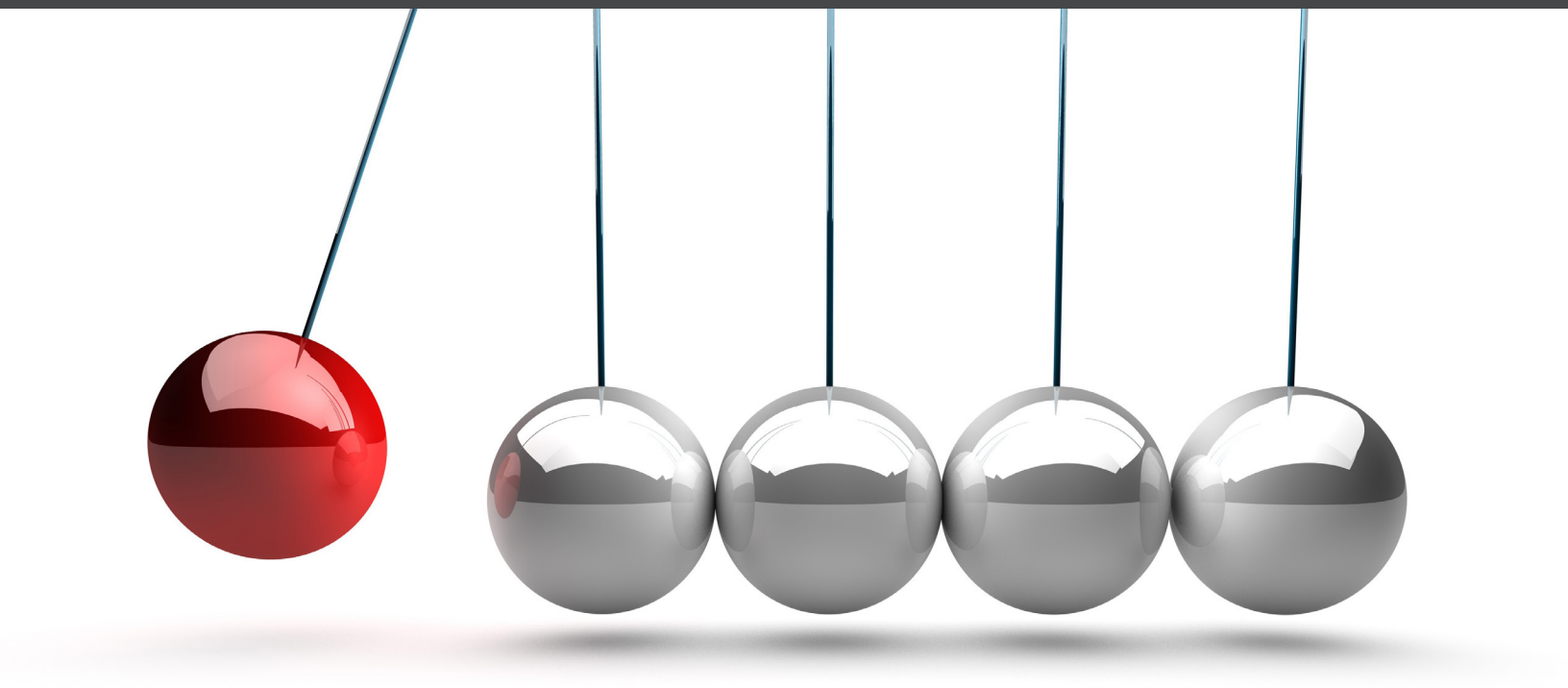
SCOTTSDALE INSTITUTE
COLLABORATION • EDUCATION • NETWORKING

Catalyst:
Sparking Change Through SDoH

SCOTTSDALE INSTITUTE **2021 SDOH HYBRID SUMMIT**



November 2-3, 2021 | Virtual Event

Sponsored by:

Epic

Executive Summary

With Social Determinants of Health (SDoH) playing an ever-increasing role in shaping and guiding community health efforts, health system operational costs and healthcare utilization, the Scottsdale Institute (SI) convened 20 participants and speakers from 11 Member organizations to discover, discuss and dissect both barriers and passageways toward the promise of greater inclusion, less duplication, more standardization and wider accessibility of health for all, from both community- and system perspectives.

Moderator **Emily Barey**, VP Nursing, Epic Systems, kicked off this hybrid Summit by reviewing a poll question regarding attendees' greatest barriers to community investment and demonstration of community health impact. Unsurprisingly, nearly half cited the difficulty in measuring impact and the delay in showing any improvement; another 25 percent lamented a lack of data-interoperability standards. In other words, getting started wasn't the problem, nor collaborating well; rather, it was the follow-up and evaluation that plagued many health systems.

As frontline workers who see firsthand the health impact of poverty, racism, bias, stress and other socio-economic factors, these SDoH professionals shared their experiences, successes, challenges and best practices in community health, including:

- **Integrating community investment:** Determining priorities around mental health, housing, food insecurity and more while standardizing needs assessment, investment and fundraising;
- **Determining community partnering strategies and models:** Joining forces with health plans, government bodies and community-based organizations toward a single, community-wide needs assessment and intervention plan;
- **Mapping the intersection of pop health, health equity and community benefit strategy:** Outlining the strategic approach, analytics, tools and structure for success in a changing climate; and
- **Innovating the next big idea:** Studying ways to aggregate and validate data around multiple risk factors with the goals of disease prevention, wellness and healthy communities.

