalence Other Conditions
Incidence

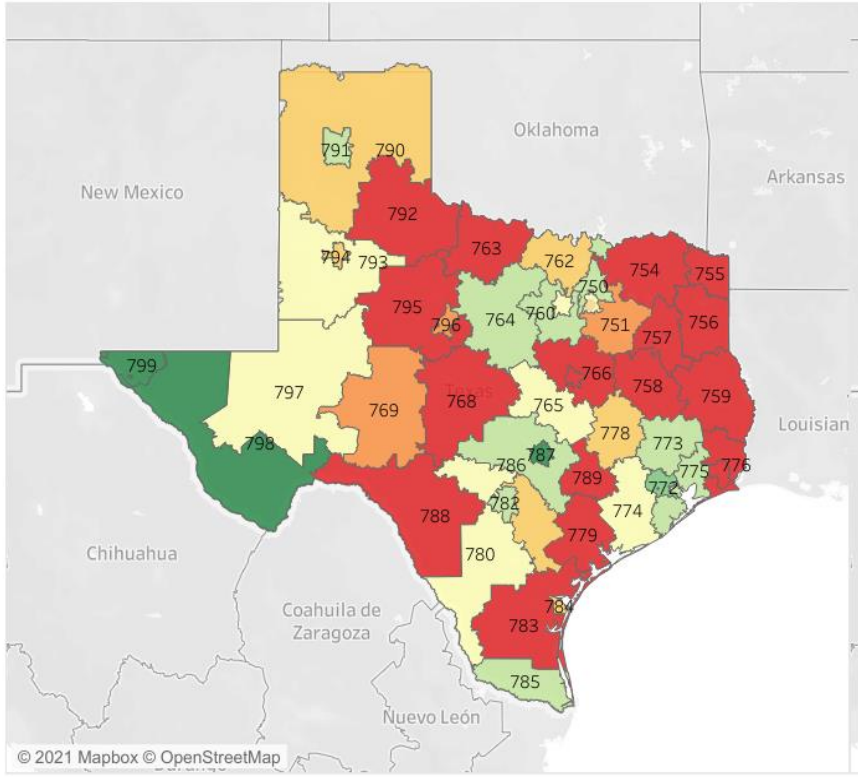
Select Measure
Stroke : All

For more information on stroke click here.

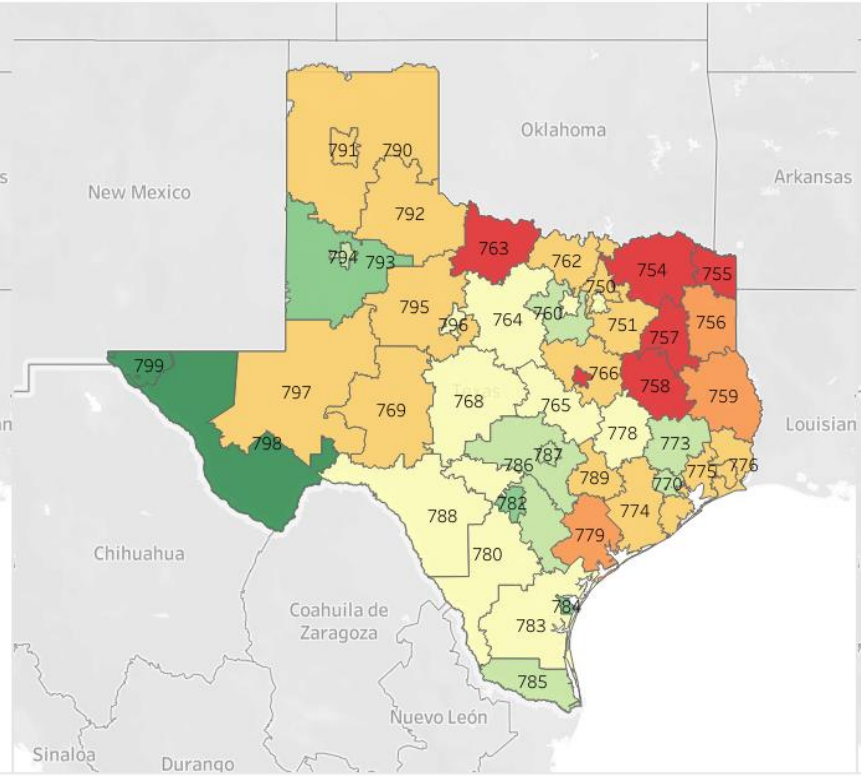
Select Medicare Type
Medicare
MA & Med Sup
Aggregated 65+

