[00:00:01.290] Announcer:

Welcome to APG on American Healthcare, the official podcast of America's Physician Groups where we discuss current issues in the healthcare value movement. APG members are at the forefront of national healthcare reform, practicing at risk-based prospective payment and other population-based payment models, the very models described by federal legislation for the entire nation. Interested in learning more about APG and the value-based movement? Join us for the Colloquium 2020, Answering the Call: Value-Based Care in Public Health Emergencies, an online conference November 17 through 19.

[00:00:38.460]

Learn more at APG.org. And now for an inspiring and educational look at the transformation of America's healthcare delivery system, here's your host, APG President and CEO Don Crane

[00:00:52.770] Don Crane:

As we begin this conversation with my friend, June Simmons, it occurred to me that we've spent an awful lot of time talking about delivery model reform and payment methodology reform. And all of that is indeed very, very important. I mean, it is indeed the case that overuse, misuse, waste is rampant in the United States. Generally, I think it's accepted that something on the order of thirty-five percent of our spend in America is indeed, quote unquote, waste. And that derives principally from fee-for-service, the payment model we're trying to jettison as we move into the value.

[00:01:31.860]

But there is also, I think, a dawning recognition across the industry now that our resources are not perhaps allocated as they should be. So many of us look to Europe and other wealthy developed democracies and have noticed they spend about half as much on healthcare as we do in the United States. But they spend more, quite a bit more—in some cases twice as much—on social care than we do in the United States. But all in all, they get much better results with this reallocation or their allocation of resources.

[00:02:13.470]

And so as I prepared for this podcast with June Simmons, I couldn't help but note the couple taglines on their Partners in Care web page that I think are a moment right now, And the first of which is their claim to be the social determinants of health specialists, the SDOH specialists. I thought how apropos that is. And then what really caught my attention was the tagline beneath their own name, which is, "This is our moment in health history. We were born for this work." So how appropriate, I think, to talk to somebody who is indeed born for this kind of work. And with that, I look forward to saying hello to you, June. Good morning.

[00:03:00.540] June Simmons:

Thank you. I'm delighted to be here and, well, thank you.

[00:03:05.430] Don Crane:

Exciting times, to say the very least.

[00:03:08.190] June Simmons:

No kidding.

[00:03:10.680] Don Crane:

So let me start by first observing and then asking you, June, I step back and I watch you here in recent years with this mixture of awe and admiration as so many people have such respect for you. So, I'm on your advisory council, as you know.

[00:03:29.700]

And I'm just thinking back to our last meeting, a Zoom meeting and looking at the sort of Hollywood Squares look on the screen of all of the, you know, sort of a Who's Who of American Healthcare, certainly California healthcare, but American healthcare, I mean, so definitely congratulations are in order for you. But I feel like saying, how did you do that, June?

[00:03:56.730] June Simmons:

How did we assemble those people?

[00:03:58.920] Don Crane:

Well, they're following you, June Simmons.

[00:04:01.590]

They're there because of your leadership. How have you done that?

[00:04:07.170] June Simmons:

Well, I appreciate that. Well, you know, we've hit a moment now when there's a lot more recognition of the social determinants of health as actually mattering. So, you know, I'm sort of a surreal founder of organizations that are working to achieve a more whole person-centeredness, more upstream

interventions, even some of the concepts that were so beautifully discussed by Dr. Chen in your recent podcast with him, which was wonderful, by the way.

[00:04:43.500]

So we're change agents that have a lot of patience because we've been waiting for the world to agree with our ideas and waiting for measurement to catch up and prove that these changes that we're promoting in healthcare makes sense, but the very lofty leaders that you note who are on our advisory council, many of them also are people we recognized in our tribute dinner. Each year we honor one leader who has had a transformational impact that we think is compatible with the kinds of values and vision that we hold.

[00:05:26.300]

And so getting that company pulled together and they get to know us in that way and they see the kinds of leadership we're trying to provide. I think they have, as you say, been very kind to warm to that as you have. You're one of them that, you know, your primary goal is not our goal, but you see the compatibility and the value that we're trying to bring to systems change, trying to really integrate medical care and social care, trying to look at how we spend the health dollar in America.

[00:06:06.830]

And there's more and more people in that choir, as you notice. So, we've been a small voice from the side, but I think it does resonate with people. As Dr. Chen said, people get in healthcare administration and then they're caught in that web of what it's like. And we really represent the alternative like he does, of how else can we look at this and approach it? So, I think that's been attractive to people.

