Better Health Partnership

2024 Learning Collaborative

Plenary

Introduction

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2024 Learning Collaborative

The Community as a Patient: Understanding and Addressing SDoH to Achieve Health Equity

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SVP, Population Health
President, Institute for H.O.P.E.™
The MetroHealth System

Better Health Partnership

Session Objectives

- Describe how a hospital can build a structure and processes for screening patients for SDoH
- Outline the most frequently screened social needs in the Cleveland community
- Explain some of the underlying factors resulting in health disparities in America
- List the types of partnerships healthcare organizations could engage in to promote health equity

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The Community As A Patient: Understanding and Addressing SDoH to Achieve Health Equity

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What are Social Drivers of Health (SDOH) and what is MetroHealth doing about them?

What do we know about the world we live in?

The "I know my world" quiz

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Understanding SDOH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

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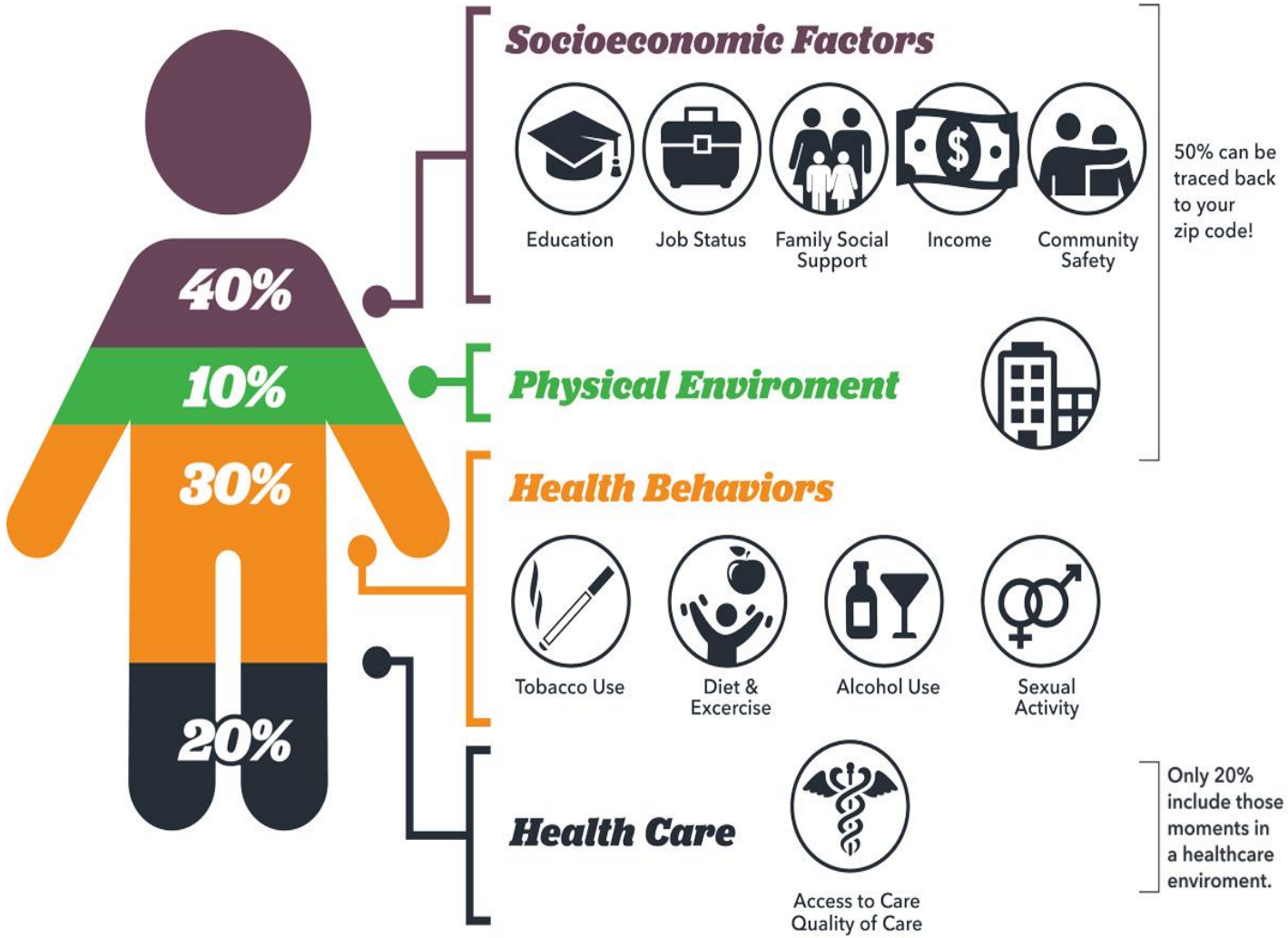

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Words Matter

Social Determinants
Social Drivers
Structural Determinants/Drivers

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The MetroHealth Approach

Strategic Alignment - SDOH

People First Culture	Effective processes for SDOH screening (and response) **contributes to care team well-being**, patient-centered care, and patient satisfaction.
Clinical & Academic Excellence	Effective integration of SDOH screening into care models **contributes to improved care and outcomes for patients with complex social needs**, in alignment with quality metrics and VBC.
Health Equity	Improved identification of our patients' health-related social needs as part of overall care **feeds response pathways that address identified needs**, which can lead to improved conditions for our most vulnerable populations.
Community Engagement & Impact	Identification of our patient's health-related social needs through SDOH screening can lead to **opportunities to address identified needs through partnerships** with community-based organizations, and opportunities for community-level interventions.
Innovation	**Developing best practices** in SDOH screening and utilization of screening results for care delivery, evaluation and research.
Accelerating Growth	Expansion of SDOH screening through integration with care models can advance organizational mission, **enhance MH reputation and improve performance on VBC models.**

SDOH Screening and Quintuple Aim

Addressing Health Related Social Needs will lead to improvements in:

- **Patient Experience:** *goal of treating the whole person and promoting health and well-being*
- **Population Health:** *health (clinical) outcomes*
- **Healthcare Costs:** *optimizing utilization of healthcare*
- **Care-Team Well-Being:** *lowering moral distress and creating holistic care plans*
- **Health Equity:** *addressing root causes of disparities*

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Closed Loop and QI Process for SDOH

Screen for SDOH

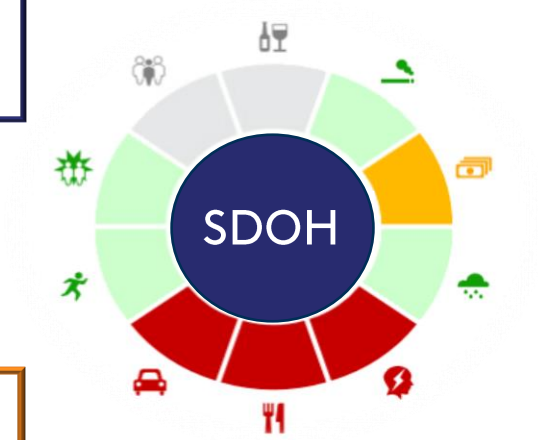
- Self > MyChart
- Provider > care setting
- CHW > community
- Team > COVID vaccination clinics

CONNECT

Connect to Meet Needs

- Electronic > Unite Ohio platform
- Curate relationships for people needing more assistance
- Design interventions based on identified community needs

RESPOND



IMPROVE

Evaluate Impact

- Track outcomes at individual & community level
- Prove impact, outcomes, & cost-effectiveness
- Supply data & narratives to drive policy change

