

Beyond boundaries: Why finding ways to address social determinants is vital to healthcare's future

A REPORT FROM HFMA'S 13th ANNUAL THOUGHT LEADERSHIP RETREAT
FALL 2019

Seizing opportunities to improve outcomes will require new collaborations outside and within the healthcare sector through approaches tailored to local markets, industry thought leaders say.

A growing body of evidence has demonstrated that health and healthcare outcomes are driven mostly by influences outside of healthcare facilities and physicians' offices. As the healthcare sector increasingly recognizes the impact of outside factors on the health of patients, leaders and innovators have begun identifying ways for their organizations to address those factors.

The challenge has been highlighted by research demonstrating that the healthcare system determines only between 10% and 20% of individuals' health status, even as providers take on increasing financial accountability for outcomes. Such financial pressures are driving more providers and health plans to look for ways to influence social and environmental factors, as well as patient behavior, which combine to determine up to 60% of individuals' health status.

These outside factors, known as the social determinants of health (SDOH), may be influenced by nonmedical services such as housing, nutrition, transportation, education, employment and social services.

Identifying the social determinants that impact individuals' health and charting ways to influence them were the focus of HFMA's 13th annual Thought Leadership Retreat in October. The gathering, sponsored by Global Healthcare Exchange, Inc. (GHX), Intuitive Surgical, AbbVie, Inc., BKD, Inc., Baker Tilly, Mapstone Veritas, nThrive and PatientCo, brought together

100 thought leaders from across the healthcare industry to share ideas on how providers and health plans can identify and implement a range of SDOH-related innovations to improve patient health.

"The truth is that you can't talk about clinical issues, you can't talk about physician issues, nursing issues, you can't talk about social determinants and not talk about them having some financial impact," said Joseph J. Fifer, FHFMA, CPA, president and CEO of HFMA. "The charge for the financial people is that you can't have those conversations and not participate and think broadly."

TOPICS ADDRESSED IN THIS REPORT INCLUDE:

- Identifying the outside factors that affect the health status of local patient populations
- Determining what roles various parts of the healthcare system play in addressing SDOH
- Finding the partnerships that can most effectively impact SDOH
- Identifying what SDOH strategies work
- Funding initiatives to address SDOH
- Enlisting patients and families in improving health-influencing factors
- Overcoming practical obstacles, such as data collection, technology and partnership issues

A Message from HFMA's President and CEO

DEAR COLLEAGUES:

Originally launched in 2007, HFMA's Thought Leadership Retreat is a forum where some of the best and brightest minds in our industry come together to discuss current issues facing us all. The focus of the 2019 event, which took place Oct. 3-4 in Washington, D.C., was social determinants of health. Our goal was not only to discuss how we might better address the social factors that impact health but also to develop recommendations on how we might redraw traditional boundaries and ultimately lower the total cost of care.

To set the stage for our discussions, we invited prominent industry leaders representing physicians and other practitioners, health plans and hospitals and health systems to share different aspects of the featured topics. These included presentations on incorporating more shared decision-making in medical education; current efforts to address social determinants within emerging payment models; and strategies healthcare providers are taking to impact social determinants and improve community health. Other speakers addressed creating a personalized approach to addressing social determinants by leveraging technology; efforts to mobilize the healthcare sector toward action and collaboration; and how health plans are using a shared-value approach to meet the specific needs of their members.

Participants also convened in smaller groups for more in-depth discussions. Topics included the role of various participants in the healthcare ecosystem in addressing social determinants, potential funding sources and strategies to scale and expand successful models. Highlights of the discussions and potential next steps were shared during a closing panel presentation.

This report summarizes the presentations and discussions. Thank you to all of the participants for contributing their insights and expertise. Thank you as well to the Alliance of Community Health Plans, the American Association for Physician Leadership and the American Organization for Nursing Leadership for their partnership in convening the retreat. And finally, thank you to this year's sponsors – AbbVie, Baker Tilly, BKD, GHX, Intuitive Surgical, Mapstone Veritas, nThrive and PatientCo – for their generous support.