[00:06:40.610] Don Crane:

So, I think you're right. I think we should spend a little time talking about Partners in Care, this most amazing organization.

[00:06:47.360]

So, tell us all about Partners in Care

[00:06:49.760] – June Simmons

Partners in Care is a not-for-profit. It’s headquartered here in Los Angeles, but it likes to function as a visionary and thought leader nationally to bring new evidence-based models of care to population health management. We're a community-based organization so we don't provide any actual healthcare to people. We bring health outcome-impacting resources and interventions. So we look strictly at the social determinants of health and what helps people manage chronic conditions up front and be supported as

they have episodes of illness, like when they leave the hospital and then help them really to remain in community-living settings as long as possible.

[00:07:50.750]

So, we've been around for 22 years. I'd have to admit that I've been actually at this work longer than that. But at Partners, we've been doing it for 22 years and it's growing in success. So, our ideal is to partner with healthcare payers and providers, health plans, hospitals, medical groups to bring them new approaches that if they will invest in them, move the medical dollar over, if you will, share some of the cheese, move some of the cheese. They'll get a better result, better quality scores, better patient experience, better cost, better health outcomes.

[00:08:37.580]

So we're all about this sort of a learning center, shared collaborative site to change the shape of healthcare we like to say we're a little guy with a big ambition.

[00:08:50.870] Don Crane:

Very good, sounds familiar, I think. You were a nurse, I think, once upon a time. Is that right?

[00:08:56.170] June Simmons:

Actually, a social worker.

[00:08:57.920] Don Crane:

Oh, my gosh. Ok very good.

[00:08:59.480] June Simmons:

People think I'm a nurse because I ran the Visiting Nurse Association of L.A., which was one the largest in the country. But I was really a social worker in nurse disguise.

[00:09:09.710] Don Crane:

Well, very good.

[00:09:10.790]

So how does Partners in Care differ from what some might recognize as a more traditional home health agency or home health company?

[00:09:22.700] June Simmons:

Well, we are outside the provision of care. So, home health, you get an R.N. who will come out and provide care in your home. We are experts in identifying what people need to optimize their health. And so, we do an assessment or an evaluation of risk factors that will harm health or improve health. And we equip people with access to resources and consumer empowerment, learning opportunities that'll help them change their health behaviors. So, you know, home health is kind of more episodic.

[00:10:11.250] Don Crane:

Sure.

[00:10:11.960] June Simmons:

Although sometimes we're episodic, we do a lot of following people out of hospitals or nursing homes as they return home. We'll do a 30-day, 60-day intervention to help them succeed so we can improve their experience, but also reduce readmissions. And we've done that with quite a lot of success. But we don't give any care. We give social care, not healthcare, not medical care or nursing care.

[00:10:42.890] Don Crane:

Spend just a second talking about your Home Meds program. I find that pretty amazing.

[00:10:49.880] June Simmons:

Yeah, so one of the evidence-based tools is one that actually was developed in home health when I ran the Visiting Nurse Association and was converted to a program.

[00:11:00.860]

You know, medications are the number one driver of readmissions, often of inappropriate E.R. use. They're quite harmful. They have major impact on people getting problems. You know, we like to say medications cure me or kill me and everything in between. So, this permits an alternative workforce. Doesn't have to be a nurse. It doesn't have to be a pharmacist, a physician. It can be a community health worker or social worker who can work with an individual to see what meds are they actually taking or not taking and how are they actually taking them.

[00:11:43.310]

We find gigantic rates of prevalence of medications, threats in the home. Right now, it's COVID. We're not going to the home. We are doing this virtually. But we do really like to go to the home and be the eyes and ears of the health system. Not to go in and take a temperature, but to go in and assess safe

environment, safe nutrition, safe self-management support, falls risks and depression, anxiety and so on. And meds are the centerpiece.

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It's something we can really bring with a more readily available workforce that is trained to utilize a software system that will take in a range of these other factors, but mainly the medications and how they're taken or not. So, it isn't just what's prescribed. You know, we see a lot of pharmacists calling people now and verifying what they have. It's over-the-counters. It's herbals and supplements, foreign meds. Sometimes it's dog meds. It's the neighbor's meds. It's amazing what people will put together to improve their own health.

