

WHOLE HEALTH: A COMMUNITY
APPROACH TO HEALTHCARE
PANEL

PANELISTS:

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MARK ISON, *SHERRARD ROE VOIGT & HARBISON, PLC*

DR. JEANNE JAMES, *STATE OF TENNESSEE, DIVISION OF
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WILLIAM WRIGHT, *PREMISE HEALTH*

Moderated by Taylor Wilkins, Riggs Davie PLC

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Larry Ramsey: I would just like to take this time to welcome everybody once again. My name is Larry Ramsey, I am the Symposium Director for the Health Law Journal. So, thank you all for being here. I would also like to make a quick announcement about our C.L.E. form. We are actually going to have the segments listed, and we are actually re-print that and distribute that to you guys so you can check each segment if some of you have to leave early or something like that. And we will distribute that to you as soon as we have it. So, without further ado, I'm going to go ahead and introduce our moderator, Taylor Wilkins for today's panel discussion. He's going to kick it over to the panel. Taylor is a founding member and former managing editor of the Belmont Health Law Journal. He also holds a degree in finance from the University of Tennessee. Prior to joining Riggs Davie PLC, he served as a law clerk for the Honorable Frank G. Clement on the Tennessee Court of Appeals. Taylor's law practice focuses on three main areas: business transactions and counsel, start-up companies, and private investment funds. Taylor assists his business clients with many different legal issues that arise during a business' lifecycle. Taylor helps the business with formation, day-to-day legal issues, and exit strategies. Taylor also represents both buyers and sellers in mergers and acquisitions. In addition to assisting businesses and start-up companies in corporate transactions, fund-raising, and mergers and acquisitions, Taylor also focuses on advising private investment funds. Taylor assists private funds with fund information, structuring, and compliance. At this time, please help me welcome Taylor Wilkins and he will introduce the rest of the panel.

Taylor Wilkins: Thank you very much for that introduction. As you can tell I don't practice in healthcare, but I am very honored to be here today, especially to be able to see how the journal has grown and where we are today. I am also very excited to have such a wonderful panel here to talk us through some exciting issues with these social determinants of health and how our healthcare system is changing. With that, I am not going to read five different bio's. I am going to kick it to our panel here and let them introduce themselves. Maybe we can start on the far end down here with Tera, please.

Tera Hambrick: Hello everyone, I am Tera Hambrick. I currently serve as the Director of Affairs and General Counsel for Matthew Walker Health Comprehensive Health Center.¹ It is a federally qualified health center here in Nashville, our headquarters are here in Nashville. We have three other locations, one in Montgomery County in Clarksville, and one in Rutherford County in Smyrna, and we have school-based facility in Pearl-Cohn Entertainment Magnet High School. So, we have those locations throughout the Middle Tennessee Region. I started with the organization in 2010 and developed the in-house legal services. I am a native of Nashville. I earned my Juris Doctor from Vanderbilt University Law School, I am a classmate with Mark Ison, 2004. I graduated from Fisk University and received my B.A. in political science and psychology. That's the gist of it from me. I guess for fun I like to do indoor skydiving and hang out with my six-year-old great niece.

Caitlyn Page: My name is Caitlyn Page. I am a partner at Waller in the Healthcare Compliance and Operations Group.² I represent many of those dinosaur health systems that Larry was talking about earlier, help them work through all of the compliance issues that they might have and trying to keep up with the increasingly complex regulations applicable to hospitals today. An increasing part of my practice is representing providers who want to do direct-to-consumer care. I effectually call it "retail medicine," kind of cutting out the payors. So, that's been an exciting new thing that I've been seeing in my practice. I'm also a Vandy Law grad and I like the idea of saying something fun. I really like to do event planning on the side so: baby showers, parties, weddings; I've done a few weddings.

William Wright: Good morning, I am Will Wright. I am the General Counsel Secretary for Premise Health.³ Premise is unlike any of the other healthcare providers that anyone has probably seen in Nashville. We are a direct-access model for self-funded employer plans. So that's a mouthful, but what it essentially means is the evolution of the factory nurse has grown into what is now 600 locations. We do occupational health, we have patients that are out

¹ See <http://mwchc.org/>.

² See <http://www.wallerlaw.com/Services/Healthcare/Healthcare-Compliance-Operations>.

³ See <https://www.premisehealth.com/>.

of our_homes, we have pharmacies, representing about 6 million lives. So instead of going through a T.P.A. or a commercial payor, we contract directly with the employer, so a large manufacturing facility or large corporate campus. We will put in a health services clinic, fitness center, pharmacy, wellness, yoga, chiropractor; a lot of different things that address a lot of different avenues for impacting the health of a work force. There's a convenience factor, but there's also productivity, and there's a retention element to it as well. I've been there since 2014, before that I was Chief Legal Officer for the Little Clinic which is a retail community care clinic. Native Nashvillian. I took guitar lessons for a 1926 Grand Ole Opry cast member when I was a wee lad.

Dr. Jeanne James: Good morning everyone. I am Dr. Jeanne James. I am the Chief Medical Officer for Blue Care which is one of the Medicaid-managed care organizations that manages TennCare members in the state of Tennessee.⁴ We are responsible for about 600,000 members within our plan. I've been at Blue Care since – for about five years now, but I spent another five years as a Medical Director with the TennCare program, so have had significant time with that area. I am a pediatrician by training, and I went to medical school at the University of Alabama in Birmingham and did residency training at Tulane in New Orleans. If anybody wants to talk disasters, you can see in my bio that I was Chief Medical Officer at Tulane during hurricane Katrina, which is how I ended up here in Nashville after the hurricane, so we can talk that on the side later. I guess I get a bravery medal today for being the doctor in the room of lawyers.

Mark Ison: I'm Mark Ison. I'm a partner at Sherrard Roe Voigt & Harbison and relevant to this, I work in our healthcare operations and regulatory group.⁵ I do a lot of mid-market small-market healthcare M&A, lot of venture capital work in this space, with start-ups, a lot of work mostly with non-hospital providers. One of the things I'm proud of is I'm delighted to have the opportunity to teach here at Belmont as an adjunct faculty member in the Health Law program and to see the fruits of the hard work a lot of the current

⁴ See <https://bluecare.bcbst.com>.

⁵ See <https://www.srvhlaw.com/>.

and former students that I've had the pleasure to work with here. It's very thrilling to see that and I'm very grateful to be here. Wow, we've got to come up with the interests. Classical music and anything in the outdoors.

