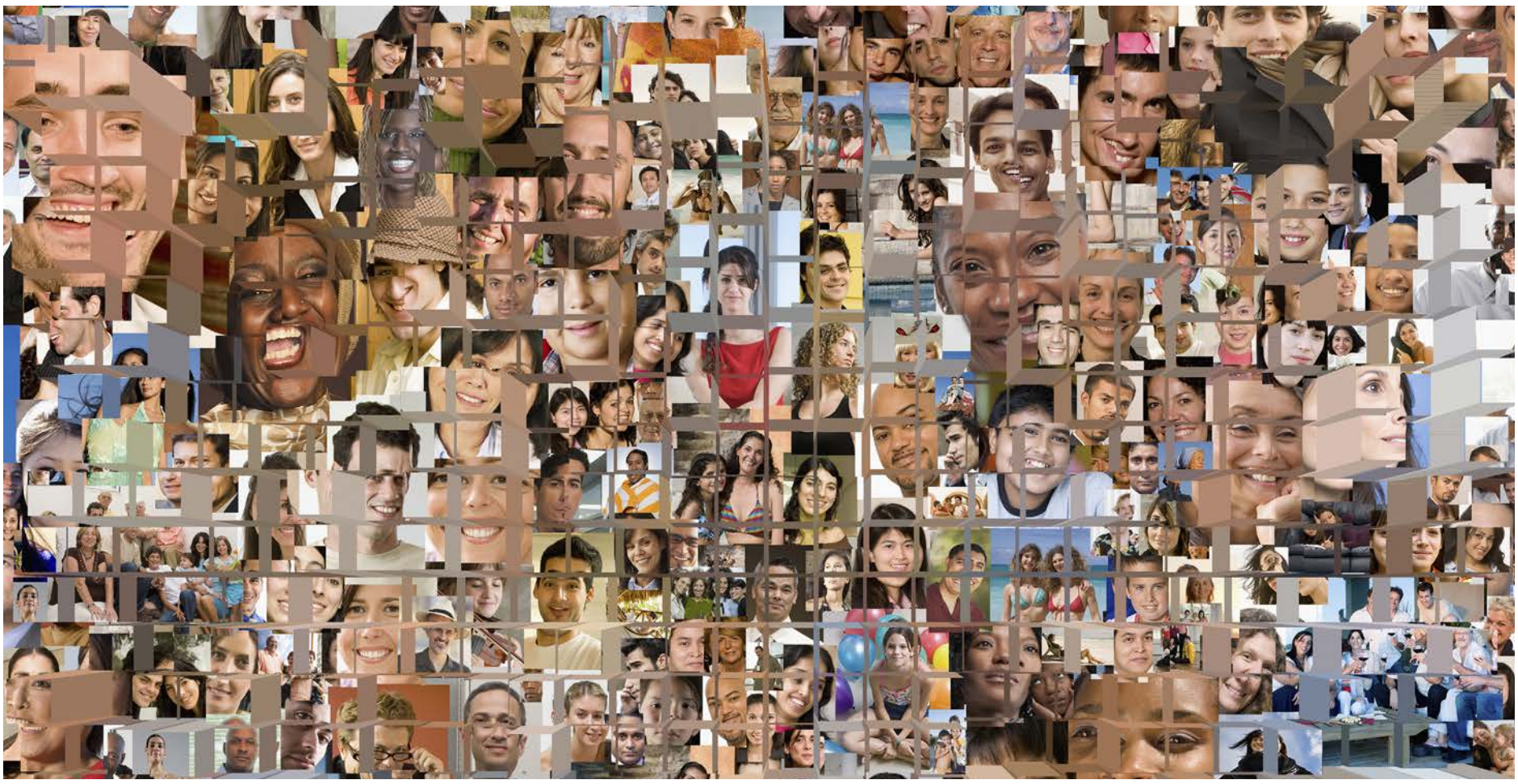
TABLE *of* EXPERTS

DRIVING HEALTH EQUITY



GETTY IMAGES

Strategies to Foster a Healthier Community

MODERATOR

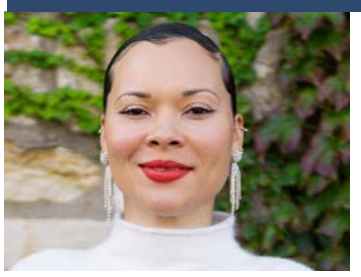
Stacie Prosser

PUBLISHER /
MARKET PRESIDENT

Kansas City Business Journal

In her role as Market President and Publisher, Stacie Prosser leads the KCBJ team to execute our mission of helping local executives and entrepreneurs grow their businesses, advance their careers and simplify their professional lives. She has been with the KCBJ for more than 20 years and served in both sales and management roles prior to being named to her current position in 2014.

