

# Trustee Insights

## POPULATION HEALTH



## Addressing the Social Determinants of Health

Boards can play a variety of roles to impact social determinants and focus on community health

BY LOLA BUTCHER

**M**aking a correct diagnosis and developing a plan of care are health care's traditional responsibilities. Understanding the social needs of our patients and the factors that influence health at the community level is a new imperative, says Nancy Myers, vice president, leadership and system innovation, for the American Hospital Association's Center for Health Innovation.

The social determinants of health

— the circumstances in which people are born, grow up, live, work and age — make a huge impact on the health of individuals and the community a hospital serves. These social determinants include access to affordable and safe housing, food security, reliable transportation, economic stability and many others. Understanding these factors in your community — and engaging with partners to effectively address them — are foundational activities as

### TRUSTEE TALKING POINTS

- Hospital and health system boards are gaining a broader understanding of social circumstances that impact patient health.
- Boards are taking steps to ensure that addressing social factors that influence health is a strategic priority for their organizations.
- Facilitating community conversations, using results of Community Health Needs Assessments to drive strategic priorities, allocating resources and influencing public policy are just some of the ways boards are getting involved to address social determinants of health.

health systems expand their focus to population health strategies and outcomes.

"These are critical components to being able to redesign care to help patients achieve better outcomes," Myers says.

For example, when a homeless patient is discharged from the hospital, life on the streets makes it difficult to follow a physician's care plan — and 1.5 million Americans experience homelessness each year. Patients living with diabetes, congestive heart failure and many other conditions need carefully tailored diets, a near-impossibility for the 40 million Americans who have food insecurity.

Recognizing these widespread challenges, policymakers are seeking systemic changes to reduce the social barriers to good health. Hawaii is using Medicaid dollars to fund job training and other supports for homeless individuals. The goal is to reduce homelessness, which in turn will reduce the high health care utilization associated with homelessness. Kaiser Permanente is also addressing this issue by creating stable housing for vulnerable populations in communities it serves.

### How Trustees Can Support Efforts

Health system trustees can encourage policymakers to adopt policies to address the social determinants of health, says Vincent Williams, a board member of Sinai Health System, the largest safety-net organization in Chicago. He recently spoke with a U.S. senator about a proposal to allow state Medicaid dollars to be used for housing, which could be a cost-effective approach to improving the health of vulnerable patients.

“Homeless people show up at our door, we treat them and return them to the street, and these people are going to keep coming back,” Williams says. “If we are serious about trying to make people healthy, we can’t send them ‘home’ to a place that doesn’t exist.”

As representatives of the communities they serve, trustees can be a link to other service providers that can help address specific challenges related to social determinants of health, says Susan Holliday, a trustee of University of Rochester Medical Center in Rochester, N.Y.

“It’s very difficult for any one organization to try to address all of these issues individually,” she says. “It’s important to educate yourself about the needs of your particular community and be aware of the resources that might be available in

“You can start small: who is it that’s coming into your ED over and over and over again?” Carraway says. “And why is this happening? That is the best question that a trustee can ever ask — not just ‘what?’ but ‘why?’”

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**Susan Holliday**, trustee, University of Rochester Medical Center, Rochester, N.Y.

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the community — both government and nonprofit organizations — so you can partner with these organizations to have the highest likelihood of a positive outcome.”

Health system boards must make sure their organizations have the infrastructure needed to support population health management, says Shirley Carraway, a board member of Vidant Health, a nine-hospital system based in Greenville, N.C.

“A large amount of money has to go into our capability to be able to collect the data that’s needed and then to extract that data in a way that helps us understand who our populations are and what their needs are,” she says.

That said, it doesn’t take a huge data infrastructure to start providing insight. Simply identifying the costs associated with high-utilizing patients can kick off a discussion about a community’s social challenges.

### Meeting Homeless Patients’ Social Needs

If patients do not have a safe and stable place to stay after a hospital visit, they are at high risk for complications that send them back to the hospital. That’s why leaders at UR Medicine’s Strong Memorial Hospital in Rochester, N.Y., teamed with a social service organization to create a short-stay residence for patients who have no home to go to after discharge.

“This is a transitional setting that allows these patients a little bit more time to recover from their hospitalization in a more supportive housing arrangement,” says Kelly M. Luther, director of social work and patient/family services at University of Rochester Medical Center.

The 10-bedroom residence was formerly a group home served by DePaul, a nonprofit organization that provides affordable housing and

## Understanding Patients' Social Needs

Health systems are developing ways to identify and address patients' unique social needs that influence their health and outcomes of care

Even as health systems are addressing the social determinants of health — for example, lack of public transportation or food insecurity — in the communities they serve, they must also understand each patient's *individual* needs.

