

MURLEAN TUCKER:

Welcome to Health Equity and the Cancer Care Continuum in Kentucky: Access to Medically Supportive Food and Nutrition. My name is Murlean Tucker, and I am here along with my colleague Jeff Bornstein. And together, we will be running this Dialogue4Health web form. Thank you to our partners for today's event, the Center for health, law and policy innovation of Harvard Law School, the Kentucky Cancer Consortium, Humana, Community Farm Alliance, and the Bristol Myers Squibb Foundation.

To start us off today, I would like to introduce Kristian Wagner. Health policy director of the Kentucky Cancer Consortium.

KRISTIAN WAGNER:

Good morning, everyone. And welcome from the Kentucky Cancer Consortium. Thank you so much for joining us. We look forward to exploring access to food and nutrition in Kentucky across the cancer continuum through a health equity lens this morning. We also have a follow-up discussion about health equity and food access on June 17, the information will be in the chat. Thank you to our panelists for lending your expertise today and thank you for the Center for Health Law and Policy Innovation for creating this unique opportunity. Now I will pass it over to Sarah Downer.

SARAH DOWNER:

Thanks so much, Kristian. I am going to ask for the slides to be taken down so I can share my slides. We will get started with today's webinar. A huge welcome to everybody for the Health Equity and Cancer Care Continuum webinar. Our mission at the Center is to improve access to care and quality of care, healthcare for folks who are living with chronic illness or are at risk of chronic illness. We have been a partner with the Kentucky Cancer Consortium for a series of discussions around equity as it relates to cancer and healthcare. So to start us off today before we get into the meat of our discussion, we are going to start with a definition of health equity so we can keep that focus throughout today's conversation.

So health equity, when we take a look at what is here on the screen, we are pretty much familiar with the quality in the healthcare space and otherwise. We know it is not enough to just have a quality. Our folks have evenly distributed tools and assistance, because sometimes the playing field isn't level. If you have the same tools and assistance, it is not going to get you to the same place. So we are really looking and focusing our conversation today on equity. The definition I am going to use comes from the Robert Wood Johnson Foundation. Health equity means that everyone has a fair and just

opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare. So the conversation we are going to have today on this webinar is going to be squarely focused on the healthcare space, but the question is if we want equity. If we want custom tools to identify and address inequality, what does healthcare have to look like? What services does it include? How does it deliver those services? That is the discussion we are going to be beginning today and continuing to have.

So what we are going to talk about today, all of the things we will talk about in this space of medically supported food and nutrition, that is going to get us a little closer toward equity. It is only if we authentically listen to community input, adjust our activities according to community input, maybe we will get there if we are building these special tools. But ultimately, what we really want to see in this space is justice. We want to fix the system to offer equal access to tools and opportunity.

That is where all our conversations are going. That is going to take transformational change. We are going to have an eye on that as we move ahead, even though we recognize some activities we talk about today might not really get at that justice piece. When we look at this, we have this representation of justice as a tree. Trees grow the way they do naturally, but we really need to understand that the reason our sort of resources are unevenly distributed has a lot to do with deliberate actions, deliberate policies we have made historically. This is not something that is naturally grown up over time, these are policies that we as folks who live in the United States have put in place. So we can also fix policy and change policy to fix the system. That is what we are really moving toward. We are going to start the conversation with equity in this space of food and nutrition access.

So I am joined today by an amazing array of panelists. I am just going to run down what we are going to do today. I'm going to first introduce Doctor Colleen Spees. She is going to help us understand the science and what the research tells us about nutrition and cancer in particular and why we really need to be expanding access to these services, especially in the context of cancer. I am going to talk about her bio and just a moment. Then I am going to come back and talk about the national landscape of what is happening across the country when it comes to nutrition and health care. And how we can really start to think about getting increased access to these types of services that we will talk about today in Kentucky. Finally, we will unite with the rest of our expert panelists. You see them here on the screen. I will introduce them in detail more later to talk about activities on the ground in Kentucky that are happening and examine those a little more closely to set us up for action in the state.

And now I will dive into and introduce our first speaker, Doctor Colleen Spees. She is an associate professor in the Division of Medical Dietetics at The Ohio State University College of medicine. She is a member of their Comprehensive Cancer Center. Her research focuses on developing, implementing and testing interventions aimed at providing optimal nutrition for vulnerable populations. She has got a lot of experience here. Our focus is on developing and improving access to culturally appropriate health promoting interventions, and right now she is doing a study and testing the efficacy of nutrition counseling and medically tailored meals in the context of cancer treatment. She will talk to us a little bit about that.

She is on the American Cancer Society's scientific review panel for dietary and physical activity guidelines. She is a real expert in this space. We are excited to have her talk to us today. So I will hand it over.

COLLEEN SPEES:

Thanks so much, Sarah. What a beautiful introduction to health equity and just so comprehensive. It is an issue that is very near and dear and also challenging to my heart. I hope everyone can see my slide. I am going to go ahead and get started because we want to give the other panelists plenty of time to share their knowledge and expertise. I can't wait to hear what they have to say.

Let's start by talking in terms of nutrition and cancer what we find to be the most pressing thing. I want to define the word malnutrition because many people don't understand what that is. Malnutrition is basically a sub optimal nutritional status or physical state of unbalanced nutrition. Again, what is really shocking to people is we think of undernutrition or malnutrition, we think of this then, someone we are seeing on commercials on TV that need food, that type of thing. But really, what we are saying more nowadays, especially with cancer, is a state of over nutrition when folks are getting an adequate or unbalanced nutrition that could then also causes them to have some optimal stores of certain nutrient and cancer fighting type nutrients, but over nutrition and other areas. They might present with overweight and obesity often. We also when we talk about malnutrition need to talk about specific to cancer related malnutrition.

Notes that this is very difficult to assess. Anything I tell you today and any statistics you just have to know that it is under representing our most disparate and high risk populations out there, leading back to this conversation around health equity. So what we know is 20 to 80% of folks with cancer have the various states of malnutrition. Up to 80% have weight loss before even treatment. Another slide, I will glance over this quickly when we get there, up to 50% show up with malnutrition upon their diagnosis. So many people are malnourished and don't even know it, but definitely that beginning of cancer and what it does in the early stages and to the metabolism absolutely leads to a greater risk of malnutrition.

I am not going to get much into the specifics of cancer cachexia or (unknown term) or these, other than I want you to understand that if we can keep folks well-nourished and follow them across the cancer continuum, we are talking cancer prevention, we are talking during and throughout treatment, and even posttreatment survivorship. We can help directly to reduce cancer deaths occurring related to terrible malnutrition.