PANELISTS



McClain Bryant Macklin

DIRECTOR OF POLICY
& STRATEGIC INITIATIVES

Health Forward Foundation

McClain Bryant Macklin joined Health Forward in 2020 as director of policy and strategic initiatives. She is responsible for establishing the strategy for Health Forward's policy priorities and executing a plan to fulfill those objectives through direct lobbying, grantmaking, and strategic partnerships and initiatives. Prior to joining Health Forward, Bryant Macklin served as director of policy and research for the Greater Kansas City Civic Council. She also practiced law for seven years in Kansas City and Washington, D.C.

C.J. Davis

PRESIDENT & CHIEF
EXECUTIVE OFFICER

Burrell Behavioral Health

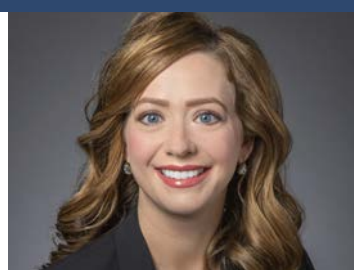
C.J. Davis is the president and CEO of Burrell Behavioral Health, which in 2022 merged with Independence-based Comprehensive Mental Health Services. With more than 25 years of experience in the mental health industry as both an executive and a clinical psychologist, Dr. Davis has managed and practiced at nearly every level of behavioral health care, including community treatment settings, residential treatment, primary care behavioral health, inpatient hospital services and criminal justice.

Michael J. Gifford

PRESIDENT & CHIEF
EXECUTIVE OFFICER

Vivent Health

Mike Gifford has been a leading force in the fight against AIDS in the United States for three decades. As CEO, he led the transformation of Vivent Health from a social service agency into the nation's premier HIV health care provider. Known as an HIV leader who applies the best principles of for-profit management to the nonprofit sector, Gifford has helped Vivent Health grow from a $2 million to a $185 million corporation.



Carmen Parker-Bradshaw

VICE PRESIDENT,
COMMUNITY HEALTH,
QUALITY & ACCREDITATION

Blue Cross and Blue Shield of Kansas City

Previously, Carmen Parker-Bradshaw served as chief administrative officer and chief of staff at Burrell Behavioral Health and in leadership roles with large integrated health care systems, Medicaid, U.S. Department of Health and Human Services, The Office of Global Affairs and WHO. She holds a bachelor of science degree in government and biology from Evangel University and an MPA in health care administration and policy from Missouri State University.

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DRIVING HEALTH EQUITY: Strategies to Foster a Healthier Community

The COVID-19 pandemic magnified longstanding structural and systemic disparities in health and well-being rooted in racism and discrimination. It also spotlighted the enormous influence of social, economic and environmental factors in health outcomes.

The *Kansas City Business Journal* (KCBJ) recently brought together several area experts to discuss how all sectors of our community can come together to improve health and health equity for residents throughout the region.

Publisher Stacie Prosser moderated the discussion, which touched on partnerships with employers, technology and innovation in delivery models.

Stacie Prosser of KCBJ: Let's start with an overview of the social determinants of health.

McClain Bryant Macklin of Health Forward Foundation: The social determinants of health, or what we at Health Forward call social influencers, are the social conditions within which people live that have a direct impact on health. Those can include access to quality education, access to jobs, access to transportation and access to quality, affordable housing that leaves you space to afford your other needs like health care. Location of quality housing also can be a social influencer of health. Is housing located near pollutants or near green space where people can access outdoor exercise activities and interact socially with their neighbors?

These social influencers of health have an outsized impact on health. Most people think of their genetics or their healthy or unhealthy behaviors as the primary factors impacting their health. But at least 40% of our health outcomes are attributed to those social conditions that I mentioned previously. If you add physical environment or genetics, that figure increases substantially and accounts for the vast majority of health outcomes.

Carmen Parker-Bradshaw of Blue Cross and Blue Shield of Kansas City (Blue KC): McClain

HEALTH FORWARD FOUNDATION

McClain Bryant Macklin

provided a good overview of social determinants of health. When we think of it very simply, they are those nonclinical factors that impact the ability for someone to have a healthy life.

All of those social factors are different for a wide variety of people depending on where they live, their education status, their financial income, their family structure, and so on and so forth. The list goes on.

When we think about health equity and how it dovetails into social determinants or influencers of health, we're thinking about being conscientious about the overall environment that impacts someone.

For us at Blue KC, when we think about all of those social factors, we think about structural racism and other political challenges. When we think about the environment as a whole, these are all factors that influence health.

Mike Gifford of Vivent Health: I'll jump in here with two things. First, I've seen studies that demonstrated social determinants of health having an 80% to 90% impact on health care. Which means that the majority of the impact on the health outcomes that people face is due to social determinants of health.