Variation from the Texas Mean
< 0.75 | 0.75 - 0.84 | 0.85 - 0.94 | 0.95 - 1.04 | 1.05 - 1.14 | 1.15 - 1.24 | > 1.24

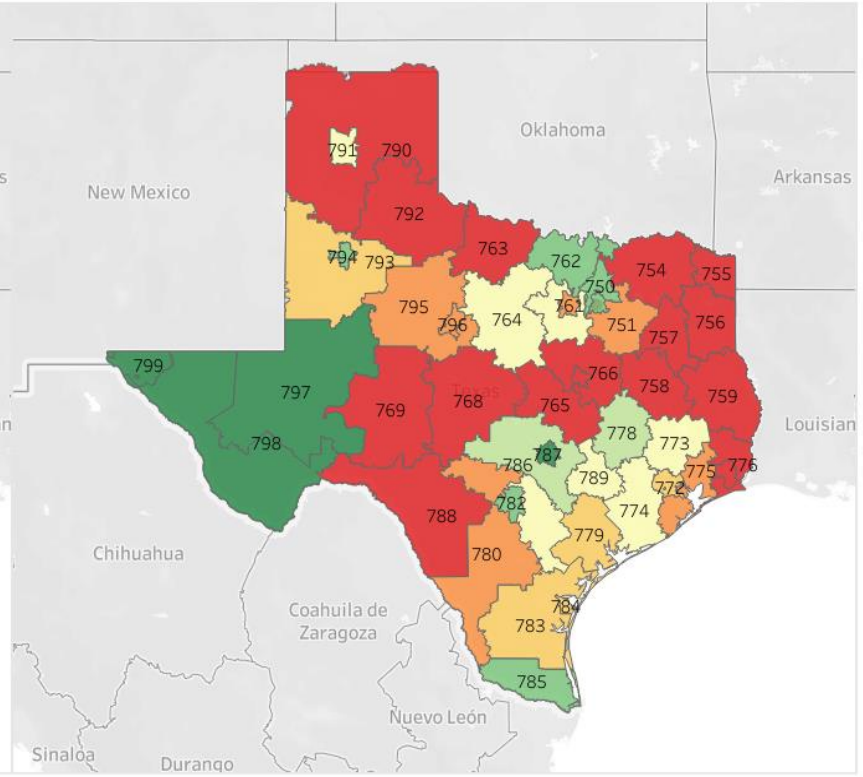
Medicaid



Medicare



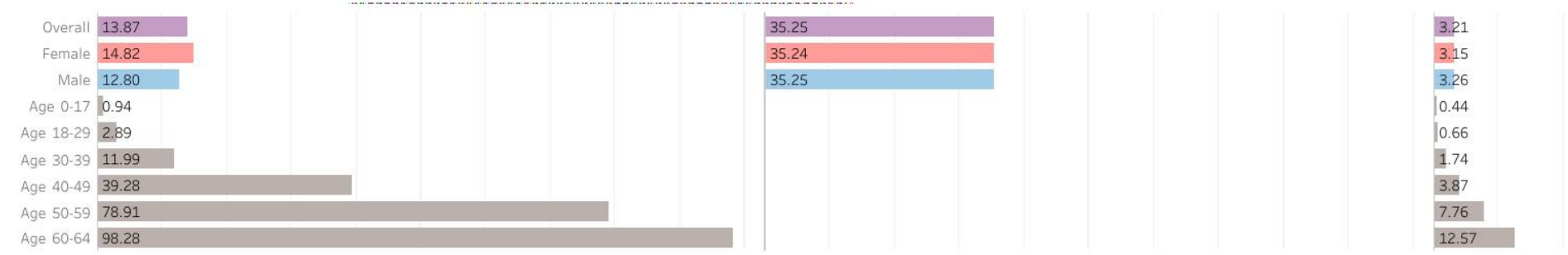
Commercial



Select Condition Metric
Mean Ratio
Percent/Rate/Events per 1000 MY

The values shown below are
Events per 1000 MY

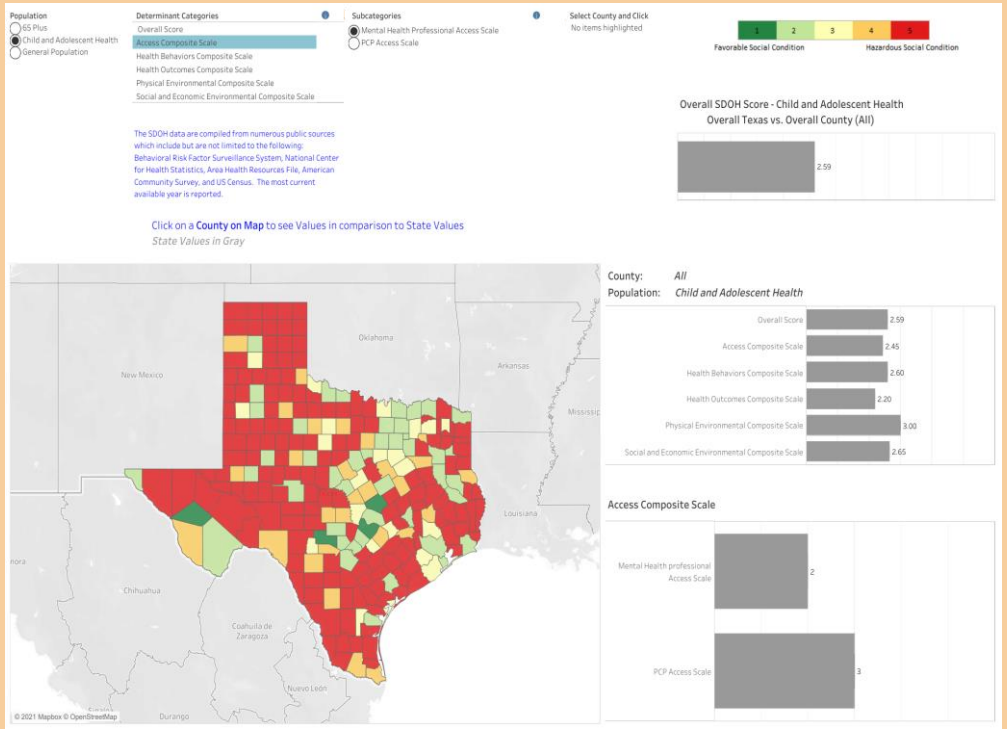
Select Zip3 and Click
No items highlighted



www.HealthofTexas.org

Illustrates prevalence of stroke by payer, age and gender against variation from the Texas mean

SDOH and Health of Texas



Associated common SDOH metrics from public data sources (county specific) with health plan enrollment data (including demographics, counties, and zip codes) and medical and pharmaceutical annual claims data.

Following correlation analyses to reduce variables, the contribution of each SDOH individually and by category to health outcomes was evaluated. Separate matrices for age populations (under age 19, general population [all ages], and ≥ 65 years) were created with assigned weights of influence for categories and the factors within each category.

The contributions of the categories varied by population, confirming that different SDOH influence populations to varying degrees.

IMPACT OF ACCESS TO HEATLHCARE ON CHILD & ADOLESCENT HEALTH

- 65 Plus
- Child and Adolescent Health
- General Population

- Overall Score
- Access Composite Scale
- Health Behaviors Composite Scale
- Health Outcomes Composite Scale
- Physical Environmental Composite Scale
- Social and Economic Environmental Composite Scale

- Access to Specialists
- Mental Health Professional Access Scale
- PCP Access Scale
- Uninsured Scale