SUMMIT PARTICIPANTS

Kristen Brey, Population Health Coordinator, UW Health
Stacy Calhoun, Director, Member & Beneficiary Engagement, AdventHealth
Nicole Cerman, MHA, Director, Community Health, IU Health
Nabil Chehade, MD, MSBS, EVP, Chief Clinical Transformation Officer, MetroHealth (Guest)
Deborah Gibson, COO, Integrated Community Investment, Providence
Krystal Green, Project Manager, Cedars-Sinai
Katie Hren, LCSW, Community Health Manager, Cedars-Sinai
Erin Jackson-Ward, MPH, Director, Community Benefit Giving, Cedars-Sinai
Robin Lankton, MPH, CHES, Director, Population Health, UW Health
Iris Lundy, MHL, BSN, RN, Senior Director, Health Equity, Sentara Healthcare
Sandra Madubuonwu, PhD, APRN, Sr. Director, SDoH & Wellness, Methodist Le Bonheur
Carol Mayer, Academic Project Coordinator, HonorHealth
Megan McAninch-Jones, Executive Director, Community Investment Strategy & Evaluation, Providence
Sherry Norquist, MSN, ACM, Director, Corporate Social Responsibility, Sentara Healthcare
Heather O'Toole, MD, CMO, Innovation Care Partners, HonorHealth
Jill Piazza, PT, DPT, VP, Operations, Population Health Services Organization (PHSO), AdventHealth
Jennifer Rosas, MD, CMIO, Neighborhood Access to Health (NOAH), HonorHealth
Aleta Rupert, Program Manager, Accountable Health Communities, AMITA Health
Jessica Shaffer, Director, Community Health Partnerships, Northern Light Health
Emily Tolman, System Director, Health Equity & Access, Northern Light Health

CONVENER

Scottsdale Institute
Janet Guptill, FACHE; Cynthia Schroers; John Hendricks; Chuck Appleby; Karen Sjoblom; Ricki Levitan; Ishmeet Kumar; Stuart Hurley, FACHE; Margaret Shea; Courtney Olson; Genevieve Hedland-Hill; Shelby Olson; Nancy Navarrette

SPONSOR

Epic
Moderators: Emily Barey, VP of Nursing, Gillian Murphy, IT Project Manager; Prerana Laddha, Software Developer; Sophie Johnson, Software Developer

Writer: Karen Sjoblom

Introduction:

James Martineau, the English Unitarian theologian, philosopher and writer, suggested well over a century ago that the health of a community could be considered an almost unfailing index of its morals. Believing an individual's conscience was the primary guide for determining correct behavior, he would have loved sitting in on this particular SI Hybrid Summit for the many compassionate, forward-thinking, innovative consciences gathered. The goal? To discover, discuss and dissect the many Social Determinants of Health (SDoH) toward the promise of greater inclusion, less duplication, more standardization and wider accessibility of health for all, from both community- and system perspectives. Seeing firsthand the impacts of poverty, racism, bias, stress and other negative impacts on health, these professionals gathered to answer the biggest questions of the day on our community health front.

Moderator **Emily Barey**, VP Nursing, Epic Systems, kicked off this Summit by introducing Providence discussion hosts **Megan McAninch-Jones**, Executive Director, Community Investment Strategy & Evaluation, and **Debbie Gibson**, COO, Integrated Community Investments, who queried attendees on their greatest barriers to community investment and demonstrating community health impact. Unsurprisingly, nearly half cited the delays in showing improvement and difficulties in measuring impact, followed by another quarter lamenting a lack of standards to exchange data. In other words, getting started wasn't the problem, nor was collaborating well; rather, it was inadequate follow-up and lack of timeliness in measuring impact that plagued SDoH initiatives.

POINT OF IMPACT: INTEGRATING COMMUNITY INVESTMENTS AT PROVIDENCE

With 120,000 caregivers serving in 54 hospitals and 1,100 care settings across seven states, Providence's Community Health Investment journey has been a long and winding one; however, the mission was always clear from its two founding orders, the Sisters of Providence and Sisters of St. Joseph of Orange, two very likeminded entities dedicated to serving the poor and vulnerable. The Sisters realized their community health work had become fragmented. To address this, the team identified specific functions that could be centralized or standardized, while emphasizing the value of subsidiarity to meet local need.

In 2016 Providence Health & Services of Renton, Washington, and St. Joseph Health System, based in Irvine, California, officially merged to create Providence St. Joseph Health. At the request of its board and sponsors to consolidate and integrate its Community Benefit function, Gibson says, they began their modernization journey in 2018.

"We created and implemented a system infrastructure at the beginning of 2019 to serve the Community Benefit teams in the regions and the work being executed locally. This infrastructure includes common job descriptions, titles and aligned responsibilities. The new CHI organization is centralized with operational leadership and strategy at the system level, which helps reduce variance in compliance with regulations regarding community benefit needs assessments, data and evaluation, grants management and community benefit reporting," Gibson outlined. "In deference to our strong belief in subsidiarity, each region is tasked to oversee the entirety of its respective administrative and programmatic caregivers and to execute the delivery of programs, services and the distribution of strategic grant-making and investments to community organizations."

Community Health Investment is foundational to both the Mission and the heritage of Providence and extends far beyond the four walls of its hospitals, enabled by close partnerships with social service and government agencies, foundations, community and faith-based organizations, universities, and many other entities to identify the most pressing needs in its communities.

Recognizing that social- and community well-being directly impact patient outcomes, Providence contributed over $1.7B in Community Benefit funding in 2020 across its family of organizations. Providence's Community Partnership Division comprises four main pillars: education programs, global and domestic engagement, strategy/innovation and integrated community investments. The latter leverages the power of Providence to invest in mutually reinforcing strategies that transform the health and well-being of its communities through the funding mechanisms shown below.

"As an example, we operate a university, a high school and a number of early child development centers through our educational partnerships. The St. Joseph Community Partnership Fund is a separate 501(c)(3) organization with certain focus areas like homelessness, community and non-profit capacity-building and disaster relief," explained McAninch-Jones. "Providence is unique in that we've set a spending target for community investment. Our philosophy is that we want to elevate the needs and strengths of communities that have been underrepresented and disinvested."

As Providence has contributed to upstream community health actions to realize its mission, improve health, and increase equitable access to care, the positive impacts continue to be demonstrated in the following ways.