The second is that our health care system doesn't deal with these issues. So the majority of what impacts the health of patients is really not addressed by health care in any way, and that's what differentiates Vivent.

Access to food, for example, is a social determinant of health. Our medical clinic is positioned next to our food pantry. So if the issue of food insecurity or poor nutrition comes up in a visit, the doctor doesn't have to say, "Good luck, here's a referral for something across town." They're walking them down the hall, and the patient is going home with two weeks' worth of groceries.

Social determinants of health are a dramatic part of the impact on overall health, and they are not truly addressed in health care.

Parker-Bradshaw: I've read a few peer-reviewed articles and statements from large national payers that say because of the COVID-19 pandemic, 80% to 90% of health care costs and outcomes is being influenced by these social factors and health-related behaviors.

So they should be a very large part of how we think about improving our community's health and what health equity looks like for Missouri, Kansas and our nation.

Prosser: C.J., describe the impact of social determinants of mental health.

C.J. Davis of Burrell Behavioral Health: The social determinants of mental health also are a combination of the social, economic and physical environment, but with a slightly different slant because these change as we mature through the developmental stages of life and have different levels of influence in each.

A tagline of Brightli, our new parent company, is "Building Healthy Communities." Mental health advocates and organizations are positioned perfectly to look at these social determinants of mental health because they provide tons of community-based services. For example, our organization works in nearly every county in the state of Missouri to support employment. How do you help people find a job while they're also trying to find appropriate housing and transportation to get their health care needs met?

Prosser: What can companies do to help relieve these barriers for employees, and how can they make their companies more attractive and accessible to the workforce?

Bryant Macklin: We focus on two things as it relates to housing as part of our new purpose strategy and our focus on place and how place impacts health: access to quality, affordable home ownership as well as access to quality, affordable rental housing.

Many people in our region are "housing cost burdened," spending more than 30% of their household income on housing-related expenses, which then limits their ability to spend on other household needs, including paying for medical bills or accessing health care.

We view home ownership as one of the primary vehicles for wealth creation within families as an asset that is more readily passed down from generation to generation.

And it has been an asset class that many communities of color have been left out of.

Philanthropy and corporations can play a part in ensuring that there is an abundant stock of housing options for people. They can be mindful that housing expenses are real for their employees and mindful of the costs of living when determining employee pay. They can think of housing and relocation stipends as an employee benefit.

We often read in the news about corporations receiving economic development incentives for relocation. When companies are awarded those incentives, Health Forward Foundation encourages some thoughtfulness around community home ownership as a way to give back to the community.

Also, we encourage companies to consider proximity to affordable housing when selecting sites and consider creating mixed-use development that incorporates housing not only for their employees, but even to others in the community to address the shortage of affordable housing throughout the region.

In addition, businesses can use their lobbying or other advocacy resources and abilities to support different policies, such as those related to low-income housing tax credits or the Housing Trust Fund in Kansas City, Missouri, which is relatively new. Those dollars are applied to constructing affordable housing in Kansas City.

But there are also things that corporate foundations and corporations could do to help to provide money to put toward the capital stack that's needed to finance affordable housing deals. Businesses and foundations can contribute in several ways to rise to present-day needs that may not have historically been a part of the scope.

Gifford: The simple reality is, 80% or 90% of health outcomes are due to social determinants of health, but corporate America is paying for our failure to invest in and address them.

Most of us get our health care coverage through our employers, which is a huge expense for

BLUE KC

Carmen Parker-Bradshaw

employers. But that investment is not getting the return it should because we're not dealing with these social determinants that impact our health.

Corporate America has a financial stake in addressing social determinants of health from a bottom-line perspective so their health care costs go down. A healthier workforce also leads to other benefits like lower absenteeism.

When I'm talking to CEOs, my challenge to corporate America is: How much are you investing in health care and what percentage of that are you investing in social determinants of health?

At Vivent Health, we spend a few million dollars a year on health care coverage for our employees or, as we say, our champions. And we have specifically developed wellness programming and investments in communities to help address the social determinants of health so that we can reduce that cost.

Corporate America is getting stuck with the cost of our society's failure to address social determinants of health.

Davis: For someone with a mental health condition, a stable home is even more difficult to come by and is a powerful barrier to recovery from addiction and mental health-related issues.

Many people with mental health issues cycle in and out of being unsheltered. They're in jail or in a hospital or multiple places in a community. From the perspective of basic human needs, when you can't find adequate housing, you're probably not going to seek treatment.

Most people who have a serious mental illness live on social security income, which is only about 18% of the median income. So finding affordable housing is virtually impossible, especially for the chronically mentally ill, which is obviously a tremendous barrier for health care for them.

Prosser: Carmen, how does housing affect the health care of Blue KC's members?