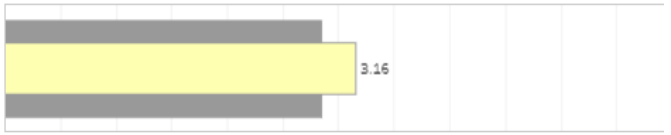
Highlight Name

1 2 3 4 5

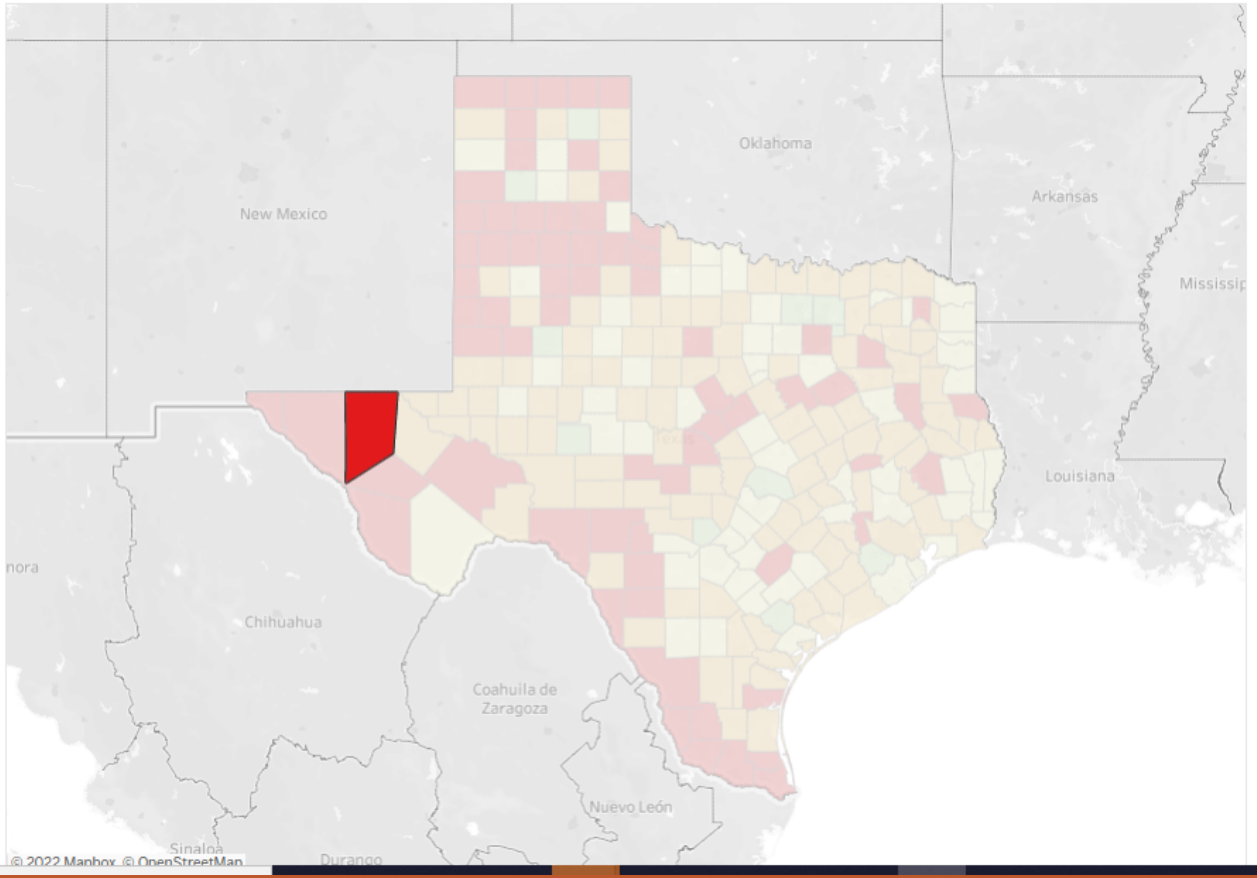
Favorable Social Condition — Hazardous Social Condition

The SDOH data are compiled from numerous public sources which include but are not limited to the following: Behavioral Risk Factor Surveillance System, National Center for Health Statistics, Area Health Resources File, American Community Survey, and US Census. The most current available year is reported.

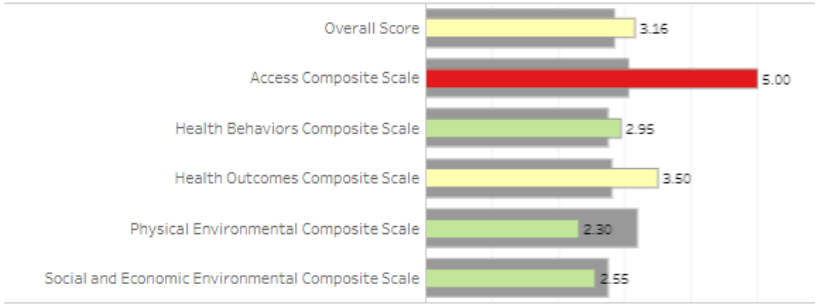
Overall SDOH Score - General Population
Overall Texas vs. Overall County (Culberson)



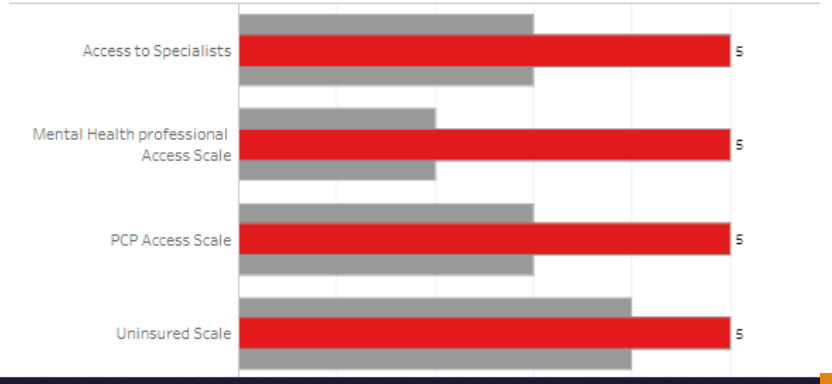
Click on a **County on Map** to see Values in comparison to State Values
State Values in Gray



County: *Culberson*
Population: *General Population*



Access Composite Scale



SDOH data in action

How does SDOH data impact process and outcome measures?

