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Tiffany Capeles,
chief equity officer at
Intermountain Health

SDOH: CONVENER OR LEADER?

Hospitals and health systems still struggle with their role.

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SDOH: CONVENER OR LEADER?



HFMA Contributing Writer

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Tiffany Capeles,
chief equity officer at
Intermountain Health,
said proactive screening
uncovered huge needs
among its patients.

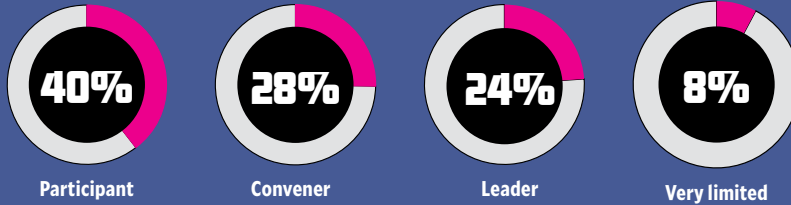
PHOTOS BY MARSHALL CLARKE

FROM THE FIELD

HFMA conducted a survey of 105 healthcare finance executives, with selected results found throughout this report.



What role should health systems most play in the execution of a social determinants of health strategy?



Source: HFMA survey, February-March 2023, 86 out of 105 respondents answering this question

BY JENI WILLIAMS

HFMA Contributing Writer

What started as a goal in 2019 to reduce avoidable emergency department (ED) visits by 8% among one health plan’s Medicaid patients in two Utah counties actually led to a 34.2% drop in such ED visits. The effort also expanded access to behavioral health services and built a deeper understanding of patients’ whole-health needs.

The improvements came as a result of Intermountain Health in Salt Lake City launching a three-year demonstration project through the Alliance for the Determinants of Health. The alliance is a partnership between Intermountain’s health plan, Select Health, and key stakeholders at the health system and at the community and state levels. The alliance sought to become a model for addressing social determinants of health (SDoH), with screenings administered in ambulatory settings and in EDs to determine: What social needs do these individuals face that affect their health? How can gaps be closed to improve health and reduce cost of care?

“The screenings uncovered

a huge need for dental care, transportation services and access to affordable housing,” said Tiffany Capeles, chief equity officer, Intermountain Health. “We also identified struggles with food insecurity and the need for medication assistance and behavioral health.”

SDoH has become an area of strategic focus for health systems across the country. About 24% of healthcare finance professionals surveyed by HFMA believe health systems should lead the execution of SDoH strategy in their communities. Nearly 28% believe health systems should serve in the role of convener, bringing key stakeholders together to

address the social drivers that contribute to health disparities and inequities, from food insecurity to lack of reliable transportation or stable housing.

As Utah’s Alliance for

“**We know social isolation and loneliness have a direct impact on health.**”

— Tiffany Capeles, chief equity officer, Intermountain Health

the Determinants of Health prepares to release a report on its findings, based on 20,000 screenings and nearly 5,000 unique service episodes over a two-year period, its work around SDoH has expanded into 19 counties in Utah, with 230 community partners and support from community health workers.

“We can’t solve for everything,” Capeles said. “There are some things that might be a little beyond the reach of our health system. We’re analyzing our data to understand where there are gaps that affect health and well-being. Where there aren’t ways to address these challenges, we’re challenging ourselves to ask, ‘Why not?’”

“For instance, we know social isolation and loneliness have a direct impact on health. How can we work with our interfaith communities and community organizations to help address these issues?”

The ability to pair people in need with services that could help close these gaps also varies by geography.

“We are able to connect people with resources a lot easier in our urban settings



LESSONS LEARNED FROM LEADERS IN SDOH

With so much at stake and so little standardization in approach, how can healthcare leaders design an effective strategy for addressing SDOH? Here are five suggestions from organizations with experience in this space.

1 Be mindful of the SDOH data that isn't captured, as this could skew your big-picture view of a population's social needs. In Alaska, for example, "Sixty-five percent of our state is considered an undetermined health equity zone," said Anne Zink, MD, chief medical officer for the state, during a HIMSS presentation in April. "You always need to ask yourself, 'Who are the undetermined?'" Without this data, organizations miss opportunities to eliminate inequities in care and health resources.