Parker-Bradshaw: Housing is a very important social influencer. As an insurance provider, Blue KC provides coverage for people to enable them to access care. And part of that process is knowing that they have a place to go after they've received care and throughout the duration of their care journey.

Housing is a need that they have to fulfill before they can focus on their other health needs.

In the past few years, Blue KC has been evaluating the 32 counties that we serve. We looked at the claims, the social needs and the medical needs for the Blue KC members in those 32 counties.

We've learned a lot by looking at the data and what we're seeing lines up with what the research says. We know a member's ZIP code has more of an impact on their overall health than genetic code or any other social factor.

We've looked at the social needs and the incoming requests, both from provider groups and from our members and their families, and housing is a very large factor.

For example, here in the Kansas City metro, there's about an 18-year disparity in life expectancy across ZIP codes, particularly across the urban core and in Jackson and Wyandotte counties. And when we look at the trends of our health outcomes, housing comes up time and time again.

To all the points that the panelists have made, it's really important to realize that if we don't address affordable housing and other social determinants of health, we cannot improve health equity.

Bryant Macklin: I agree. Plus,

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the impact of stress on health and health outcomes isn't missed on anyone. You have to put yourself in the shoes of the folks who we're talking about and think about how stressful it would be to not have a place to lay your head at night, how stressful it would be to have five people in a one-bedroom apartment, how stressful it would be just knowing that you're living in an infested environment, or how stressful it would be to not know how you're going to make ends meet next month.

Those social influencers impact your health through the stressors that they add to your life.

Prosser: C.J., how has the pandemic affected the need for mental health services, and what's the status of mental health services in the Kansas City area?

Davis: In terms of projecting out or a prognosis right now, things will get worse before they get better. Before the pandemic, about 20% of typical Americans would say they had a mental health symptom that concerned them. Those numbers generally are elevated all the way up into the 50th percentile now — it's almost 1 of every 2 Americans.

That's pretty much true in almost every area across the state of Missouri as well as throughout the country.

Also, before the pandemic, 1 of every 5 individuals suffered from a mental health issue or a diagnosable mental health condition, and now it's more like 3 of 5.

We saw that coming when the pandemic hit. Early on, we talked about the second curve or the second wave, which is the mental health crisis that is upon us now. When you look back at prior pandemics, you noticed there was an increased incidence of substance abuse, anxiety, depression, suicide and psychiatric hospitalization.

Our behavioral health care environment and infrastructure are better than they were in 1918. But the mental health system has been fragile and underfunded for years, which is one of the reasons with the influx of people seeking services now that it's hard to find same-day services.

We will continue to see levels of depression, anxiety, substance abuse and, unfortunately, even suicide continue to increase for the next couple of years. We are at the very beginning stages of this.

Missouri has a very high suicide rate for kids. Adolescent girls are at risk, individuals between 20 and 25 are at risk, and now we're seeing people 60 to 65 at increased risk for suicide.

So the mental health crisis is upon us. And access is more important now than ever.

One more piece of data that is important to share: In the past year alone, 13,000 more people have sought behavioral health services at our organization alone. People are finally able to talk about mental health, and the stigma is starting to decrease. But the mental health systems are unable to tackle the demand.

Gifford: We need to talk about solutions, and the system of care, unfortunately, continues to bifurcate medical and mental health. They may be provided by the same provider, but not in an integrated way.

At Vivent Health, every medical patient who comes in is screened for mental health and drug use, and we have mental health services on-site. Mental health therapists come into the medical exam room when the issue of mental health arises during the medical exam.

In responding to the increase in demand C.J. so eloquently talked about, we have to integrate medical and mental health because they have such a great impact on each another.

Parker-Bradshaw: C.J. and Mike made some very important points. It's become even more clear to us here at Blue KC during the past two years of this pandemic that there has been an incredible spike in the overall need for utilization of behavioral health services.

Mindful by Blue KC offers a lot of services and tools to our members to help them navigate and get connected quickly to affordable care in the real-time moment that they need it.

But the bigger issue is this workforce challenge. Whether you're coming at this from an integrated health care system, community mental health center, private practice or school-based setting, collectively we need to figure out two things.

First, how do we truly integrate mental health into this bigger, personalized-care strategy in which we're treating the whole person and all of their needs at every point of service? How do we include that in our quality and reimbursement measures and think more carefully about those early interventions to help people stabilize and manage their care for the long term?

SUBMITTED BY VIVENT HEALTH

Mike Gifford

And second, how are we getting creative about bringing in all levels of providers so that we have adequate resources available to serve our community?

These are national crises you see across the board. Kansas City is uniquely prepared to think creatively about ways that we can channel in providers and treat more people who have significant needs.

The data show it. Our suicide rates, especially among our adolescent population, both on the Kansas and Missouri sides of the metro in the past two years have substantially increased, and it's time we do something about it.