[00:13:09.470]

And many of them interact. So, with community dwelling elders, about 25 percent will have serious issues of therapeutic duplication. If they're taking five or six meds or more…cause even if you're taking, you know, an antidepressant and then you take, you know, a homoeopathic solution or you're taking a sleeping pill and then you take an over-the-counter that's going to, you think, not be a problem. And these things really add up. Suddenly we see people looking as if they're old and going downhill.

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And, you know, now you see a lot of de-prescribing.

[00:13:57.620]

So, in addition to that, we're now building a partnership because our evidence came from partnership with Vanderbilt and the Beers Criteria—Mark Beers chaired our national panel, and, you know, it has a lot of solid evidence, proof under it. We're now also working with the physician, Dr. Ray Woosley, who's a pharmacologist and a cardiologist, who's the past dean in the School of Medicine in Tucson and a renowned cardiologist specializing in medication safety, especially cardiac arrhythmia.

[00:14:40.040]

So, we're going to also be encouraging because we try to lease home meds out. We think people should utilize this screening tool. But his can be used at the point of discharge; can be used otherwise, but he's doing a lot of it with a number of systems. His is available free to look at on Web. It's called Med Safety Scan that really looks at risk of sudden death. It's a very important tool that looks at QT risk score.

[00:15:19.410]

You know, the spacing between your heart heartbeats and reports major drug interactions. It's just shocking, we had recently looked at the hospital where we're doing post-acute work and looked at what

we found and the level of medications issues that people, good practitioners with all good intent, but without a full database about who else is prescribing…

[00:15:47.340]

what do the people have at home before they came in? What are they going home with? 50, 60 percent prevalence rate of really risky drugs and his found different than ours,

[00:16:01.240]

so we're thinking they're very complementary. So, we're going to be taking this out to market because we feel like these are tools people really need to be really efficient.

[00:16:14.040] Don Crane:

Very good. Very, very good. So, listen to you talk. I have the impression that it's very important that you—I'm hearing the importance of your eyes on the scene. You come to the door, you knock on the door, somebody opens it. No small feat, according to my members.

[00:16:30.470] June Simmons:

Yes, that's right.

[00:16:31.320] Don Crane:

Click, click, click.

[00:16:33.120] June Simmons:

First of all, getting someone to open it.

[00:16:34.650] Don Crane:

Talk about that, how do you get somebody open the door?

June Simmons:

Yeah, we have a contact center. We reach out. We do this for the Health Homes program. People who show up at the E.R. a lot and then disappear into the night and show up again. And how do you capture some of these high-risk people, whether they're leaving the hospital or whether they're just out there kind of misusing the system.

[00:17:00.630]

So we can do it. We have a contact center, can use letters, can telephone people or can text. Text is really good now because it doesn't use any minutes. So, it's very helpful for people who are low-income and concerned about the minutes on their phone. But sometimes those things work best as if a provider like of a physician group engages us as an extender for the high-risk people that should have at least one visit in the home. If they say, I'm going to have June come and see you, the odds go way up.

[00:17:36.600]

You know, we did this with Health Care Partners. We did a post-acute pilot with them. And while they were in the hospital, the hospitalist would tell them, these people are going to come see you. Here's a piece of paper with a picture of the coach. Let them in. So, then we had 90 percent uptake, which was great.

[00:17:54.690] Don Crane:

I was going to ask you, what's your batting average? Ninety, at least in that case, is it generally that high?

[00:18:00.390] June Simmons:

Oh, we can get up to 60 or 70 percent. We're doing a lot with Providence now. And the people they refer who don't have the benefit of somebody really making such a warm handoff, we are pretty persistent. We will even do a drive by. You know, sometimes somebody is either not answering the phone or maybe they don't really think they want you to come by. And so our team is pretty good about talking to them on the front porch in the non-COVID days.

[00:18:37.830]

And eventually they usually let us in because once we're in there as eyes and ears, as you were asking, you know, it's one thing to call someone and ask them what do you take? What do you do? It's another to go in to root around in the refrigerator, to look at the La-Z-Boy, look by the bed, look in the bathroom and the amazing things you discover that people don't think to report that are really substantial, you know, like Tylenol PM and pain meds and sleep meds. If people are combining all of these, it can be quite dangerous. And then you have, you sit at the kitchen table and go through and enter all these in the system. And the patient ends up with their own copy of that record. Sometimes they even create it themselves and so that prescribers really know what they're doing. But the other thing is to interview them, to really chat at the kitchen table about what they are taking or not taking.