- **Investing Proactively:** Providence invested $355M in targeted and strategic investments in response to critical community needs in 2020.
- **Meeting Targets:** As a system, Providence exceeded its 2020 "outstanding" target for investing in proactive community benefit as a percent of Net Service Revenue.
- **Focusing Intentionally on SDoH:** Teams purposefully focused on key issues like housing instability, homelessness, food insecurity and equitable access to care and services (i.e., telehealth, ambulatory services, COVID testing, etc.). This has allowed for shared learnings and adapting best practices across markets.
- **Aligning with Population Health:** Providence worked across functions to improve patient and community health, including sharing data and aligning Community Health Improvement Plan (CHIP) implementation, conducting community outreach and forging partnerships with regional Medicaid, Mental Health and Health Equity strategies.

MAXIMIZING INVESTMENTS & IMPACTS

Providence has restructured within Community Partnerships to provide a more holistic approach to investment opportunities. This approach leverages its traditional community benefit investment strategies to align programs, grants and donations to specific initiatives outlined in the community health improvement plans for each hospital, driven directly from the Community Health Needs Assessment (CHNA). On the right-hand side is SJCPF, previously a legacy SJH private grant-making founding entity that has now been expanded system-wide under the Community Partnerships Division.

Integrated Community Investments

Leveraging the power of Providence to invest in mutually reinforcing strategies that transform the health and well-being of our communities.

Community Health Investment

- Strategic grants, partnerships, and direct programming to address prioritized community health needs
- Generally single-year funding
- Region or service area specific programs and initiatives
  - CARE Network
  - Mobile Health Clinic/Dental programs
  - Outreach/Education
  - Perinatal programs
  - Medical Respite
  - Supportive Housing projects

St. Joseph Community Partnership Fund

- Funding and partnerships for transformational initiatives, focusing on community development, collaboratives, and systems change
- Scaling best practice partnerships across the regions (i.e. System-level contract with Community Solutions)
- Capacity-building and technical assistance, community building, and a focus on holistic approaches
- Independent 501(c)(3) and Board
- Multi-year funding and sustainability

Providence is committed to both CHNAs and CHIPs and has been conducting them for each ministry since the early 2000s. The former offers an opportunity to engage communities every three years to intentionally assess unmet health needs and identify existing community assets. Common prioritized needs include homelessness and housing instability, equity and disparities, mental health and substance use disorders, food insecurity/nutrition and obesity, and access to healthcare services. In addition to fulfilling the federal requirement per 501(r), the CHNA informs the CHIP and drives strategic priorities. Then, the CHIP—a three-year strategic plan stating how CHNA-prioritized health needs will be addressed—documents strategies for reaching long-term goals and measures to monitor impact.

"We're trying to move toward interactive CHNAs and build dashboards and tools that folks can navigate on their own," McAninch-Jones said. "We want to make sure we're getting the perspective of those individuals who historically have been overlooked in the publicly available data, so we work with trusted community partners and also have a qualitative specialist on the team. We aim for equal input into the CHNA and to produce a product that can be a resource for these communities and our partners—not just meeting an IRS requirement."

Toward this end, Providence utilizes interactive tools and visualization to:

- **Map demographics, social risk and other indicators at the census-tract and block-group level;**
- **Partner and provision community-level data for internal and external data tools; and**
- **Define risk scores within service areas based on population characteristics [e.g., life expectancy at birth, linguistic isolation, high school diploma rate, population below 200 percent of the federal poverty level (FPL)].**

"With our mapping, we can look at California Supplemental Nutrition Assistance Program (SNAP) enrollment and are able to differentially deploy healthcare workers to areas with high eligibility but low enrollment," explained McAninch-Jones.

EMPLOYING A DIFFERENT LENS

Highlighting housing instability and homelessness as a specific example, Providence adapted Health Begins' Upstream Strategy Compass to outline strategies and interventions across the continuum, from an individual in crisis to population-level prevention measures (below).

Housing Instability & Homelessness

Level of Intervention	Patient/individual Person-focused interventions	Organization Interventions at the neighborhood, city, and/or organizational level (i.e. internal policies and practices)	Population Interventions that serve the population at-large; County/state/Federal level
Prevention Programs and interventions to prevent homelessness	Skills-building Child development Nurturing families	Inclusive zoning Preservation of affordable housing Community/coalition-building	Economic development; living wage jobs Poverty reduction Anti-racism Paid parental leave Tenant protections
Mitigation Programs and interventions intended to prevent homelessness amongst those at-risk of losing their homes; ensuring homelessness does not become chronic	Eviction prevention Utility assistance Rapid re-housing Shallow rent subsidies Short-term rental assistance Housing First Permanent Supportive Housing Diversion programs (i.e. LAHSA)	Medical-Legal Partnership Affordable Housing Stock Holistic Community Development Community Solutions/Built for Zero	Housing First
Treatment Programs and interventions to support those currently experiencing homelessness	Recuperative care Medical respite Transitional care Emergency shelters* Housing with Services	Trauma-informed care Motivational interviewing Sanctioned encampments*	B4Z/Coordinated Entry

"We're finding this is a good example of best practices and what works—a resource to draw upon. Housing, access to care, health equity, food insecurity…the needs are consistent. So who are the right partners? Where is there readiness? This work is locally-driven, so we're working to have specific best practices for those priorities so we can map back to promising, evolving practices and determine the best areas to put our dollars for a balanced portfolio," McAninch-Jones said. "As a country, we spend the most money on treatment versus prevention… the real push is, how do we improve measurement and story-telling to demonstrate our ongoing commitment? Quality data is key."

CONTINUING THE CONVERSATION

We prepare a community benefit report (IRS 990) but also create an annual report for the community in which we highlight stories and list other funding that may not fall under IRS guidelines but still demonstrates our overall commitment.

–Debbie Gibson, COO, Integrated Community Investment, Providence

The first tax exemptions in the United States date back to the initial tax code from the early 1900s which ultimately paved the way for hospitals—a lot of which were faith-based—to achieve a tax-exempt status in exchange for providing benefits to the community. Most of the community benefit laws were left unchanged between the 1950s enactment of Medicare and Medicaid and the introduction of the ACA, which made room for states to add additional laws and parameters.

–Erin Jackson-Ward, Director, Community Benefit Giving, Cedars-Sinai Health System

Listening forums, faith-based leaders, other nonprofit organizations…for us it's very important to hear from the grass roots folks. We've been very intentional to listen for that voice, especially in those places where voices have been muffled.