Davis: Historically, the entry places for mental health have generally been very traditional. Someone calls a mental health center or an organization that offers behavioral health services and requests services. And generally, they are presented with a pretty long and hopeless process. They have to wait several weeks or months to get in.

One important thing about behavioral health integration is that you can access behavioral health services in the primary care setting, and you can receive whole-person care where the physical and mental concerns are addressed together.

We also need to teach people that emergency rooms and jails are not the place for mental health care, even though we know that jails become a de facto mental health center system for our respective cities.

So that people receive the right care at the right time, we need dedicated behavioral crisis centers. When someone has a psychiatric or addiction emergency, they need to have a place to go where they don't have to wait in line or are discriminated against because they have a mental health condition.

Far too often, people are experiencing mental health crises, and you can't schedule an appointment for a crisis.

We need to have more accessibility, which means same-day service and crisis centers that are treating the immediate demand. We're starting to see the creation of these types of crisis centers across the state. Comprehensive Mental Health Services is starting one in the Kansas City area in Independence.

It is important for us to teach people to be different consumers of behavioral health care when they're stressed, because the old methods, the old highways and the old bridges that we once depended on are no longer effective in terms of immediate access.

Gifford: I agree with you, C.J. We have to reeducate the population about how, where and when to access mental health. As we've gone through this pandemic, every time that Anthony Fauci gave a COVID medical briefing, a mental health equivalent of Anthony Fauci should have given a mental health briefing.

That's the sort of response we need to help change how we view mental health and access.

Prosser: That leads us to the concept of medical homes. Mike, tell us about the medical home model and how it can help solve inequities.

Gifford: Vivent Health is the only HIV medical home in the country recognized by the Centers for Medicare and Medicaid Services (CMS). That is a fancy way to talk about how we bring health and social services together to comprehensively meet the needs of our patients and clients.

At Vivent Health, patients can walk in one door and access their doctor, dentist, mental health therapist and pharmacy. It's literally right there.

So it's not your doctor transmitting a script electronically to a pharmacy across town. It's your doctor walking with you to the pharmacy with the script to make sure you're getting the medications you need in your hands.

And then it's all the work we do around social determinants of health. C.J. made the point about hierarchy of needs. We know that people with HIV who are hungry are going to be more focused on putting food in their stomach than taking the medicines that can keep them alive. So we have a food pantry on site as well.

This also applies to housing assistance, legal services and financial services. By having care management on-site and bringing all of this together in one location, we've been able to achieve 95% of our patients having an undetectable viral load. For HIV specialty clinics throughout the country, it's somewhere in the 80% range.

When you look at the racial equity piece, we have closed the gap in the different clinical outcomes between our white and Black patients to about 2%. Throughout the country, it is somewhere between 15% and 50%.

That's the impact of bringing all of these services together and addressing the social determinants of health.

We started our medical clinic in Kansas City six months ago, and we've enrolled about 150 patients during this time — far more than we expected. About 60% of these patients didn't have an electronic health record or any health record to transfer to their care. They weren't in care anywhere. These are people living with a disease that is fatal if not treated.

Being able to address social determinants of health while providing medical care is what helps create those better outcomes.

Prosser: McClain, how does Health Forward Foundation view the medical home model?

Bryant Macklin: As a foundation focused on public health, not as a provider of care like some of the other panelists, we are supportive of medical homes and the elements of that leading to improved whole-person care. Taking care of the entirety of the person inside and out, from top to bottom is a priority for us.

Medical homes provide conveniences for people who are already strapped for time and resources. Having all of the services in one setting can reduce the number of visits people have to make.

That coordination also leads to improved outcomes all across the board because nothing is missed and everything is taken into account.

This model is intriguing because it also offers the possibility of some cost savings in the overall health care ecosystem.

We are fully supportive of many one-stop-shop concepts because it is easier on everyone, particularly when various needs around the social influencers of health are being met. Health Forward Foundation is looking for opportunities to be innovative and to support innovation in this space.

Prosser: Carmen, why does the medical home model make sense for your members?

Parker-Bradshaw: Blue KC has supported the patient-centered medical home concept for quite some time. We've had several evolutions of it. Currently, we call it our "primary care first" model.

We've been a longtime partner with CMS on an innovation strategy to drive the medical home model and use concepts like value-based contracting with providers to incentivize them for high-quality care, ultimately improving the health of our members. We want our members to trust and get to know their care team, and to manage their care as a shared relationship with the ultimate aim of seeing greater outcomes by receiving whole-person care while improving costs when possible. To achieve this, we need greater compliance with members accessing affordable care through annual preventive visits, such as age- or condition-specific screenings and immunizations, and stronger collaborations with providers and our community-at-large to address social needs, close gaps in care and target members who need more support.