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So, then you find the guy is worried his memory is getting a little shaky. So, he decides, OK, I really want to be adherent. He takes all the meds in the morning. So now he's taking his sleeping pill, his blood pressure, his pain meds…

[00:20:02.050] Don Crane:

I've heard the stories. It's amazing.

[00:20:03.980] June Simmons:

Yes. Or the little old lady who says you have to take this with food but I only eat once a day so I take them all at lunch, you know. Or what meds people don't have or they're worried about the cost. They cut them in half, you know, they don't get them filled. Under COVID, a lot of people couldn't get their prescriptions filled. They couldn't reach their docs. So, we did a lot to help them. We did a lot to help set up telemedicine, to really keep them connected with their physician as a centerpiece, you know, because we're not going to do anything with this med report.

[00:20:39.920]

We are going to get it to the prescriber, but preferably prescreened by a pharmacist because we don't want to give the doc any false alerts. You know, it's too exhausting in the world of alert-itis to give anybody anything that's not critically accurate and appropriate and something they should act on.

[00:21:04.700] Don Crane:

Well, speaking of our world and thinking about the importance of eyes and ears on the ground, how are you doing in COVID? You're not making house appearances right now, are you?

[00:21:16.550] June Simmons:

We are atypically making them. We are doing some work now with the Beverly Hills Fire Department, with some of their complex people. And since they go to the home, we just gown up, you know, PPE up and we go to the home, too. But in general, we're working very hard to do everything virtually. Our home visits, we're just doing them more frequently. We have a lot of people that are nursing home-eligible that we follow.

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We have a couple thousand people that are medically complex or old and frail. And so, we're following them more often because the risks now are a little different. So much as we would like to go, we do sometimes go to the porch, drop off food, smile and wave and talk. But one of the big issues under COVID is loneliness and social isolation. And so calling weekly and building people into, if they need it, friendly, caring calls, volunteer support.

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And a lot of people, older people used to deliver meals. They can't deliver meals to the home but they can do this kind of support. So, there's a lot of conversion to virtual kinds of interventions because as I'm sure you know, loneliness and social isolation, two separate issues...they are really deemed to have a life reduction likelihood of seven or eight years…they're equivalent to smoking 15 cigarettes a day. So, it's a risk factor we didn't used to track, but we're now all over it to identify it, to prevent it.

[00:23:13.340] Don Crane:

So, does this increased frequency of telephone visits and I guess other kinds of televisits—Zoom and the like—Does that counterbalance some of the shortcomings of a phone visit as compared to an in-person visit? I mean, are four phone calls better than one in-person? I mean, I don't know.

[00:23:34.220]

I see some advantage to frequency, frankly. Is that right?

[00:23:37.820] June Simmons:

Exactly. Yeah, there are some and you can, you know, take the time you spend driving and what you spend on mileage and, you know, so it leads us because we're always trying to stratify and say who needs what. But I think a single home visit or an occasional home visit accompanied by calls is good. But we don't want the calls all to be professional either. We like to connect people to natural support systems. We don't want to pay and rule out love, you know.

[00:24:11.090]

So, part of what we do is mobilize friends, neighbors and natural volunteer systems. There's a lot now that's being done for caring calls with volunteers. They get trained and they get put through a call hub that motion picture and television fund is doing so that their numbers aren't exchanged. So there's a little social distance and some matchmaking. So, you think you want to hook people up, but you don't want them to get in a scam, you know? So we do a lot of that. But the other thing we do is we had been doing a lot of in-person workshops for people with chronic conditions to help them change their behaviors to get better health results. They're all evidence-based programs. A lot of them out of Stanford for managing things like chronic pain, diabetes, hypertension, depression, anxiety, and then some are around falls prevention, which were done out of other research background.

[00:25:17.610]

So, we can't do those in person now. So, we've been converting to virtual interventions for those people. And while that's working and it's, you know, it's been a gigantic adjustment for our team. And to get the

evidence base converted to a non-face to face and make sure it had fidelity was important. But then what do we run up against next? It's the digital divide.

[00:25:52.190] Don Crane:

Sure. Sure.