How can SDOH information be used to improve patient outcomes?

- **Effect of SDOH on HEDIS measures**:
  - Evaluation of the effect of different SDOH (24) on quality measure performance.
  - Models including SDOH were better at predicting whether a member met the criteria for the measure numerator, suggesting SDOH play a part in predicting measure performance
  - Effect was more pronounced for children and adolescents.
- **Accountable Health Communities (CMS):**
  - Medicaid/Medicare members who screened for SDOH needs were randomized to Referral or Referral + Navigation.
  - Linked screening and SDOH collected information to claims data and evaluated utilization and cost.
  - Results in progress, early evidence of significant impact, in particular for higher risk individuals.
- **Prospera/Superior:**
  - Evaluation of a collaborative program between an affordable housing provider and a managed care organization.
  - Intervention & comparison groups
  - Assessing effects on ambulatory care sensitive utilization, preventive care and cost.

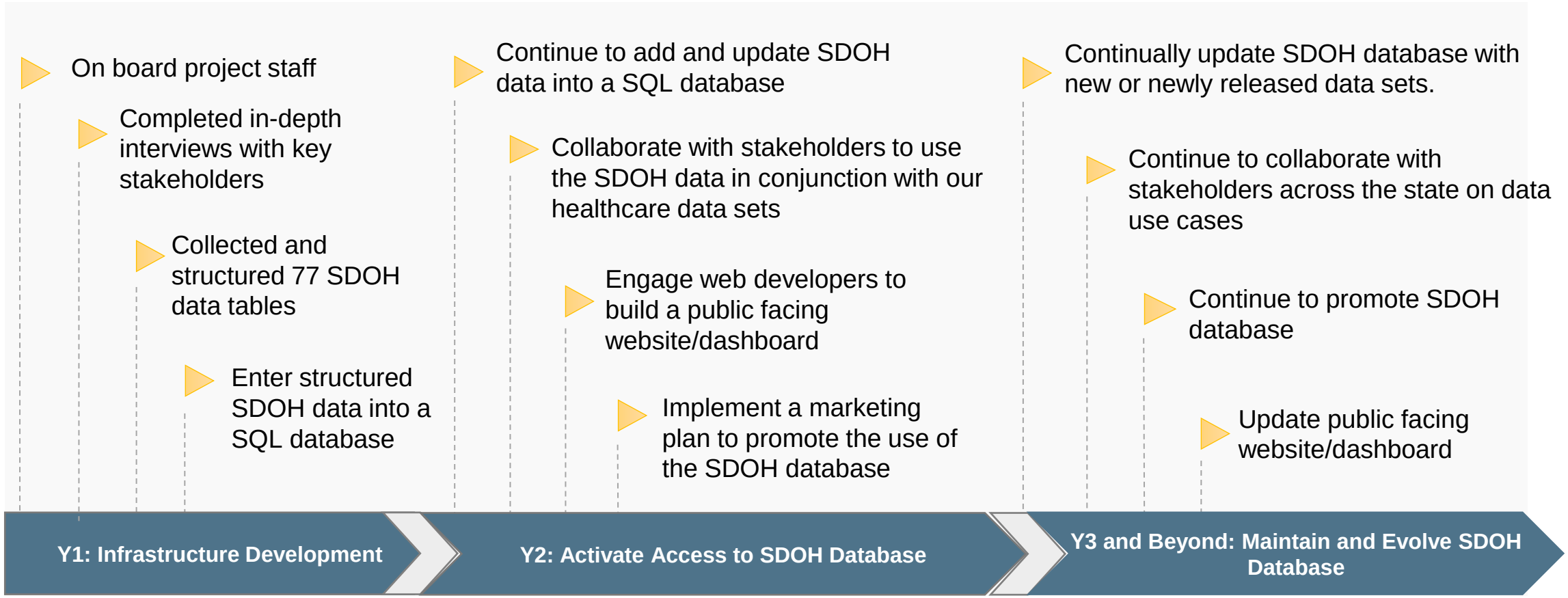
SDOH Project: more accurate and granular data, easily accessible and easy to use

Enhance our ability to evaluate health outcomes by **supplementing health care datasets with SDOH data** → Creating a robust data center to address and evaluate the health of Texans.
The standardized database will be accessible to researchers, non-profit organizations, policy advocates and others for non-commercial use

- Involving stakeholders across the state in the design and execution of the tools to ensure that they meet community needs.
- Acquiring and curating a comprehensive library of administrative, clinical, social, economic and environmental datasets that impact population health.
- Making data available to those seeking to answer questions related to improving the health of populations.
- Providing technical service support and analytical expertise in the use of this data across disciplines.
- Creating a web based display and other tools for public information on the current status of health and the disparities in cost, prevalence and outcomes across Texas.

