SCOTTSDALE INSTITUTE 2020 SOCIAL DETERMINANTS OF HEALTH VIRTUAL SUMMIT

Addressing Community Health

September 10, 2020
Executive Summary

As healthcare moves toward a value-driven model, the social determinants of health (SDoH) stand at the intersection of community, public and population health.

Understanding the importance of SDoH screening data, how to effectively implement meaningful programs and how to get funding for those programs are the keys to future success. The Scottsdale Institute’s 2020 Social Determinants of Health Virtual Summit: Addressing Community Health, sponsored by Epic, gathered leading executives from health systems across the country to share strategies and collaborate on ways to make lasting community impact.

While each health system approaches SDoH solutions in their unique way, they all face similar challenges:

- Integrating SDoH into health delivery and health-system operations;
- Effectively connecting patients with resources;
- Improving clinician and patient engagement.
SUMMIT PARTICIPANTS

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Erica Bentley, VP, Clinical Services, Bon Secours Mercy Health

Pablo Bravo, System VP, Community Health, CommonSpirit Health

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Mikelle Moore, SVP, Chief Community Health Officer, Intermountain Healthcare

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Alan Weiss, MD, MBA, FACP, CMIO & VP, BayCare Health System

Kimberlydawn Wisdom, MD, MS, SVP, Community Health & Equity, Chief Wellness & Diversity Officer, Henry Ford Health System

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Evolution of Community Health

Historically community health was viewed largely as external to healthcare and separate to the work of the hospital and the clinic. However, as traditional bricks-and-mortar care delivery organizations shift to value-driven strategies, the need to look beyond the walls of traditional healthcare to improve outcomes and effective utilization increases. This work was already underway for many healthcare delivery organizations for years when it was accelerated by the COVID pandemic and social justice movements of 2020.

Top Social Determinants of Health Needs

During the summit, community health and population health executives gathered virtually from around the country to discuss the social determinants of health. Screening of patients for the social determinants is a great start to understanding the needs of the populations healthcare organizations serve. Results from a pre-summit survey show that organizations are putting most attention on food insecurity, followed by housing, depression, transportation and intimate-partner violence. Other focus areas include building financial knowledge and understanding how to address institutional racism.

Currently, organizations address these areas in a variety of ways. According to the pre-summit survey results, the majority of organizations do one of three things: provide a list of community resources to the patient; utilize a care coordinator or social navigator to refer the patient to a community resource; or provide internal resources. According to the survey, these interventions result in care-gap closures, prevention of readmissions or unnecessary ED visits, and reduced no-show appointments.

Screening takes time, but is fundamental to change. Lynn Todman, PhD, VP of Health Equity at Spectrum Health, noted, "We find that screening is actually the work of building trust and relationships which is critical to the long term buy-in and sustainability of these efforts. They are a means to an end, not the end." Samuel Ross, MD, Chief Community Health Officer at Bon Secours Mercy Health, agreed: "When you look at the intersection of community, public and population health as it relates to COVID, the social determinants of health are at the intersection, regardless of the population."
Kinneil Coltman, SVP & Chief Community & External Affairs Officer at Atrium Health, has worked in this space for her entire career and is amazed at how much attention it is suddenly receiving. “The whole country woke up and started paying attention. We have to use this opportunity to implement real and permanent change within our organizations. At Atrium Health, we are looking at ways we can do even more to support the communities we serve.”

NARROW THE GAP

One measure organizations are using to quantify the impact of interventions is closing the life-expectancy gap, a topic that arose many times during the summit. Scottsdale Institute Senior Advisor Shelli Williamson cited a 2019 Chicago Tribune article: “In Chicago, people living in Streeterville have an average life expectancy of 90— in Englewood it’s only 60. One of the largest divides in the U.S.” Tom Moran, MD, VP & Chief Medical Information Executive at Northwestern Medicine, noted, “The distance is only 9 miles apart.”