So Sarah set this up beautifully with the social determinants of health disparities and cancer. Again, along the bottom you can see the cancer continuum, from prevention to posttreatment survivorship. We have to keep this Venn diagram very much in mind when we are talking about potential interventions or policy or any of the things we need to do to try to fix this. I love the tree analogy because we need to think about each one of these areas and even more than this. This is just three huge areas we know to impact the cancer continuum. We really need to take about these along the route, and that tree analogy is so fantastic.

So let me tell you what we know. I already mentioned 50% of cancer patients present with some level of malnutrition. Sarah also mentioned a study I am currently involved with, which I will present to you here, and what we know about lung cancer is that up to almost 70% of patients at some point are diagnosed and found to be malnourished. 35% of patients have clinically significant weight loss, and it is defined different ways now, but still greater than 10% of body loss equates to what we categorize as severe malnutrition that affects prognosis. Again, 50% of low income and minority patients are food insecure.

This is just compounds and makes treatment more complex. It makes access to food more complex and all of that. So we did a national survey across all the cancer centers. It was frightening, our results. We found that there was only one registered dietitian for every 2300 cancer patients in oncology outpatient ambulatory settings were over 90% of cancer patients are currently treated. The ratio based on the evidence that would be more ideal would be one dietitian for every 120 patients. So one dietitian every 2300 patients is not OK. We need to be talking about fixing that. I know many folks are great stakeholders on this call today, and I want you to be thinking about your patients and are they receiving any kind of nutritional care or are the dietitians being called on just to put a Band-Aid on something quickly, and they are running around with their heads cut off. Is your cancer center meeting these needs?

So here's some of the economic burden of malnutrition. You can see we have overweight and obesity related illnesses, not even talking about undernutrition, equates to about 190 billion per year. That is such a burden on all of us, isn't it? In terms of cost-effectiveness, for implementing and fully integrating nutrition into oncology care, I just quoted you about a terrible ratio that is almost, should almost be – I don't want to say, the standard of care is just not there. I don't know how to say it any other way. The point being that in terms of cost-effectiveness we don't have enough trials on the impact of nutrition because we don't have enough dietitians and people who can do them because they are not already part of the standard of care. So therefore we don't have enough folks across the nation we can follow to really measure the impact.

The lack of reimbursement is the major problem at this point. CMS and other payers do not reimburse for oncology services in the United States at this point. There are some places statewide where there is package and they have some sense of reimbursement, but again, across the nation this is not reimbursed for oncology at all. This becomes a burden because it comes down to money.

Most of the CMS guidelines are based upon for cancer the NCCN cancer guidelines, and there are 165 guidelines because we don't have enough evidence at this point. We were successful, our oncology national group, in getting nutrition into five or six of the guidelines in the last two or three years. We are working on that.

So why does nutrition matter during cancer care? We do have solid evidence to show that folks who are well-nourished have higher rates of morbidity and mortality, and the treatment interruptions directly impact their prognosis. Every time there is a treatment interruption based upon a nutrition impact symptom, they have to stop, they miss some treatments, their prognosis actually is poor. Readmission rates are higher for hospital stays. Also, the length of stays are much greater. The nutrition related side

effects are colossally greater. Then you can see the decreased tolerance to chemo, radiation, overall quality of life, functional performance, all of those things.

I added this slide because sometimes when we talk about science and the statistics, what we sometimes forget is the patient. The most meaningful trials I do always measure the quality of life because in the chaos of cancer, these folks and their caregivers and families are just devastated. We have to think about how to improve their quality of life. We know if we have nutrition fully integrated throughout the cancer continuum, dietitians are equipped and trained to handle much of their nutrition related consequences that cause them to have interruptions in treatment and have anorexia and all those types of things. We have to always keep that quality of life in mind.

Here is what we know from the evidence. This is mostly during treatment. Therapeutic nutrition or medical nutrition therapy delivered by oncology dietitians can help to solve a lot of those problems that were mentioned about reducing quality of life in the previous slide. I this is recorded and you can sit with the slides later, so I won't read all these to you, but I think you will see this in your patience. You have had many of these types of side effects may be or in the folks you work with.

So what is our strategy? So my lab is called HOPE Lab. Our strategy is really to promote individual biobehavioral interventions that spanned the cancer continuum. I have randomized trials currently funded in each of these three areas and I wanted to share what we found to be most helpful. That might get some of you thinking about what you might be able to apply in your area or look at Kentucky as a whole, and those types of things.

So what we basically did in the past decade is try out active ingredients, which are listed at the bottom. The active ingredients for all our biobehavioral intervention trials seem to fall into the same domains. That is providing food provisions. So here what you see are pictures of my actual garden. I am virtually coming to you from the garden today. It is a 2 acre garden. We have cancer patients you can see at the bottom, these are beautiful cancer survivors and patients right off of treatment that come out and harvest. We provide the food provisions. I talk about another trial where we shipped the foods to the folks house, we are starting a new trial doing a CSA to people's homes who are underserved and have transportation barriers. We provide evidence-based education because folks often get confused or pulled into the internet with misinformation, so we want to let them know about what we know to set them up for success.

One of the biggest things we do is individualized behavior counseling. That is informed by motivational interviewing, it is nutrition, physical activity, but again, it is a way that individually we can help address and help our lower resourced patients to understand their own barriers to success and help them to set reasonable goals. They also have than a relationship with the dietitian in my lab that follows them throughout the continuum of care. We do a digital tracking as well.

So this is a crazy busy slide. There is no test on this, and these are all published, but these are three trials across the bottom. These are what we measure. You can see here we find in every one of our garden based behavioral trials here is clinically meaningful and significant results in all of these areas. Improved body composition, functional status, blood pressure, lipids. What we are trying to do is set

them up for success because we know if we can encourage folks to adhere to the evidence-based guidelines for diet and physical activity, we can actually improve their outcomes and their quality of life. So both physical and mental health. We do a lot of biomarkers too, which is fantastic, and we're getting more and more into that, so it is great.

Now, this is the study Sarah mentioned that is launched across the nation. I am a co-PI with tufts. This is nutri care. It is the first randomized trial we know of to actually fully integrate nutrition into cancer care for vulnerable lung cancer patients. This is an overview that shows you a map of the four cancer centers currently enrolling for this trial, and we enrolled about half are participants. We start enrollment last year. Again, we have a goal of 150 vulnerable patients. You can see who our target population is here on the side. As many of you probably know, by the time someone is diagnosed with lung cancer, they are mostly stage III or stage IV. Many are smokers or already coming from rural or disadvantaged areas that have less access to healthcare. But we on top of that are putting in the highest risk. We are only accepting folks who meet this vulnerability criteria. This is funded by Bristol-Myers Squibb, so we were so thrilled that they recognize the importance of a nutrition intervention such as this.