Not long ago, we launched Spira Care, which involves treating the whole person by integrating our medical, behavioral and social support services in a single location. Currently, we have nine Care Centers in the metro area. During the past year, we've learned a lot about the needs, patterns and behaviors of our members and communities.

We've also recognized that many of our provider partners are burned out. They are challenged to communicate and engage with members who can't get into their offices for whatever reason. And at times, they don't know how to connect with members who are challenged by certain social influencers.

So we're reimagining what a medical home looks like. We're thinking about all of these unique platforms that have been around for some time through telehealth, tele-behavioral health and mobile care to make sure that our care plans are as personalized and targeted as possible.

An example of that is introducing the concept of community health workers, who work hand in hand with every single member navigating the care needs that they have throughout the full continuum, no matter what. They address those social influencers, whether it's housing, food, transportation or education, that a member may need so that we can engage them in all of those important practices of care.

We know we're going to see some pretty exciting results over the next few years as we really hone in on some of these areas.

In this concept of health equity, it's not about having a platform and saying this model of care is available to everyone in this one shape or size. It's saying we believe all of our members — and frankly, our entire Kansas City community and nation — need a fair and just opportunity to achieve their very best health. We recognize that we must adapt and challenge how we live our mission and partner with providers and our community to serve our members' unique needs so that we collectively improve our community's health. We are committed to addressing racialized disparities, social needs or influencers, developing respectful and trusting relationships with members and providers, and leading how health insurance connects care in affordable ways that drives quality.

But most importantly, it's about how we tailor and target it for communities that need us the most or in heavier or deeper ways. So, it's an evolving concept, and one we're very committed to.

Prosser: What steps can we take to create a high-quality health ecosystem that is grounded in

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equity and dignity for all Kansas Citians?

Bryant Macklin: For starters, we need to be intentional about and devoted to culturally competent care and ensure that there are people who reflect the communities being served in positions of power at all levels of a health organization.

People in administrative positions in addition to those interacting with patients need to be familiar with the life circumstances of the patients they are serving. They need to be zealous about overcoming any language or cultural barriers to ensure that patients are having a good medical experience and that patients understand what's happening to them and for them and what they can do to better contribute to their own health status.

It is incumbent upon us who have resources to not expect people to always come to us and to not always expect people to pull information from us. We need to be in community and establish relationship with community and be thoughtful about how we communicate through our word choices.

We need to make sure that we're using asset-based language and refer to these communities and patient populations not from any deficit mindset, but from a recognition of all the many assets these communities have. We need to make sure we are partnering with community organizations in our media and community outreach.

We need to make sure that the health services that are being provided are widely known and understood so that people can take advantage of them.

Earlier, Carmen talked about using community health workers. Health Forward Foundation has put a lot of money behind community health workers not only with our grantmaking, but also in our policy and advocacy to see their work reimbursed with parity in both Kansas and Missouri and nationwide. Community health workers provide a tremendous service through their connection to communities and how they are able to help solve for some of the things that I mentioned previously.

Last, it is critically important that doctors, hospitals, clinics, pharmacies and insurers disaggregate data by race, language, ethnicity and ZIP code so that we are better able to identify where the issues and inequities are. Then we can channel resources to the areas of greatest need.

Davis: When I look at the ecosystem, there are three important buckets for payers, clients and providers to think through: It has to be convenient. We have to look at virtual models first, and most importantly, it has to be designed around the needs of the people we serve and the people who need the care.

To me, that's a simple formula. Now, how you execute that strategy may not be simple. But the formula has to include all of those buckets if we're going to move the needle on health care equity.

Prosser: Mike, is there anything you'd like to add on health equity?

Gifford: When we think about health care and racial disparities and inequities, we have to be honest about the extent of them. And for me, it's always helpful to think about important historical references, and that's the concept of red lining.

We have health care deserts in major cities throughout the country, including Kansas City. Food and health care deserts don't happen by chance. They happen based on decisions of policy makers and corporations. We have to own up to that and we need to overcome it. The convenience factor C.J. mentioned is important.

As we're talking about the challenges and the problems, we also have to lift up the successes, such as the people of Missouri advocating for Medicaid expansion. There's probably not a more important initial step to address poor health outcomes in Kansas City and Missouri than the power of the people of Missouri standing up and saying we're going to expand Medicaid in this state.

That should be a clarion call for all of us — payers, providers, patients and policymakers — that we have to do more. People are telling us that they want us to do more.

Bryant Macklin: I agree. We are so fortunate that Medicaid expansion was not only passed by voters in Missouri, but also that it was fully funded in this last budget-making cycle. But it begs the question of when are we going to accomplish the same thing in Kansas.

We also need to put resources behind education around the enrollment opportunity and then get people to enroll. There are tens of thousands of

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C.J. Davis

applications that are still waiting to be processed in a backlog that has brought us some national shame. It is taking us 119 days to process applications, and the federal government only gives us 45.