2 Embrace opportunities to leverage data for a collective approach to addressing SDOH. "As health systems, we sit on mountains of data," said Tiffany Capeles, chief equity officer, Intermountain Health. "We have an obligation to use this data to determine where gaps in social needs are. Then, we can work with local governments or community partners to make a meaningful impact. We perpetuate harm by not sharing that information."

3 Look for entrepreneurial opportunities to strengthen SDOH. "Where can we leverage our chambers of commerce and Small Business Administration to say, 'Hey, there's a need here. How can we as a community build a viable model for addressing this need, whether it's grocery delivery or transportation to medical providers or care for the elderly?'" Capeles said. "There are so many opportunities for a business to help bring the right player to the table."

4 Lean into the expertise of community health workers. "Many of these professionals come from the communities they're trying to serve," said Claudia Fegan, MD, chief medical officer, Cook County Health. "They have a deep knowledge of all the local players, and they have the opportunity to make a big impact on the social determinants of health."

5 Understand that your health system's role isn't to solve everything. "Your role is as a stakeholder and partner," said Jurema Gobena, MPH, system director, social care integration for CommonSpirit Health. "When you accept that role and understand that you could be a catalyst for change, you are much better positioned to build trust and partnerships within the community you serve and let the community lead, making sure they have the capacity and tools and resources to meet these needs."

— Jeni Williams

than our rural settings," she said. "Especially in very small communities — those with just 1,500 people, for example — the infrastructure is not there. In those areas, residents often call family and friends for help with transportation because they are so close-knit and don't have other resources they can rely on."

MORE ACTIVE ROLE FOR HOSPITALS

Today, socioeconomic factors alone affect 47% of health outcomes, recent research shows. And another study found just 20% of county-level variation in health outcomes stems from differences in clinical care. SDOH influences 50% of health outcomes.

These are just some of the reasons why federal officials are pushing health systems to take an active role in addressing SDOH. In 2024, the CMS will require hospitals to screen for social drivers of health and report the positive rate of SDOH screenings, or the percentage of patients screened who have at least one social risk factor. Hospitals may voluntarily report this information in 2023.

And the U.S. Department of Health and Human Services has designated SDOH as a strategic focal point, given the impact the conditions in which people live, learn, work, play, worship and age have on health outcomes, functioning and quality of life.

"There's so much that we can do right now once we accept that we're in this mess together, and we embrace the fact that we are the guides we're looking for," Thomas Fisher, Jr., MD, MPH, an ED physician for UChicago Medicine and author of *The*

Emergency: A Year of Healing and Heartbreak in a Chicago ER, told attendees of the HFMA Annual Conference this past June.

But there currently is no common road map for addressing SDOH at the health system level, nor is there guidance around how to fund these initiatives or build the right partnerships to make a meaningful impact. As healthcare leaders determine their organization's path forward, they must develop an SDOH strategy that is grounded in data and builds upon lessons learned from first movers in this area (see sidebar, left).

One of the biggest challenges in addressing the whole-health needs of the community lies in developing standardized processes for data collection. From there, health systems need strong analytics to dig deep into the data and determine where to focus.

"Everyone has the potential to have a need," said Kevin Halbritter, MD, chief medical information officer, West Virginia University (WVU) Health, and vice president of population health, West Virginia University School of Medicine. "It's making sure that you cover all the different facets of healthcare that involve patients and identify the right interventions at the right times to connect them to the resources that can make a difference."

And even when health systems do standardize their approach to SDOH screenings, the view health systems gain into the social needs of their communities depends on how comfortable patients feel disclosing this information.

"Social needs are very

Leveraging the science of kindness for health equity

“Quiet acts of humanity,” such as taking the time to form a bond with patients prior to surgery, demonstrate compassion for a patient’s health and social needs, and offer reassurance after a diagnosis, can improve health outcomes and medication adherence and reduce the need for sedatives before a procedure, researchers have found.

The link between compassion and outcomes is one reason why CommonSpirit Health launched the Lloyd H. Dean Institute for Humankindness & Health Justice in December 2022. It’s an initiative that tries to tap into the power of human kindness to treat the social causes of poor health, advance health justice and accelerate health equity.