What does that intervention entail? Well, what we are doing is we are engaging the healthcare team by asking them to we have adapted this 5A model, and I won't spend much time on that because we can read about the study. We are providing remote nutritional counseling once a week to these patients the minute they are diagnosed and throughout survivorship for eight months. It is informed by medical nutrition therapy informed by motivational interviewing, and we are shipping medically tailored meals that are decided by our dietitian in terms of what the patient needs at that moment in time. It is 100% remote for the entire intervention. It is fascinating because it is something that can be scaled up and taken nationally to other cancers as well and other cancer centers.

So let's talk more about the medically tailored meals. This is a study that was put out by MANNA and published in JAMA Internal Medicine and showed that tailored meal programs and shipping meals to folks actually resulted in less hospital admissions and a skilled nursing facility visits, savings per month total healthcare, which is fantastic, and healthcare costs.

So because of this we were able to say we need to be trying this. This is much cheaper to be shipping meals to folks to their home, especially if they are food insecure or don't have access to meals or if there cancer treatments have them too sick to go out and seek food provisions. So what we are doing is shipping them for eight weeks they are getting three meals a day, and then we do a step down fashion. Again, all through this eight months they are talking almost weekly to dietitians there helping them to learn how to change their dietary patterns so they can start to incorporate, because we know shipping meals to people isn't sustainable the rest of their lives. We have to teach them the behaviors and help them to adopt what is culturally sensitive and what works for their families and what they have access to it is convenient and they enjoy. So that is really where the dietitians and the food access come together. We find, and other studies have proven, it is like a dose effect when you have those two together. It is very important to think about.

Again, a busy slide. This is really just showing you what we are measuring. I'm going to move along in a second. It is an eight month trial. This is basically all the things we are measuring. If you remember

in the first few slides when I talked about malnutrition, he mentioned many of these things. Nutrition impact symptoms or they might have difficulty swallowing or anorexia. All of these things we are measuring because we now they are directly tied to malnutrition or sub optimal nutritional status. I highlighted the gut micro biome because this actually wasn't in the original trial, but we added an investigator from Ohio State that said they would love to join the study and measure this. The reason I measure this is because there have been some studies that show a high-fiber diet is actually altering the gut microbe I am in a way they have proven and melanoma patients so far that they have a five fold increase response to immunotherapy. That is just an amazing, amazing thing. So we are measuring it, and our dietitians are making sure our patients in this trial are getting the adequate amounts of fiber.

So what can you do in the meantime? I would say follow the research. I always advocate for more research. Because until we can prove that nutrition matters and we can even improve quality of life and hopefully some outcomes of folks, we are not going to be able to get funding reimbursement for all of this. Always help to educate the payers and the stakeholders about the importance of nutrition. For yourself and your patients and those you work with, and even if you are on today and you have a family member, create a culture of health for your family and for your patients. If you are in a healthcare setting, screen for malnutrition. There are very simple screening malnutrition tools. We found in the national survey that less than 50% of outpatient cancer centers screen for malnutrition. And we asked them why. They basically said be careful what you ask for because they know if they are going to diagnose or find in the screening many are at high risk for malnutrition and they don't have the dietitians and people available to deal with it. So it is a problem like food insecurity that if you don't ask then you don't have to deal with it. I don't think that is part of the giving tree, right? And encourage adoption of the evidence-based guidelines. Know them, understand them, follow them. Try your best to understand and acknowledge individual patient barriers. It doesn't mean you're going to solve them, but if you can help to refer patients to dietitians or get them to somebody or community resources, food pantries and things just to help, but you have to have somebody who has a minute to ask them about their barriers, if you don't have access to dietitians who no motivational interviewing and that type of stuff. I will stop there and handed back to Sarah.

SARAH DOWNER:

Thank you so much. That was wonderful. I am going to come back really quickly to talk about the national landscape when it comes to food as medicine or medically supported food and nutrition services. So given all that Colleen said, she really helped us understand what is at stake for folks long the cancer continuum, both from a standpoint of prevention to treatment and into survivorship.

This is the opening of this conversation. We are going to think more about how we can bring things to Kentucky specifically and a second conversation. There will be a link in the chat. It is going to be a meeting and discussion format for folks. We will be able to see each other and talk more in detail about the kinds of things we will be able to do in the state, windows of opportunity in the state.

So let's talk about the food is medicine in the national landscape. When we are looking across the country, there is this consensus. Understand nutrition is a major driver of health. It is really closely interconnected with health. So there is a consensus among healthcare organizations, healthcare

companies, insurance companies, all of our government systems that we need to address some of the nutrition challenges we are facing as a country through the healthcare system. So we made some strides toward this. I am going to talk a little bit about what that looks like today and sort of where we can go in the future with that. We will open it up to the rest of our panelists and talk through what is happening on the ground in Kentucky.

So first of all, when we talk about medically supported food and nutrition services, what we are really talking about are things that are happening in this overlap between the healthcare system and our food system. So this is where we are starting to deploy these equity tools. We are starting to think more deliberately about what is it that people need, who needs it, what are they not getting? How are these services being delivered? How are we understanding the kinds of services people need? This is the area we are really starting in. We really need to recognize that there is a context in which these two mammoth systems sit. Lots of things that are pressing on these systems and making them work the way they do, tensions within them, things that need to be unpacked. We have systemic racism that has informed the development of both of these systems over time, so when we think about them coming together we have to be deliberate about the ways we are approaching this particular space.

So just to put this conversation and the scope, we are going to talk today about what happens at the intersection of these two systems. We recognize all these other things are playing into this and are factors we need to be also thinking about as we move forward.

So what is happening at that intersection right now across the country? Well, there's a couple of things that have started to come to the forefront of interventions that are deployed in this scenario. We are talking about this here today, I am going to talk about interventions that combine provision of food or financial support for food purchases with a nexus to the healthcare system. Although nutrition counseling is amazing, and Colleen talked about why it is so, so important to make sure it is employed throughout the cancer continuum, I am going to focus on those interventions that are also combining that with food provision. We know it is not just about education. Lots of people know what they are supposed to be eating or at least maybe have an idea of what they're supposed to be eating, although they can always use more and better information. But it is also about accessing the actual food itself.