–Iris Lundy, MHL, BSN, RN, Senior Director, Health Equity, Sentara Healthcare

Creating Momentum:

UW Health's Partnering Strategies & Models

The Dane County Health Council in Madison, Wisconsin, convened in 1999 so health systems could aim toward a simple yet complex goal: Optimal health and well-being for all county residents. Originally trying to reduce ED usage and connect pregnant women who weren't eligible for Medicaid to primary care providers, they designed and implemented a collaborative Healthcare Access Pilot to provide access to $2.5M in care and pharmaceuticals and connect nearly 400 uninsured patients with primary care homes. Additionally, the Primary Access for Kids program provided preventive and primary care at no cost for all uninsured children in the Madison Metropolitan School District and started a pilot to integrate mental health professionals in three pilot schools.

"Our structure is interesting because it's an executive committee consisting of CEOs of partner organizations and staff teams, which has been really important," explained **Robin Lankton**, Director, Population Health, UW Health. "These are people who are authorized to make decisions, but we're not a 501(c)(3), so it's a unique model of people working together."

In 2017, we studied the list of priorities and asked, 'Can we do one thing to move the needle?' Ultimately, it came down mostly to maternal and child health. Madison has some of the worst inequities in terms of black infant mortality rates –twice the norm. It's definitely a 'Tale of Two Cities' between black and white residents. There are persistent underlying factors, and those babies with low birth weights will have long-term health conditions, too. This is what we came around to solve, together.

–Robin Lankton, Director, Population Health, UW Health

Ultimately, their mission became to eliminate gaps and barriers and reduce disparities in health outcomes. In 2017, the Council shifted to a coalition focus—Healthy Dane Collaborative—comprising four hospitals and health systems; public health and local health departments; local school districts; the United Way; and partners like Black Maternal and Child Health Alliance (BMCHA), which was launched to improve the birth outcomes of Black mothers and babies in Dane County. The first step was to focus on community engagement via a "Saving Our Babies" forum for Black moms and dads. Ultimately, Dane County found the people making the decisions didn't necessarily represent the people who needed the programs…so by partnering with BMCHA they better learned key assets, strengths, resiliencies and underlying causes of issues, which informed their action plan moving forward.

"We have a motto at UW Health: There's nothing about us without us. The key things that came from our community members were that we needed to address racism and bias in healthcare, and then also improve accessibility for those disconnected, hard-to-acquire resources. It's hard to get housing, for example, which impacts the quality of pregnancies and infant health," Lankton described. "Other issues included economic insecurity, inadequate social supports, gaps in health literacy and chronic stress, among others."

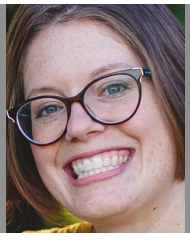
A COMMUNITY-WIDE SOLUTION

Lankton described their Maternal and Child Health Strategies as a pyramid, with individual concerns at the top, population strategies in the middle and SDoH challenges at the base, thereby depicting greater population impact. To support every level, the Dane County Health Council banded together to offer a "social prescription to resources" called **Connect Rx Wisconsin** Care Coordination System—a community-wide solution that focuses on continuous Black family engagement and leadership, universal SDoH risk screenings, community resource coordination and navigation workflows, a closed-loop referral system and workforce diversity (i.e., new maternity care team composition). Since 2017, when the needs assessment was approved, Lankton and her team have:

- **Started community engagement (2018),**
- **Signed on for advocacy at the state level and secured a $1M Wisconsin Partnership Program Grant to launch health workers (2019),**
- **Gained an additional $1M *Dream Up* grant to focus on technical aspects and interfacing with Epic (2020), and**
- **Hired a program director and conducted the Connect Rx WI go-live and DEI in Workforce alongside neighborhood-based education planning (2021).**

The long-term funding plan is a braided model: payers, philanthropy/grants and partnerships. Governance comes from the Dane County Health Council to the Staff Team, which oversees the Community Engagement Work Group and the Care Coordination Work Group. The staff team is responsible for care coordination, community engagement, individual organizational work plans, meeting prep and facilitation, advocacy, grant writing/management and fundraising, and public relations.

"Currently, our total budget for this program is about $1M annually, with 90 percent funded through grants and 10 percent through our health system partners. Over time, we'll need to scale up our health system funding," she said. "This program is unique in that it's community-wide, which presents some complexity in one system. But everyone contributes and works together. All of our health systems will conduct Epic Wheel SDoH screenings using the provided initial screening questions. We'll also launch navigation workflows—having staff on tablets and using MyChart messages so people can validate their responses. For those who are eligible to enroll, we'll do a more comprehensive screening and connect them to appropriate resources. And by ensuring those making the decisions truly understand those they're serving, we'll finally have a workforce that looks like the patients we serve."



Kristen Brey, Population Health Coordinator, UW Health

Stacy Calhoun, Director, Member & Beneficiary Engagement, AdventHealth

Nicole Cerman, MHA, Director, Community Health, IU Health

The Intersection of Pop Health, Health Equity & Community Benefit Strategy

Established in 1973, AdventHealth now serves 5.4M patients annually across 50 hospital campuses in nine states, plus numerous skilled nursing, home health, hospice and urgent care facilities. One of the largest nonprofit, faith-based healthcare systems in the country, AdventHealth is headquartered in Florida—serving a large Medicare-aged population.

"From a value-based care perspective, we have nearly 500,000 lives and $2- to $3B of revenue under risk-based contracts and so have pivoted to this being a core strategy. The threat of more advanced Medicare risk-based payment models has accelerated the focus on this strategy," described **Jill Piazza**, PT, DPT, VP Operations, AdventHealth Population Health Services Organization (PHSO). "We're actually grateful for that sense of urgency so we can be ready. Additionally, COVID accelerated a lot of conversations around SDoH and health equity."