CDC. Social Determinants of Health Image . Retrieved 6/3/20/21 from https://www.cdc.gov/publichealthgateway/sdoh/index.html.

SDOH Database Project Timeline



Current SDOH Dataset Catalogue

To date, we have collected data on all key areas of SDOH and will continue to identify additional SDOH datasets and update current data as part of our on-going process.

Education

American Community Survey (ACS): Educational Attainment

Healthcare Access and Quality

Texas Hospital Survey

Behavioral Risk Factor Surveillance System (BRFSS)

County Health Rankings

Area Health Resource Files

United States Diabetes Surveillance System

National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation

Mapping Medicare Disparities Tool

Neighborhood and Built Environment

ACS Housing Geographic Mobility

Area Deprivation Index

Environmental Public Health Tracking Network

CDC WONDER Environmental Data

Safe Drinking Water Information System

Comprehensive Housing Affordability Strategy

Social and Community Context

CDC Social Vulnerability Index

Census

ACS: Geographic Mobility

ACS: Social Characteristics

Economic Stability

ACS: Economic & Housing

ACS: Population and Poverty Status

Texas Workers Compensation Commission (TWCC)

Feeding America: Map the Meal Gap

Bureau of Labor Statistics

Small Area Income and Poverty Estimates

All datasets originate from reputable sources.

Texas All Payor Claims Database

As of September 1, 2021, The Center for Health Care Data (CHCD) was appointed the Texas administrator of the All Payor Claims Database (APCD).

The TX APCD will use the data to provide public information on statewide, regional, and geo-zip reports available through a public access portal that address:

- Health care costs, quality, utilization, outcomes, and disparities;
- Population health
- The availability of health care services

The APCD shall be a resource for qualified research entities that may receive access to data for research in the public interest with the purpose of analyzing the delivery of health care in the state.

https://go.uth.edu/txapcd

Project Milestones –Year 2022

- APCD Legislation
- APCD Stakeholder Advisory Council appointed
- TDI publishes draft rules for comment
- Final rules adopted
- First biennial report to Legislature
- *Historical data (2019 – 2021) submissions*

Data Prompts Opportunity:

We'd like to hear suggestions from you:

- As stakeholders, what would be useful information for you?
- What would be important to make accessible through a website?
- Other thoughts?

For more information, contact us at:
CHCD@uth.tmc.edu
Cecilia.M.GandugliaCazaban@uth.tmc.edu
Thank you.

Questions?

Center for Health Care Strategies

MCO/Food Bank Partnerships to Address Food Insecurity

Stephanie Muth, Consultant

Center for Health Care Strategies

Accelerating Partnerships Between Food Banks and Managed Care Organizations

Stephanie Muth

Stephanie Muth Consulting working with Feeding Texas

Addressing Food Insecurity

- Episcopal Health Foundation is funding a one-year initiative to address concrete ways to address food insecurity through partnerships between Food Banks and Medicaid Managed Care Organizations.
- Participants include:
  - Associations for Medicaid Managed Care Organizations: Texas Association of Health Plans and Texas Association of Community Health Plans
  - Feeding Texas food banks
  - Health and Human Services Commission
  - Episcopal Health Foundation
  - Texas Health Improvement Network
  - Medicaid Managed Care Health Plans

Project Overview

- Strengthening Partnerships with Food Banks and Medicaid Managed Care Organizations
  - Goal is to identify sustainable sources of funding to support providing healthy food and improve health outcomes
- Project has 3 Phases
  - Food Insecurity Working Group
  - Landscape Assessment
  - Pilot Design

Landscape Assessment
Phase 2: 9/21 – 12/21

- Conducted interviews with 12 Health Plans.
- Designed to complement efforts of the Texas Health Improvement Network study with health systems and food banks.