The institute is named after Lloyd Dean, former CEO of CommonSpirit Health and a nationally recognized healthcare leader, who was driven to close gaps in care for vulnerable populations based on his experiences growing up without regular access to care in rural Michigan. Dean retired in 2022.

“I heard Lloyd Dean speak many years ago, and something he said stuck with me: that one of the most innovative things he’s seen in healthcare today is that kindness has the ability to heal,” said Alisahah Jackson, MD, president of the institute. “That resonated with me so much.”

By galvanizing staff at CommonSpirit Health — one of the nation’s largest health systems — to demonstrate kindness and compassion in their interactions with patients, Jackson believes the organization could make a significant impact on community health in the 22 states the health system serves.

“We know from the science that altruism actually leads to better health outcomes,” Jackson said. “It reduces chronic inflammation; it reduces stress; it reduces risk for cardiovascular disease and dementia. At a time when we’re seeing some of the lowest levels of civility our nation has experienced in decades, now is the time to remind people that kindness not only helps improve the health of others around them, but their own health as well.”



Alisahah Jackson, MD, is president of Lloyd H. Dean Institute for Humankindness & Health Justice.

— Jeni Williams

personal,” said Jurema Gobena, MPH, system director, social care integration for Chicago-based CommonSpirit Health. “You’re asking very intimate questions of patients, and they’re not necessarily used to having those questions asked by a physician or nurse, Gobena said.

“You’re limited by what people want to disclose or how well people are trained to tease out the answers, which means you’re never going to get a 100% accurate data set across all the populations you serve. But screenings like these put us in a good position to optimize our approach over time so we can learn to engage patients in ways that help them feel more comfortable disclosing that information.”

At CommonSpirit Health, SDOH data currently are collected in clinics and CommonSpirit’s managed services organization. Over time, the health system plans to expand data collection to its EDs, inpatient areas and more, “because patients are never just in one place,” Gobena said.

CommonSpirit Health team members created the

“Connected Community Network” five years ago to connect community partners, healthcare organizations and government agencies that are working to address specific social needs. It’s a model that creates an infrastructure for all community partners to work collaboratively together to maximize collective impact and center care in the community.

OUTSIDE IN APPROACH

“We anticipated that regulations around social needs screenings were coming, so we took an outside-in approach to first building community networks focused around the social domain,” Gobena said. “Social determinants [are] a structural problem. When you see your health system as one stakeholder in this problem, it makes it a lot easier to embark on forming partnerships to approach this work, especially when you realize that the community organizations that provide these services are already at maximum capacity. Thinking about who to partner with and how to support their needs from the outset is critical.”



“When you see your health system as one stakeholder in this problem, it makes it a lot easier to embark on forming partnerships.”

— Jurema Gobena, MPH, system director, social care integration for CommonSpirit Health

CASE STUDIES: 3 HEALTH SYSTEMS USING TECH ON SDOH TO IMPROVE HEALTH



Building and sustaining internal momentum for social determinants of health data collection, a key component of SDOH management, depends largely on a health system's ability to follow through on the insights they receive.

"You have to have processes in place to be able to connect patients to resources that meet the needs that are identified," said Kevin Halbritter, MD, chief medical information officer, West Virginia University (WVU) Health, and vice president of population health, West Virginia University School of Medicine. "You can't just collect the data. You have to act on it."

Just as important is connecting patients to resources available in their community, where possible. That can be particularly difficult when patients travel for care.

"We have patients come to our clinic in Morgantown (West Virginia) from two to three hours away," Halbritter said. "A nurse cannot be expected to know all the resources available within her own town, let alone in another part of the state. We're trying to make sure our nurses are not bound by local knowledge when it comes to

addressing social determinants of health."

WVU Medicine team members have moved from compiling lists of resources on their own to using a nationally focused website called "FindHelp," where staff can input a patient's ZIP code and find an organization or service to match a patient's need, including such things as food pantries, transportation assistance and shelter.

"We're trying to integrate tools like these in our EHR, but this is a stepwise approach that helps team members connect as many patients as possible with resources that meet their needs," Halbritter said.