"As health systems, we have a duty to understand the things going on in a person's life that impact their ability to carry out their medical plan of care and stay healthy," says Nancy A. Myers, Ph.D., vice president, leadership and system innovation, for the American Hospital Association's Center for Health Innovation.

The concept of social needs is related to, but distinct from, the concept of social determinants of health. Social needs reflect an individual's personal circumstances; social determinants of health reflect systemic issues that affect a community and cause individuals to have social needs that impact their health.

"Asking the patient the right kind of question is key to assessing their social needs," says Kelly M. Luther, director of social work and patient/family services at University of Rochester Medical Center. "It's 'how do you get to and from your

medical appointments? Does your refrigerator have food in it? Do you have a support system — family or otherwise?'"

A new AHA resource — "Screening for Social Needs: Guiding Care Teams to Engage Patients" — says there is no one-size-fits-all approach for social needs screening for — and addressing — social needs. At URM, clinicians know how to recognize a patient's needs, and they know to refer patients to Luther's department.

"It's our responsibility as a social work team to mobilize resources that might be of assistance to help an individual succeed," she says.

In Chicago, Sinai Health System recently teamed with other area health systems in a new initiative to screen emergency department patients for social needs, says Helen Margellos-Anast, senior research analyst and senior epidemiologist at Sinai Urban Health Institute.



**"Screening for Social Needs: Guiding Care Teams to Engage Patients"**

Through the Connect ED program, the health systems jointly developed a uniform social-needs screening tool to ask patients about housing, utilities, food security, transportation and access to health care. Sinai added questions about domestic violence and gun violence, two issues that bring many patients to its emergency department.

"We have integrated our community health workers into our emergency department to screen for social needs and also to intervene when they find patients have needs," she says.

The Connect ED program is designed to address patients' individual needs but also help identify issues that warrant broad attention from the health systems.

"We will find out about needs that we are currently not able to address and, if we get a better sense of the true need, we'll be able to advocate for policy changes or ways to bring more resources to address homelessness, for example, or other major needs," she says. "This is an excellent way to get data about what your population really needs that will inform where to prioritize future resources."

— **Lola Butcher**

other social supports. More than 125 patients have been discharged to the residence since it opened in 2016; two-thirds of those have subsequently been placed in permanent housing.

The facility is staffed round-the-clock by DePaul staff members who assist with meals, transportation to appointments, house-

keeping and laundry service, while working to arrange the stable housing and social supports the patients need. UR Medicine's home care agency provides services and therapies as needed.

The patients served by the program must be able to administer their own medication, feed themselves and need only minimal assis-

tance, but they provide complex challenges. Many suffer from multiple medical conditions, mental illness and/or addiction. The average length-of-stay at the residence is 53 days.

The program allows Strong Memorial to discharge homeless patients when they are medically ready, which frees up beds needed

by other patients. The facility always has a waiting list, but expanding it to fully meet demand is not a realistic option.

“The housing experts have a lot that they have to manage in terms of the cohabitation and the complexity of achieving long-term housing,” Luther says. “It’s been important for us to start this project very small so that we can learn for our future needs and scale appropriately.”

### Focusing on Social Determinants to Reduce Asthma

In Chicago, Sinai Health System has demonstrated that addressing the social determinants of health can reduce overall health care costs.

The proving ground has been the low-income neighborhoods near Sinai Health’s flagship Mount Sinai Hospital. Asthma rates in Chicago are higher than the national average; in three neighborhoods near the hospital, one in five adults has asthma.

Sinai Urban Health Institute, the health system’s research arm, has developed a “healthy homes” approach to improving asthma control, which reduces asthma symptoms, emergency department visits and hospital utilization. The Asthma CarePartners program employs community health workers (CHW) to make home visits to patients who have poorly controlled asthma. The CHWs assess the homes for conditions that might trigger symptoms — the use of air fresheners, for example — and educate the family about the importance of controlling dust, using nonallergenic cleaning products and laundering bedding frequently.

With support from the U.S. Department of Housing and Urban

## AHA Trustee Resources

### Addressing Social Determinants of Health

<https://trustees.aha.org/education/powerpoints>

This AHA slide deck with presenter’s notes provides an overview of the social determinants of health and their impact on individuals and populations. It also discusses hospitals and health systems’ role in addressing the social determinants of health, and offers additional resources and practical case examples. It concludes with a set of in-boardroom discussion questions so that boards can begin or continue their conversations about how their organizations are tackling this important issue.