EVALUATE

Close the Loop in Real Time

- Inform clinical team & CBOs
- Verify patient needs met
- Reduce duplication
- Identify strength & gaps within social service delivery system

Utilize process and outcome data to drive program evaluation, research and continuous program improvement

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Social Determinants of Health (SDOH) Screening

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As of:

9/5/2024

Unique Patients Have Been Screened:

155,842

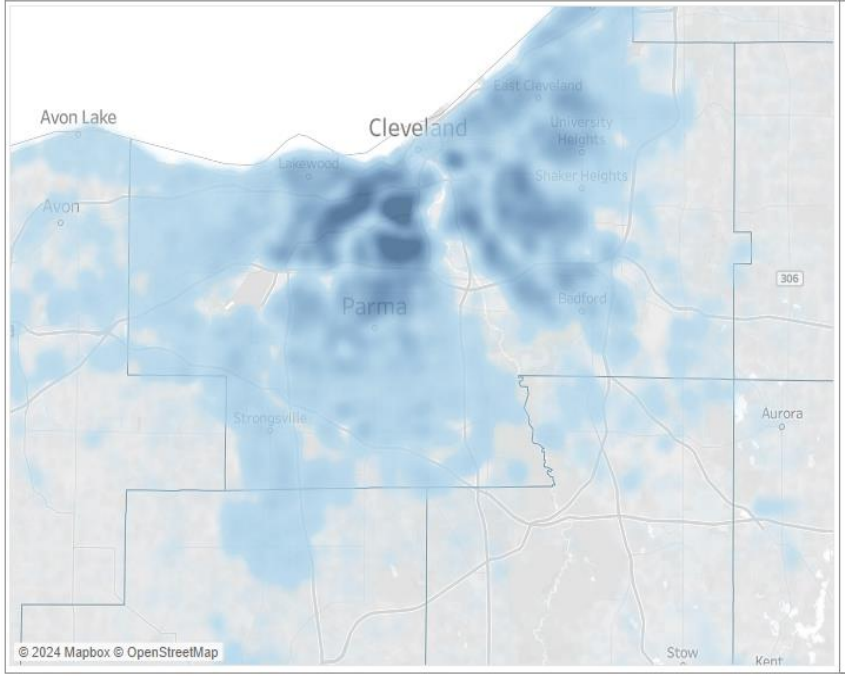
	Year / Quarter1								
	2019	2020	2021	2022	2023	2024			Grand Total
	All	All	All	All	All	Q1	Q2	Q3	
Ambulatory	1,191	2,121	1,041	963	1,290	651	543	561	8,361
Care Coordinators	3,627	6,785	5,456	4,138	4,160	868	842	483	26,359
Inpatient	76	447	779	3,754	2,921	667	710	794	10,148
Mailer				163	147				310
MyChart	22	16,849	17,882	20,851	31,355	6,173	5,992	4,510	103,634
Special Events			6,606	223	201				7,030
Grand Total	4,916	26,202	31,764	30,092	40,074	8,359	8,087	6,348	155,842

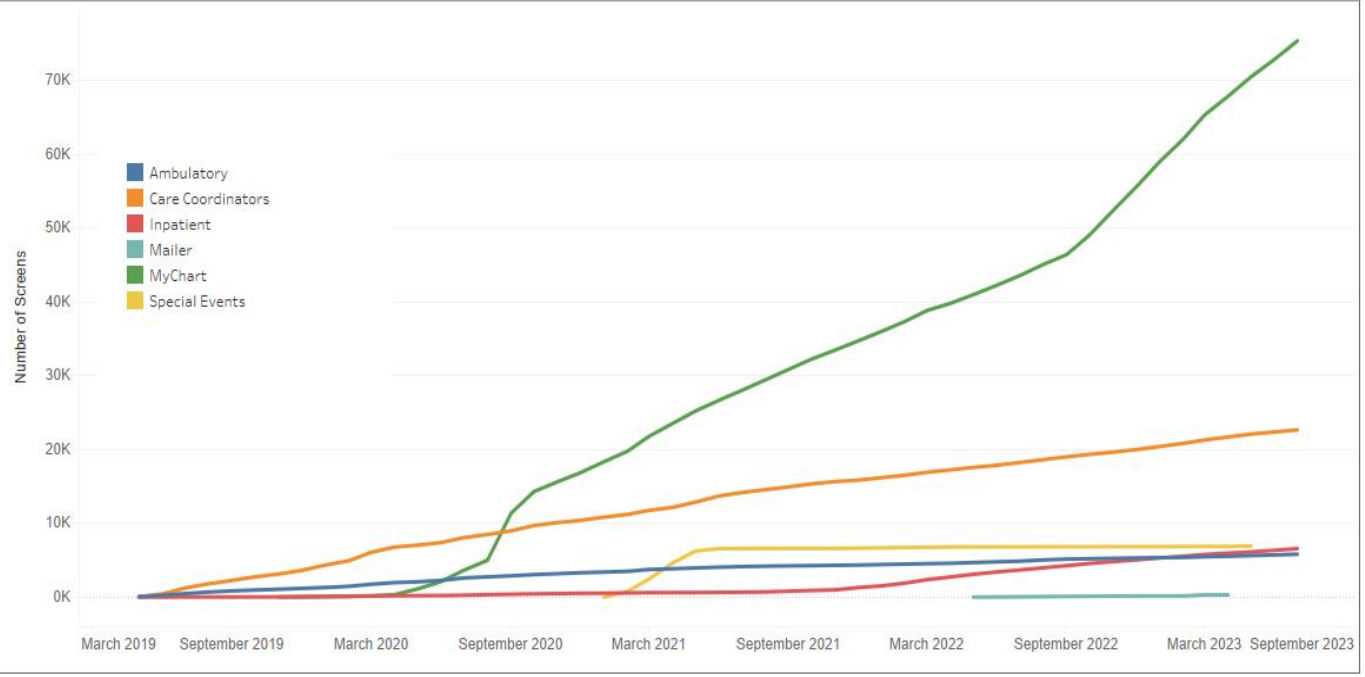
Filter Map By
Density

First Screened By
All

Show Data By
Cumulative Screen

First Screen Date
5/18/2019 to 9/5/2024





Connect Patients and Employees with Social Needs

	Community Health Workers
	E-referral Platform
	Online Education and Information
	Direct Programming

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Responding to Identified Social Needs

Electronic Referral Platform

UNITE OHIO

250 MetroHealth users have access to
357 Community Organizations offering
757 Programs in Cuyahoga County

Over 22,000 Referrals Made*

On Behalf of 12,835 Individuals*

MetroHealth Founding Sponsor of Unite Ohio

All Major Health Systems in Region Also Use Unite Ohio

Local Community Advisory Council

Statewide Expansion Underway Through CliniSync, Ohio HIE

*Since inception 9/20/2020 through 7/4/2024

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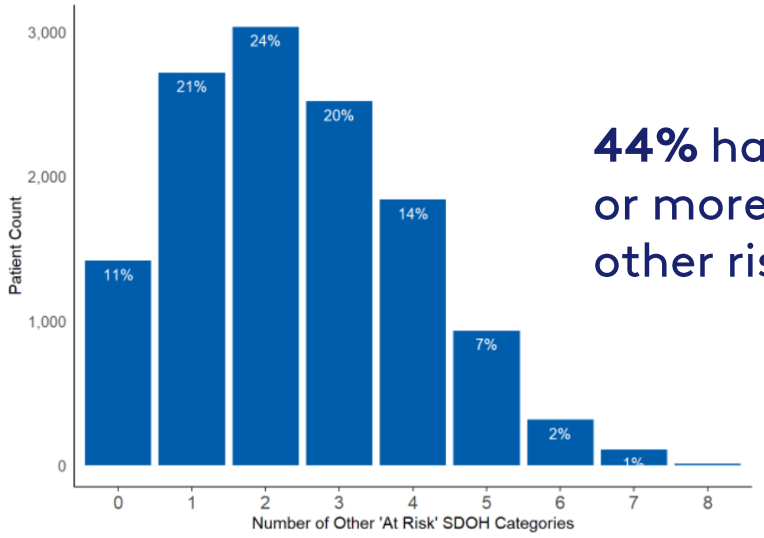
Utilization and Health Outcomes - Patients with Food Insecurity