Best regards,



Joseph J. Fifer, FHFMA, CPA

President and CEO

Healthcare Financial Management Association

CHALLENGE 1 HOW TO IDENTIFY LOCAL SDOH NEEDS

Although funding sources are the primary concern for many healthcare finance leaders when considering the challenge of addressing SDOH, industry leaders at the retreat said first steps should focus on understanding the extent of an organization's community needs. Speakers and attendees identified a range of approaches that can provide healthcare leaders with a better understanding of the specific SDOH factors in their communities.

The community health needs assessment (CHNA) – required of not-for-profit hospitals every three years under federal law – is a way for hospitals to identify needs and potential partners in SDOH efforts, according to participants. University of Chicago Medicine has developed a robust CHNA process that allows it to gather a detailed understanding of the socioeconomic needs of its community and how it can address those needs, said Brenda Battle, RN, vice president of the organization's Urban Health Initiative and chief diversity, inclusion and equity officer.

The hospital's CHNA development process includes focus groups, community surveys, "key informants" and data from the local health department, among other sources. Once needs are pinpointed, action steps are identified and prioritized in partnership with a council composed of former patients and local residents.

"The key to all of this is that the community is very much at the table and part of this," Battle said.

Many healthcare leaders may focus on nutrition over other social determinants because it is more understandable to them and they frequently already know of community groups that are focused on

that issue, said Brenda Schmidt, founder and CEO of Solera Health, a company that connects patients with evidence-based, nonmedical wellness programs. Attendees identified nutrition as the SDOH category on which they were most focused.

Healthcare organizations also can identify local SDOH needs by screening for them among patient populations, as El Rio Health in Tucson, Arizona, has done.

Nancy Johnson, RN, PhD, CEO of the federally qualified health center (FQHC) with 11 locations, said the organization recently added check-in kiosks to facilitate what has been a 40-year effort to collect SDOH data from patients. That data is auto-populated into the patient-encounter record, alerting the clinician if any concerning points are identified in the SDOH screening.

Other software forwards any automatically flagged SDOH data submitted by the patient to other members of the integrated delivery team. Team members can take steps such as requesting services for the patient from social service organizations in the community.

Another data collection point allows those service organizations to input data they collect from interactions with the patient into the electronic health record (EHR). This supports care coordination by allowing the clinical care team to know that key items on the care plan have been addressed. And if those needs have not been addressed, the care team would know it needs to follow up.

That way, "I can close the loop on if I am addressing the social determinants of health," Johnson said.

CHALLENGE 2 DETERMINING WHO IS RESPONSIBLE FOR ADDRESSING SDOH

The size, variety and complexity of SDOH challenges can appear overwhelming to healthcare leaders, whose organizations often already face extreme financial challenges, attendees noted. The reluctance to take on a costly new responsibility was seen in the response of a plurality (42%) of retreat attendees, who said local, state and federal governments bear primary responsibility for addressing SDOH. Only 15% saw primary responsibility as falling on the healthcare system.

Mike Allen, CFO of OSF Healthcare System in Peoria, Illinois, and 2019-20 Chair of HFMA, was among those who pushed attendees to look past the challenges.