In the context of that, it is also really important that our clinicians understand nutrition in the way Colleen described. So what I want to do is sort of draw attention, this is a visual representation of what is happening and that overlap between the healthcare system and the food care system. I want to draw your attention to the bottom of that sort of pyramid where we have the emergency food and antihunger social service programs, SNAP, WIC, etc. All of the things going up in this space, these medical nutrition interventions, are sitting on top of the social safety net food programs. So we need to keep an eye on that because it is really important that those programs exist, are robustly funded, are as innovative and sort of also addressing the equity concerns we have as possible. That is the foundation in which all of these other things can exist. If that bottom layer goes away, we are going to have a real issue with making the rest of the interventions that we see in this space as effective as they need to be. So what we see is that there is a spectrum of intensity of need and complexity of the intervention and the populations that need them.

So we have a prevention to treatment spectrum that we are plotting these along, and these categories are really dynamic. These are all developing in the past decades or 15 years. We really need to note that these are new to our healthcare system, fairly new to our healthcare system in terms of being deployed specifically within the healthcare context. We have these produce prescriptions and medically tailored grocery boxes. Colleen mentioned community supported agriculture box of produce being sent to participants in her study. This is through provision of food for folks who have some kind of health condition, or maybe they are identified as at risk for some health condition, or just concerned because they are food insecure in the clinical context. There are also the medically tailored meals she discussed for a smaller population with special needs. These are the patients we are seeing in the cancer context. They are on lots of medications. It is tough to go through cancer treatment. There is a lots of interplay of side effects and things that are happening that can be ameliorated through nutrition interventions. So a medically tailored meal might be appropriate for those folks.

This is what we are seeing in that space right now. So when we think about the challenges of making it possible for these things to be integrated into the healthcare system, let's think of the healthcare system, the traditional healthcare system, as this house. You've got this healthcare system as a house. Imagine if you are going to invite new folks over to your house who have never been there before. That is really the case when we are thinking about food, transportation, housing, support for other things. These things have not traditionally been included in our healthcare system. If you had a house and you were going to invite people over, you would know they were going to come into your front door. You would kind of look around and make sure there were no things lying in your walkway. You would make sure the rug was flat so people could come in the door and a really easy and comfortable way. You think about the layout of your home once they were inside. You think OK, maybe we will clean the bathroom or put this guest next to discuss because they would really enjoy talking to each other at dinner.

In this case, the healthcare system, the door is locked for a variety of reasons, which I will get into in a moment. That means what is happening is when these interventions come all the things we now are important and support people's health, when they are coming into the healthcare system they are getting through these little cracked open windows. It is awkward. The fit is awkward. It is difficult for healthcare providers and organizations to support people. These aren't built into reimbursement streams and payment streams and delivery mechanisms. There is no infrastructure for figuring out how to get folks to the things they need. This is the situation that we are in. What we are trying to do is retrofit healthcare system to fit these things in and transform it moving forward.

Just to get a little bit into the barriers, and then we will open it up to conversation, one of the locks on the door is the idea there is not enough research. We do have a lot. The evidence is growing. Doctor Colleen Spees is a big part of that. We do know from the peer-reviewed literature that medically tailored meals are associated with reduced cost, hospitalizations, ER visits, reduced ambulance transports. It helps people go from the hospital back to their homes instead of to skilled nursing facilities. We have some evidence also from produce prescription or medically tailored food boxes that there is also improved clinical outcomes and an impact on stress and depression, which I think is an underexplored area. Doctor Colleen Spees talked about that as well. The patient experience peace is huge. And then improve dietary quality as well. Another barrier is we are wondering, is this

healthcare's job? We have a consensus that we should get more out of our healthcare spend. In the United States we make a disproportionate spend as opposed to other countries on healthcare as opposed to our social service programs. So if we are going to spend all this money on healthcare, we should get more out of our spend. This is one way to do that. There is confusion. What are all these things? How are they defined? How do we know when we use them? Some of the best practices are emerging. But we need to be careful because this is such a dynamic space, things are still developing over time. If we are centering equity in these conversations, we need to be clear that we need to be developing the interventions with community input, having really robust opportunities for participant and community input along the way, and then changing and adapting things to that. There is a tension between standardization and rolling out these interventions across the board and making sure they are flexible and can adapt to local situations and local communities.

Then there is this question of but what about all the other things people need? We focus on food, what about housing? What about transportation? These things often go hand-in-hand in terms of what the needs are. So healthcare is really striving to meet multiple needs at once. It is hard. They are adopting a standard practice to screen for these multiple needs. What this is pointing to is this need for really deep multisector collaboration. We need lots of different systems to be working together. We haven't really developed a perfect way to do that yet in the way that we need to.

And then this final piece is something that Colleen really underscored. I think we are going to continue to talk about this in our expert panel when we bring on Leslie and Martin, where we are going to talk about infrastructure. The nuts and bolts of community clinical partnership and what we need in the healthcare system to be able to respond to nutrition needs across the continuum in the healthcare space.

So we've got this clinicians and staff need to be able to recognize nutrition needs and identify the appropriate response. I think what Doctor Colleen Spees underscored is this is not always your standard everybody eat more fruits and vegetables and go forth, or everybody lose a little bit of weight and go forth. In cancer it presents very differently. People need to understand that. Especially when we have – I have seen a question in the chat about how we are talking about overweight and obesity. We need to really sort of delve into all the things that go into the interactions that are happening between patients and their clinicians in the nutrition space because a lot of times clinicians are shutting down the conversations from the outset because they don't have the knowledge and they are not equipped with the knowledge they need to really respond to what their patient is actually experiencing and what their patient actually needs to support their health.

Healthcare providers and plans have to be able to provide the responsive service themselves or for people to it in the community. That takes an infrastructure buildout that we are just now engaging in and doing on a national level. Sometimes this is happening and offer people whom I have diabetes or prediabetes, but it has really made it all the way into the cancer space yet. We need to be thinking about how that works. And then healthcare and community organizations need to be able to work together. They have different cultures and different legal regimes they are operating underneath. Different laws and regulations that apply. So when they are trying to work together, sometimes there are barriers in that process. Everybody can get really into those barriers that prevent them from doing

their work, and we can forget about centering the patient, the individual, the program participant at the heart of this and making something that really works for them. As opposed to making something that really works for the healthcare provider and the community organization.