Unfortunately those trends exist in metro areas of Toledo, Ohio and Charlotte, N.C. Erica Bentley, VP of Clinical Services at Bon Secours Mercy Health, said, “The median income in a part of Toledo is $14,000 per year, and a life expectancy of 62.5 years. Just 2.3 miles away in Perrysburg, the median income is $91,000 per year, with a life expectancy of 80.3.”

Coltman shared similar data: “While only six miles apart, there is a 16-year difference in life expectancy between one of our most affluent communities and one of our lower-income neighborhoods. As a healthcare organization, we are focused on using every lever we have to close the gap in life expectancy.”

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Moderator Emily Barey, Epic, challenged summit participants: “Don’t just look at zip codes, but focus on neighborhoods. Big data can be helpful, but one of the challenges is that using zip codes to understand these inequities might be too large an area.”

Strategies for Connecting Patients with Resources

Organizations can gather data using several mechanisms like screening, questionnaires and outreach. Once organizations acquire data, they are faced with the dilemma of what to do with it. Communities have growing needs, and the health disparities are getting wider between socioeconomic statuses. One clear theme from the day: focus on iteration and being intentional with your efforts.

VALUE OF LEADERSHIP

Kimberlydawn Wisdom, MD, SVP for Community Health & Equity and Chief Wellness & Diversity Officer, Henry Ford Health System, urged participants to move with confidence and joy. “You just have to get started. I can’t underscore the importance of system leadership. One has to be willing to engage in new experiences, to fail fast, and start again. While others wonder ‘why start?’ strong system leadership provides support for innovative opportunities. Strong leaders say, ‘If you believe there is value, let’s pilot test it.’”

She shared an image of a cliff to evoke the contrast between merely treating illness versus encouraging wellness. Current U.S. healthcare is designed to help individuals who’ve fallen off the cliff and need care. And early community health initiatives reflected that perspective by emphasizing provision of a safety net to ease the fall. Today, Wisdom said, the focus should be building a fence before the edge of the cliff in the form of a healthier lifestyle. Combining primary care and prevention enables earlier intervention to avoid later catastrophic illness—falling off the cliff. The more we provide transportation, nutritious food and safe, affordable housing the farther we keep individuals safely “away from the fence” and out of the hospital. Ultimately this also saves money.
Coltman highlighted how Atrium Health—and by inference other health systems—can shape the community health landscape: “What is Atrium Health’s actual power? We are the largest employer and healthcare provider in our community, with a widely recognized community conscience we call our ‘for all’ mission. That provides us a strong and influential leadership voice. When one of our leaders calls the mayor or governor, they get a call back.” She is working with other Atrium Health executives to consider how they can use that influence to generate new conversations that effect positive change in community and public health.

DEVELOPING COMMUNITY PARTNERSHIPS

Pablo Bravo, System VP for Community Health at CommonSpirit Health, stressed the importance of finding non-traditional partners. “Credit Unions and local utility companies make great allies in this space. They have insight into many of the social risk factors surrounding housing or financial insecurities.” Working together as a community can help keep the lights on, and fight off predatory lending as well. “Get into the neighborhoods. Identify those issues that can be addressed through partnerships. You can’t address all of them, but you have to do what you can,” he said.

Intermountain has a three-year grant for a demonstration project focused on reducing avoidable ED usage in two counties. The project leverages six Community Health Workers in each county, helping connect patients with resources. During his presentation, Gene Smith, Operations Director, made it clear they are focused on the bigger picture, and have a long-term perspective beyond the three-year grant. He noted, “This is not just a two-county and three-year goal. This is a journey, and we plan to continue expanding and growing this work across our system and statewide.”

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Jessica Shaffer, Director of Community Health Partnerships at Northern Light Health, lauded the collaboration and learning from others. “We’re still early in our SDoH screening development and reinforcing the message to focus on what we can change will be important in our efforts.”