AdventHealth's strategic approach to SDoH requires structure, integration and partnership: Between identifying needs and resources, establishing preferred CBO networks and closed-loop referrals, tracking impact and outcomes, and advocating for systemic change and reimbursement, Piazza and her team are studying how to address these tasks at scale- and contract levels. While AdventHealth started its value-based care/Population Health Strategy work in 2014, they were operating on parallel paths with the community benefit teams to develop both strategy and programs. They've been collaborative and friendly but not necessarily connected strategically. Further, while they're not in Medicaid risk today, they have a lot of commercially insured populations and participate in many CMS risk programs where members have SDoH needs to address.

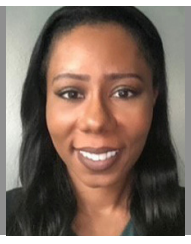
To better identify needs, they started by collecting data, standardizing work processes and gaining alignment (i.e., data collection/ingestion, prediction dashboards, outreach/engagement, comprehensive SDoH assessments and a holistic approach to care). Further, truly understanding the needs of a population entails a multi-faceted approach—gathering data from payers/claims, EHR/clinical, third-party/SDoH, surveys, CHNAs, health equity and patient assessments.

PREDICTING THE FUTURE

"How can we really make sure we're focused on the right people? How do we prioritize those most likely to succeed and engage? Our prediction dashboard is helping us do that," Piazza said. "We didn't want to focus on a single disease; rather, when we engage with a member, we look more holistically, taking into account their spiritual, financial and social health as well. Patients with unmanaged illnesses often have social co-issues, so it is important to understand the whole person in order to provide effective intervention."

Nabil Chehade, MD, MSBS, EVP, Chief Clinical Transformation Officer, MetroHealth

Deborah Gibson, COO, Integrated Community Investment, Providence



Krystal Green, Project Manager, Cedars-Sinai

CONTINUING THE CONVERSATION

We've wondered how to best tell our community benefit story and how to account for investments dedicated to community building and resilience. We are committed to building stronger places for people to live, work, play and learn, but our outgoing grants and gifts don't always link to a hospital line item, so they don't meet the traditional definition of "community benefit".

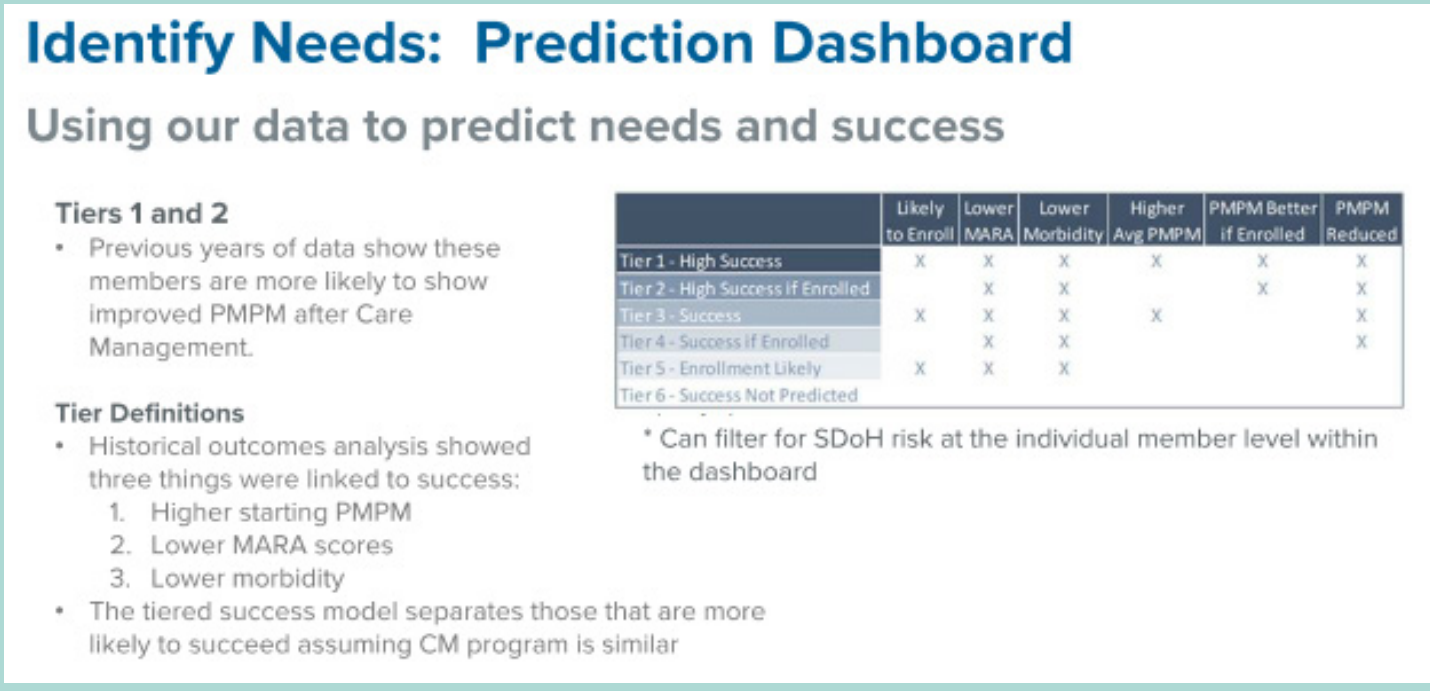
–Sherry Norquist, MSN, RN, Director Corporate Social Responsibility, Sentara Healthcare

How do you define community benefit? Is it government-defined or community health system-defined? I wish it was more the latter. IRS claims are very detailed and depend on state-by-state minimum spending flows, while FQHCs have to do CHNAs and show community benefit in slightly more defined areas and ways.

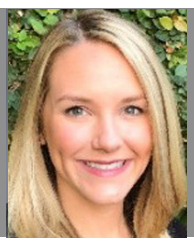
–Jennifer Rosas, MD, CMIO, NOAH, HonorHealth

We're doing SDoH screenings/pilots and training down to physician/provider levels and frontline staff, but we won't get buy-in until we get down to that level. Our medical assistants do the screenings, and while they are closest to these issues, many of them are struggling too, which I think makes it easier to get their buy-in. We have food boxes in our clinics and they can see direct impacts of these screenings. Our providers do sign-off on SDOH referrals, but the MAs are the ones asking the questions to start.