Those are some of the barriers. There's a lot of really innovative stuff that is happening with respect to integrating some of these services into the healthcare space. We are seeing incredible innovation within healthcare organizations and healthcare companies where they are doing lots of different activities. These are often started by true champions and these spaces. Never underestimate the power of an internal champion to get this program started. They are deploying food as medicine programs, creating medical food pantries on site within hospitals and clinics. They are making sure that patients and members are accessing SNAP and WIC and that the healthcare system is actively participating in making sure that happens. They are adapting bidirectional community referral platforms that can refer people easily into the community and the community-based organizations can say yes, I saw your patient, and here are the things they received.

But right at the heart of all this innovation is that in order for them to be sustainable we have programs that need to be generally integrated into policy. That can be institutional policy, so a hospital or health system can say we will have this medical food pantry, it will be available to everyone and we will put that into our operational funds. Or it can be through government, that big P policy, like we are going to get reimbursement through Medicare or Medicaid for this service, and that is how we are going to make sure it is sustainably available, not just through time-limited grant funds. And medically supportive food and nutrition can become a benefit. That is one way we are starting to see for the sustainable access.

And just to spotlight on this a little bit, when we are looking at this we see that there are a couple different Medicaid programs in the country that are doing incredible work right now. In Kentucky, about a third of the population has access to Medicaid, so we can imagine this would be a transformative thing to include in Kentucky's Medicaid program. We have different states that are doing different things. In Massachusetts, through the Medicaid program, they created a fund that they are accountable care organizations and provider care organizations could spend just on health-related social needs like food. So a wide variety of services they could spend this money on. If they don't spend this money on housing and food supports are things that fall into the parameters of this fund, they don't get the money. It is a use it or lose it fund. Then we have North Carolina. They are implementing these Healthy Opportunities pilots, again, rolling out funds within Medicaid they can address five areas of need, including through this one. And then in California, through their waiver there giving explicit permission to all of their Medicaid managed care organizations to cover food and nutrition services and have those services included in their capitation rate. That is great for the MCO's to be able to offer these services as a benefit. The path California is taking is something that can be deployed almost immediately in Kentucky.

Finally, just to say some potential next steps. We are going to think about viewing opportunities and pathways in the Medicare Advantage and Medicaid programs. I am going to ask my colleague to drop a policy scan into the chat. We talked at a high level today about what you may be able to do to expand access to these key programs. We have done a complete deep dive into all the ways that can

happen. So if you want more information about that, how you do that through Medicare, Medicaid, and some of the other programs, we have a list of the ways that happens. We will drop that into the chat. You can identify other sources of funding. There has been an influx of federal dollars into states for the COVID-19 response. We know that food insecurity and nutrition issues have become worse with COVID-19. So you can gather stakeholders and come to consensus on how we expand access to these services in Kentucky, use them to scale the reach of these programs, especially to people who haven't been served, and then conduct research on the best way to move forward. We have to center racial and ethnic equity and that research and be sure that the programs and policies that we are developing are things that the community wants, that the community needs, that are designed in the ways the community can really benefit from them and use them, and that are actually providing value to the community potentially and otherwise. Are they employing people from the community to deliver these services? Are they using community-based vendors for these services? There's lots of different ways we can think about this. So we should be actively doing that.

So now I'm going to invite Doctor Colleen Spees to come back and I'm going to ask Leslie Clements and Martin Richards to join us. They will have an opportunity to introduce themselves and their programs. But just to give you a really quick sense of who is here with us, we have Leslie, who is Humana's lead for corporate citizenship and impact. She is really in charge of making Humana's mission of inspiring health and well-being for all. She is in charge of making that real. She brings a focus on inclusion, diversity, equality, and belonging and that work. We are really excited to have that lens on our conversation today. She also is very passionate about arts and social justice, so we are going to bring it all together in this conversation. Then we have Martin Richards joining us, executive director of the Community Farm Alliance in Kentucky. He really embodies this idea of multisector collaboration to bring these things to life. He was a partner in a design and construction firm, was the economic development organizer for Kentuckians for the Commonwealth, thinking about energy and sustainability issues, now the executive director at Community Farm Alliance, which has a number of programs we will talk about today, including an active produced prescription program. So Leslie and Martin, if you can come on and join us. I'm going to maybe ask Leslie to start by giving us a sense of her role at Humana and what Humana is doing in this space.

LESLIE CLEMENTS:

Thank you so much, Sarah. I am going to share my screen and if I can just get a verbal confirmation from you that you are able to see my slide.

RACHEL LANDAUER:

It is great, Leslie.

SARAH DOWNER:

Leslie, just swap to presenter view.

LESLIE CLEMENTS:

Thank you. How does that work?

SARAH DOWNER:

Perfect.

LESLIE CLEMENTS:

Excellent. Thank you so much for having me today. As Sarah mentioned, I have been with Humana for the last 15 years. So it has been but a journey for us as we learn so much more about this space, about food insecurity and how that impacts our members, how that impacts the other communities that we serve. So I want to share with you really a timeline here that talks a bit about Humana's journey and what we have learned. Really starting with 2015. But those of you all that are based in Kentucky, you have maybe heard of what Humana referred to as our old school, which is a population strategy to improve the health of the people in the communities we serve to make it easier for everyone to achieve their best health. It is really a focus on social determinants of health and health equity. Both Humana Inc. and the Humana foundation have implemented priorities to address these health disparities we see and our communities. Health disparities are types of health differences that are closely linked with social, economic, and environmental disadvantages, some of which we talked about already. It is our belief that Humana that if we address the root cause of health disparities then we will improve health equity. So this timeline really shows what we have been doing in this space since we launched the Bold Goal in 2015. He made a decision to refocus on social determinants of health with a specific focus on food insecurity because we saw a strong correlation with our members who were experiencing unhealthy days and food insecurity. If you are not familiar, the Centers for Disease Control has an assessment they use called the Healthy Days Assessment. That is what we use at Humana to determine really how people perceive their health. We found it is a pretty good leading and lagging indicator to really help us understand what health is like for our members.

So we've been leveraging that since 2015. We started to implement some pilots at that time. Starting in Florida, Humana has quite a few Medicare members in Florida, so we started an early pilot screening people for food insecurity. And also screening them for their healthy days. When we identified that someone was food insecure, that is when we implemented our first intervention in this area, which was sending those folks home from the clinic where they received a screening with an emergency box of food and also making sure they had connections to SNAP, WIC, and all the other resources they might be entitled to. So we learned a lot from that.

One of the things that was mentioned earlier is this idea that for a lot of providers it is tough to have conversations about food insecurity. Particularly if it is not an area that they now much about. Or if it is not something they feel like they can actually address. If you don't have a solution to offer to your patients one they tell you you are food insecure, it is not typically a conversation that providers really wanted to bring up. So based on the learnings from that, based on some of the interventions you are putting into place, we pulled together and partnership with Feeding America a position to get to make it easier for providers to have those kinds of conversations and know what to do if they did indeed identify that someone was food insecure.