Taylor Wilkins: Well thank you very much. We've had a lot of talk today on how healthcare is changing and the social determinants of health. Dr. Folwer, Professor Folwer gave us a very good demonstration of that so I'm not going to go into detail on that. But with all of this conversation in the healthcare circles about changing the way we address healthcare, what are you seeing with your practice and your clients that may be examples of how the industry is starting to think differently?

Tera Hambrick: Well I can start. For our organization, because we are a federally-qualified health care center, of course social determinants of health are always a factor in how we structure our care model. We definitely are focused on an integrative approach in a patient center. We are a patient centered, primary care medical home. So, we always integrate some of those considerations about food insecurity, housing stability, and what we've recently done in one of our truly successful projects, we partnered with Second-Harvest Food Bank to have a food pantry on site.⁶ So, for those patients who have, are screened for food insecurity, and also have chronic diseases such as cardiovascular disease or diabetes, they will actually have access to the food pantry to go there and select food items that are inclusive. So those efforts are in-house on-site and integrative. We have social service workers who are present and can actually come down and talk with the patients when those clinicians identify those determinants that are present or are higher risk for the patients. They are to connect the patients with those resources. Of course, that requires for us to think creatively about the private and the partnerships and funding. One of the things that Professor Fowler talked about is the funding challenge. Those things are usually grant-funded so we don't have a significant—there is no reimbursement for that social worker's services. So those are things that we have to find extraneous revenue to actually supplement the salary of that social worker. And of course, it's one person. I

⁶ See <https://www.secondharvestmidtn.org/>.

mentioned that we have four sites, we have four access points. Those services are strained sometimes because we don't necessarily have the ability to have that integrative model available at all times for every single patient. But where we can, we deploy those resources. So, it makes you think creatively about how to integrate the model and, of course, aligning resources to make it a possibility.

Dr. Jeanne James: I think for us as we've done as a health plan, case management services for members with chronic disease, we've realized, certainly for a long time now, that it's very hard to get a patient to or a member to think about making a change in their diet or their medication regimen if what they're worried about is whether or not they're going to be able to pay their rent or whether or not they have food access. So, we very often we have to solve or address those kinds of issues before we can even engage a member in anything that's medical. I think for us, we think about as a health plan as having list of resource of providers, but our inventory now of community agencies and partners like that for us to partner and work with and refer members to is probably just as big as our list of providers now because we've got to address those things before we can even get someone's attention about something that's a health need.

William Wright: I would say for our clients which are the employers, we see them increasingly focused on not just a medical model, but that integrated touchpoints. We have some that are very invested in lifestyle medicine, which is forks over knives, and we have gone so far, we hired registered dieticians, chefs to help people to learn how to cook within rural communities where they don't have access to a lot of things, not quite food desserts but pretty close. I think they're starting to see the value in bringing that into an integrative model and we do some of the condition management with the pharmacy.⁷ Having access, and our model is a essentially on-site work clinics, so its where the people are showing up to work, and being able to reach out and have a constant line of communication with that work force and to reinforce those messages of health and wellbeing, I think we are able to see some

⁷ See <https://www.forksoverknives.com/>.

outcomes that are sort of outliers. We really focus on that constant contact point and communication and reinforcing those good habits.

Mark Ison: And I would say from the other direction, seeing a lot of entrepreneurs really starting to push against the current payment models. They're thinking maybe even more aggressively than government and payors in terms of outcomes-based care, and bundled payments and coming up with ways to manage certain disease states or certain conditions that are multi-disciplinary that just wouldn't work in a fee-for-service model at all and they're being aggressive and actually going out and negotiating with payors. To say "here's what we can offer your members who have this condition or who are dealing with this type of factors" and actually pushing from that direction and saying "we have a better mouse trap, you know, if you'll come up with a way to pay us for it, you know, let's talk about how that could work. We think this will be a mutually beneficial arrangement." We are seeing more and more of that and that's really exciting as well to see the innovation coming from that direction.

Caitlyn Page: I would say, on the hospital side, my clients are, especially with this, movement away from fee-for-service to paying for quality, my clients are starting to recognize the importance of addressing factors outside of just the episode of care. Especially when you as a provider are going to be responsible for paying for any complications that arise out of a procedure, that's really helped my clients to start to pay attention to what causes these complications, what is causing these patients to have issues that make them come back. Currently the legal landscape is very challenging for hospitals to do a whole lot about that, but we are seeing some movement from the government in the form of new safe harbors and exceptions. I have seen several clients getting out there and trying to do things like transportation programs to help those who don't have a car get to their appointments, discount programs for certain patient populations to help them get access to healthy food, so we are definitely seeing a shift in our world as well.

Taylor Wilkins: Recently, H.H. Secretary Alex Azar stated that Medicaid may soon Medicaid may soon allow hospitals to health systems to directly pay for housing or healthy food or these other

solutions we've discussed today for "the whole person."⁸ I know we've kind of addressed it throughout the day, but what's the theory behind that statement maybe why now is the time that we've really made a push for that? Dr. James I'm going to single you out on this one.

Dr. Jeanne James: Okay. Well I think, and we've done some work recently in our health plan around members who frequently utilize the emergency room. Folks are going to the emergency room every two or three or four weeks and we look at a very long list of chronic conditions that they may have. But when you actually meet with those members and talk to them about why they're going to the emergency room, it's because they've run out of food. It's because they're lonely and isolated. It's because their caregiver is exhausted and needs rest bed and so they just come to the E.R. So it's really just been eye-opening for us to see and while you look at all these diagnoses on these E.R. claims, the real reason that they're coming there links much more back to these sort of social determinate-type issues, and we've got to solve those problems. You know, maybe it's somebody whose housing is unstable and maybe they can stay on somebody's sofa for a couple of weeks but when they get tired of them, then they end up in the E.R. again. Until we solve the housing issue, we are never going to solve that recurrent use of the E.R. I think that's true of lots of Medicaid programs and I think that's part of why C.M.S. that has started to recognize this. One of the things that I'm interested though, in then, if those then become things that we include in our services, what's the end point? How do we categorize those things and what do we include and not include? We've seen in Medicaid for a while now, we already do cover some housing services, we've covered transportation for a very long time, but we cover some things now that we call "supported housing" that are for people with chronic mental health conditions that have some supervision of medication administration and that sort of thing. I think we're starting to see that. Some of you may have seen a news article not too long ago that Kaiser bought an apartment building a

⁸ Paul Barr and Virgil Dickson, *CMS may allow hospitals to pay for housing through Medicaid*, Modern Healthcare (Nov. 14, 2018), <https://www.modernhealthcare.com/article/20181114/NEWS/181119981/cms-may-allow-hospitals-to-pay-for-housing-through-medicaid>.

few weeks ago in the California area.⁹ I think we are starting to see even big health plans thinking about housing in particular is an issue that the default very often becomes the E.R. if that's your challenge.