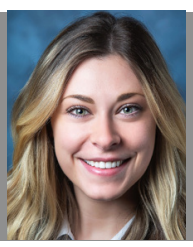
–Heather O'Toole, MD, CMO, Innovation Care Partners, HonorHealth



Identifying needs via prediction dashboards (above) helps the team learn who is likely to succeed and engage (i.e., those enrolled) and those likely to increase spend whether they're enrolled or not.



Katie Hren, LCSW, Community Health Manager, Cedars-Sinai



Erin Jackson-Ward, MPH, Director, Community Benefit Giving, Cedars-Sinai

Robin Lankton, MPH, CHES, Director, Population Health, UW Health

"The use of our prediction dashboard helps our teams focus their time, effort and limited resources on those with the most likely chance of good outcomes. We get risk propensity indices on SDoH from Optum, which we incorporate into our dashboard. We're still working through our models and determining which are best to use. But we use these scores as a guide and then do our screenings. And while we feel like we have to explore other areas, part of that focus is around SDoH and how to target those with outreach. A heat map/dashboard/ZIP code drilldown would be helpful but that's currently untapped," Piazza reported. "Collecting primary source data is our ultimate goal, however, and every acute inpatient now receives an SDoH screening as part of their care management assessment. This is in addition to risk members enrolled in ambulatory chronic care management."

This process will be made easier once AdventHealth moves to Epic in 2022, but they still wrestle with big gaps in their ambulatory primary care and specialist settings, because they don't want to screen patients if they don't have the resources to meet those needs.

DEFINING HEALTH EQUITY STRATEGY

To establish resources, strategy and structure, AdventHealth is focusing on ensuring alignment between community benefit strategies, processes and the broader strategies of health equity, diversity, inclusion and Population Health. Further, they're aligning efforts and approaches around SDoH and Population Health and informing principles of community engagement that align with their broader DEI approach.

AdventHealth is working to establish a committed and engaged CBO network, and will integrate the Aunt Bertha closed-loop referral platform into their Epic EHR as it rolls out. This will be branded as the Whole Health Hub.

Ultimately, their data is key to informing their work: future resource needs, budget allocations, program development, CHNA/CHIP priorities, service gaps, organizational priorities, funding requests, and advocacy.

"We didn't have a good understanding of the drivers before, so this has been great progress for us—to connect our advocacy with our outcomes work. We've planted seeds and things are taking shape, but we need to integrate our strategy across. As we progress in our Population Health work, we'll gain a greater understanding of patient needs, how to get into good partnerships, and how to complement our work without stepping all over each other," Piazza concluded.

MetroHealth's Institute for H.O.P.E.™:

What's Your Next Big Idea?

As a medium-sized, public health system in Cleveland, MetroHealth has spent the past 183 years caring for the chronically ill, aged and poor while also functioning as a major teaching hospital. **Nabil Chehade**, MD, EVP, MetroHealth's Chief Clinical Transformation Officer, admittedly looks at life through a Pop Health lens and thus was the perfect choice to head up MetroHealth's Institute for H.O.P.E.™, which aims to:

- **Improve the health of populations by leading efforts to address social and economic influences;**
- **Identify and promote opportunities for change in practice, learning and policy;**
- **Convene and leverage partnerships to make the greatest impact for individuals, neighborhoods and communities; and**
- **Co-create a self-sustaining community where everyone is empowered to live their healthiest life.**

Sandra Madubuonwu, PhD, APRN, Sr. Director, SDoH & Wellness, Methodist Le Bonheur

Carol Mayer, Academic Project Coordinator, HonorHealth

Megan McAninch-Jones, Executive Director, Community Investment Strategy & Evaluation, Providence

CONTINUING THE CONVERSATION

We're grant-funded to address SDoH in the clinic area, with Outreach Coordinators (OCs) facilitating paperwork with doctors. Once in a [treatment] room, the OCs go in and help the patient do the paperwork and then they do a warm handoff between the patient and the doctor. Our Physician Champions talk about SDoH and it's been helpful, as they look to OCs to mention issues. Our physicians actually are our greatest allies.

–Sandra Madubuonwu, PhD, APRN, Sr. Director, SDoH & Wellness, Methodist Le Bonheur

Leveraging key learnings from our Accountable Health Communities model which focuses on helping patients insured by Medicare and Medicaid, we received third-party funding to start up a similar program around SDoH focused on helping patients with diabetes and set within primary care settings. We filled those SDoH Screening and Navigation roles with Community Health Workers (CHWs) and set goals that align with physicians' Diabetes management quality measures. The CHWs are bilingual and trained with basic Diabetes knowledge. The program is already showing value in somewhat unexpected ways such as patient satisfaction and diabetes diagnoses data correction/quality improvement. We are eager to see the impact of SDoH assistance on other measures such as reduced blood glucose levels and attendance at diabetes education classes among the patients served.

–Aleta Rupert, Program Manager, Accountable Health Communities, AMITA Health

Clinical workflows are a real concern. Our MAs are currently screening as part of the rooming process but, thanks to a grant, we're going to pilot placing the SDoH screening in the patient portal for patients to self-administer prior to their office visit, which removes some of burden from the MAs onsite.

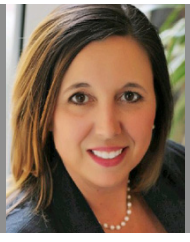
–Jessica Shaffer, Director, Community Health Partnerships, Northern Light Health

"When I joined MetroHealth six years ago, we didn't have anything called Pop Health. I was hired to change that. Since then, about 80 percent of our patients are under some sort of value-based contract; we have the largest Medicaid Accountable Care Organization (ACO) in Ohio and over 100K of attributed lives," he outlined. "We've been very successful…but how could we optimize a significant return to the community?"

Chehade recalls that, initially, when it came to the SDoH initiatives, there wasn't well-organized ownership. Across four hospitals and 25 outpatient clinics, no one claimed data ownership, knew where it resided or who was in charge of the various SDoH programs, which numbered around 140 including some redundancies. The consensus was that these were great investments…but how were these programs organized? Were they all worthwhile?