**COMMUNITY AND PLACE-BASED INVESTING**

Once health systems develop a data-driven understanding of their communities’ social needs they can identify targets for action. Community or place-based investing is a great place to start.

Given that Bon Secours Mercy is one of the largest employers in its geographic area, Bentley asked why that distinction shouldn’t drive its SDoH strategy. “If we aren’t willing to hire the people, how are we really willing to support them in other ways? We invest time and energy into the community health needs assessment. What are we going to do with it? Is it driving change, and what action is coming out of it?”

David Marshall, JD, DNP, SVP & CNE at Cedars-Sinai Health System, agreed. “Every three years we do a community needs assessment and let it drive the focus. In 2019 the survey conveyed the need to address mental health, housing, substance abuse and access to care.” Cedars Sinai is well positioned with an extensive community network that includes schools, places of worship and other neighborhood organizations. “Cedars put $25 million into strategic investments with a focus on the social determinants of health,” he noted.

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Alisahah Cole, MD, System VP for Population Health Innovation & Policy at CommonSpirit Health, challenged the group to consider how they spend their community benefit dollars—and to be deliberate. Many health systems invest in sponsorships, galas, lunches and the like. “What if that money went to community investment instead of the one-time events?” she asked. Charity care is expensive. If community benefit dollars can be spent upstream to prevent costly interventions like trips to the emergency department, it can end up being the best investment both clinically and financially.
Most health systems are in the midst of budget planning for the following fiscal year. COVID hit nearly every organization hard economically. Ross from Bon Secours asked summit participants whether their organization was increasing or decreasing community investment. While the response was mixed, many executives said it should be a priority. Most departments were subject to cuts but somehow organizations are finding grants and other funding to support community health initiatives. And groups are pursuing those funding streams more deliberately this year with increased success.

“Everyone is 100 percent at risk for the uninsured,” asserted Cole. “If you’re providing care to the uninsured, you are participating in value-based care initiatives.” Carleen Penoza, CNIO at Michigan Medicine, agreed. “Historically, the highly complex, highly expensive patients are likely getting readmitted, because there hasn’t been enough focus on the social risk factors; organizations are addressing medical needs only.”

**Strategies for Clinician and Patient Engagement**

**ACCESS TO INTERNET—RURAL OR COST**

Because COVID is driving the explosion of virtual patient/provider communication, internet connectivity is often becoming the first social risk factor that organizations address with patients. Do they have reliable access? If so, do they have the technical literacy to navigate digital tools and participate in successful telehealth interactions?

Melinda Cooling, DNP, VP for Advanced Practice/CCE, Saint Gabriel Digital Health, OSF HealthCare System, works with a largely rural population for which the ability to connect virtually is critical, even without COVID. Transportation to their main campus in Peoria, Ill. is unrealistic for many patients where travel times can be three hours or more. “Historically, patients can be labeled as noncompliant if they don’t show for an

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appointment, but realistically, it is just social factors keeping them from making their appointments. That is a different concept.” OSF offers the Saint Gabriel Digital Health Center, which is essentially a hospital without walls. They were able to stay agile and set up a COVID hotline within 72 hours in March when cases started occurring locally. Many of the patients accessing the digital health center needed assistance. “Patients are able to get a low-cost device with cellular access through the program, removing many of the barriers we experienced before,” she said.

Kenneth Fawcett, Jr., MD, VP for Healthier Communities, Spectrum Health, questioned the effectiveness of virtual communication given that Michigan encompasses many areas that lack access to Wi-Fi or cellular service. Cooling noted OSF is fortunate to not face that obstacle and has been able to find digital access if cost and technology is not a barrier. A large contributing factor to the success of OSF’s broadband access is the relationship that Jennifer Junis, SVP, Saint Gabriel Digital Health, built with the Illinois governor’s office. “We’ve had the opportunity to sit on the task force and be part of the solution,” she said.