SDOH Co-Occurring Risk

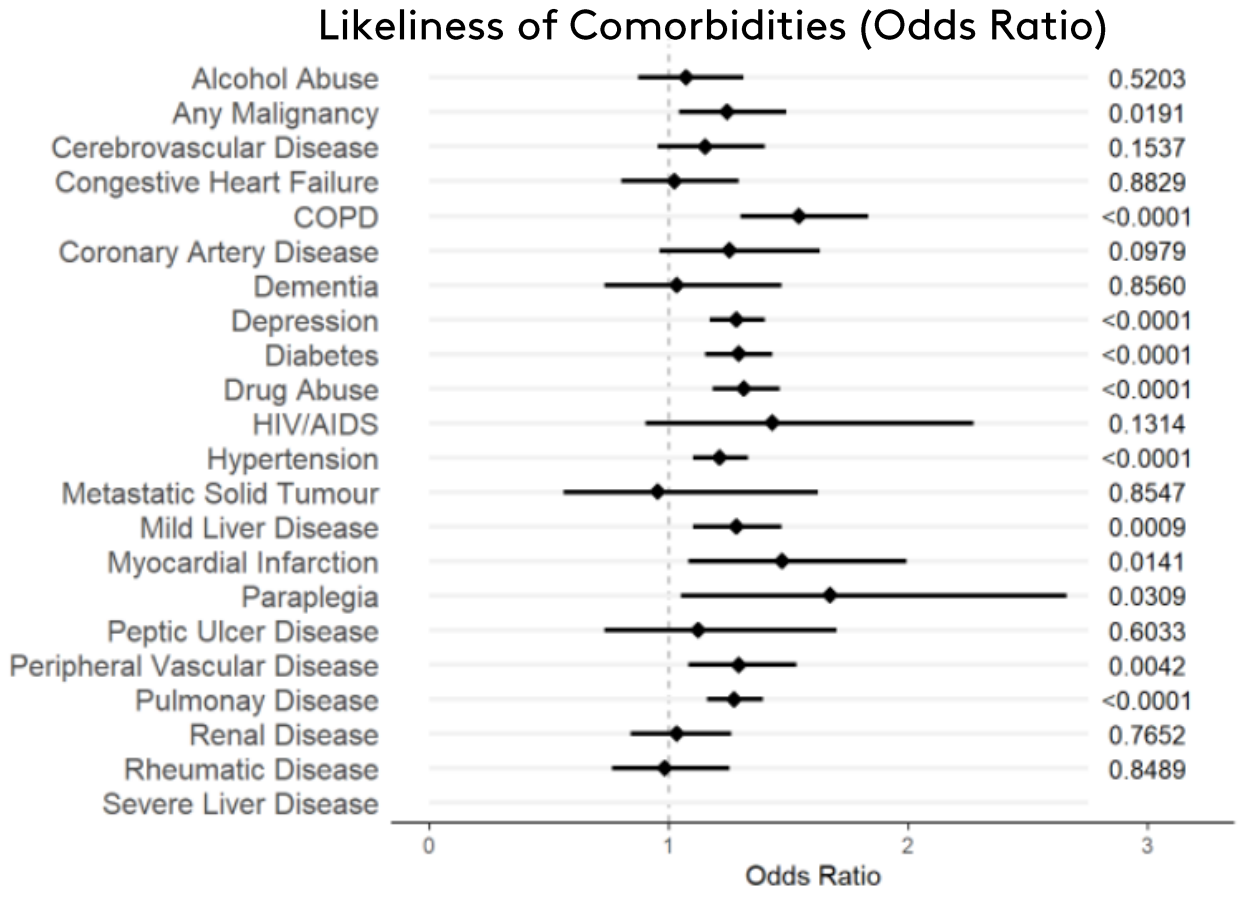


44% have 3 or more other risks

11.7x More Likely	Financial Resource Strain
3.4x More Likely	Transportation
3.0x More Likely	Housing Stability
1.9x More Likely	Intimate Partner Violence

*p-value < 0.01

Patient Comorbidities



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Program Evaluation

Food As Medicine Program

Conduct an evaluation to determine:

1. How do participants utilize the FAM program?
2. How does the program change dietary habits?
3. How does the program impact participants' health?
4. How do these changes compare to non-participants?

Key Findings

Evidence of improvement in patients' **hemoglobin A1c** and **systolic blood pressure**

Reduction in **ED visits** and **healthcare cost**

Medically Tailored Meals

Conduct an evaluation to determine:

1. Total program cost savings
2. Clinical utilization
3. Program retention rate

Key Findings

Cost Savings: **$1,532** per participant per month

Program retention rate: **80%**

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Equity Analyses

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Health Equity Dashboard

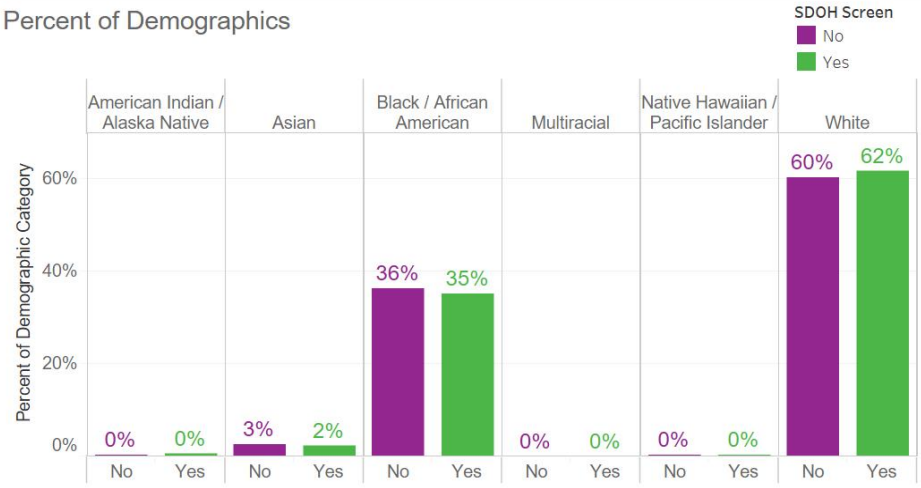
Social Drivers of Health Screening

Dashboard Filters

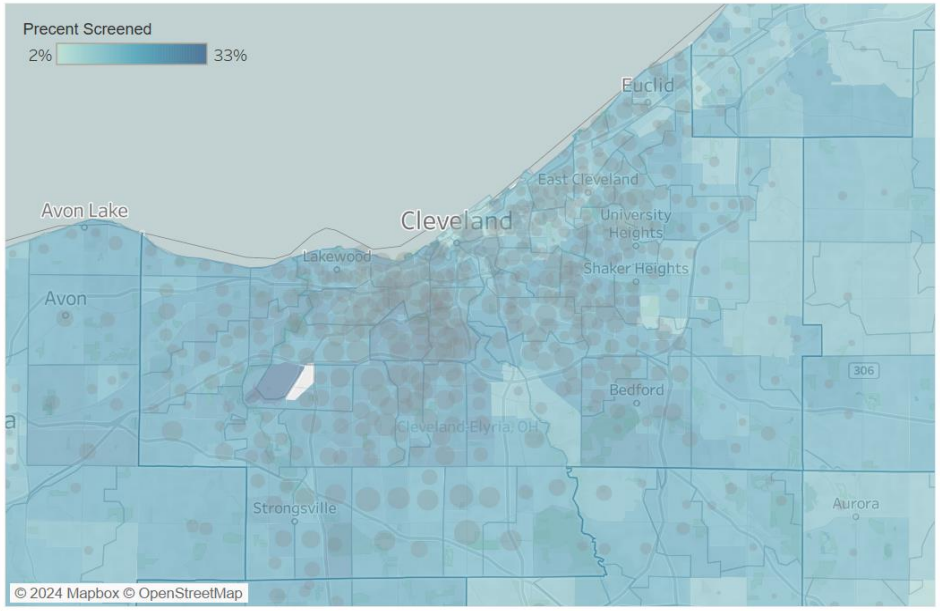
Demographics
Race

Demographic Category
- All
- American Indian / Alaska Native
- Asian
- Black / African American
- Native Hawaiian / Pacific Islander
- White

Percent of Demographics



SDOH Screen Plot and Patient Population



Risk of Social Drivers of Health by Selected Demographics

Financial Strain	Black / African Amer..	36%
	Other	22%
	White	22%
Food Insecurity	Black / African Amer..	30%
	Other	17%
	White	14%
Housing Problems	Black / African Amer..	16%
	Other	8%
	White	7%
Housing Stability	Black / African Amer..	32%
	Other	17%
	White	15%
Intimate Partner Violence	Black / African Amer..	5%
	Other	3%
	White	3%
Lack of Internet	Black / African Amer..	12%
	Other	7%
	White	6%
Lack of Physical Activity	Black / African Amer..	27%
	Other	16%
	White	19%
Lack of Transportation	Black / African Amer..	16%
	Other	9%
	White	7%
Lack of Utilities	Black / African Amer..	16%
	Other	5%
	White	5%
Social Isolation	Black / African Amer..	56%
	Other	42%
	White	46%
Stress	Black / African Amer..	44%
	Other	34%
	White	40%

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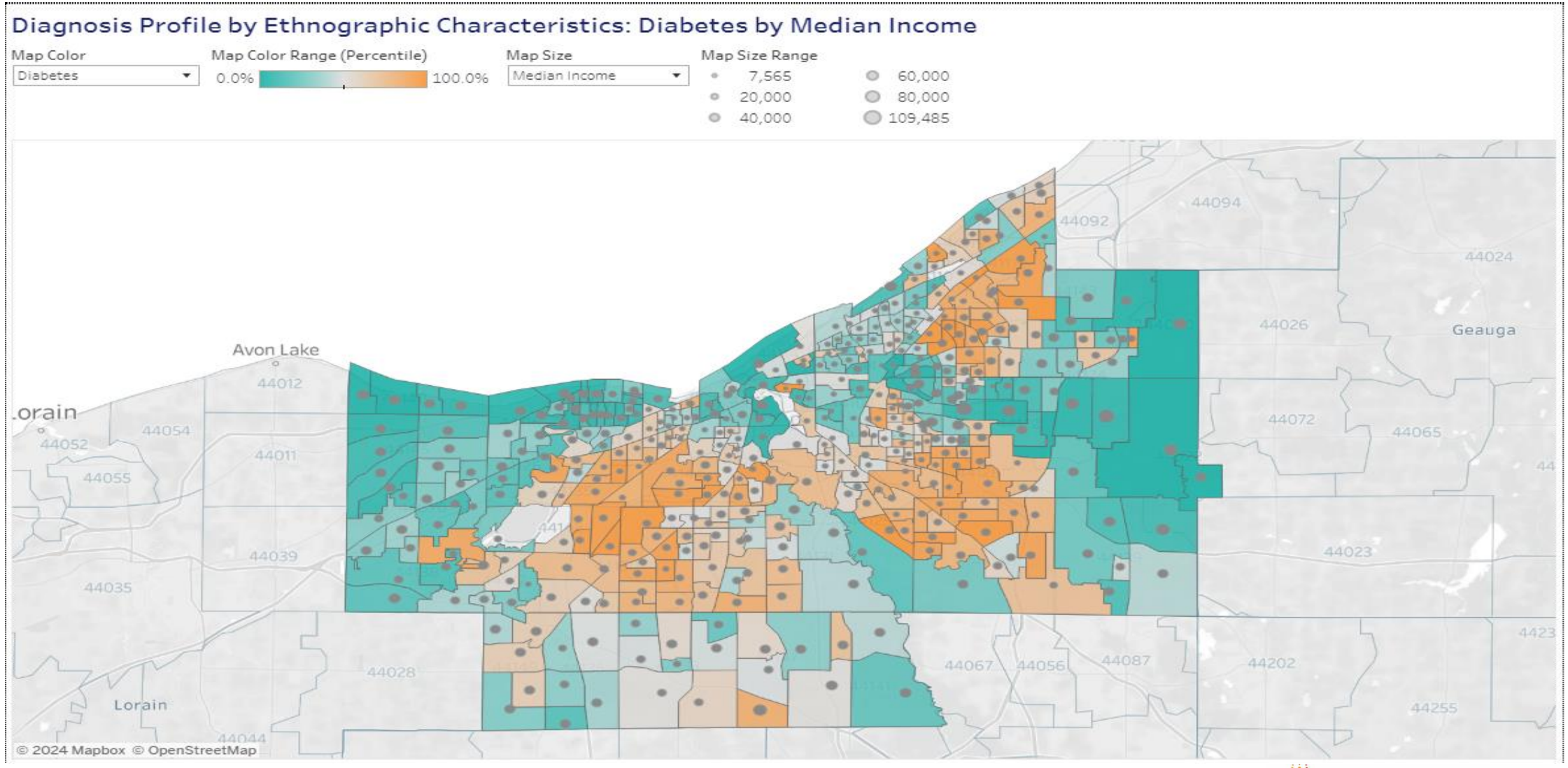
Intersectional Analyses