Now that we don't have to worry about the program itself in Missouri, we have the opportunity to focus our attention on getting people enrolled.

Prosser: Let's discuss digital access and how it negatively and positively impacts social determinants of health.

Bryant Macklin: We can't ignore the importance of digital access, which has been recently dubbed in the pandemic as the super social determinant or influencer of health given its impact on all of the other social influencers and the inability of anyone to participate in nearly every aspect of the 21st century economy without it.

I want to draw the connection between digital access and health outcomes. Kansas City, Missouri was a leader in this recognition, having prioritized digital access in its Children's Health Insurance Program (CHIP) six or seven years ago.

With the onset of the pandemic, the importance of digital access became abundantly clear for everyone as care was nearly completely shifted to being provided remotely or virtually. Studies show that while innovation in technology has the opportunity to lead to greater affordability and be a great equalizer, it has not yet proved itself to be the case.

With the greater reliance and utilization of health care information technology and telehealth and telemedicine, we saw people of color not positioned to take advantage of telehealth and telemedicine and a drop in visits and access to care during the pandemic. Others who were better resourced did not experience those same issues or barriers to care.

This is prevalent in our rural areas as well because many rural communities don't have the broadband infrastructure for high-speed Internet. Thus, they couldn't avail themselves of remote access to specialty care or even primary care during the pandemic.

Digital access is one of those issues that's only going to get worse unless we address it.

And it's not just access to health care. It's access to everything right now and will become increasingly important as we become even more reliant on AI and go deeper into virtual reality.

Digital equity and inclusion advocates are glad that these issues are now getting the attention that they deserve. But it's going to take quite a bit of resources to solve because the broadband infrastructure issue in rural areas, and even in some urban deserts, is expensive to solve.

Some policy mechanisms would help with that, such as treating broadband as a public utility. But it's an issue that we cannot ignore because it permeates into everything else.

Prosser: How has digital access affected mental health services?

Davis: We've had decades to train people who struggle with a mental health condition on how to access service, which usually involves transporting themselves to a clinic.

Prior to the pandemic, we only provided about 10% of our services across all of our locations in the state via telehealth. In a matter of a couple of weeks, we were providing about 90% of our services via telehealth. We had to train everybody from the marginalized population about the benefits of a telehealth visit versus no visit, and that was a radical transformation for people, especially those with a severe and persistent mental illness.

About 70% of people in marginalized populations have smartphones. Unfortunately, however, someone with a mental health issue faces three problems to use technology for mental health services: a lack of skills, motivation and access — not necessarily to get the service, but to find privacy to use the service and an understanding of the ins and outs of how that service is delivered.

According to the data, the life expectancy of someone with a chronic mental illness is about 20 to 25 years less than someone without. They will die 20 to 25 years sooner than somebody without a chronic mental illness.

About 50% of people with mental illness don't go to their primary care doctor or get any sort of wellness check. So, we're looking at scenarios where people don't have the motivation.

There is a tremendous digital divide, which ultimately results in people struggling with severe mental illness and not seeking or receiving care.

Gifford: McClain and C.J. have covered the importance of technology well. I sit on the board of a health information technology company that has integrated social determinants of health into the medical record and now screens a million patients around the country on social determinants of health. Getting this information to providers and insurers in a way that allows them to actively work on the issues is an important step in addressing the problem.

Prosser: Carmen, any additional comments about digital access?

Parker-Bradshaw: There comes a point when given the digital divide and a myriad of other challenges, people almost disengage, even if the platform or access would be theoretically available to them. When we think about the digital needs, first and foremost, we have to build trust with those we are serving and understand their needs. One of the best ways to do that is to have data.

This is a strong focus for us at Blue KC. We collect information about not only race, ethnicity and preferred language, but also sexual orientation and gender identity and expression.

We also have embedded social needs assessments in our digital tools to quickly identify key needs our members may have and to help understand how these needs impact their behavioral health or medical care. We are enhancing ways to understand and build engagement (or trust) with our members through predictive analytics and other forms of intelligence to quickly identify preferences and concerns that aid us in responding to members with real-time support. When a member has a critical need, these tools help us escalate how we respond to and serve our members to help them get the right care at the right time and place — whatever that may be.

We're also trying to not rely solely on our digital concept of care and think more about meeting people where they are. There will always be access issues if there are trust issues, if someone hasn't had a positive relationship with a provider or if they don't feel they can talk through that digital mechanism to the provider or the health plan.

So, we're thinking about how we get out of our space and into the space of where this person is and how we build trust so that when someone is seeking care in person or virtually, they're going to feel like they can engage and have a productive interaction to get the care that they need — preference-matching around someone who understands the patient's social needs or comes from a common neighborhood, race or ethnic background or speaks the preferred language. Using all of those insights to enrich how we take advantage of technology is important.