Taylor Wilkins: I guess we have talked about it a little bit but, is C.M.S. the best agency to be dealing with this? We have other agencies to deal with housing and deal with nutrition, should healthcare be the one that's stepping in and saying, "yeah we'll find you adequate housing."?

Dr. Jeanne James: Yeah, I don't know that I know the answer to that. I do know that we as a health plan have recognized the need that, I spend as much time in meeting with the United Way and the food banks and those kinds of folks as I do with providers today. Because, particularly for our population, those are the kinds of resources that we really need. So, I think we sort of recognize that we have to have that broader view. Professor Van Horn mentioned earlier about those studies and it really is true, the medical intervention is about 10% and genetics is about 20% and the rest is all environmental and social factors, so we've really had to add that to our spectrum. But whether it's for C.M.S. to reimburse for those things or for us to find more ways to not be siloed and have us work more closely with those who do housing and those who do food and those sorts of things, I'm not sure where we'll end up but I am excited that that's the focus now because I think that that's where we need to be. We as a health plan have recognized the need that, you know, I spend as much time in meetings with the United Way and the food banks and those kinds of folks as I do with providers today. Because, particularly for our population those are the kinds of resources that we really need. So, I think that we sort of recognize that we have that broader view. Professor Vanhorn mentioned earlier about those studies, and it really is true that you know the medical intervention is about ten percent, and the other ninety percent is genetics about twenty percent, and the rest of it is all environmental and social factors and so we have just really had to

⁹ Kimberly Veklerov, *Kaiser funding helps keep Oakland apartments affordable for 50 residents*, San Francisco Chronicle (Jan. 15, 2019), <https://www.sfchronicle.com/bayarea/article/Kaiser-funding-helps-keep-Oakland-apartment-13536854.php>.

add that to our spectrum. But, whether it's for CMS to reimburse some of those things or for us to find more ways to not be siloed and have us work more closely with those who do housing, and those who do food and those sorts of things. You know, I'm not sure where we'll end up. But I am excited that that's the focus now because I think that that is where we need to be.

Taylor Wilkins: Well I won't continue to single you out Dr. James, but not being in the area of healthcare, I remember somewhat from law school that I had Professor Ison, a very good professor. So, in recalling these, what are some of the federal laws that inhibit some of these things? Trent just mentioned transportation, we have mentioned housing, what are some of the federal laws that prohibit providers from actually providing them services currently?

Mark Ison: I can start off. In addition to the fact that the way the statutes are currently written I don't think there's federal funding, FFP, housing is not eligible for FFP under Medicaid for instance. But, from more provider specific categories, I mean certainly we have laws in place that would affect CMP (Civil Monetary Penalties Act) that would prevent a provider from saying, you know, in some cases, "Hey, let me help you out with that." You know that can be an inducement to a beneficiary.¹⁰ Now whether that's helping somebody out with a social determinant of health, a social need impacting or medical care should be looked at that way. That's certainly something for further discussion, but the way that it's currently written, other than some narrow categories for things that you can give to pregnant women for instance to encourage them to take advantage of prenatal care. Limited transportation, carve outs missing in the Anti-kickback statute (Inaudible). You know there are some very specific things, but, usually government is really lagging behind. The Anti-kickback Statute, the Stark Law, a lot of these regulations are sort of, years ago, Professor Glenstine at Vanderbilt would call it the "Soviet Style of Regulation."¹¹ Everything is illegal. Except for what we say is legal. So his point there is that under those laws it is all forbidden, you can't do any of these things. There is no flexibility, except for the twenty-eight safe

¹⁰ 42 U.S.C. §1320a-7a.

¹¹ 42 U.S.C. §1320a-7b(b); 42 U.S.C. §1395.

harbors and the twenty-nine Stark exceptions and some guidance from the OIG on this or that.¹² So that structure is definitely slowing things down in terms of the ability to find ways to provide these additional non-medical benefits to patients.¹³

Caitlyn Page: You know, compounding the problem is that even when there are exceptions set forth the OIG declines to define any part of the exception. So CMP does have some safe harbors for financial need but they refuse to tell you how you can determine financial need. But, if you do it wrong, then you can be subject to some severe penalties, possibly exclusion. So, it's very terrifying for clients, especially those who have targets on their back already just by virtue of their size and the nature of their business to, you know, get out there and just try something new and just hope the OIG thinks it's okay.

William Wright: I was going to say, even where there are exceptions and preventative incentives or something for preventative care, you know, what one agency may give the other takes away. DOL will look at some biometric incentives or something for meeting certain health standards with a suspicious eye that you're collecting some information that can be used in an ADA or Gina ill manner, so it's not just one hurdle you kind of have to look at them all together. So, sometimes people just throw their hands up and say we don't want to even get close to it.

Taylor Wilkins: Would there need to be maybe specific waivers that the government could come out with guidance, or would it just need to be complete reform on those?

William Wright: Inter-agency communication I think is what we have not seen.

¹² 42 CFR §1001.952 (Safe Harbor provision of The Anti-Kickback Statute); 42 CFR §411.357 (Exceptions to Stark Law).

¹³ Office of Inspector General, Dept. of Health and Human Services, <https://oig.hhs.gov/compliance/safe-harbor-regulations/index.asp> (last visited Oct. 6, 2019).

Mark Ison: That is true. You know, something as simple as employee wellness programs. They have shown to be effective. Get people out there providing employees with better food and options at lunch and exercise opportunities and helping them, encouraging them to do things like a health assessment and understand what morbidities they may have and how to manage high blood pressure. You know, things like that. Something as simple as that runs into all sorts of issues with the ADA and with HIPAA. There is guidance from CMS, there is guidance from the OCR, there is guidance from the department of labor and none of it dovetails. You are constantly wondering, “Well when they said it this way and they said it this way, do those two things mean the same thing or do they mean something a little different?” So what is the least common denominator for what I can do for my program? So to your point, interagency communication would be key.

Caitlyn Page: Stark and Kick-back (inaudible) in particular they are so very similar, but so different once you get down into the details, and I think I read that right now CMS and OIG both requested comments on potential proposals to deal mostly with coordination of care but presumably as part of that dealing with some social determinants of health, so I’m hoping that the timing seems such that they are considering trying to keep things in line with each other which would be extremely helpful if they could do that.