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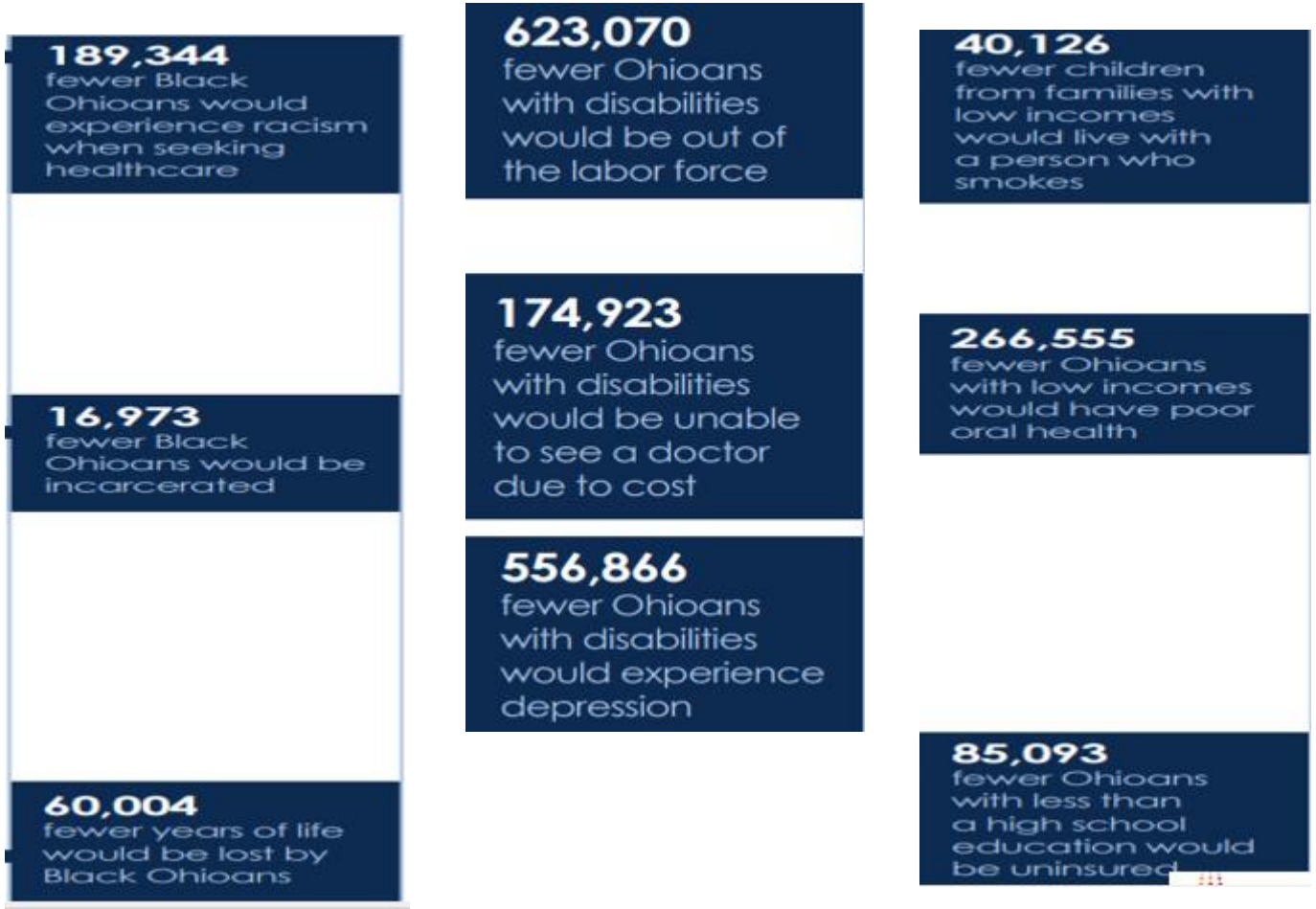
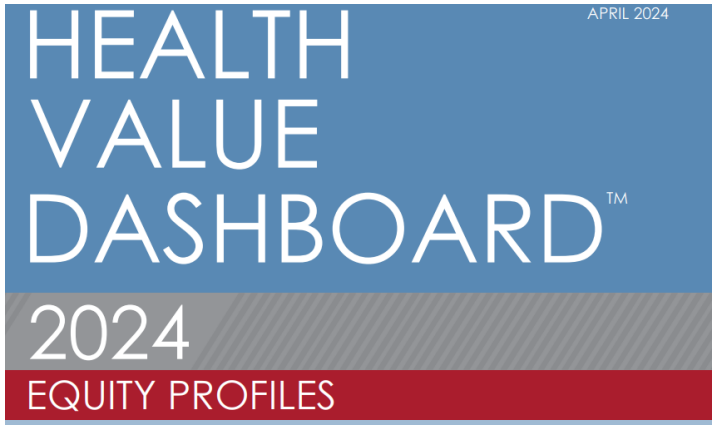
Why Equity Matters – Ohio

If healthcare disparities were eliminated…





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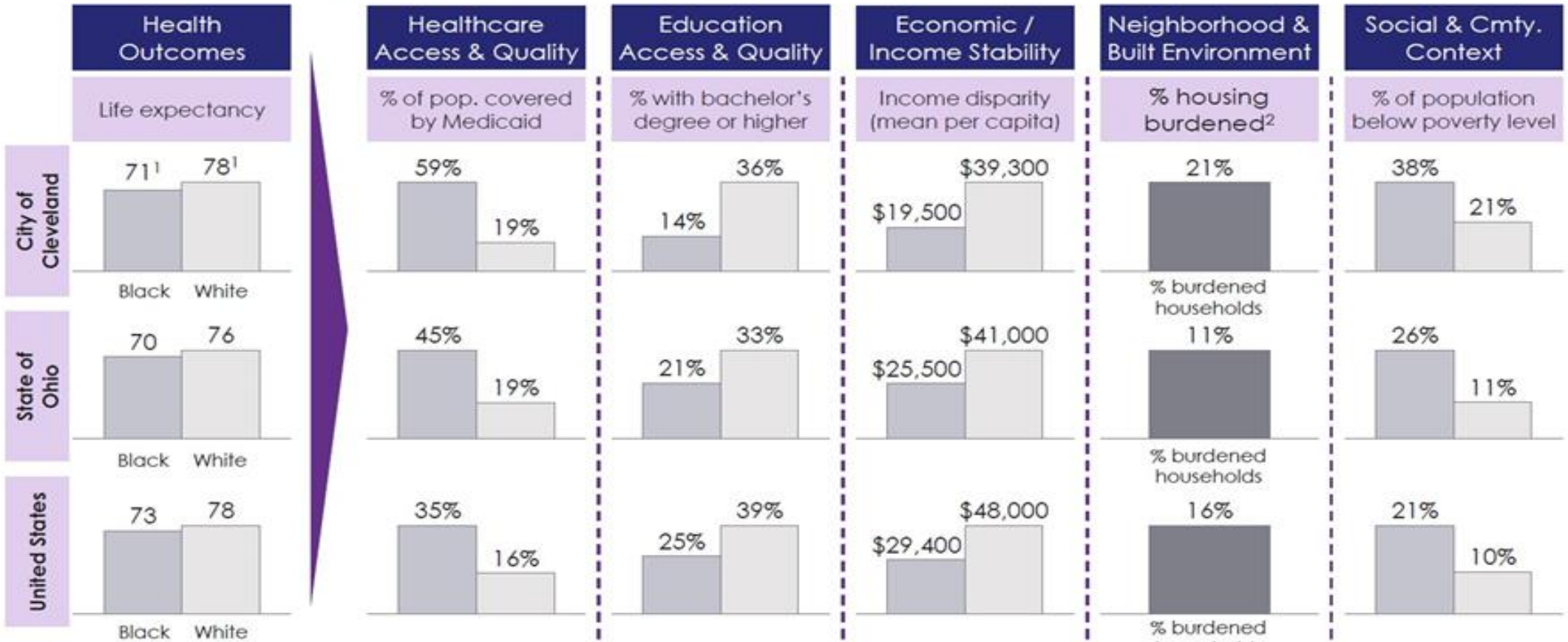
2024healthvaluedashboardequityprofiles04.09.2024.pdf (healthpolicyohio.org)

Why our focus on Health Equity

Cleveland health outcomes and socioeconomic indicators differ from Ohio averages in a significant way



1) Figures represent Cuyahoga Co. life expectancy data
2) Housing Burden = % of households spending half or more of their monthly income on rent
Sources: US Census Bureau, CDC, Cleveland Housing Equity Plan, State of Home Affordability in Ohio, Harvard Housing Report, KFF