[00:25:53.090] June Simmons:

So now we're really focused on the digital divide where we're thinking even eventually, I guess COVID will give us a break. We can get back to face-to-face. But when we aren't having to be, it's like telemedicine. Finally, we could do it. Everybody went, wow, this has some benefits, you know? It's really good not to have to drive. It's really good people not to have to scrape themselves together and get presentable to go out and be with others.

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There's a lot of benefit.

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So, we're working hard on the digital divide. Older people especially, it's a big adjustment.

[00:26:43.970] Don Crane:

So. let me interrupt with a question. So, I listen to hear you on a couple of occasions now use the words evidence-based, right? Which is perhaps a fancy way of saying that it works or at least its proven to work and based on data and all good, good things. And it reminds me of a Kaiser Family Foundation slide that was, I think, at our annual conference. Was it two years ago, fully three different speakers had it in their deck.

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So, it was definitely making the rounds. And I think it, you know, captured what most people regard as a truism, which is that in the United States, we spend like half of what they spend in Europe for social care. And yet we spend like twice as much as they do in Europe for medical care.

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The sum of the expenditures may be roughly the same. The outcomes are not, frankly. In other words, the care, the status of the health of the population, the United States not as good, but the total spend is about the same. But it's the allocation of resources that's so different. And as I listen to you talk about the

social side, I can't help but, you know, want to ask you your perspective on the current allocation in the United States. Does it make sense?

[00:28:03.860]

Should we look more like Europe? I know you don't want to disparage the physicians and the nurses that are providing the actual medical care, but you certainly must be a believer in the social side of things and would have a perspective on what our American healthcare system would look like and the results it obtains were we to reallocate resources. So, what are your thoughts on that?

[00:28:26.780] June Simmons:

Well, you know, America spends really four times as much as any other developed nation, even though we haven't insured everyone and our results are quite low relative to other countries. But I think that it's not that our practitioners aren't skilled and aren't good value-based, solid people, it's the reimbursement system. And I'm guessing you would agree with me. Fee-for-service, however well-intentioned it was, it's piecework, you know, and so it lends itself to the need to drive for volume, as Dr.
Chen actually had a rather nice descriptor of this, I thought, talking about how this kind of we get caught in a system where it's our job to keep the system strong, of course. But the way to do that under the current rules is kind of driven right now. They're riding two horses, I guess, but we're big fans of high-quality managed care. I guess any system can have its flaws, but we believe care coordination is critical.

[00:29:38.300] Don Crane:

Well, I was going to say if social care is so important, so effective, what's the status of funding for it in the United States? What's the organizational status? Two very separate questions, but where's the funding? And then start with that.

[00:29:56.090] June Simmons:

Well, it's starting to come. It's not been funded, typically. You know, mental health was even late to the table, which would be one piece of it, and insuring everybody so that they have access to care would be some of it. Housing is obviously a giant issue and access to food. We've been seeing all these cars lined up in food lines recently, but addressing these financially is emerging. Now Medicaid waivers have been pretty good about this.

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And for years we have watched over very complex people on a very low rate of pay. Like people nursing home-eligible that we keep home for average of five, six years at about under five thousand a year, avoiding the fifty thousand dollar nursing home stay.

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So, we know that it can be cost effective, but for whatever reason, probably because it's saving Medicare more money than saving Medicaid.

[00:31:02.350]

So, Medi-Cal then limits how much they'll spend to save the other guy money. But it's coming. It came around care transitions around the readmission penalties. We did a lot of work to try to demonstrate the power of addressing the whole person in their environment with their own behaviors and resources and skills. And we have, you know, we've published the results. UCLA just recently published it in our partnership with their medical group. We dramatically drop readmissions for high-risk Medicare fee-for-service patients through a single in-home visit and some phone calls and then home meds reconciliation.

[00:31:54.760]

But who should pay for that? The hospital...some hospitals actually are paying for it because they'd like to work their way out of their readmission penalty. But by and large, the hospitals driving away revenue by paying us to drop their readmissions. So, it should be the health plan or it should be the global risk medical group. So, we're looking at that and then

[00:32:22.150] Don Crane:

Who is paying you currently then? And how are you being paid?

[00:32:28.240] June Simmons:

Medi-Cal pays us for the high-risk nursing home, the nursing home diversion program. About a thousand people we have under care. They pay us, I think, three hundred and fifty-nine dollars a month. And we have that set number of people.