Tera Hambrick: I too am hoping that there be some specific guidance that addresses these unique situations that are coming about to talk about the pilot program that CMS is doing in some states where the programs actually allow for direct payment of housing costs. You know, that is in itself is unique and it’s not just providing food. That’s a healthy option to the patient that’s directly tied to their diabetes case or improving their health outcomes that you can measure pretty quickly. So that’s something that’s so unique that I think that we really need and are hopeful for some specific guidance on those types of things that we will be including on our platform as we provide our model of care.

Taylor Wilkins: For our panelists who represent either insurers, providers who are not really tethered by the Medicare or Medicaid,

what are you seeing in the industry that is shifting to this kind of thought, this outcome based, social determinants of health thing? Will you kind of touched on what Premise health is doing, what exactly is how the industry responding?

William Wright: Well, I think the number one thing is the fundamental economic model; sort of what Larry was touching on, we don't do fee for service, we build a capacity model. So, we work with a client to develop what sort of their outcomes are. Start with a goal and start with a target. But, we don't bill fee for service. So, again our average patient visit is 27 minutes, 30 minutes, probably 40 minutes on the first visit and the following visit is an average of about 27, 30 minutes. So that the physicians don't have to meet the grind of clicking people through and the staging between a nurse or nurse practitioner, a PA. The physician and the escalation model is totally different and we just see better results with the more time we can spend and then some of the inter-coordination we have with pharmacies and the ability to use pharmacists to help with condition management stuff, they are a fantastic resource. So the more communication and the collaboration we have with them and our pharmacies are also on site. So there is just a care model there that isn't based on fee for service, it is not based on volume. Then we have performance for guarantee so if we don't reach the outcomes or show a savings then we haven't a financial incentive to meet that, but it's quality driven it's not volume driven so it's a model that is working for us, it's working for our clients and employers. How it could be expanded in the community or in a different scenario is yet to be seen. It's very interesting to not be tethered to the fee for service model.

Tera Hambrick: In the community health center context it is a little bit different because you do have those quality outcomes and those are driven by the progress of the patient. At the same time, you do have service that you have to deliver to a certain number of patients to continue that federal funding that we receive in order to provide the subsidized care. So, volume is at the same time tied to these quality outcomes. But, what it really drives is how our teams are structured so we are looking at and considering the medication therapy management with the pharmacists, so we have clinical pharmacists that we're recruiting so the actual structuring of your

clinician and your care team, that model of recruitment is different so you are going to have more social workers on your staff, you are going to have those clinical pharmacists, and those case managers who are important in terms of coordinating the care. So the care team for the patient is driven by the level of staff that are actually following the patient after the visit. So they are following up to say, “hey did you get your prescription, are you doing those things,” so the care is starting with the clinicians inside, but those that are following up after they leave the clinic, so a lot of the work happens after they leave that point of care.

Taylor Wilkins: To the extent that we are starting to get more changes to the reimbursement structures and specifically ones that include reimbursements for these social determinants of health programs, what potential abuses do you guys see these health care programs? I know that a lot of the anti-kickback or fraud abuse statutes try to prevent these things, but I don’t know how that is going to adjust to reimbursement for these social determinant programs.

Mark Ison: Well as long as you are going to reimburse for service you are going to have those same problems, you are just going to shift them into other areas, right? Now you are going to have housing fraud, and unnecessary food. I don’t know, make it up. There’s no end to the creativity of the criminal mind, right? Lex Luthor, the criminal genius has to be a bigger genius than the regular genius. And, people will come up with ways to abuse the system. I think fundamentally for a lot of this stuff to work, you’ve got to move away from fee for service and toward an outcomes-based reimbursement and wow... that’s intrusive (inaudible). How do you do that? If I knew, I’d be on a beach somewhere. The fact is that if the government healthcare system is going to move into more and more and more and more of the rest of our lives, you can’t just keep paying people for input, you’ve got to pay them for the output. I think you can back into the rest of it from there, but I think that is the only way, personally, that it’s going to work.

Caitlyn Page: You have your standard issue of people who are trying to get a particular patient population, so they are going to offer benefits to those people but not these other people who are

financially less desirable patients, and that's always been an issue. I think that is in part what CMP laws were designed to protect so the more you open that up there is obviously a potential for further abuses, but that's true with any innovation and I feel like we should start by solving these problems and then we will deal with those when we get there. So, see what kind of abuses are coming up, you know that's how the home health space became so much more challenging, is we opened it up and realized like oh it's really easy to take advantage of this system, let's ring that back in.

Tera Hambrick: The other concern that I think ties into what I think Dr. James talked about, how do you know when those supportive services should reach an end point? So, in terms of what's a reasonable amount, is it six months of housing support or subsidies? Is it a year? How do you determine what the cutoff is to provide those additional points to address in social determinants of health? So, there you are going to get to the point where you have this ballooning cost because you have to define where there is a bright line as to where you do it and it is going to be different for every patient. So, I think that factors into how some of these services can bleed over into abuses and how does the government regulate that in a way to make it fair to the patient to actually support true quality outcomes in the patient's care. That's the biggest question I think is going to come out of that too.

Taylor Wilkins: And on the opposite side of that, what are some of your clients fears with reliance on these outcome-based reimbursement models. I mean it sounds great, but when you start putting it in practice, what are some of the issues the clients face or just their concerns moving forward?

Mark Ison: I think it's a lot like when teachers get upset about compensation models based on educational outcomes. I mean the human is a complicated animal, and health is a complicated thing. When you decide you want a pay based on outcomes, you have to decide who is responsible for the outcome. You have to decide where to put the incentive, or the punishment. Like the carrot or the stick, and where does it operate? Who gets punished financially if things don't turn out the way they could have, or should have, or might have? Is that person the one who had the ability to control

that? So, one example, just a small micro example. I've worked with a relatively small OBGYN practice in a rural part of Tennessee. Pretty much the only game in town, in terms of OBGYN. They see a lot of TennCare patients and TennCare implemented their episodes of care program where childbirth (OB) is paid based on... your payment to that can be, I think increased or decreased, based on cost of caring for the mother and the child from the period of time, I think it is a couple of months even prior to pregnancy through a couple of months afterward.¹⁴ The doctor who does the delivery is the one who receives the incentive or the punishment. Well, this OBGYN practice, and we actually were on phone calls with folks at TennCare about this, were upset because they were not seeing the patient in many cases until midway through pregnancy. There were months that went by before the patient had even sought prenatal care. In some cases, these were mothers, well, I mean it is the same social determinants of health we are talking about, in many cases they were on TennCare. Many times they were lower income, they had housing issues, they have domestic issues, they have other financial issues, they have opioid addiction, you know all of these things that tend to... you know, Charles Marie would say in his latest book a clustering in these certain parts of our country. They said, "What are supposed to do about that? You say that you are incentivizing us to practice more effectively, and to deliver better outcomes, but we can't impact some of these outcomes. We can't impact whether someone has gone to the emergency room for routine care five times before they ever come to see us. We can't guarantee you that they are going to show up for all of their prenatal appointments." So, that I think if you are going to start moving into that model you have to think critically about who is responsible for various aspects of the outcome and how you parse that in terms of the financial or other incentives.