You might be asking why we care about this. Some of this has already been addressed in the earlier conversation, but one of the things that we know at Humana and in the healthcare space is that 60% of health has to do with the interplay between socioeconomic and community environments and health behaviors. Health habits outside of the provider's office, it really happens in our communities. We were

learning through looking at the data of our members and seeing their healthcare utilization was that as their social needs increased, so did their healthcare costs.

We also saw a decrease in their compliance with getting their preventative care and taking their medications that they needed to. So it is a really obvious link for us. We can address this. That can help make people healthier, and ultimately that is a lot less expensive than buying medication on the backend. That is really the reason why we decided to do this work and it put us on this journey to start some of these pilots and really taking a deep dive on our food and security pipeline of research and partnerships and analytics and interventions.

So I mentioned we did this early discovery work with partners like Feeding America. We also got really involved with the Robert Wood Johnson Foundation. That is how we learned initially to define food insecurity, starting to identify some of those best practice screening instruments, which we heard a bit about earlier, and then relayed the insights on how food insecurity can impact health outcomes. That is what led us to these small test and learn quality improvement projects, looking at mechanisms for screening, documenting and referring to solutions.

And since then, you can see on this timeline we have done a lot more work. We have been able to develop a food insecurity predictive model using member food and security screening data. We can look at our members and identify do we think they would be at risk for food insecurity. That triggers us to reach out proactively to those members. We started that in 2018. We have done a lot of development of risk for food insecurity, doing predictive modeling and even using natural language processing technology to start to identify words our members might use to help trigger us to bring in an intervention. It was also 2018 that the Humana Foundation named their first cohort of food security investments. So while Humana Inc. was working on social determinants of health, the foundation evolved its strategy to focus on social determinants of health.

So lots of work to implement screening opportunities through foundation partners as well. As we continue to learn, we were able to start integrating this into our benefits. So just as you saw some states that are integrating food security benefits through Medicaid, Humana is doing similar work for Medicare. We started some of that testing of benefits through a partnership with Meals on Wheels, which not only impacts food security, but also social isolation and loneliness. It was mentioned before that if you have food insecurity, chances are you probably also have other social needs. We recognize the isolation and loneliness is a challenge that affects a lot of folks. It often does show up with food insecurity. So Meals on Wheels was a really natural partner for us to start working with. We brought on other working partners and communities, lots of food banks to help us think about how we wanted to bring and other interventions.

And now we started to work with the National Quality Form, because it is our intent to codify food insecurity as a quality gap and care. So by working with NQF, we are trying to create policy measures to be that much more consistent. We are now scaling some of this work in clinical operating models, and in 2019 alone we had over 1 million screenings for social determinants and food insecurity. We have been able to scale that into more insurance product benefits. At first we did that with postacute supplemental benefits with Meals on Wheels and now we are doing that with newer opportunities.

As they say, hindsight is 2020, and certainly that highlighted many issues related to social determinants. It really provided an opportunity to expedite some of these interventions we have been putting into place in Florida and expand it into other markets. So it has been an interesting learning journey for us. We are working on this, as I mentioned, both the foundation and through Humana Incorporated. We talked about prescription produce programs and things like that earlier. That is a big part of what we are doing too with these food benefit cards, making that available to our members.

And then also not only thinking about that immediate intervention, someone screens positive for food insecurity, let's put them in touch with this kind of resource, like a food card, but we are also realizing there is so much more to do generally in the system. That is where a lot of the foundation work comes in. We have a lot of restrictions that come with the Center for Medicare and services that the Humana Inc. site is allowed to do, but with a Humana Foundation we can test and learn all sorts of things. I really appreciate the model that we saw earlier. The foundation also has a 5A model, but ours are access, really addressing swamps, deserts and food apartheid, affordability, making sure food is affordable to the people the foundation serves, making sure it is available, not just once a week at a farmers market when you get your food delivery, but all the time. Awareness, which brings in that education piece, and appeal, recognizing that different cultures and different medical conditions require different kinds of food. So also the autonomy, making sure people have access to choose the food that is best for their diet.

So lots of work happening in this area. I know we will talk more about some of the things that we are learning and some of the metrics we are using and how we are integrating equity into this space. So looking forward to sharing more.

SARAH DOWNER:

Thank you so much, Leslie. That was an awesome overview of all the stuff human is doing and how it has developed over time. And now I'm going to turn over to Martin and asked him to share work about the Community Farm Alliance in this space.

MARTIN RICHARDS:

Thank you. It is a pleasure to be here. I guess it is now afternoon. So yes, my name is Martin Richards. I joined Community Farm Alliance 25 years ago as a farmer who was transitioning our traditional cattle and tobacco farm into organics. So these days I often say I am a recovering farmer. CFA was formed 35 years ago during the farm crisis in 1980s by Kentucky farmers who felt they didn't have a voice in the policies that created the farm crisis. But even before that, they created a suicide hotline to help their friends, family, their neighbors to weather that storm. Then they created CFA to help be a voice and those policy discussions.

You know, what we have learned over the years is that people on the ground know their problems. They also have a pretty good idea of how to solve them or what the solutions are. But CFA kind of helps them take that to the next level. Whether it is policies, whether it is resources, whether it is connecting one community to another that has the same problems. Our theory of change is about beginning at the grassroots, having those conversations, and then we often create programs or

projects that directly address those problems instead of just waiting for policy. But then we use those projects to be examples to secure public policy, whether in Frankfurt or in Washington. One of the things is that several years ago we created the Healthy Communities Initiative is a comprehensive approach. It is already been mentioned, the health of a community goes beyond just the physical health but the social and economic health. If we don't address all of those things comprehensively, it is just a drop in the bucket. We also do this work and collaboration with a whole lot of partners. We come from the farming point of view. These are our three goals around the Healthy Communities Initiative. I want to talk about two of the programs we do as a direct response to what folks on the ground have identified that they need.