Jennifer Quillin, a Program Consultant at HonorHealth, said, “Schools are finding broadband access solutions for students during the pandemic, and we need to find those same solutions for our patients.”

Shaffer said Maine was somewhat unprepared for the explosion in demand for telehealth. “We were pushed to telehealth sooner than the expected trajectory and at a time when Maine lags behind most others states for broadband availability. Many residents don’t have reliable internet access, and this lack of infrastructure amplified existing barriers to care.” Exacerbating the crisis was the closure of public institutions like libraries, often a critical Wi-Fi or internet access point for patients and their families.

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Bentley described a creative solution: “We worked with our payers, and received hundreds of cell phones to distribute. We also found reduced-cost transportation options working with the payers.”

While Tamera Larsen-Engelkes, Clinical Information Officer at Avera Health, works in a largely rural area in Sioux Falls, S.D. she felt fortunate. “We have good coverage and connectivity across our footprint. It has not been a big issue that we've had to overcome.”

**FUNDING COMMUNITY HEALTH WORKERS**

Throughout the summit participants highlighted the importance of community health workers. Wisdom noted that Henry Ford utilizes a hub-and-spoke model, with 19 Community Health Workers (CHWs), funded by a combination of grants and institution contributions. “Departments fund the CHWs; however, they all work out of the central hub. This allows them to have centralized management and collaboration with one another,” she said.

OSF’s Cooling wants to take what they learned from their pandemic health worker role and permanently transition those responsibilities to a digital health worker. “This will allow us to continue to intervene much sooner on social needs.”

Cindy Levey, Director of Community Benefit Systems and Planning at Cedars-Sinai, highlighted a similar role. “Cedars-Sinai is launching a program focused on identifying a patient’s social-determinants-of-health needs and connecting patients to community-based organizations to meet those needs. Community Resource Connectors will assist with that patient navigation. Also, because needy patients interact with the health system at any entry point, it has been essential that planning and implementation is managed through a commitment from leaders across functions.”

Mikelle Moore, SVP for Community Health at Intermountain Healthcare, also would like to see the community health worker role expanded. “We want to build trust in the community, truly work at a community level, perhaps independent of a health plan or healthcare organization on an integrated digital platform.”

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PREPARING FOR A SECOND SURGE

Health systems are just getting started on the task of screening for social determinants and determining how to address those risk factors. Those initial steps are occurring while summit executives all agree a second COVID surge is coming or already underway and will add to the pandemic’s mental health impact.

Said Karen Amstutz, VP of Community Health at IU Health: “Indiana has already experienced full behavioral health inpatient census as early as July, which is seasonally unusual. Pre-COVID, we had expanded behavioral health telehealth coverage such that all 16 emergency departments had behavioral health services available to patients. Fortunately, this gave us the experience in telehealth to rapidly expand services during the early COVID surge. Telehealth visits were rapidly adopted by our medical staff and grew to a peak of 90,000 a month compared to a volume of 10,000 in 2019.”

Bravo believes community health needs transcend the patient dynamic. “We need to focus on aligning employees with community health initiatives, in an effort to address their SDoH issues as well.”

Fawcett is looking beyond the second wave, concerned about what he terms the receding tidal waters. “The economic recovery is far more protracted, and more socioeconomic gaps and racial disparities will widen as a result of this.” He acknowledged that different people need different levels of support. For some recently unemployed individuals, receiving a list of community resources will be extremely valuable. Others need more high-touch care management, including physical navigation to leverage those same resources.

Conclusion

Resolving systemic health, economic and racial disparities is anything but a walk in the neighborhood park. Permanent change must be built on reform resulting from both the COVID pandemic and social justice movements of 2020. The vision and resulting action of population and community health executives at the Scottsdale Institute’s 2020 Social Determinants of Health Virtual Summit: Addressing Community Health paves the way for healthcare organizations to close the gap.
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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.

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