As a health plan, we need to make sure that we wrap all of this up in a way that is reimbursable and easy to access and manage as well.

Prosser: How does community mental health interface with the business community? How can businesses and leaders support the mental health of their workforces?

Davis: Behavioral health services have evolved over time. We're not just treatment providers; we're not just into prevention. As community mental health centers and leading experts in behavioral health, our job is to truly support and educate the community on important local behavioral health needs.

Business owners and managers ask me all of the time what they can do to address the overall behavioral health concerns of their workforce or the issues that result in turnover and absenteeism. They are feeling flooded with behavioral health concerns from their workforce.

First, I encourage business leaders to be aware that 3 of every 5 individuals are now suffering from a mental health condition. For many businesses, they can't continue operating as they used to. They have to take stock of their policies that support mental health services.

They have to take a hard look at their culture. Are you a trauma-sensitive business? Do you understand that everybody has a story that they bring into the workplace and that those stories are important?

What sort of social supports are you putting in place as business leaders to ensure that your employees not only come to work every day and are productive, but also can thrive? Organizations are starting to embrace this culture — that you can come to your workplace and have tough conversations and that we're here to support you.

I also encourage any business to seriously consider adopting programs. For example, our organization has a program called ONE, which stands for Our Networks Engaged. Companies and individuals sign pledges essentially promising to support these programs and conversations around mental health.

At the end of the day, the organizations that embrace these important issues are the organizations that are going to win some of the workforce and hiring challenges in this competitive market.

Prosser: Carmen, what would you recommend to people in the business community who want to address these issues linked to social determinants of health?

Parker-Bradshaw: In general, we don't talk or invest in things if we don't know about them. So the first challenge is understanding these pervasive issues that are driving costs. They're driving concerns for our young population who are going to live with us for many, many decades. They're driving health care outcomes that affect employee health and well-being and ultimately the work the employee does.

The first challenge for businesses is to think more broadly, widely and deeply about these issues.

As a health insurance plan, we have a unique opportunity because we serve people from many different sectors of businesses. An approach that we're taking is working in

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DRIVING HEALTH EQUITY

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partnership with businesses to understand what their employee population looks like and to provide resources for those employees and employers.

Together, we can accomplish a lot to not only meet the employees' needs, but also to drive health equity and better community health overall, and do it in a way that's transparent and that's accountable.

We've got to start becoming comfortable with being uncomfortable. What is health equity? What's driving inequity, and what are we going to do about it?

It requires influential leaders to have a mind shift in terms of understanding what is necessary to engage in both meaningful and inclusive conversations.

Second, check your bias. Even proponents of this work bring a certain filter to the discussion, and we need to mitigate any predispositions that hinder change. We all have biases.

Last, you need to commit. We have been so grateful for the conversation that we've been able to be a part of through the Kansas City Health Equity Learning and Action Network.

If you're going to commit to the work, step up and be a part of the solution. No matter the industry or sector, you have to demonstrate action if you're going to be part of the conversation.

There's definitely room to strengthen how we get participation at the business and individual level. And I'm looking forward to people reading this wanting to jump in to support the work.

Prosser: Mike, how can people help mitigate the social justice issues that are tied to health care access and make sure that there is health equity for all?

Gifford: We need to build awareness that corporations are bearing the brunt of the impact of social determinants of health — absenteeism, presenteeism, decreased productivity. That also includes cost. Business is one of the biggest funders of health care whether through insurance they provide to their employees or the taxes they pay. So this is a financial problem, a business problem and a humanity issue that businesses need to rally around, and they are not.

Businesses need to step into this space around equity and justice. Employees want it. C.J. made a great point about how you can win the war for the best talent. We know that workers, particularly those of younger generations, want their employers to be socially active.

This is the time for businesses to step in and not only address the problems of social determinants of health, but also to step in and say it's time for a fairer, more equitable, more just society, and we, as a corporation, are going to advocate and use our resources for that.

That will give them a better workforce. That will allow them to compete for better talent and wind up with a better society.

There's a national group called CEO Action for Diversity and Inclusion. It was initiated by the managing partner of Ernst & Young a number of years ago. I'm proud to be among the 3,000 who've signed the pledge to work on these issues of equity and justice in our community. It's an easy thing for corporate leaders to do, and I invite other leaders in Kansas City to take this step.

Prosser: McClain, any closing thoughts?

Bryant Macklin: Mike and the others put it well. Businesses need to focus not only on their internal policies and practices, but also wield their influence to positively impact policy and systems change writ large. Corporations are abundantly resourced and vocal and have the attention of our policymakers. They should use that power to empower and power-share with others.

Advocate for public health policy and legislation that will mitigate the social influencer issues, rising health care costs and other issues discussed today.