"We decided this wasn't the way to work. We needed a framework to base our decisions more on the science," Chehade determined. "So we asked, 'Do we know what the need is for our community?' That's why we started looking at the data and organizing our programs and partnerships within the community."

The Institute for H.O.P.E. organized its myriad programs into seven buckets (Center for Healthy Families and Thriving Communities; Education and Training; Research and Evaluation; Health Resilience and Trauma Recovery; Arts in Health; Operations; and Faith-Based Engagement). To fund the work, MetroHealth restructured and reorganized its existing funding and received net new funding to distribute programs amongst the seven main focus areas. After initially receiving the majority of funding from Operations, they now have more than 70 percent of the programs paid for through other sources (e.g., philanthropy).



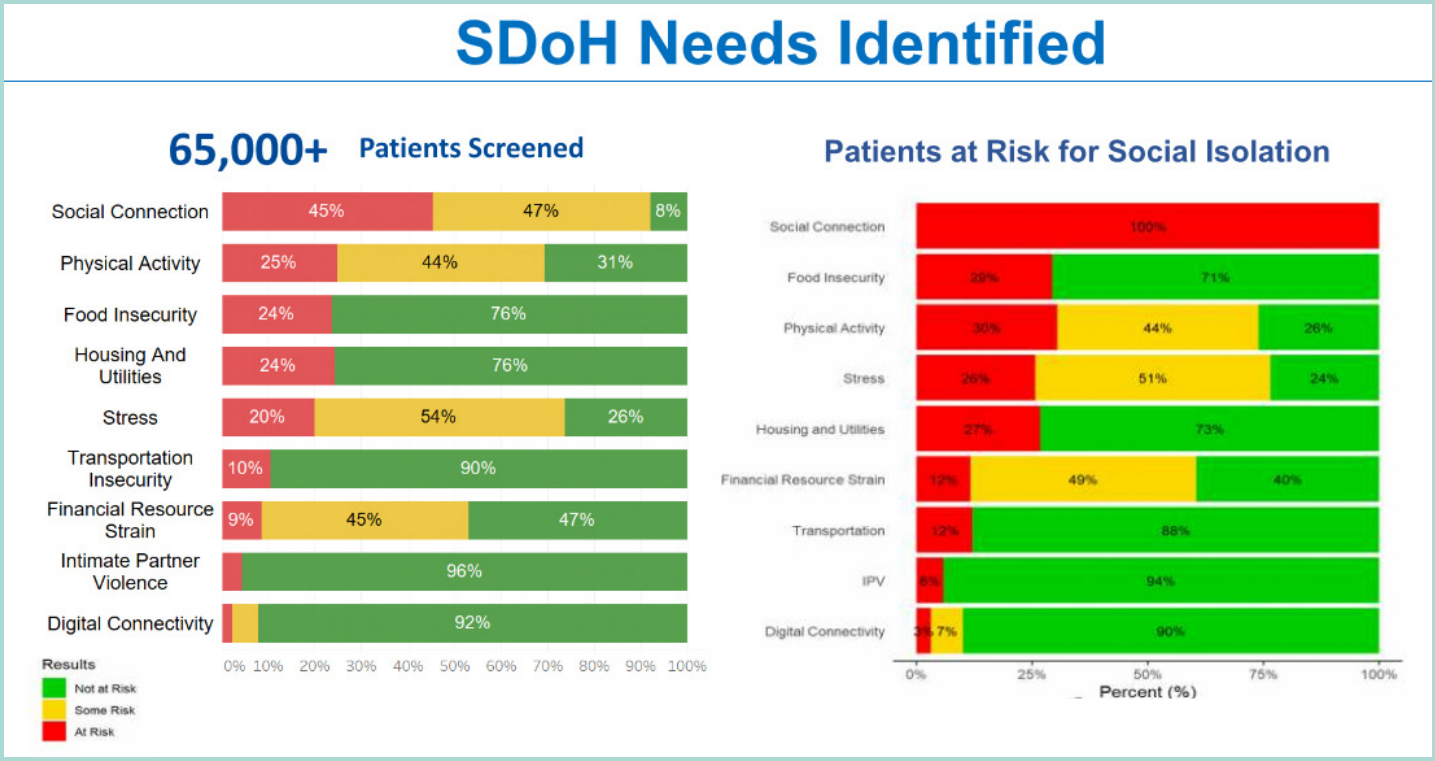
Sherry Norquist, MSN, ACM, Director, Corporate Social Responsibility, Sentara Healthcare

Heather O'Toole, MD, CMO, Innovation Care Partners, HonorHealth

Jill Piazza, PT, DPT, VP, Operations, Population Health Services Organization (PHSO), AdventHealth

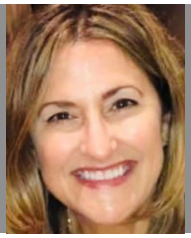
SCREENING FOR STRONGER FUTURES

To better reveal the health impacts around social connectivity, Chehade's team conducted a detailed screening. Out of approximately 300,000 unique patients, 210,000 were eligible for screening (adult only). They then initially screened about a third (65,000) who qualified for services. Of these, over 90 percent had some sort of risk around their social connections, and those who screen positive for social isolation also tend to screen for other risks, such as food insecurity (29 percent), physical inactivity (30 percent) and other challenges (below). In their efforts, everyone who screened positive received a connection to relevant services, and those experiencing critical safety issues (e.g., domestic violence) were connected to resources in real-time. Ultimately, the goal was to screen year-by-year and note any changes to determine whether such interventions were successful. Since social isolation can lead to high utilization and inpatient use, the hope was that decreasing social isolation would also decrease costs spent for utilization.