Key takeaways:

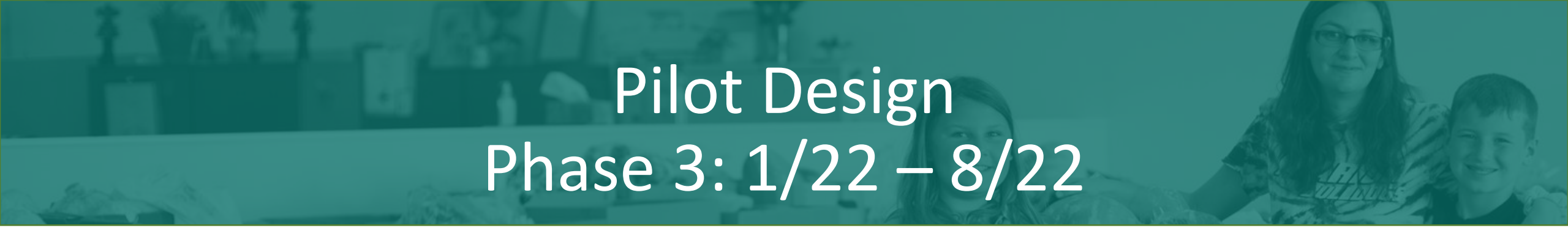
- Health plans have universally expressed support for exploring partnership opportunities.
- Various partnerships currently exist.
- Conversations to date have spurred further collaboration.
- Health Plans are referring members with food insecurity

Current Partnerships: Overview

- Partnerships are designed to reach community at large or target specific membership.
- Partnerships are designed to address food insecurity or to target a health intervention for a particular population.
- Partnerships exist in urban and rural areas.

Key Partnership Opportunities

- Building on the capacity of the food banks for application assistance to create a managed referral process that includes meeting immediate food needs and assisting with SNAP applications.
- Explore opportunities for MCOs and food banks to partner on providing medically tailored meals to specified populations including meals related to certain conditions or targeting food insecure households in urban and rural areas.
- Building on the capacity of food banks to provide evidence based nutrition education programs.



Pilot Design
Phase 3: 1/22 – 8/22

- Consultants will design framework for at least two pilot programs with input from the working group.
- Framework would include identification of potential partners.
- Pilot evaluation will be designed.

Questions?

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In Lieu of Services

Diana Crumley, Senior Program Officer, Center for Health Care Strategies

Center for Health Care Strategies

Project Goals

- Learn about other states' approaches to *in lieu of* services (ILOS)
- Apply these learnings to a Texas context
- Discuss potential ILOS candidates, with a focus on services that address health-related social needs
- Inform the Value-based Payment and Quality Improvement Advisory Committee's recommendations for the legislature

In lieu of Services (ILOS): Federal Rule & Example

An MCO may cover, for enrollees, services or settings that are **in lieu of services or settings** covered under the State plan as follows:

- The State determines that the alternative service or setting is a **medically appropriate and cost-effective substitute** for the covered service or setting under the State plan
- The enrollee is not required by the MCO, PIHP, or PAHP to use the alternative service or setting
- The approved in lieu of services are **authorized and identified in the MCO, PIHP, or PAHP contract**, and will be offered to enrollees **at the option** of the MCO, PIHP, or PAHP

Example: "in-home prenatal visits for at-risk pregnant beneficiaries as an alternative to a traditional office visit"

Cost & Utilization of Services: Developing MCO Capitation Rates

- **Projected Benefit Costs** (a.k.a., "Benefit Load")
  - → State plan services
  - → *In lieu of* services (some exceptions) ✓
- **Projected Non-Benefit Costs** (a.k.a., "Non-Benefit Load")
  - → Care coordination and care management
  - → Other material non-benefit costs (e.g., other quality improvement costs)
  - → Administrative costs

✘ The cost of **value-added services** cannot be included when determining payment rates.

Finger on the pulse: California's CalAIM initiative

- Next phase of Medicaid transformation in California, which includes two waivers:
  - → 1915(b)(4) – authorizes mandatory Medicaid managed care
  - → 1115 – authorizes new capacity-building funds, among other initiatives
- A key component: Community Supports, designed as ILOS
- Community Supports can substitute for *and potentially decrease utilization* of a range of covered Medi-Cal benefits, such as hospital care, nursing facility care, and emergency department (ED) use.

CalAIM Community Supports (approved as ILOS)

- Housing Transition Navigation Services
- Housing Deposits
- Tenancy and Sustaining Services
- Respite Services
- Day Habilitation Programs
- Nursing Facility (NF) Transition/Diversion to Assisted Living Facilities
- Community Transition Services/ NF Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically-Supportive Food/Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

CalAIM Community Supports (approved via an 1115)

- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)

✓Will still walk and talk like the other services, even if not technically ILOS (e.g., still used to develop rates)

Now, back to Texas!