[00:32:42.490] Don Crane:

Is that one of them? Is that the Medi-Cal plan that pays you or is it Medi-Cal the state agency?

[00:32:47.950] June Simmons:

Yeah, it always was the state.

[00:32:49.660]

But now and in the duals counties, it's the Medi-Cal plan. But it's capped in size. We're only allowed to serve X number of people. So, and then we have another program called Home and Community-Based Alternatives, which serves any age, including neonates. And those are tiered.

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Each tier has a capitation rate for ongoing monthly care coordination. The one with older people includes us purchasing services so we can do home repair, bill paying, supplement their food, supplement DME that isn't covered, home and community-based alternatives. The state pays all those things and the state pays us directly for this ongoing care management. So that's a growing program. Health Homes is another kind of a program that is Medi-Cal. It's for people 18 and over. They've been to the E.R. at least three times in a recent period of time or they're homeless or at risk of homelessness.

[00:33:55.540]

And we find them. And if we find them and engage them, then we will get an ongoing care coordination fee. We get something if we get the health risk assessment completed and the health plan set up, the care plan and then something to keep them and implement it, get them to a consistent medical home, keep them from being homeless or get them out of being homeless. So those are again, those are acuity level rates. But Medicare Advantage now is, you know, moving in this direction.

[00:34:31.720] Don Crane:

Sure. With supplemental benefits. But so, tell me, though, it sounds like some of your payments are kind of almost fee-for-service, June, frankly.

[00:34:39.710] June Simmons:

That's true.

[00:34:40.800] Don Crane:

And now are you taking risk for you also made reference to a care management fee. Is that in the nature of a per member per month payment, for example?

[00:34:48.610] June Simmons:

Well, let's say let's take the nursing home diversion program. If we overspend, it's on us. So, it's capped. The size of the population is set and the dollar amount is set. So, if we get someone and we have to repair a broken stairwell, we need to…their refrigerator died. They can't stay home if they don't have a refrigerator, they don't have adequate incontinence supplies. And Medi-Cal doesn't cover them all. They need more than IHSS will cover in personal care.

[00:35:24.830]

They need a hole in their roof repaired. It's a heat wave and they need a window air conditioner. We're supposed to get them what they need that's not covered by Medi-Cal. So, we search where is it available in the community. And if it isn't, then we cover it. So, yeah, we carry risk in that regard. We have to keep them safe. We have them meet their standards and it's a flat rate. Same with the others, their flat rate typically the volume is controlled. So, it's still not like a full array. With the Providence Health System has invested quite a bit in trying to manage and optimize the post-acute experience with us. So, they pay us a case rate IF we serve the person. So, we do have to find and engage people typically for most of these programs. That's on us. If we can't find them and actually serve them, we don't get anything. But if we do find them and actually serve them, then we get a case rate.

[00:36:33.500]

Same thing Blue Shield of California and Anthem. We created a statewide network for them because how are they going to work with community organizations? You know, we're a community-based organization. We're not a health organization. We did have to get NCQA-accredited so it would be legal for them to contract with us. So, they pay us for some of these services. But we had to create a network of agencies like ourselves. So, wherever there's a Blue Shield or an Anthem member in California, we could verify that they would get served, get served timely, and get served consistently with a predictable, verifiable, evidence-based intervention.

[00:37:22.310]

So those are case rates also. But then the plan controls the volume because they're deciding who to give us just like health homes. They are giving us prequalified. These people are tough. If you can serve them, you can serve them.

[00:37:40.190] Don Crane:

So, you know, I listen to this…and correct me if I'm wrong…but it sounds like quite a patchwork quilt of providers and organizations you alluded to.

[00:37:54.560]

Sometimes hospitals will use you even if it's against their interest in some way. But health plans are using you. I'm aware of county agencies. You see churches are involved in this

[00:38:05.420]

to some extent…it seems like a rather, you know, oh, how can I be polite? As I say very.....