Claudia Fegan, MD, chief medical officer, Cook County Health, remembers when team members relied on a purple book with staff-compiled lists of homeless shelters, food pantries and other resources. One of the many challenges with this approach was ensuring the information was up to date.

"We would often reach out to our social workers to ask, 'Does this shelter still exist? Is this food pantry still open?'" Fegan said. At times, staff who have an interest in a particular need will take the lead in building a more efficient approach.

"I had a physician whose sons became very interested in food pantries and actually created an app that each of our physicians could have on their phone called 'Got Food,'" Fegan said. "It allows you to see what pantries are within a mile radius of a particular address."

At the height of COVID-19, Cook County Health partnered with local hotels to secure safe shelter for people with unstable housing who contracted the virus.

"We've found that it's actually cheaper to find housing for patients with acute care needs than it is to admit them," she said. "Not only is temporary housing cheaper than hospitalization, but patients with unstable housing are also more likely to have poor outcomes as a result of the frequency with which they change locations."



Intermountain Health adopted a technology platform called "Unite Us" to create a coordinated network that connects healthcare, mental health and social services partners — including state and local health departments and federally qualified health centers — with the resources they need.

The network first began to meet the needs of residents

in Washington and Weber counties in Utah and is now available statewide. The health system also looks for ways to build capacity in areas such as behavioral health, where virtual care helps meet the needs of children and those living in rural communities, and intimate partner violence. The latter carries a focus on local community partnerships that strengthen Intermountain's ability to identify and respond to potentially life-threatening domestic situations.

"'Unite Us' gives us a sort of clearinghouse for all of the requests we receive based on patients' social needs," said Tiffany Capeles, chief equity officer, Intermountain Health. It allows Intermountain to track whether or not the dots get connected.

"It's a collaboration with a number of local- and state-level partners that helps us connect with one another through a single network to pair people with the resources they need without putting the onus on providers or clinics or patients to find these resources themselves," she said. ■

About the author

Jeni Williams is a healthcare writer and editor and a frequent contributor to *hfm*.



A nurse cannot be expected to know all the resources available within her own town, let alone in another part of the state.

— Kevin Halbritter, MD, chief medical information officer, West Virginia University (WVU) Health, and vice president of population health, West Virginia University School of Medicine

Pinpointing the needs of the most vulnerable

BY JENI WILLIAMS
HFMA Contributing Writer

At Cook County Health in Chicago, which provides care to half a million people, including a large Medicaid managed care population, the health system discovered the importance of asking all patients questions about their relationships in the home back in the 1990s.

“We found a lot of people felt unsafe in their space,” said Claudia Fegan, MD, chief medical officer, Cook County Health. “One of our emergency room physicians was stunned when she discovered people of all economic strata had been victims of domestic abuse. She realized if you don’t ask

the question, you can never assume. It opened the door to a lot of conversations that gave us a deeper understanding of the prevalence of problems people face in the home.”

Later, in the early 2000s, Cook County Health began to add questions around food insecurity.

“We were surprised to learn that if someone in the home was over the age of 65 or under the age of 6, the odds of food insecurity were much higher than for other populations,” Fegan said. “We started to realize that maybe there were other questions we should be asking, too. If people don’t have safe housing, if they don’t have adequate food, if they don’t have safe transportation, these all become health issues. And

in Cook County, we wind up seeing the results of the failure of society to address these problems.”

These experiences informed Cook County Health’s approach to asking all patients questions around social determinants of health (SDoH), regardless of income level. All staff are trained on how to ask these questions because the quality of the data collected depends on the skill of the interviewer and how a question is phrased, Fegan said.

But standardizing SDoH screenings is complex work in large systems. At CommonSpirit Health, which operates more than 700 care centers across 21 states, there are “multiple EMRs with multiple ways of asking

questions around patients’ social needs,” said Jurema Gobena, MPH, system director, social care integration for CommonSpirit Health.

While the data are pulled into a social determinants dashboard to gain a community-specific, regional and national view, “My colleagues in IT would say it takes quite a bit of money and analytical power to do that across all of our EMRs,” she said. “It’s a huge challenge for us.”