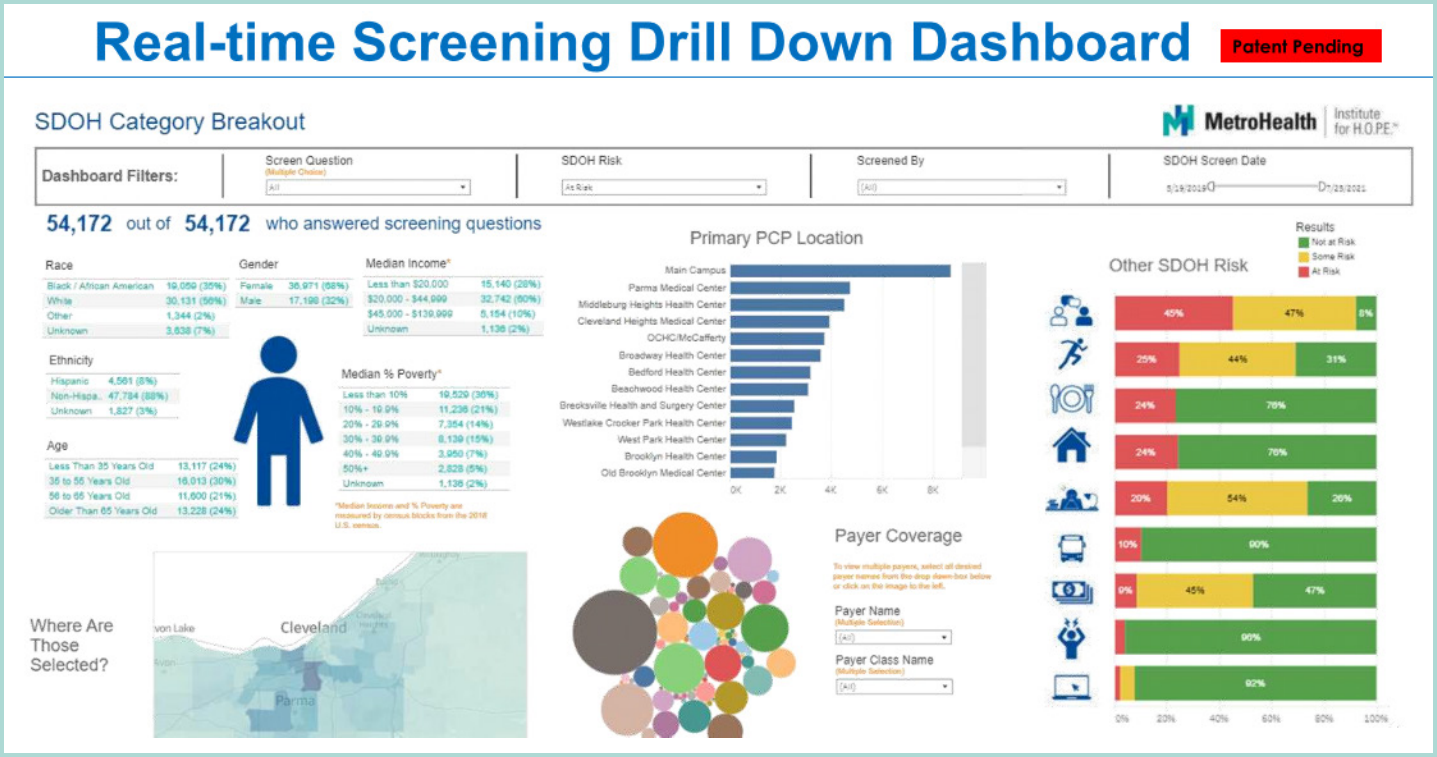


"We've created a clickable, real-time screening dashboard; the demographics on the left side of the screen allow for drill-down—race, gender, median income, ethnicity, etc.," Chehade explained. "Then, on the right, we can see specific scores. Circles are by payer group, for each contract we have. This screening is done by leveraging our patient portal or bin person and so is providing key information across the board."

Jennifer Rosas, MD, CMIO, Neighborhood Access to Health (NOAH), HonorHealth



Aleta Rupert, Program Manager, Accountable Health Communities, AMITA Health

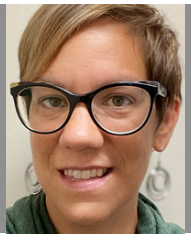


Drilling down even further, the team has revealed some real-world impacts for those screening positive for social isolation: for example, 2.4 times as many ED visits, twice as many inpatient visits and 2.5 times as likely to be no-shows for clinic visits.

"This is intuitive—we know these kinds of results occur, but we didn't have the data to show it before. Eighteen percent of patients at high risk for social isolation also have a diagnosis of drug abuse, compared to six percent of patients without that high risk," Chehade detailed. "Can we attach a dollar sign to moving from 2.4 to 1.4 as many ED visits? Our leadership would love that. And this data is just for one of the nine main risks; we've completed the same for all of them and are getting ready to publish this data.

"The Institute of H.O.P.E. and Pop Health teams are the main consumers of this data," he concluded. "We'll leverage this data to better understand which interventions yield the highest impact on health outcomes and the total cost of care."

Jessica Shaffer, Director, Community Health Partnerships, Northern Light Health



Emily Tolman, System Director, Health Equity & Access, Northern Light Health

ABOUT THE SPONSORS

The Scottsdale Institute (SI) is a not-for-profit membership organization of over 60 prominent, advanced, not-for-profit health systems and academic medical centers whose mission is to improve healthcare quality, efficiency and personal experience through IT-enabled transformation. Our North Star is thought leadership guided by SI's Three Pillars of Collaboration, Education and Networking. We convene intimate, informal and collegial forums for senior healthcare executives, including but not limited to CEOs, CMOs, CIOs, CMIOs and CNIOs, to share knowledge, best practices and lessons learned. Our goal: Gather the right people to discuss the right topics at the right moment.

For more information, visit www.scottsdaleinstitute.org

SCOTTSDALE INSTITUTE
COLLABORATION • EDUCATION • NETWORKING

Epic develops healthcare software to help people get well and stay well. From the beginning, our software has been designed with patients at the heart. Founded in a basement in 1979 with 1 ½ employees, we're a Wisconsin-based, employee-owned company—now with a global footprint. Health systems in all 50 states and 14 countries use our software, and over 250 million patients worldwide have a record in Epic. To read Epic's story in a nutshell, go to **www.epic.com/about.**

Epic