Caitlyn Page: And I would say that the way that CMS is implementing pay for performance now is ... you know I think some people would question whether the right way to do it is to just piece by piece by piece. We're going to do joint replacement; we're going to do this cardiac episode. The individual programs they are coming up with are extremely complicated, very difficult to stay in

¹⁴ TennCare Episodes of Care, <https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html> (last visited Oct. 6, 2019).

compliance with. They do come with some waivers from the fraud and abuse laws, but even those, I was looking at the one for BPCI advance, it's 25 pages just explaining the waiver itself.¹⁵ So, I think a lot of my clients are very concerned about trying to stay in compliance with the existing healthcare laws and all of these additional layers that CMS has put on top of them. Not to mention the coordination of care issues. We've got HIPAA and all these other laws that really make it difficult to work together and we have to invest a significant amount of money in infrastructure for EHR and data management. Which, those EHR companies have been getting hit a lot as well. It is a little bit of a scary world out there, and I think some of it is by verge of the fact that CNS is doing one thing at a time and not really looking at it globally.

Mark Ison: It creates a lot of jobs for lawyers.

Dr. Jeanne James: I think too that it's systematic of the fact that we are trying to accomplish some pretty significant transformations, but the current processes still have to go on. So we are living with one foot in each world right. So you know, ultimately, and even if you get back to the example about episodes what we are hoping to transform care to be is that you know a provider has a panel of patients that are their panel that they have you know responsibility for and then benefit from the successes in their improved outcomes. But we still live in a world today where things don't start until the patient shows up. You know, so um, so things like a practice move to do this sort of outreach that my health plan does today to try to get people into a visit. You know, we're still living in that, in that, transition world of you know, how we look at, um you know, do providers just see one patient at a time when they come in the door, or are we going to move to something where it's a panel or a population of folks that they, manage and then we can measure and build these programs of the It's really hard to be in the middle of both, you know.

Taylor Wilkins: So in these systems, where do the social determinants help play into these reimbursement models? You know if you got your situation where someone comes in and they haven't

¹⁵ Bundled Payments for Care Improvement Advanced (BPCI Advanced)

been going to prenatal care, they haven't been doing that does it need to, does the reimbursement need to be adjusted for that? Is the? Does the, do the social determinants of health need to be ahead of that time where they are making sure that patient is in the hospital earlier? Or is it something where you've got maybe a bundled payment system and part of that payment is for things such as prenatal care and I mean where do the social determinants play into the outcome space?

Dr. Jeanne James: I think we are just starting to develop the tools to keep track of those things, you know, in all of the value based in outcome and payment models. You got do some risk and adjustment right? You can't just say that all patients are the same, you got to account for the fact that one provider that takes care of a lot of really sick people, then I want that counted into my risk adjustment so that the outcomes and the successes are measured fairly. And I think that many of these social determinants are in fact other risk factors, right? But we haven't had a way until recently to have codes and ways to keep track of those things for us to take those things into account. So I think that is one of the things that, that I hope will be into, to increase soon so that we can, you know, we can take that into account and give a provider credit for that. The fact that you manage this difficult homeless population, or you managed this difficult population that also, you know, has, some other concerns so that we can factor it into, into those models.

Mark Ison: And there is already some of that right? I mean, you know hospitals get paid more for taking patients that come in with this list of preexisting conditions and this media health care issue that they do for somebody without those things. And you know, physical therapist, when a patient comes in they have to evaluate that patient, and say "where are they now?" And based one where they are now, based on that indicates where they have to go. And that indicates, you know, the way the reimbursement is going to be. So, maybe we will have ICD 11, you know it includes all sorts of other social determinates in health, in addition to being attacked by an alligator.¹⁶ Which I think it is one that we tend, yeah.

¹⁶ International Classification of Diseases, 11th Revision, <https://icd.who.int/en> (last visited Oct. 6, 2019).

Taylor Wilkins: You know we've talked about it a little bit today and how technology really plays a role in tracking and telemedicine how is this really changing the world of health care? Um, what are you seeing in your practice in ways clients are responding to new technology as we move to telemedicine and, uh, other aspects? So, so what are your clients seeing or what are you seeing from clients?

William Wright: Well for us, we just made a big investment in epic bariatric care shop primarily. But any secondary, tertiary any health systems we want to interface with more or less epic has won that battle. And so for us to be able to communicate, and the meaningful use did a lot of good but it also scrambled the field a lot so there are a lot of dispirited systems that do not talk to each other, um inapproachability really has kind of come out of that as a project, uh as goal result. So, it allows us to do a lot of good things with the local health system so we can see if there has been any ER visits a scan that we don't have to reorder, there is a lot of savings there. And then the virtual health, telemedicine angle of it. You can distribute your capacity, among the geography. There is restrictions on, you know, state licensure and the federation model that's allowing more and easier access for uh physicians to practice across state lines. That's still an issue, but we're making progress. I think it's, you know, five years ago it was the next thing and then it stalled for a little while and I think it's back. I think the expectations are lowered to quote Larry. But I think it's, it's not going away. And so technology is going to be used in every interaction you know we see in the physician care provider interaction encounter.

Mark Ison: Even outside of reimbursement, you know, technology can be used in ways that you don't really pay for. I mean obviously, uh, it helps to get paid for them, but in a lot of cases you know. . . . And you called me professor earlier and I do not claim that on a rarity, you know, the title. One of the reasons is that I don't put the work in that professors put in right? I did teach a class, but I don't do the research so I don't have research on this. But my thought is that, you know, touching an encounter with a patient in terms of compliance with the health care plan, in terms of checking in with them to see if there are things that can be helped. Can you, in today's environment, can you refer them to, um, a medical legal partnership,

can you refer them to a housing agency? You know, some of these things you would have to do now. And technology can help with some of that in ways where the patient doesn't have to come into the doctor's office every day. Maybe there is a, maybe there is a transportation issue you know? But everything doesn't have to happen in the doctor's office, and so if what you've done is, and this is what I mentioned at the beginning, when I'm seeing this with some startups that are coming up with different ways to deliver, um, care and certain limited circumstances, and going to payers and saying "here is what we can do, and let's come up with a way for you to pay us for it because I think you're going to save money in the long run." And what these innovators are doing is saying, "Look, you know, we can communicate with that patient and using social workers and lawyers and you know, chaplains and whatever else you need. We can do that through video conferencing, and we can use wearable tech to keep track of people, and as long as there is some way for that to be financially viable, it doesn't have to be even in the current, you know, difficult state of telemedicine reimbursement. It doesn't have to be the doctor actually doing a diagnosis over Skype or over a telemedicine platform. So that's another way that I am seeing it used.