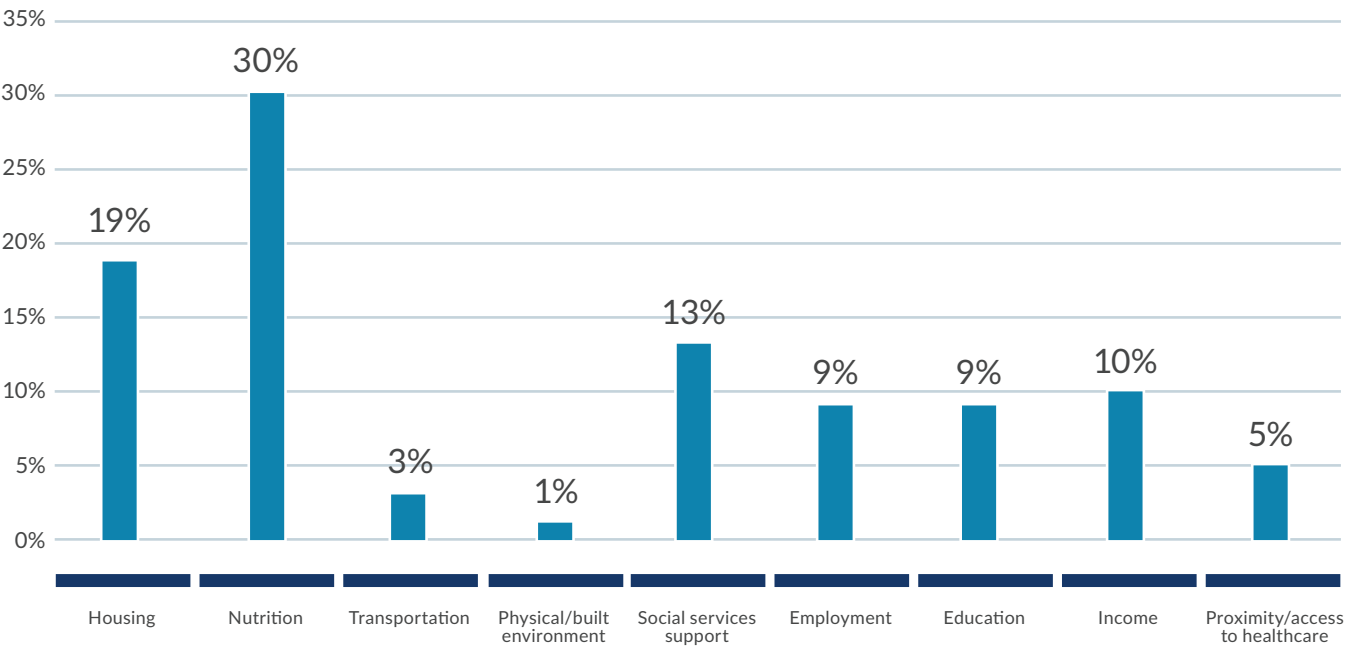
“Violence recovery and other things fall into the category of ‘Not our fault, but it is our problem,’ and if not us, who? Somebody has to step up,” Allen said.

Among healthcare organizations not content to leave SDOH to governments is MetroHealth System, a safety net facility in Cleveland.

Akram Boutros, MD, CEO of MetroHealth, “has made a firm commitment in the city of Cleveland that in the absence of anyone else, the MetroHealth System will step up and try to make our communities healthier,” said Susan Fuehrer, president of the system’s SDOH-focused

WHICH ONE OF THE FOLLOWING SDOH DO YOU SEE AS THE LARGEST INFLUENCER ON HEALTHCARE COSTS IN THE PATIENT POPULATION YOU SERVE?

Source: Poll of 2019 Thought Leadership Retreat attendees.



institute. “And it’s not just our patients, it’s the neighborhoods and it is actually the economy and the future.”

Fuehrer became convinced of the importance of the SDOH push when she saw compelling population data, such as the finding that average lifespans in the 58 ZIP codes in Cleveland differ by as much as 20 years.

“If we’re going to change the narrative on this and get others to pay attention to this and perhaps afford it, we all have to do it,” said Battle of University of Chicago Medicine.