So double dollars was started in six Eastern Kentucky farmers markets in 2014 to provide incentives for folks utilizing their WIC farmers market nutrition benefits or seniors or their SNAP benefits. Again, to support food access into support Kentucky's family farmers. So in 2021, that has grown beyond farmers markets to five retailers and this great consortium of Fresh Stops, community farmers markets and CSA's. There is now over 70 double dollar outlets in Kentucky, and that is only growing. I did see Karen's name on there with New Roots and I am glad that Karen is a part of this. The other one is fresh RX for moms. This grew out of the pharmacy program in a county in which CSA was a part of along with a bunch of farmers markets and Mountain Comprehensive Healthcare. We tried to expand the program and simplified a little bit. For the first two years we hope to pilot a communities farmer market in Bowling Green with support for WellCare, and after two years we worked out the kinks and are ready to expand that with the USDA funding to additional farmers markets in the state. So last year we did that expansion. It turns out 2020 was not a great year to expand to a vulnerable population like expecting mothers, but we worked through that for this year. This program is not just about increasing food access to healthy fruits and vegetables. We also, along with community partners, including nutrition education. There is a dietitian on site with every one of the farmers markets. Now we are able to offer cooking kits along with the food. As well as cooking demonstrations, recipes, the list goes on and on. It is much more comprehensive. So this year and moving on, we are going to rapidly expand this program to make up some lost ground. Including next year where we have the funding for seven additional markets. I suspect some of those will be in Louisville, but we haven't identified those markets as of yet. It is pretty exciting what this program does, the impact that it has on in the communities. Those participants, because it really is family based, so our goals are really we would love to see this kind of prescription program not only cover the full term of pregnancy but to be on, to the point where the kids are starting to eat their first whole foods. You want that food to be fresh and local and all of the above. We are also doing, because a lot of this funding is coming from USDA National Institute of Food and Agriculture, it is technically a research project. We are working through that to gather the data, to continue to evaluate that data, and continue to make the point.

A big part of that data is the economic impact of not only Fresh RX but Double Dollars, and the impact is huge. Especially when you factor in the impact to the local economy and agricultural farmers. I don't have those numbers in front of me because I don't have a head for that kind of stuff, but it is encouraging. We will have a more comprehensive report probably by the end of this year on all that economic impact. The next step is to include in that economic impact the impact of the nutritional aspect of it. As we have been talking about, through prevention, the upfront impact as opposed to on the backside of healthcare. So put in all those numbers together. It is huge. It is huge from a policy

point of view. We are already seeing that for public investment of funds it is a really good investment of public funds to invest upfront in the food access, the healthy food access. We all collectively just have to make that case to policymakers, both in Frankfurt and in Washington. I think we will talk more about that. I just want to end with the collaboration. This is a huge collaboration. Again, from Double Dollars, it is actually separate programs with separate funders and evaluation and data collection systems. It is the behind-the-scenes infrastructure that makes all this happened. And the funding that goes along with that. So I want to thank all those folks that you see here for making this happen. So hopefully, I have created a little - gotten us back on track timewise. Thank you very much.

SARAH DOWNER:

Thanks, Martin. That was an awesome overview of the program at the Community Farm Alliance. Given where we are in time, I am going to focus us on equity concerns. As you have been thinking about the programs you been doing, the research you have been doing, as you have been expanding the things you have been working on or shaping them, where are you finding some of these inequities coming up? How are you moving to address these things? I will start with Colleen, actually.

COLLEEN SPEES:

That is a very important question. I will say that in my trials we actually recruit folks that fall under the health and equity umbrella. That is very unusual for most clinical trials because we don't have a lot of great evidence and the trials of a folks who are from underserved or underrepresented minorities. Part of that has to do with transportation barriers or timing barriers or a lack of trust in the system, especially with research. The list can go on and on and on. What we need, so we and our studies, and that is why it is very difficult, address all those barriers. Transportation is a huge one for us and our clinical trials. I suspect Martin runs into that with the farmers market sometimes. That is why utilizing and thinking, it takes a village. It really does. I agree so much with Leslie and Martin in terms of the collaborators. No single entity can do this on their own. We really need to work together. But I also don't want to sound doom and gloom and that I have been a dietitian for 30 years. I am telling you, it is amazing that we are even having these discussions now. We never talked about food like this in the past. It was always about medical nutrition therapy for hospitalized patients. Here we are talking about food access, food patterns, fruits and vegetables, all the wonderful things. I also hold out great hope. It doesn't mean we don't have much work to do in this area, but I think these kinds of webinars, forums and introductions to other people and our growing collaborative efforts are all the start to something amazing. I finally, after 25 years, I am like we are talking about food! We are talking about food! It is thrilling. I will stop and let them pass on. It is something we need to get better at addressing and get more folks in my arena and the clinical trials so we can have more evidence to support the greater need.

SARAH DOWNER:

Leslie, can I go to you next about this? All of Humana's work over the years, I am sure you have been thinking about this a lot.

LESLIE CLEMENTS:

Yeah. We have a pretty long-standing commitment to try to understand what the social context is, where our members live, and what those personal challenges and barriers they are experiencing are.

So beginning this year, we are starting to study and share racial health disparities within Humana member populations. It is just one lands on health disparities, but it does bring the right opportunities to achieve health equity. Now as we start to marry that information with other demographic and socioeconomic data we have on our members, that even more opportunities are going to emerge. Here in Kentucky in particular, we are really starting to expand on what I was talking about before. We just launched the Louisville Community Opportunity. Humana is headquartered here in Louisville. We have a lot of access to information here, members, and a lot of our employees work here too. This is giving us an opportunity to focus on collaboration, as you mentioned before, with new and existing partners to focus on health equity, particularly in the West End of Louisville, which sees a lot of health disparities. Certainly COVID-19 has resulted in more disparities for different populations in our communities, and we have seen how the pandemic has had a disproportionate effect on Black community in particularly to a loss of employment and employment that was affected by the pandemic and quarantine. Fewer opportunities to work from home, greater reliance on public transportation. We talked about that being a barrier. We are partnering with Feed the West and Black Market Kentucky and Food Mart to try to address that. From a foundation perspective, we recognize there is also an equity when it comes to which nonprofit partners receive funding to be able to provide nutrition to the people that they serve. A lot of a BIPOC led organizations and organizations that are led by other diverse people just don't receive the same amount of funding that larger nonprofit organizations to that are white light. So the foundation is really trying to focus more on how to address that disparity as well. Working with federally qualified healthcare centers because we know lots of Medicaid eligible patients are going there because these are folks more impacted by food insecurity and other social needs. So here in Louisville as long as other FHC's across the country, we are putting in screening opportunities and connecting folks to food insecurity resources, not only making sure they have all those fundamental supports you mentioned earlier, but also things like the Healthy Food card. This has been an important learning for us. As a result of what we are learning throughout health inequities, we created a new role recently. You may have seen where Humana just hired our very first Health Equity Chief Officer, a doctor from The Ohio State University, and so we are super excited because we know she is really going to help to define what our enterprise wide measures of equity will be. The foundation reports to the doctor, the team reports to the doctor, so this will be a great opportunity for us to coalesce those learnings and hopefully bring to bear more interventions for more people that we know have a particular need.