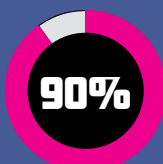
“We would often reach out to our social workers to ask, ‘Does this shelter still exist? Is this food pantry still open?’”

— Claudia Fegan, MD, is chief medical officer at Cook County Health

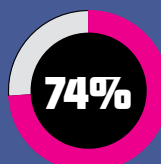
FROM THE FIELD



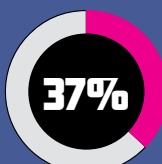
Who are your partners for addressing SDoH?
(Check all that apply)



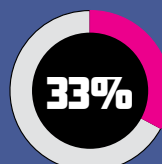
Public health departments, local, city, state and national



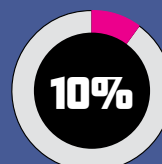
Local not-for-profit groups focused on the unhoused, substance abuse, hunger, jobs, etc.



Religious groups



National foundations



Other*

*Answers include: Medicaid programs, businesses, community leaders, insurers, colleges-universities and the patient.

Source: HFMA survey, February-March 2023, 82 responding out of 105 participants

BY PAUL BARR

HFMA Senior Editor

This third installment of the Healthcare 2030 series this year examines some of the ways that healthcare providers are addressing social determinants of health. One thing that comes across is that there is not a single solution to how to go about it. But there are some fundamental strategies that could be adopted, and mainly that involved putting the patient's needs first. Below you can find further analyses by the supporters of the Healthcare 2030 series, which will finish off with a report on personalized medicine.

MAKING A BUSINESS CASE FOR ADDRESSING SOCIAL DETERMINANTS OF HEALTH



FORV/S

DANIELLE SOLOMON

National Industry Partner, Healthcare,
Forvis

Yes, a strong business case does exist for hospitals and health systems to have a part in addressing social determinants of health. The article points out the degree of involvement, whether lead or participant, is the struggle. Because I believe the industry must shift towards treating the whole person, then SDoH is an integral part of the overall strategy to improve patient and community health. Personally, I like it when hospitals and health systems serve as a catalyst for change in this effort. The industry has made some progress but there is still more that can be achieved to enhance collaboration and increase connections with community organizations and influencers to successfully carryout the efforts.

GETTING STARTED IN ADDRESSING SDoH

Understanding your community's unique needs and connecting resources provide the most opportunity. However, herein lies the challenge, since we may or may not have enough data or we may not be using and sharing what data we do have. Equally important to knowing what SDoH component to address, is also identifying the gaps in resources to help with that identified SDoH. There is a quote in the article that is a phrase I ask myself a lot when evaluating options, "why not?" If we see gaps and there aren't current ways to address the need in our community, then I encourage everyone to challenge themselves and ask, "why not?"

ADDRESSING SOCIAL DETERMINANTS OF HEALTH UNDER THE CURRENT REIMBURSEMENT MODELS

While the majority of the traditional fee-for-service payment models do not financially incentivize the spend, this gap wasn't the focus of the article or really addressed. I fully believe that the concepts introduced in the article — human kindness to treat social causes of poor health, advance health justice and accelerate health equity — are core to doing the right thing for the patient and that payment models need to evolve to align to properly address SDoH. ■

SIMPLIFY PROCESSES, INFORM THE PATIENT EARLY



Xtend
Healthcare

MIKE MORRIS

President and CEO, Xtend Healthcare

In recent years the healthcare community has made considerable progress in collecting, analyzing and acting on social determinants of health data. The health systems and public health departments Xtend Healthcare works with have done a noble job of leveraging SDoH analytics to better care for their most vulnerable communities.

Despite these herculean efforts, the gap in health outcomes continues to grow. The bottom line: Patients without any form of insurance coverage are the least likely to seek health services before they are in need of acute care. And when they do need urgent healthcare intervention the cost of that care is much higher, and the likelihood of reimbursement is much lower. It is a vexing problem for healthcare providers, and it will only worsen as Medicaid patients continue to fall off the rolls as part of the redetermination process.