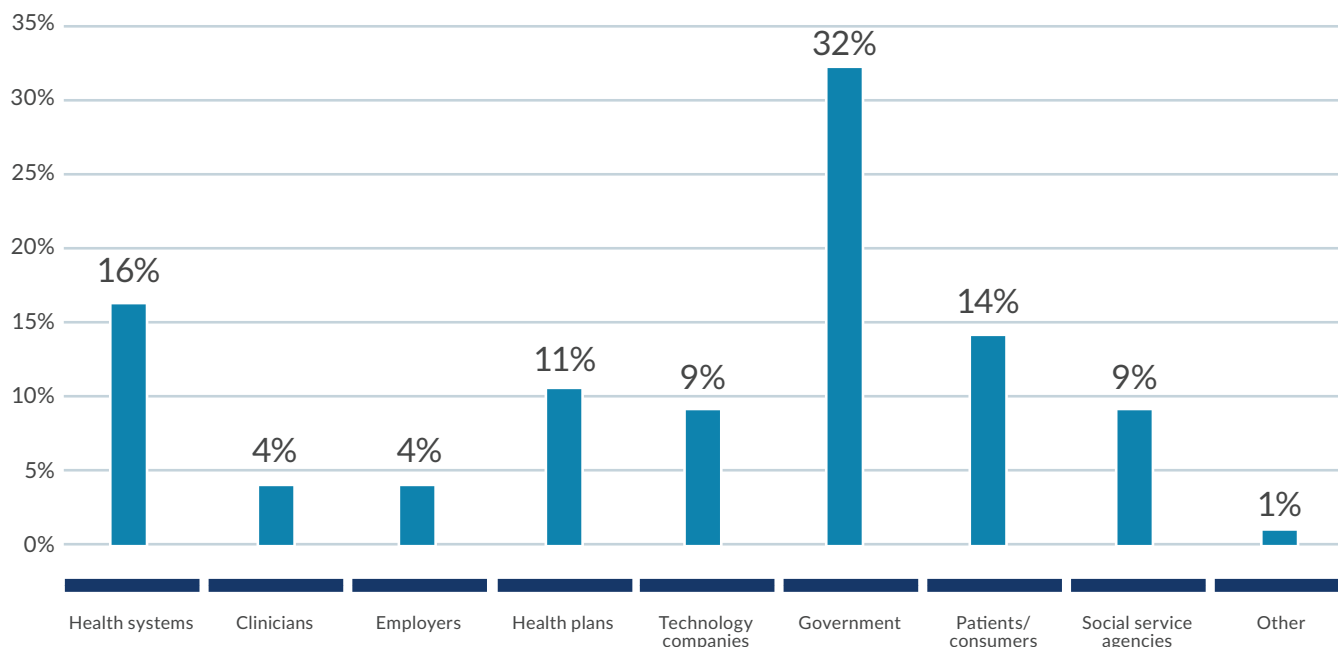
Hospitals and health systems are well-positioned to convene SDOH-focused collaboratives, even if they are not always the leader of such

groups, Battle and some attendees said. However, such a part could become more difficult to play because of the wave of consolidations that has diminished the role of local community advisory boards in guiding independent community hospitals, said Linda Knodel, senior vice president and chief nurse executive with Kaiser Permanente and formerly president of the American Organization for Nursing Leadership, which partnered with HFMA to present the retreat.

Health plans have taken a leading role in developing complex initiatives focused on SDOH, but they are incapable of executing those initiatives without a range of partners, said Russ Elbel, Medicaid program director for SelectHealth, the health plan division of Intermountain Healthcare.

WHEN YOU THINK OF POSSIBLE CATALYSTS FOR IMPROVING HEALTH OUTCOMES AS THEY RELATE TO SDOH INTERVENTIONS, WHICH DO YOU THINK WILL BE THE MOST SIGNIFICANT FORCE?

Source: Poll of 2019 Thought Leadership Retreat attendees.



“Health plans and health systems can be conveners, but to be successful the state has to be involved and counties need to be involved and other stakeholders have to be involved,” said Ray Prushnok, associate vice

president for UPMC Health Plan. “Some of the danger in only health plans being involved is then the health plan is looked to for solutions that are really much broader societal solutions.”

CHALLENGE 3 IDENTIFYING SDOH STRATEGIES THAT WORK

Among the increasing number of initiatives that have aimed to address SDOH, several nutrition-focused efforts have generated positive results. For instance, a not-for-profit health plan, Health Plan Partners, implemented a first-of-its-kind food delivery service in 2015. Over two years, the program was credited with a 28% reduction in hospital admissions and a 7% reduction in emergency department (ED) use among those enrollees, Schmidt of Solera said.

“Just providing food had a huge impact,” Schmidt said.

A Commonwealth Fund review of evidence for health-related social needs interventions also identified savings found in four categories of actions (see the exhibit below).