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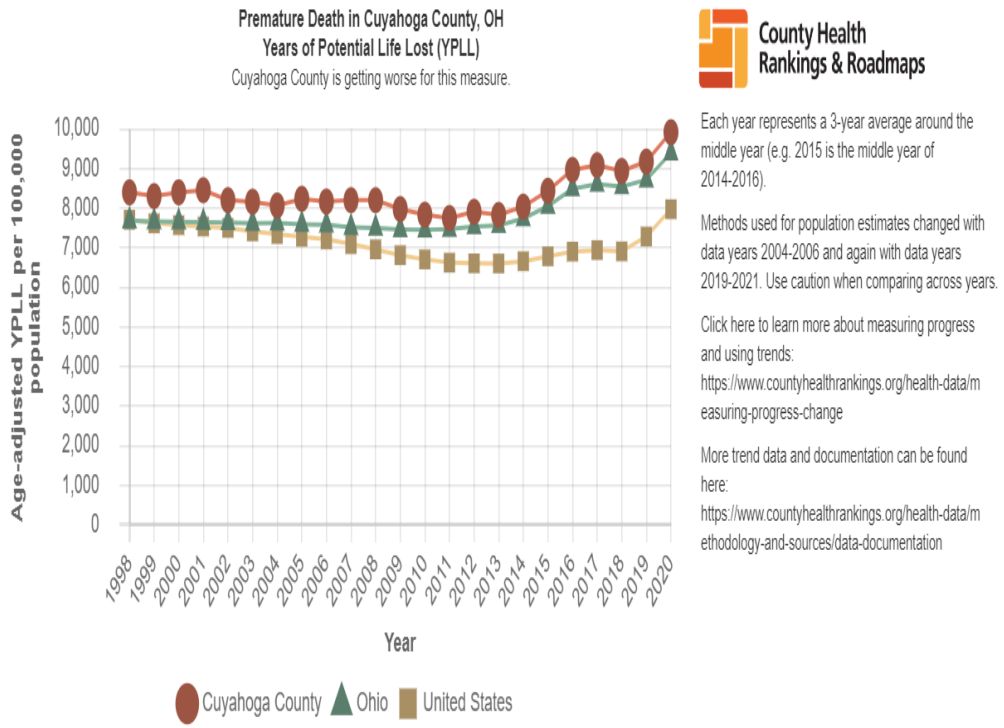
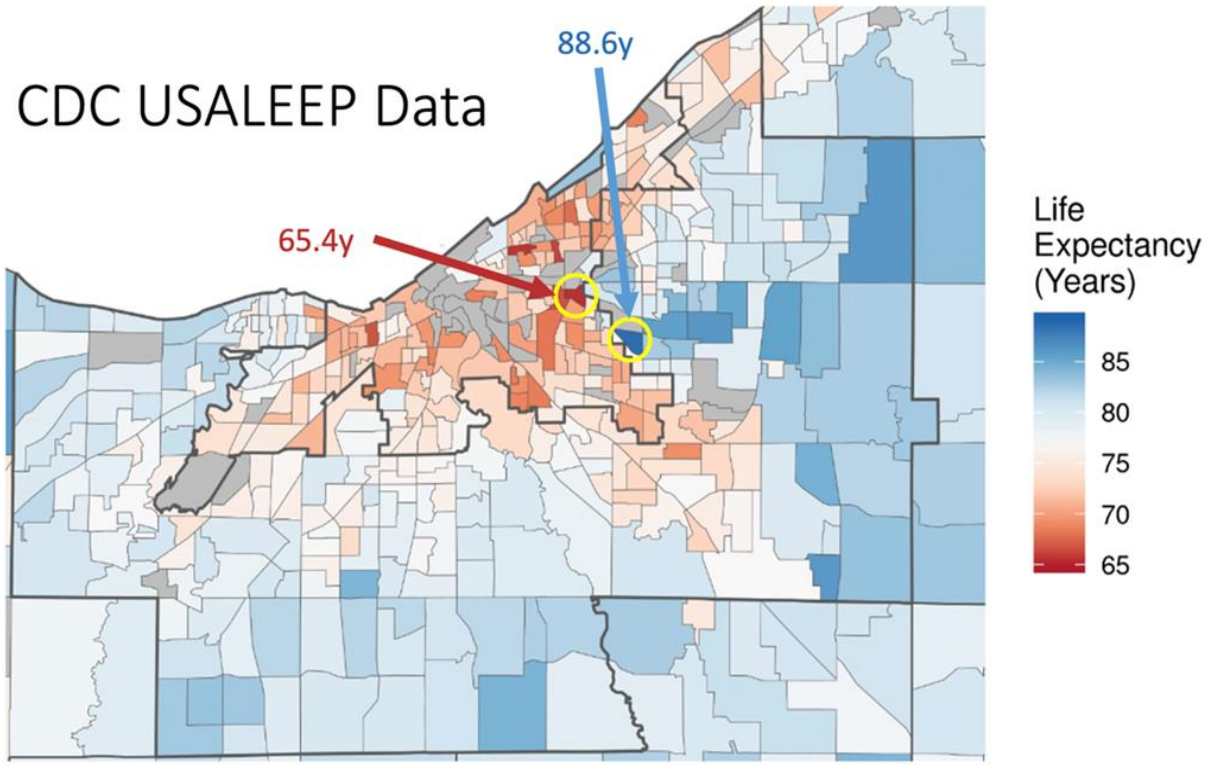
"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death.“ – MLK





But truly – are we making a difference?

Aka, are we there yet?

The *BEST* Healthcare System With the *NOT the Best* Outcomes?

2003

It's the prices, stupid: why the United States is so different from other countries