Caitlyn Page: And I think that, you know, in addition to making access to care easier, uh, technology has really helped in the data management side of things. You have to think about physicians' offices with paper records and nobody was ever sharing anything, you don't really learn a lot from that but now we are having you know, EHR systems in place to share information. You know, the law is still trying to catch up with that but uh there are opportunities now to start learning from what we are seeing and sharing that information with each other in way that we haven't been able to do before. And I think that's one of the big drivers of you know social determinates of health becoming so prominent is through starting to realize that this is a, this is a, big issue. That this is what is causing a lot of our unnecessary expenditures a lot of visits to the ER which you know, as a hospital you have to, you have to treat them no matter what their situation is financially, and so it's you know, ringing in ER visits is in everybody's best interest and learning how to help in other ways helps with that problem. And technology is really creating some opportunities to do that.

Tera Hambrick: One thing for technology and opportunity, and I know we keep saying that it's a lot, but there is so many parts of the equation to have to catch up to what we are already doing. When you talk about the social determinates of health and all these different partners of stake holders that come to the table the EHRs and the technology that is out there isn't built towards their focus and their work. So it's catching up it's a lot of times in our practice and lots of practices around the country the record keeping is disjoint. So, tracking some of those outcomes takes a lot more work, so it's labor intensive and that can be one of those factors that's a little discouraging. Because you have the social workers' report center here and they're not in a coding field, where you can mine that data very easily and so it takes a little bit of manual labor. So trying to take that component out of it is what the commissions and the other providers are asking or the stake holders are asking to see and hopeful that it's coming pretty soon where these EHRs will become some open type of network where all of these inputs can come in meaningfully spit out outcome results that you can quickly adapt and change your strategy with the basic population.

Caitlyn Page: And I think the OCR is actually currently requesting for proposals to help them deal with the coordination of care issues in relation to patient privacy so that's kind of been exciting to see that they're going to pay attention to that. I think that they are started to recognize that even if you can with health care operations sort of cobble your way towards a compliance situation that a lot of people are afraid to do that especially with the stakes these days and penalty that are closing so. It sounds like they're actually going to start thinking about creating some specific, you know, exceptions or permitted exposures in connection to coordination to care would be really nice.

Dr. Jeanne James: That's a particular issue in Tennessee around the opioid epidemic right? Because there are even some additional things, and um, rules about not disclosing because of employment impact and all of those kinds of things. So on the one hand I want to help coordinate care after a patient has had an overdose in the ER but what things can I tell some other provider without needing additional expressed permission of that member? And so, I think it's

another one of those that across agencies you know it is important, and I understand why there is employment protection so that your employer doesn't find out about this opioid addiction issue, but it gets in the way of us being able to get people quickly to care. So there are a lot of those kind of siloed examples.

Taylor Wilkins: Um, and, you know, with that, the technology what are some obstacles that you or maybe your clients specifically facing in trying to develop these laws that obviously move a lot slower than technology does. I mean I know telemedicine there's specific issues maybe with state law that address certain things, so what are some obstacles that your clients are facing with trying to develop these new technologies in the health care field?

Dr. Jeanne James: I think for us at the practice level, and I think that's even with working with practices with their electronic health records is depending on the size of your practice you know hospitals have and IT department to update their medical record and that sort of thing. Um, but um, a medium-sized office practice, you know, then it maybe one of the doctor's is sort of an IT guy on the side, but you know, they don't have that same level of support. So we've actually had to do some of those as a health plan. To sort of help them, you know, learn how to run reports on those EHRs or update it to something that's more useful so there's that whole sort of IT, uh, support need that I think a lot of small multimedia providers feel the pain of.

Caitlyn Page: You know, telemedicine, is a great, a great thing and it really helps you get, um, helps people to get care who otherwise can't make it to a doctor's office for any number of reasons. But the state laws are just now starting to consider making that an option so up until now it's been extremely difficult to engage in telemedicine. Some states have requirements that you have to physically examine a patient as a doctor in order to authorize anybody to treat them, that obviously makes telemedicine kind of useless. So, some states are starting to roll that back or institute new exceptions for telemedicine and others are not. And so, if you want to do something on a national scale it becomes very tricky because you have to go state by state and assess can "I operate here" And if so, "What do I need to change

about my business model to do that?” and often times it is your entire business model has to change so. Which is obviously not ideal.

Taylor Wilkins: We’ve talked about a lot of the issues with data and being able to move these electronic health records and recently there has been a lot with, uh, these disrupters in the field such as Amazon or Apple with their resources and what they’re doing with super data now. What issues do you all perceive arising out of you know them coming into the health care field with the use of data and information? No issues?

Will Wright: Yeah, and this is aside from the JP Berkshire mega health solve solutions that they are going to come up with. Um, you know, I think they are mining the data, it’s there, they’re finding out there are startups in play one called X, E, A, L, T, HXealth, xealther, cross-out ealther. But they are partnering with physicians, this is exactly, uh, to offer ancillary products, uh nobody represents them, to their patients after you see your physician they will push a panel of not prescription things not DME, but some of those ancillary products.¹⁷ They will show up in an email and they can select what they think is best for you, so it, that is where we start to get into the creepy sort of “why is my physician recommending, you know, this sort of arm brace for me opposed to just letting me kind of pick it out?” There could be some benefits to it, but there could be a lot of inadvertent information that could derive from that. The example of, obviously arm sleeve but, here is the blood pressure monitor you should use for your home use, well amazon might not have the ICD-10 that your hyper tensive or pre-hyper tensive, but they know that you just bought a, that it was pushed through a blood pressure cuff and you know with two or three little cookie crumbs they can piece together pretty quickly what your health status is. So I mean, I’d say we be very careful.