But not all SDOH are equally modifiable through interventions. For instance, Schmidt noted there is strong evidence that social isolation impacts health, including its association with a 29% higher risk of developing heart disease. But there’s no evidence any effective interventions exist to address isolation.

REVIEW OF EVIDENCE FOR HEALTH-RELATED SOCIAL NEEDS INTERVENTIONS

Source: Data from the Commonwealth Fund. Presentation by Brenda Schmidt, Solera Health.

INTERVENTION	POPULATION	OUTCOMES
Nutrition	Massachusetts dual-eligible	Monthly net savings of \$220 for medically tailored meals
	Maine Medicare	ROI of 387% from post-discharge meals in congestive heart failure
Transportation	Nationally representative sample of transportation-disadvantaged people	Estimated savings of \$927 per patient with diabetes, \$333 per patient with asthma and \$2,743 per patient with heart disease
Housing	Oregon Medicaid	Average reduction of nearly \$50 PMPM from affordable housing
	California dual-eligible	ROI of 157% from supportive housing
Home Modifications	Dual-eligibles with ADL difficulty	Estimated \$10,000 per patient per year in savings to Medicaid

“Right now, we’re all kind of rowing in slightly different directions.”

—David Gregory, leader of the healthcare consulting practice at Baker Tilly

SelectHealth has found adding even a few community health workers can improve the value of care given by providers and care managers. Such a step allows them to impact patients’ lives outside traditional healthcare settings, as they covet the opportunity to do.

“That momentum goes a long way because as you build champions within your system, you end up getting a lot of support,” Elbel said.

David Gregory, leader of the healthcare consulting practice at Baker Tilly, said it is critical that healthcare organizations undertaking SDOH initiatives publish their results in peer-reviewed literature.

“Because that’s one way that everyone starts to get aligned,” Gregory said. “Right now, we’re all kind of rowing in slightly different directions.”

CHALLENGE 4 COMING UP WITH FUNDING TO ADDRESS SDOH

Despite its demonstrated importance and the effectiveness of some approaches, SDOH will become “just another buzzword that will go away” without the support of sustainable revenue models, Schmidt said.

The financial benefit of El Rio’s SDOH efforts mostly has come through value-based payment models that reward reduced ED use and hospital readmissions. As a result of the organization’s efforts, its 55,000 Medicaid patients have the lowest ED use and readmission rates among any group of Medicaid patients in Arizona.

“We can see over a two-year period that when we take care of food, shelter and we see them regularly and assign them to an RN care coordinator, all of that other data begins to shift,” Johnson said.

Many provider organizations seeking to address SDOH in their communities or patient populations have funded those efforts primarily through philanthropic sources.

“There are many grants out there,” said Imelda Dacones, MD, CEO and president of the not-for-profit Northwest Permanente and a board member of a federally qualified health center. “The things that we have

found have been really very helpful are doing these small pockets of change and then seeing what the potential is; to see what the potential ROI is and then decide whether to go with it.”

Some commercial health plans have begun to plan or even actively fund SDOH initiatives tied to improved health outcomes, but federal incentives still are seen as needed.

SDOH initiatives can be part of value-based payment models, including those sponsored by the federal government.

Amy Bassano, acting director and deputy director of the Center for Medicare and Medicaid Innovation (CMMI), said her office is focused on how to advance SDOH initiatives but warned it faces many more funding restrictions on such initiatives than commercial health plans face.

“People get really anxious if it looks like the Medicare-Medicaid dollars might be spent on things that are not under our statutory authority,” Bassano said.

“We need as healthcare providers to bring more people to the table to have this conversation because I’m not sure that we can do it ourselves.”

—Brenda Battle, RN, vice president of the Urban Health Initiative and chief of diversity at University of Chicago Medicine

As part of its focus on SDOH, CMS is “talking a lot to you and your partners in the community about what you are doing at the community level and how we as the government can help facilitate some of that, recognizing that social determinants of health is a big, broad process that means a lot of different things to a lot of different people, and how it’s executed can be very unique,” Bassano said.

The first federal payment model to explicitly focus on SDOH funding was the Accountable Health Communities model, which screens Medicare and Medicaid beneficiaries for a range of health-related social needs and connects them with health and social services.