Fortunately, there are steps health system revenue cycle leaders can take to combat these challenges:

SIMPLIFY THE FINANCIAL ASSISTANCE PROCESS

The complexity of the application process for Medicaid or any form of financial assistance can be daunting for anyone,

especially if they are at high-risk based on SDoH criteria. To be effective and sustainable, financial assistance programs need to be carefully designed, targeted to the specific needs of the population they serve and regularly evaluated to assess their impact on healthcare utilization and the overall healthcare system. This effort is worth it. Improving access to quality healthcare services can have a profound impact on health outcomes. This includes increasing the availability of primary care, preventive services and addressing healthcare disparities. Financial assistance programs that are simple to navigate reduce financial barriers to healthcare, making medical services more accessible to individuals who might otherwise avoid seeking care due to cost concerns. And you will achieve a reduction in bad-debt and minimize uncompensated care.

HELP YOUR PATIENTS UNDERSTAND THEIR HEALTHCARE BILLS.

Medical bills are confusing. They can be even more daunting for vulnerable populations without experience in healthcare. People that are newly insured are less likely to understand the portion of that bill they are responsible for. Taking the time up front to explain to patients what they should expect and then being available to explain the Explanation of Benefits as well as payment options will increase overall reimbursements. And flexibility in payment options and timing can minimize the financial impact on patients on a tight budget. Better access to healthcare is key to narrowing the SDoH gap. And revenue cycle teams can play a vital role in educating vulnerable patients and guiding them through options that lead to coverage. It is a journey with a great payoff for all stakeholders! ■

“Despite ... herculean efforts, the gap in health outcomes continues to grow.”

— Mike Morris, President and CEO, Xtend Healthcare

STAKEHOLDERS NEED TO WORK TOGETHER IN ORDER TO TACKLE SOCIAL DETERMINANTS OF HEALTH



CHARTIS

BETHANY RICHMOND

Director, Chartis

The impact of social determinants of health on individuals, communities and the healthcare industry is substantial. Health systems, community organizations, and health plans alike have a responsibility and vested interest to serve as leaders and conveners to address these challenges because doing so will both reduce the overall cost of care and improve health outcomes.

Common challenges include food security, transportation access, housing stability, financial stability, social support and community safety. Individuals experiencing these challenges have increased risk for negative health outcomes that can lead to depression, obesity and other chronic conditions. These health effects are compounded by limited access to preventive care, missed appointments and decreased medication adherence. When healthcare organizations work collaboratively to address these root causes of instability, they progress toward a healthier community and reduced cost of care.

HIGH PRIORITY SOCIAL DETERMINANTS OF HEALTH

Food security and transportation must be prioritized due to the high impact on health outcomes and cost of care. Enhancing food security — specifically for people with chronic conditions, pregnant individuals, and children — has far-reaching effects. Improving transportation options impacts access to food, employment, and education but also to critical preventative care appointments, dental care and behavioral

healthcare. Housing is also important to tackle, but is more challenging because it's essential to identify long-term funding sources for this high-cost need. States are beginning to offer incentives and funding sources through Social Security Act section 1115 demonstrations to meet these needs. There are opportunities for developing programs that focus on specific populations to address multiple determinants, which in turn offer a great opportunity to improve health. For example, doula programs for mothers can help with social cohesion, health literacy, transportation, resources to combat violence, and food security. These programs have been tied to reducing low-birth weight babies and higher attendance for pre- and post-partum care appointments.

INVESTING IN SOCIAL DETERMINANTS OF HEALTH

Many stakeholders are implementing and investing in solutions to address SDOH, including payers, providers, technology vendors, community-based organizations and the government. However, efforts are fragmented, and challenges exist with measuring improvement, aligning incentives and identifying funding. Investing in SDOH requires health systems and payers to continue to explore and adopt alternative payment models and to develop customized programs that target specific populations based on factors like health conditions, medical spend and community traits.

MEASURING SUCCESS

Ongoing analysis must be performed on specific, high-risk populations to track improvements (e.g., maternal and infant health measures, ED utilization, preventative visits, no-show rates, medication adherence and food insecurity rates). Pilot programs with specific focus on targeted population cohorts can achieve the initial success to secure additional buy-in. Solving for these SDOH challenges that impact health outcomes will require long-term investment, and the industry has both the moral and financial obligation to do so. ■

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2001 Butterfield Road, Suite 1500

Downers Grove, Illinois 60515

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