Mark Ison: A couple of things on that. One is people wring their hands an awful lot about privacy and yet we got an entire generation growing up now that has no sense of privacy, right? I mean everything is on, you know, social media and you know you’re just sort of out there. Um, we also have, you know, we carry around these

¹⁷ See <https://xealth.io/>.

iPhones, right? And it's very convenient to have Google Maps and Fandango and you know and to have and let them tell you what the movie is showing at the theater near you. You don't have to search for it, why? Because they are tracking your location, you know? It's very nice to have amazon recommend things to you, because they have your entire purchase history. I have always maintained that my amazon history is much more incriminating than my health record. I mean, because they could write a complete profile on me probably. What I read, what I eat, what I do in my spare time, what -- you know. So, I wonder, just wonder I mean I've always felt personally, and this is pretty controversial statement that HIPAA is the biggest solution in search of a problem in US history, right? I mean, don't we have laws that you cannot discriminate on someone based on their health care, you know their health status, right? We have laws that prohibit identity theft and fraud from somebody's social security number and all this stuff. So, I wonder if, you know at the end of the day we've got a society that is kind of moving on a little bit from this notion of everything has to be super-secret. And frankly there is nothing in my health record, and I know that is not true for all people, right? I know that there are some things that carry stigmas and you know, and some people have personal concerns, but I'd say most of us, there is nothing in our health record that would, so what? You know? It's like, so on the one hand, you know, I wonder if this is overblown. I think if our society may eventually realize we are going to have to give up a modicum of privacy in order to have these conveniences and these efficiencies. On the other side of that though is, in our country there is only a couple countries in the world that allow advertising of pharmaceuticals on television. It's us and then I think it might be New Zealand or something, and we use pharmaceuticals at a rate that is you know many many times, ten times more than other countries that do not allow that.¹⁸ Expand that to health care in general and put that in the hands of amazon.com. You know? All of a sudden, we are being recommended a lot more than just, you know, Lipitor. We are being recommended whole suits of health care solutions, shopping carts of health care services or items that you know we need, that they think, we didn't know we needed now we have to have. I wonder if that's not the more

¹⁸ John Marshall, *Why You See Such Weird Drug Commercials on TV All the Time*, Thrillist (Mar. 23, 2016) <https://www.thrillist.com/health/nation/why-are-prescription-drug-advertisements-legal-in-america>.

dangerous question. It's not that I went to the doctor last year and my cholesterol was a little higher than maybe it should've been. It's that, you know, is that going to damage the economics of our healthcare system moving further? So.

Caitlyn Page: I will say that the data analytics and logistics are you know are a huge part of advancing healthcare and I don't know anybody better than Amazon for those services. So if there's a possible opportunity here for Amazon to come in and help address some of the issues that we've talked about with data, managing data, and getting everybody on the same platform or getting the platforms to act together and just the algorithms necessary to take the data and actually do something with it and produce reports and make decisions so it could be a very exciting thing for them to start taking an interest in healthcare as well.

Dr. Jeanne James: I mean even something as simple as scheduling appointments in a doctor's office is really archaic when you think about how other industries handle scheduling. Right? You know? You think its 8-5 it's you know I've got to you know call a week ahead, those kinds of things. So I really think in some ways I've always thought that healthcare was a little too isolated from some other industries in terms of innovation that we don't borrow from other industries for things like that you know were schedule flexibility is much better at my veterinarian's office than it is at my primary care provider's office.

Taylor Wilkins: Well, with that I think we've still got some time, I think we're on schedule. If anyone has any questions, feel free please.

Question: Yes. It seems that the issues that you're addressing may be two fold. We're talking about what might be going on now, as Dr. James said we've have our foot at one side and then we're trying to look at another side. But when we kind of look at the big picture of why we are even here. You look at children not being able to get fed at school for different reasons. Professor Fowler talked about the MLPs, are there other types of partnerships that we could consider that we could give voice to even help us not in this state? I mean at some point how would we slow down so that we're not in this

constant state? How do we help people not stay in this state of constant need? You know can we give voice to that? I mean it's bigger than us, I get it. But should we be talking school systems are there things that we can give voice to that can help that?

Tera Hambrick: I definitely think it takes a strategic alliance with many different organizations. So yes, we should go to the schools. We should be looking at programs that help deal with early educations and give the support and services that can address those things that keep the student from finishing school. So that's part of what it is. But the number of stakeholders that need to come to the table is broad. You know? It's not just the school. It's also the employer who's work hours don't permit the parents, they're working two jobs and they can't come home and help the student with homework. Or, the child is up late because they're caring for siblings. Its pulling in childcare resources and all that. So it's such a large platform that I think we're just taking one bite at a time. But I do think that organizations have to align, and healthcare entities play a role in identifying what those things are so when you have those patients that come in and screen positive for some social determinates of health risk factors. . .(inaudible) The more integrated the services are the better the outcomes. So one of the things that we do is, we integrate behavioral health at the point of the primary care visits so that when the patient comes in for their physical, they have access to a mental health professional that same day. Because if they are identifying this issue or these stressors at that visit, but you're waiting to get them into care, like someone else mentioned, on the panel, they do make it to that appointment. But if you create the integration right there, there is a realistic arc of actually seeing some benefits as they continue in the process. And it's a slow-moving evolution but it's something that requires so many different stake holders in the community coming to the table: non-profits, the for profit sector, governmental agencies, and all the social services agencies that actually bear on that because it's actually more than one factor that prevents that child from graduating or finishing their education. That's my take on it.

Dr. Jeanne James: I wonder too if the professional education system can help with this some too. You know all of us as doctors, or lawyers, or other professionals are educated in a pretty solid

system as well and if there's an opportunity like the partnership that you talked about with the medical school and the law school and your partnerships. If there were ways to cross people over early in their training, then we train physicians to be used to interacting with all those other types of professionals from the beginning instead of just our lane of this is the thing that doctors do. I hope that at the education level we can see that happen.

Tera Hambrick: That model is developing at the Area Hills Education Consortium so communities throughout the country and Tennessee area "consortium" actually has those students that are in the clinical fields: dentists, physicians, and social workers who all are actually learning those things in the school system and professional education. And then when they leave they are placed in settings such as community health centers and clinics and actually developing that practice perspective before they even start their professional practice.

Question: Many public schools in the state don't have school nurses anymore, I mean that's a frontline position to help families and students in this holistic health experience that we are trying to achieve. So are there any programs to help get medical professionals back in the public school setting?