In 2019, CMS introduced the Direct Contracting (DC) models, a set of voluntary payment models aimed at reducing

spending and bolstering quality for beneficiaries in Medicare fee-for-service.

Beyond incentivizing screening and referrals for SDOH needs, CMS is looking at whether to integrate efforts to address SDOH in its DC models. CMS planned to seek applications for two such models in the fall of 2019 and was constructing a third model.

One way that CMS has greenlighted SDOH funding (although it has provided no new funding) is through recent guidance to Medicare Advantage (MA) plans, Schmidt said. She noted that special supplemental benefits tied to clinical benefits now can be offered to chronically ill enrollees. Such *nonuniform benefit designs* can be based on socioeconomic status.

CHALLENGE 5 THE NEED FOR PARTNERSHIPS

Healthcare organizations with extensive experience in addressing SDOH underscored the importance of forming partnerships – in many cases with nonhealthcare entities – to obtain lasting results.

“It’s taking this village of expertise to obtain these outcomes,” said Battle of University of Chicago Medicine. “We need as healthcare providers to bring more people to the table to have this conversation because I’m not sure that we can do it ourselves.”

At El Rio Health, the EHR tool that incorporates community partner feedback on referred patients also is used to assess the “bench strength” of those partner organizations, Johnson said. The provider uses the tool to hold its partners accountable for fulfilling the identified patient need.

“We have lots of social service partners out here working around social determinants,” Johnson said. “Some of them are powerful and great partners for us, others are writing a grant to meet payroll next week.”

To incentivize quality, Johnson launched a pilot with a food bank to give it 10% of any value-based payments received by the FQHC when it achieves savings.

To address the challenge of finding high-quality community partners, Northwest Permanente created a social services community listing, Thrive Local, that is available as a continuously updated add-on for EHRs. The system allows hospitals and health systems in the market (including an ongoing expansion to non-Permanente hospitals) to

receive up-to-date information on available community service providers and for those providers to add care plans to the EHR that clinicians can review with patients.

“It should be an ecosystem of medical and community-based service organizations to take care of the patient in a more holistic, complete way,” Dacones said.

CHALLENGE 6 FINDING WAYS TO OPERATIONALIZE SDOH

SDOH initiatives at Northwest Permanente have aimed to avoid medicalizing social needs and instead to add new categories of assisters – such as community health workers, peer supporters and nontraditional roles for social workers – who can focus on such needs as identified by clinicians.

“It is mostly nonlicensed people that we need to partner with as physicians and clinicians,” Dacones said.

Healthcare leaders also aim to use their purchasing power as large organizations to economically bolster their communities. Such economic efforts are critical, said Marla Weston, PhD, RN, former CEO of the American Nurses Association Enterprise, because “the cycle of poverty drives the social determinants of health.”

Such initiatives include Intermountain Healthcare’s choice of a local coffee supplier, which provided not only a local business boost but fueled tangential community donations from that supplier.

“We can align efforts and start to have some downstream impact,” Elbel said.

Needed partners are not always available in some communities, attendees noted. To address that void, SelectHealth has started making low-interest loans to organizations building community services, Elbel said.

Another economic focus is on opportunities to provide employment to patients and plan enrollees. UPMC is launching a project to connect some of its Medicaid plan enrollees with job openings at the health system.

UPMC also has a *soft skills* program to help female employees advance within the system and recruits local environmental services workers through a training program operated by a community organization.

Although some attendees were openly skeptical of launching costly SDOH interventions like providing housing for patients, some identified

Lessons learned on best practices for operationalizing SDOH efforts

- Employing staff with expertise in addressing SDOH
- Adding community health workers and peer support
- Obtaining initial SDOH funding from grants
- Using pilots to test approaches for effectiveness
- Implementing needed data infrastructure

“Instead of it being your pilot and you’re giving money away, you can make a loan that is relatively low-risk and build affordable housing.”

—Ray Prushnok, associate vice president for UPMC Health Plan

financially manageable ways to support housing programs. UPMC is among those that provide loans to community organizations through community development financial institutions focused on building affordable housing.