- For our work so far, we have explored:
  - → Housing-related services, specifically for those with behavioral health needs
    - Housing Transition Navigation Services
    - Housing Deposits
    - Tenancy and Sustaining Services
  - → Asthma Remediation
  - → Food is Medicine interventions, including:
    - FoodRx
    - Nutrition education, paired with food assistance

Consider existing Texas programs and research

- Within Medicaid:
  - → Many HCBS waivers and programs!
  - → Many existing and emerging MCO programs and pilots!
- Outside Medicaid
  - → E.g., Factor Health program portfolio
  - → E.g., Texas Supportive Housing Institute
  - → E.g., Texas's moonshot bid to beat homelessness
  - → E.g., Community benefit initiatives

State Decision Points: Startup

- Should the state pre-approve ILOS?
- Should the state create a process for MCOs to submit ILOS for approval?
- How will the state or MCOs engage communities to determine appropriate ILOS? Who will be consulted?
- Which services should be approved?
  - → Is the service a "cost-effective and medically appropriate substitute," and what evidence will be considered?
- How will approval of the services be formalized in contracts?

State Decision Points: Implementation

- Supporting partnerships between MCOs & CBOs
  - → Credentialing
  - → Rate guidance
  - → Model contracts
- Member protections & continuity of care (length of ILOS elections)
- Capacity building
- Technical assistance

Questions?

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Small Group Discussion/Working Lunch

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Report Out from Small Group Discussions

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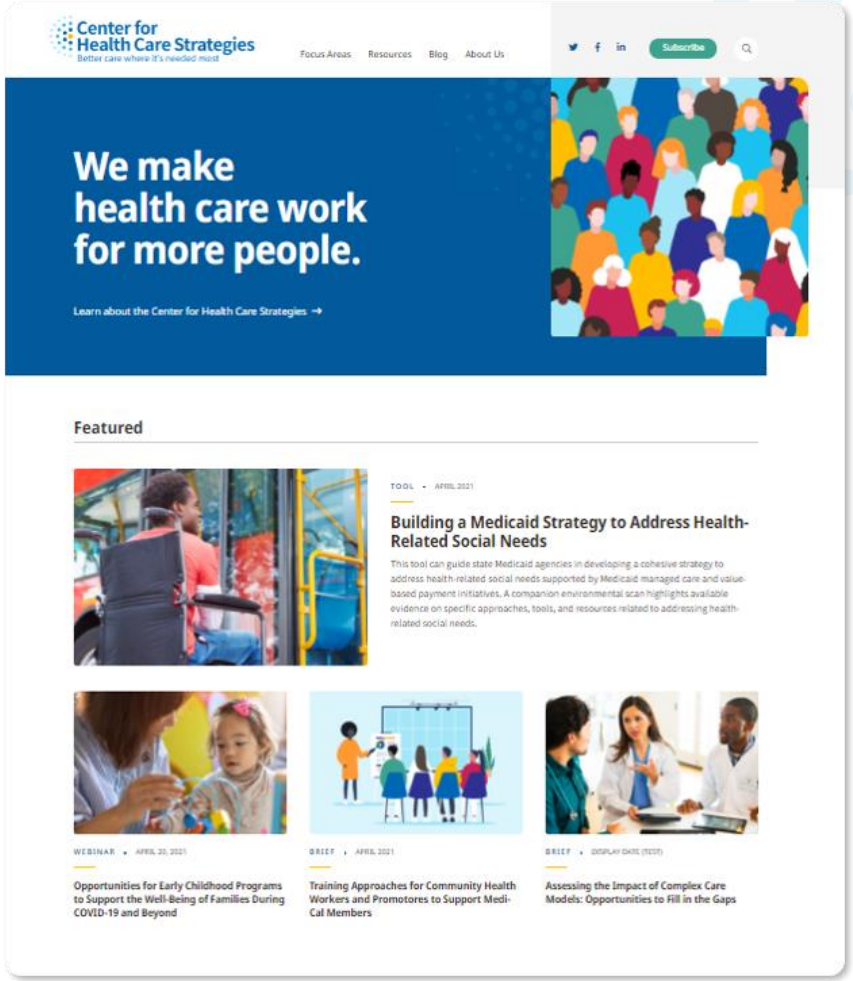
What additional topics related to SDOH, health disparities, or health equity would you like to learn more about?

Next Steps

Visit CHCS.org to…

- **Download practical resources** to improve health care for people served by Medicaid.
- **Learn about cutting-edge efforts** from peers across the nation to enhance policy, financing, and care delivery.
- **Subscribe to CHCS e-mail updates**, to learn about new resources, webinars, and more.
- **Follow us on Twitter** @CHCShealth.



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