Gerard F Anderson [1], Uwe E Reinhardt, Peter S Hussey, Varduhi Petrosyan

Affiliations + expand

PMID: 12757275 DOI: 10.1377/hlthaff.22.3.89

2014

POLICY / HEALTH CARE

The giant problem American health care ignores

by **Adrianna McIntyre**
Jul 7, 2014, 2:50 PM EDT

The giant problem American health care ignores | Vox

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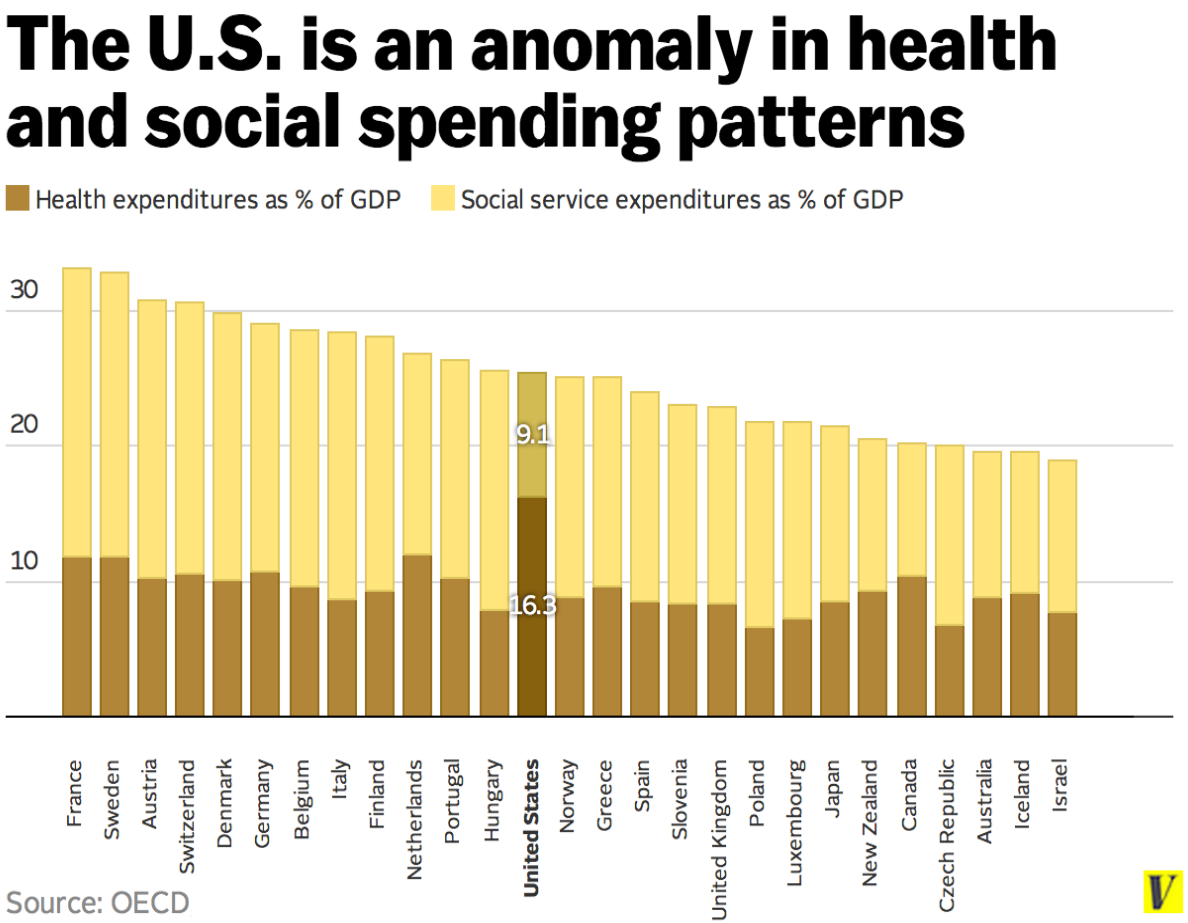
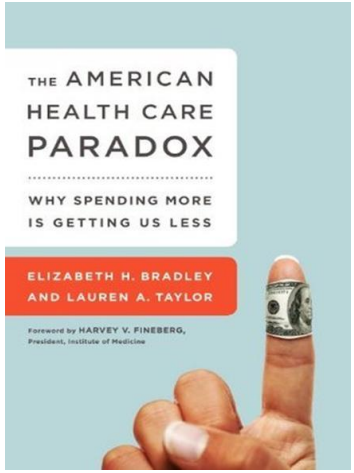
Spending Does NOT Buy Health OR Is There More To This?





The U.S. spends more per capita on healthcare than any other nation, yet Americans fare worse on many health measures

Social Services vs. Healthcare Spending: When combining healthcare and social services spending, the U.S. spends less than many other developed countries

Spending Ratio: Nations with a higher ratio of social to health spending (including public health) had significantly better health outcomes across several measures

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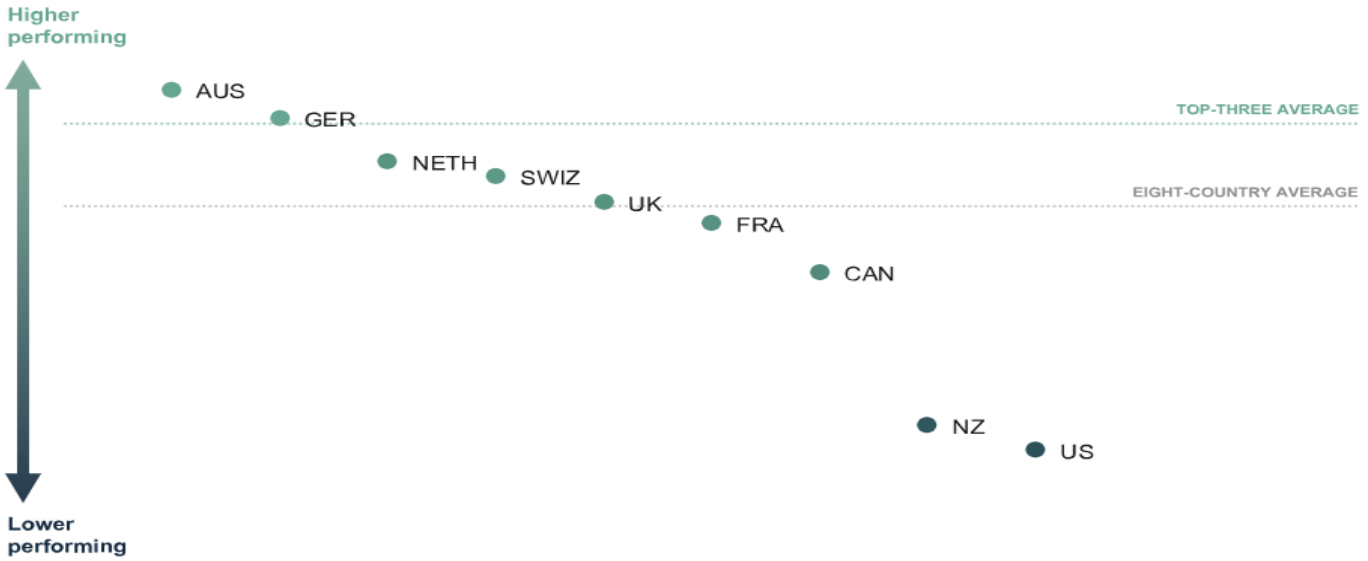
Surely...things are better in 2024!

EXHIBIT 8 — *Equity*

The U.S. and New Zealand trail peers for equity in health care access and experience.



Note: To normalize performance scores across countries, each score is the calculated standard deviation from, in this case, an eight-country average that excludes SWE and the US. See "How We Conducted This Study" for more detail.

Data: Commonwealth Fund analysis.

Source: David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (Commonwealth Fund, Sept. 2024). https://doi.org/10.26099/ta0g-zp66

"The U.S. is failing one of its principal obligations as a nation: to protect the health and welfare of its people," Joseph R. Betancourt, MD, the Commonwealth Fund president, said in a public statement. "*The status quo -- continually spending the most and getting the least for our health care dollars -- is not sustainable*."

[Mirror, Mirror 2024: An International Comparison of Health Systems | Commonwealth Fund]