[00:38:15.000] June Simmons:

It hasn't been recognized as a regular benefit, but it's evolving. As you see, DSNPs now are starting to really be required to have these kinds of systems. Do they want to do it themselves and do they have enough volume that it's sensible for them or would they be wiser to contract with us as a lead entity for a regional delivery system customized to their client needs? And they could do that on a risk arrangement or not, but it's getting more close to being a benefit. Anthem is actually doing a breakthrough because Anthem is now saying and they're doing this…

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they started with seven states and they went to fourteen, twenty-eight. Now they're going to forty states that have what we call a home and community-based services network. And an IPA-like device like we have. Now they're just starting this month to allow the primary care physician to refer directly to us if the client...if the patient…meets criteria. Now, that's like a benefit. So, all of this is you know, I said we were a change agent. We're trying to move this as proof of concept. We're going where we can. We're showing a value prop. We're showing economic sustainability and other advantages to these kinds of interventions and working to prove them enough that they will hopefully eventually be mainstreamed.

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And they're progressing. You know, you see it.

[00:39:56.810] Don Crane:

As a change agent, what would you perhaps recommend as an optimum design, were you to architect a new design, a new organizational scheme, basically, for this whole function, what might it look like? Would it be owned by health plans? Would it be owned by physician groups? Would it continue to be completely disowned and, you know, operating in its own way? Who's going to take charge basically of the social determinants of health?

[00:40:34.580] June Simmons:

Well, we do think that the community-based organizations, the ones that are like us, you know, focused on this like a laser and skilled and have developed business systems, that we should do it. We like to say nothing about us without us. There's always a build versus buy. You say, oh, I see, social determinants really matter. I'm just going to address them. I'm going to have my team just make a few phone calls. You know, I'm going to do X, Y or Z.

[00:41:05.780]

We say this is a specialty. We believe it is actually knowledge and skill-based and it should be an alternate delivery system that is joined in to be fully integrated. But I don't know that it should be owned by the medical world that should move their dollars upstream when it's of benefit. Some of it should just be a social investment or society just isn't that good at that.

[00:41:36.440] Don Crane:

Made by the physician group?

[00:41:37.970] June Simmons:

No, made by society. Society should provide housing. You know, we should have social policy that works to have…get these people off the street. Really, should doctors have to get everyone off the street? But if doctors are at risk and they have someone in the street, then it's to their benefit to let us help get that person in a positive health-impacting zone instead of a devastatingly expensive and destructive health-impacting zone. So, then we become a tool for medicine.

[00:42:16.610]

So, it should be both. Societies should shape up and address some of these issues. But in the meantime, healthcare needs these solutions in order to really manage cost and quality measures and patient satisfaction.

[00:42:33.010] Don Crane:

I couldn't agree more, June. Time is running here and they're grabbing at me. We're running out of time.

[00:42:40.730] June Simmons:

One more thing. There is new move now to have information technology groups like Unite Us enter into partnerships like they have a national Kaiser contract and they make it possible for a closed loop referral so healthcare could say, oh, I'm going to refer out for social work, social interventions, and I'm going to find out if that worked or not. But I'm…but they haven't thought, oh, I need to pay for that. So, we believe that that's really a step forward to make this mainstream.

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But at the same time, we think it's critical that we then find a way to pay or we're just going to create a lot of big fat waiting lists and people will be frustrated. So, we're working with Unite Us now. We're working on a new offering we're going to take to market together to see if we can get there, the groups that have an arrangement with them to include a brokered network of services like we have. And we'll have the same kind of model I'm talking about.

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And it'll be paid for by the plan, but it'll be facilitated by an internal easy referral in and out. So, I think that's a next generation towards ultimate integration of health and social care.

[00:44:12.840] Don Crane:

Well, I certainly hope we get there. There is indeed so much talk about social determinants of health, but I don't think we've wrestled it down yet. And I think you're going to be one of our lead wrestlers, June. And it's going to be, how's that for a vision? You like that image?

[00:44:31.280] June Simmons:

Let's call it arm wrestling,

[00:44:34.040] Don Crane:

And it'll be really a pleasure to work with you on it going forward.

[00:44:38.480] June Simmons:

You've been so supportive. APG has been fantastic about this and we really appreciate this visibility as well. The story to tell. We have to show it. So. thank you for that.

[00:44:49.250] Don Crane:

OK, all right. Well, stay healthy, June. Thank you very much.

[00:44:52.400] June Simmons:

Thank you. Take care.

[00:44:54.530] Don Crane:

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We're going to have three days of excellent education to attend. Please just go to our website, APG.org, and you'll be able to do that readily. And finally, please stay healthy and we look forward to seeing you again.

[00:45:31.490] Announcer:

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