SARAH DOWNER:

Martin, I'm going to turn to you.

MARTIN RICHARDS:

It is a huge issue for the Community Farm Alliance. I have to say the whole reason for CFA was formed is the lack of equity for farmers and the say in the food system and policy. This is even more so in agriculture and the systematic racism that has been part of agriculture since this country was colonized. But coming back to food access, a big challenge has been breaking down the stigma that farmers markets are pricey, they are expensive, they are for rich white people. That is not the case. The pandemic has been great to lift up the issues. It was Kentucky farmers that stepped up and Kentucky farmers market saw an explosion and sales as we did with Kentucky Double Dollars. It is an ongoing thing. Another challenge is to scale up these programs to make them accessible across the

state to every farmers market. Some of that has to do with funding and partnerships for that. We are fortunate that in Kentucky the legislature was a very innovative 20 years ago and how Kentucky has utilized the tobacco settlement funds. Unlike every other state, Kentucky decided we are going to use this \$3.5 billion and use it to impact Kentucky's health and diversify Kentucky's agriculture. We are at the stage now where we could and should utilize a very small percentage of those farms to bring down these federal dollars, because there's a lot of federal dollars out there. They require a match. Without that much, we can't access it. Kentucky is actually leaving money on the table right now that we could use to expand these programs to see what other innovative programs to other. I will put a link in the chart. As you all know, I can talk for days.

SARAH DOWNER:

Martin, I think you mentioned in a previous discussion working with some new partners on trying to bring more people to the farmers market and making some deliberate choices about cultivating those partners. I wonder if you would speak to that.

MARTIN RICHARDS:

The other aspect is culturally appropriate. I think it is fair that farmers markets and the farmers in particular are providing food for those neighborhoods they are and that is culturally appropriate. Because otherwise what is the point to that? I am sorry, Sarah, what was the question?

SARAH DOWNER:

The new partners you worked with over the past year or change to bring focus to the farmers markets.

MARTIN RICHARDS:

Boy, the list goes on and on. This collaboration is the hardest work and also the most fruitful. Kind related to this equity question, we saw when the pandemic hit and the Black Lives Matter movement really brought it forthcoming to everybody, so we have also worked with Feed the West and West Louisville specifically to be able to buy food from Black farmers to get into the hands of West Louisville. We also created a Black Farmer Fund and partnership with Kentucky Black Soil to directly address the impact of COVID to Black farmers. So the collaboration goes on and on. The research component, so I was just on a call with Allison Davis this morning about how do we develop a more comprehensive and collaborative research approach in Kentucky to healthy food access? We have some data available to Community Farm Alliance and Double Dollars, but there is a lot of data out there. I don't know all the different data points that would make a difference, but I trust there's a lot of smart people out there, and including on this call, and including our work with all the MCOs and Medicaid and Medicare and all the stuff. I think it is to the point where we need to put our heads together and come up with that. Then we need to make the case to the policymakers like hey, Medicaid, it is a much better investment of Medicaid dollars upfront to improve access then on the backend. I think all the healthcare providers would agree to that. Did I answer your question, Sarah?

SARAH DOWNER:

You did. You did a great job. I want to reflect a little bit of what we have been hearing, and then I'm going to ask everybody a lightning round to close our webinar today. So just to reflect, I think with all of you have brought to the forefront really powerfully is that we need to be listening to the people we

hope to serve with these programs, with these interventions, folks that are involved with these systems and shaping the systems. The idea of where is the money going, what is allowable in our system, how are we investing, how are we designing our research studies so we are getting data we can actually use. Because the data is telling us meaningful things. I think Colleen talked about how you design a research study that people can participate in. That we want to know what is the impact on folks you have a lot of these challenges. So the design really matters. And bringing the community voice into that process really matters. Martin, you spoke to that. Leslie, you also spoke to that when thinking about how are you making investments both from Humana Inc. and from the foundation side. I really appreciated this conversation. I'm going to ask one final question. Given everything we have heard today and setting us up for a follow-up conversation on June 17 that I hope everyone is registered for and where we really dive into how we take the next steps are, what is one program, service, or policy would be excited to see either come to Kentucky or expand in Kentucky?

MARTIN RICHARDS:

Well, I put the link in the chat. I hope everybody got it. It is a policy campaign we have been working on for a while. It is now public. We hope to get a bill introduced in the 2022 legislative session to create this healthy farm and food fund that allows these good programs to access Kentucky funds to bring down those federal funds. This connection between food and health and agriculture and local economies, the synergy is really exciting.

SARAH DOWNER:

Thanks, Martin. Leslie, can we go to you?

LESLIE CLEMENTS:

In response to the pandemic, CMS really reacted quickly. They gave us a lot more flexibility. It allowed us to send meals to our members that were in need, especially during quarantine. They also helped really clarify what the nonmedical services were that we were able to provide. So that gave Humana and other payers so much more flexibility to be able to find these social needs. But we all know the pandemic is far from over. All of the after effects from the pandemic, including the recession we are seeing, those are not over either. And then when you couple that with natural disasters, when those happen, there is always going to be a need to provide emergency assistance. So Humana intends to continue working with CMS to maintain and define all of those parameters around what our flexibility is to respond so we continue to work with providers and social service providers all the time, not just during COVID.

SARAH DOWNER:

Thank you so much, Leslie. Colleen, you have the last word here.

COLLEEN SPEES:

Again, I'm very hopeful for how things are going, but I will say I think the emphasis on all these programs need to be in doing a better job of measuring health outcomes. We can get through to the people, and we can get them to eat it, but if we can't prove it is a thing with mental health, physical health, keeping them cancer free for having a less aggressive cancer, or helping them through survivorship, it is kind of all for not. We just have to be better about partnering with folks who know

how to really measure the impact of these programs on health outcomes, both mental and physical.

SARAH DOWNER:

I think that your point is so well taken and that if we want the healthcare system to really be active in this space, that is definitely the ones they are using. At the same time, we have to be mindful of the fact that what the healthcare system wants and what people want are not always the same. That tension is live for. We're going to continue to be negotiating it as all of you on this call so beautifully do. I'm so grateful to have you all join us. We are going to have a follow-up Session on June 17 for this topic. Nuts and bolts, next steps, concrete. It has been a real pleasure. Thank you so much to all the panelists and for everybody for joining us today. Have a wonderful rest of your day.