### A Trustee’s Guide to Population Health: Building New Foundations Linking Care with Community

<http://trustees.aha.org/populationhealth/trustee-guide-to-population-health-video-series.shtml>

Hospitals and health systems are adopting population health strategies to transform their approach to caring for patients and improving health outcomes. The videos included in this AHA Trustee Services resource are designed to provide trustees with an overview of population health strategies, the foundational capabilities that health care leaders are using to redesign care, and the importance of developing new partnerships, as well as specific actions for how trustees can participate with their organization’s leadership team to advance health within their communities. Six video modules are available for boards to view, along with a discussion guide designed to prompt discussion, conversation and reflection.

Development, the health system in 2011 partnered with the Chicago Housing Authority to offer the program — six visits over a year — in six housing complexes managed by the Authority.

“We worked with the children and adults who had asthma within these six properties to help them better manage their asthma, connect them to medical resources if they didn’t have those connections, help them eliminate home triggers and deal with the environmental issues that are affecting their asthma,” says Helen Margellos-Anast, senior research analyst and

senior epidemiologist for Sinai Urban Health Institute.

The result: A nearly 60% reduction in asthma symptoms and use of quick-relief medication for patients enrolled in the Asthma CarePartners program. That means children miss fewer days of school and are more physically active; adults miss fewer days of work.

Beyond that, program participants reduced emergency department visits by 75%, hospital inpatient days by 80% and urgent clinic visits by 91%. “As a result of that, we are able to save between \$3 and \$8 for every \$1 we invest in the

program,” Margellos-Anast says. “This is a program that will pay for itself if the investment is made.”

That encouraging return-on-investment should not suggest the program is easy, she says. Sinai Urban Health Institute started focusing on improving asthma patients’ lives a full decade before the Asthma CarePartners program — a community initiative supported by Medicaid managed care organizations and private insurers — came together with its current staffing model and care protocols. Substandard housing conditions — which is a root cause for poorly controlled asthma — still remains to be addressed in this community, and families who live in substandard housing are often difficult to reach because they move or change phone numbers frequently.

## Partnering to Address Food Insecurity

After operating a medical food pantry on its main hospital campus, Vidant Health leaders learned that it costs the health system almost nothing — and the value to patients is immeasurable.

“We’ve had people come into the lobby to redeem their food voucher, sit down and start eating from their food bag, then pull insulin out of their pockets to give themselves insulin,” says Melissa Roupe, senior administrator of community health improvement. “They are diabetic patients who couldn’t give themselves insulin because they didn’t know where their next food was coming from.”

In 2017, Vidant Health started

## TRUSTEE TAKEAWAYS

- Social determinants, such as adequate food, housing and education and safe living and working environments significantly impact overall health of individuals and quality of life in communities.
- Health care organizations are partnering with other community resources to address these factors to improve community health and meet patients’ social needs.
- Boards can play a variety of roles—strategic advisor, facilitator, influencer—to advance understanding of community health needs and determine how their organizations can support development of sustainable solutions to address them.

assessing food insecurity among inpatients at Vidant Medical Center, its tertiary care hospital, and a large ambulatory practice in Greenville; it found that up to 50% of inpatients suffered food insecurity.

The health system serves 29 mostly rural counties across eastern North Carolina. While there are food distribution sites in most of those counties, many of them are open only one or two days a month, so patients discharged from the medical center often could not obtain food promptly.

That’s why Vidant opened the medical food pantry as an emergency resource on the medical center campus. Patients leaving

an ambulatory clinic or being discharged from the hospital who screen positive for food insecurity receive coaching from a registered dietitian, a list of food resources in their home community and a food bag — healthy balanced diet, carb-controlled or low-sodium, depending on the patient’s medical condition — that contains about 20 pounds of nonperishable food.

“We want to give our patients enough food to cover them and their families for about two weeks until they can get connected with one of those local resources,” Roupe says.

Roupe has learned that Vidant Health’s ability to harness community resources is its most important asset. For example, the medical food pantry is a partnership between the health system, the Food Bank of Central & Eastern North Carolina and ECU Physicians, the medical practice of the local medical school.

In the first year of operation, the pantry received more than 8,000 pounds of food and nearly \$6,000 in cash, all from donations from community organizations and individuals. The pantry is primarily staffed by volunteers from students — high school, college and medical school — and members of local service organizations.

“Our contribution has been about 400 square feet of space and having someone from Vidant Health there to provide oversight, making sure that the volunteers show up and that we have the food bags we need,” Roupe says.

**Lola Butcher** is a contributing writer to Trustee Insights.