Tera Hambrick: Yes. I will try not to monopolize. So again there are safety net providers like community health centers and the governmental departments that have some resources to make physicians available, there are options to do that. But when that community health center establishes a school based clinic, the model is geared toward the students. But you have to think outside the box: is this model profitable? Does this work in terms of us allowing that amount of resources for the number of students that actually access the care there? So in terms of the business model, thinking about how that works. How do we expand that beyond just the student? We want the teachers and the professionals that are in the school to actually access the services too. Can we open that to the community and make it a model of something that fizzles out. Because that's what happens a lot. We actually have an access point that is available but then the model is not sustainable. So in order to make that sustainable, how do we reach a diverse patient population outside

the four walls of the school? But yes, being there integrated to the school makes a difference and it gives you an access point for identifying some of those social determinates of health that impact the entire family because of that one contact with the student. That model is a revenue intensive model in terms of the outputs you have to make for that because you may have a provider, a clinical support person (a medical assistant or a nurse), and some administrative personnel on site. And they may at that point see two patients, so that's a significant investment. It's worth it, but at the same time how do you make that sustainable? I think that has been the challenge for organizations like ours and other entities that want to make a difference and have been greatly impacting the school system.

Question: It seems that we've talked about sort of two buckets in terms of trying to address social determinates. One is like government coordination so to the extent that all the different departments that handle all of these different things that are arguably supposed to be under the Social Security Administration, right. So we could go with government and have government better coordinate so that we have housing and food and some of the safety nets that are one side alone are health safety nets. Versus, I mean I think the other bucket that we've been talking about is do we need to think totally outside the box and think about this just outside the government: innovation, doing healthcare differently, going through new models of care, new ways of thinking about it. What do you think is going to come first or needs to come first or those two things exist together? What are your thoughts on those two pathways in thinking about this issue?

Will Wright: They live together now. Like Larry said, basically we do half of them through a government funded and half through the ESI, the employer sponsored insurance. And so they live together and I think the innovations are different and they have different motives. But this doesn't mean that they can't grow up at the same time. So what I see on the employer sponsored side is but you have to have that employer, that employer's got to be sort of sophisticated and really caring about their workforce. I mean what I see when an employer is really invested in their workforce its usually in the manufacturing facilities. There are smaller rural in Mississippi,

Alabama, Indiana, Midwest and they don't really have that option and so its access to healthcare it's not even getting them to the minutia. They don't have nurses, they don't have primary care, but for the employer stepping up and saying, "I care about this workforce so I'm going to invest and ensure that they have that access." I think it helps from the administrative side. We can cut a lot of the expense by the way our model, which is low administrative overhead, as opposed to the government where you have to sort of coordinate, and make sure you have to jump through this hoop and that grant is funded or you don't run afoul of that part. There probably blessing and talons on both sides of it. But I think they can coexist and work together. Hopefully we can work some of this from each side.

Mark Ison: And that's fantastic. That's really impressive. Like on the employer's side particularly. On the provider's side, the government is the largest purchaser of healthcare and not only that but the government regulates so many other aspects of healthcare. Right? I mean, HIPAA applies whether it's a Medicare claim or a BlueCross claim, you know? So a physician practice, a primary care practice, that may be a lot of what we're talking about here, right, is primary care that would be dealing with the social determinates of health is already making such an invest to comply with this model of reimbursement, this regime of regulations, do they have resources? Money? Time? Expertise? To really boldly experiment when they're outside that. I wonder because in so many cases its difficult on the innovation side. I mean something as basic as the corporal practice of medicine rules. Those apply regardless of whether you're doing government healthcare or private healthcare. And you know that's a big impediment to healthcare entrepreneurship and some of that I know is based on concerns of public health but some of its just based good old competitive conduct by physicians who control physician licensing boards, etc. So I mean, there has to be a balance. Government has to be willing to come to the table because of its primary role. I mean most practices and most hospitals can't survive without government reimbursement without participating in these government programs. That has driven the standard for so long. Everything from reimburse is always tied to "What percentage of Medicare is it?" So many other things that have to have come to be understood as common practice

in the healthcare areas are all driven by what the government does. It can come from all angles but without massive reform at the government level, I just don't see how the physician caught in the middle is going to be able to both be able to spend all this time on working with patients through social determinants of health and yet on the other side stamp widgets and get patients through every fifteen minutes so he can get his Medicare reimbursement.

Caitlyn Page: I think the best thing the government could do would be focus to removing barrier to the innovation that the providers are coming up with because I think the providers know more than anybody on how to help their patients. At least better than someone very far removed from the situation. You know I have some clients who just said "well we're not going to take Medicare and Medicaid and we're just going to do this directly with the consumer." And they're using telemedicine and they're using some really great sophisticated software on the patient intake level and they've created some really great efficiencies, and through all those technologies such that they can offer these services directly to the patient. You come in this urgent care center and it's a hundred bucks a visit and then if you have, we can treat you for these things, and they have a price sheet and it kind of that dream where you treat healthcare like you do other services. You go in and there's prices and you know them in advance and you can get what you need and have some predictability there. So they're able to do that but only because they said we're just not going to take Medicare and Medicaid. And that creates. And as you said that's a big payer so that's a big turn off.

Question: Since you're talking about the social determinates of health, Chattanooga and Hamilton County and BlueCross BlueShield are involved in on a project to identify fifty people who are chronically homeless and severely and persistently mentally ill who are cycling through the criminal justice system as well as the healthcare system over and over.¹⁹ That is supportive housing is probably cheaper. But HIPAA is creating some of the difficulties there because it's easy for the jail to say we see these people all the

¹⁹ Megan Gienapp, *An Ambitious Approach to Homelessness*, Metro Ideas Project (Mar. 13, 2018) <https://metroideas.org/blog/an-ambitious-approach-to-homelessness/>.

time but you and that industry can't communicate back. And as we do social determinates of health, that's in that over and over again as you're working with housing homeless agencies and other non-medical institutions. You see work arounds because that is definitely something that needs to change at the federal level.

Dr. Jeanne James: I think we're continuing in trying to work on it. Sometimes the short term work around is we identify a member and as long as they give permission we can move forward. But sometimes it's hard to get to folks to get that individual consent. I know we're continuing to work on that because it's such an important issue. We've done some work recently across the state with some wanting to share information and referrals with some other community agencies and we are still working through the barriers of how do we do that between a primary care practice and the United Way or some other agency like that. And in the short term, we as the health plan sort of have to be intermediary because at least for now we are the ones who can pass those referrals back and forth. I hope eventually we will solve some of those things. I guess I would defer to my legal colleagues about what has to change in terms of regulations for that to work. But you're right, there's so much important use case of it right in front of us that I think it's something we've got to continue to pursue.

Taylor Wilkins: Any other questions? Bueller? Bueller? With that, go ahead and join me in thanking our panelist.