“Instead of it being your pilot and you’re giving money away, you can make a loan that is relatively low-risk and build affordable housing,” said Prushnok, who also represented the Alliance for Community Health Plans, which partnered with HFMA to present the retreat.

CHALLENGE 7 OBTAINING THE DATA NEEDED FOR SDOH INITIATIVES

Access to and utilization of effective patient data is critical to identifying and effectively addressing SDOH needs, attendees said. And clinical data in the EHR or claims data from health plans frequently is insufficient.

“What your claim doesn’t tell you is that there is a service coordinator who visits with you a couple times a month; it doesn’t tell you that there is a personal care attendant in your home each and every day,” Prushnok said.

That gap has led some stakeholders to identify nontraditional sources of such data, including social data collected by front-office admitting staff, community workers and partner school systems.

For instance, UPMC Health Plan has established a close collaboration with a county government to find plan enrollees who are eligible but not enrolled in programs that could address some of their SDOH needs.

El Rio has made use of verbally collected SDOH data that it already has been gathering from some patients for 40 years for submission to the Health Resources and Services Administration as part of its Uniform Data System report.

CHALLENGE 8 GETTING PATIENTS ENGAGED IN SDOH EFFORTS

Healthcare organization leaders repeatedly stressed that addressing SDOH requires establishing trust with patients and a commitment from them to engage in needed steps.

One way to create that alliance is through better implementation of shared decision-making, said Peter Angood, MD, president and CEO of the American Association of Physician Leadership, which partnered with HFMA to present the retreat.

“We’re patient-centric until what? Until it comes time to establish process, and then we organize around ourselves, we organize around our health system, we organize around our payers, we organize around our physicians,” said Fifer. “If we’re going to be patient-centric, then let’s be patient-centric.”

Karen Conway vice president of healthcare value at GHX, said one way to organize around the demand (the patient need) instead of the

supply (the hospital) is to standardize SDOH efforts that are known to work and then allow clinicians or community workers to customize initiatives based on the unique needs of patients and communities.

Danielle Solomon, health industry partner leader for BKD, noted that younger patients, who have come of age as highly selective consumers, are more likely to demand patient-centered care.

UPMC Health Plan has derived savings from efforts to engage so-called super utilizers of hospital EDs. In one example, a health plan case manager found out a high-utilizer was in jail. The case manager used his organization's capabilities to send a social worker to the jail to persuade the patient to seek substance use treatment, helped get his case diverted to drug court, transported him to residential treatment and settled him in stable housing.

"The downstream effects were huge," Prushnok said. "Now, it's [a question of] how do you move then towards a value-based payment that engages all of the right parties, because we had to do a whole lot of work to engage all of the right parties."

Some attendees questioned whether patients should face some type of accountability for not engaging in efforts to improve their SDOH-related circumstances. However, Bassano said CMS lacks the statutory authority to require as a condition of participation that Medicare beneficiaries perform actions such as designating healthcare proxies or engaging in end-of-life planning. CMMI is looking for ways to encourage such actions voluntarily within its payment models, she said.

"This is a lot about behavior modification at the end of the day," said Gregory of Baker Tilly. "We're identifying all of these attributes with the goal of modifying behavior."

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HFMA would like to thank our report's sponsors, GHX and Intuitive, for supporting the 13th Annual Thought Leadership Retreat.

The two-day event brought together a diverse group of industry leaders to discuss challenges and solutions to improve healthcare delivery.



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With more than 43,000 members, the Healthcare Financial Management Association (HFMA) is the nation's premier membership organization for healthcare finance leaders. HFMA builds and supports coalitions with other healthcare associations and industry groups to achieve consensus on solutions for the challenges the U.S. healthcare system faces today. Working with a broad cross-section of stakeholders, HFMA identifies gaps throughout the healthcare delivery system and bridges them through the establishment and sharing of knowledge and best practices. It helps healthcare stakeholders achieve optimal results by creating and providing education, analysis, and practical tools and solutions. HFMA's mission is to lead the financial management of health care.

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PUBLISHED BY:

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