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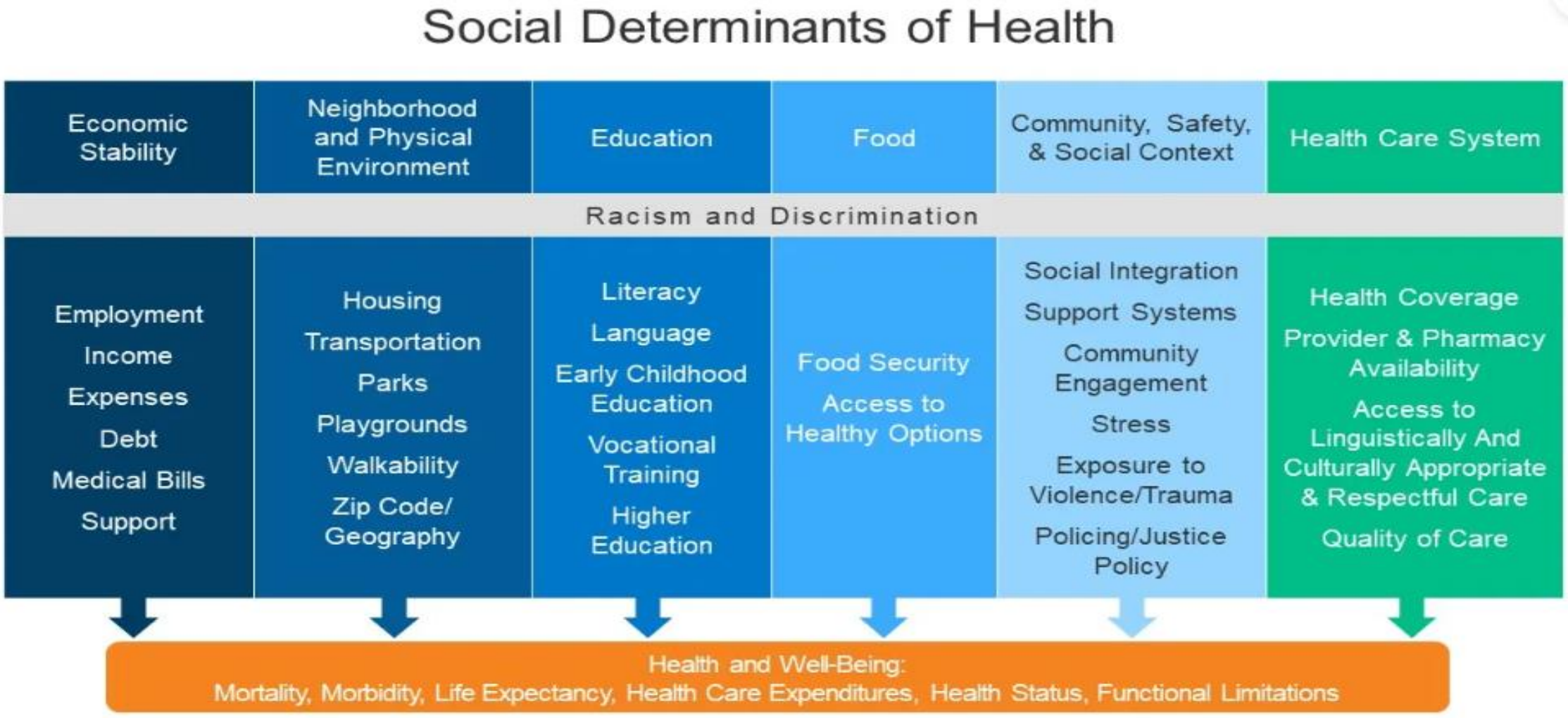
"Health disparities are a symptom of broader social and economic inequities." – Kaiser Family Foundation



https://www.kff.org/racial-equity-and-health-policy/dashboard/racial-equity-and-health-data-dashboard/

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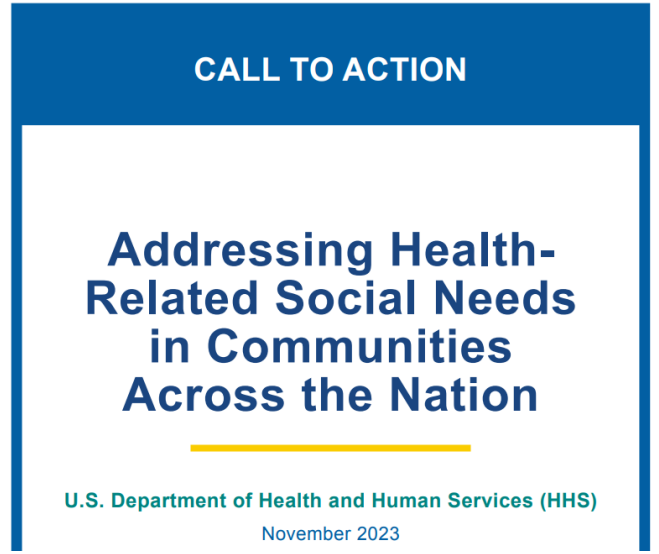
More Than Semantics?

Defining key terms:

- **Social drivers of health (SDOH):** The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH refers to community-level factors. They are sometimes called "social determinants of health." (Adapted from CDC Healthy People 2030)

- **Health-related social needs:** Social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They put individuals at risk for worse health outcomes and increased health care use. HRSN refers to individual-level factors such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation. (Adapted from HHS)



Call to Action: Addressing Health-Related Social Needs in Communities Across the Nation (hhs.gov)

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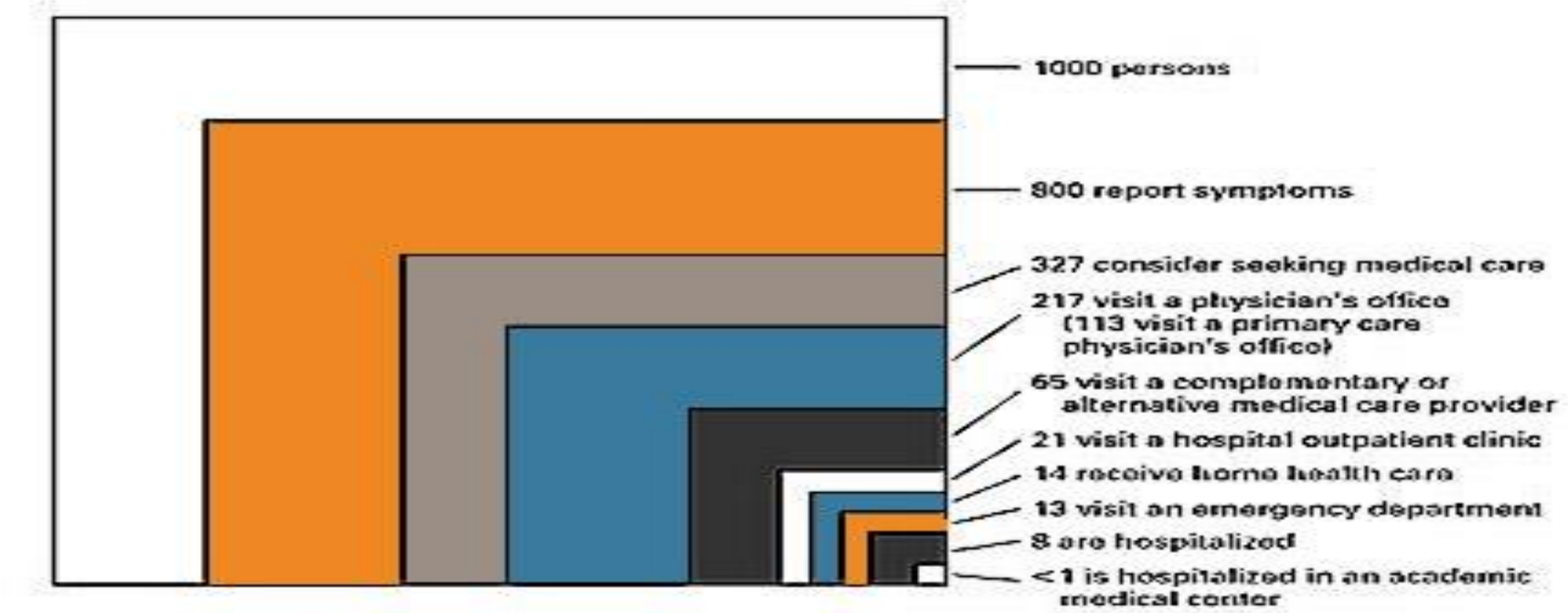
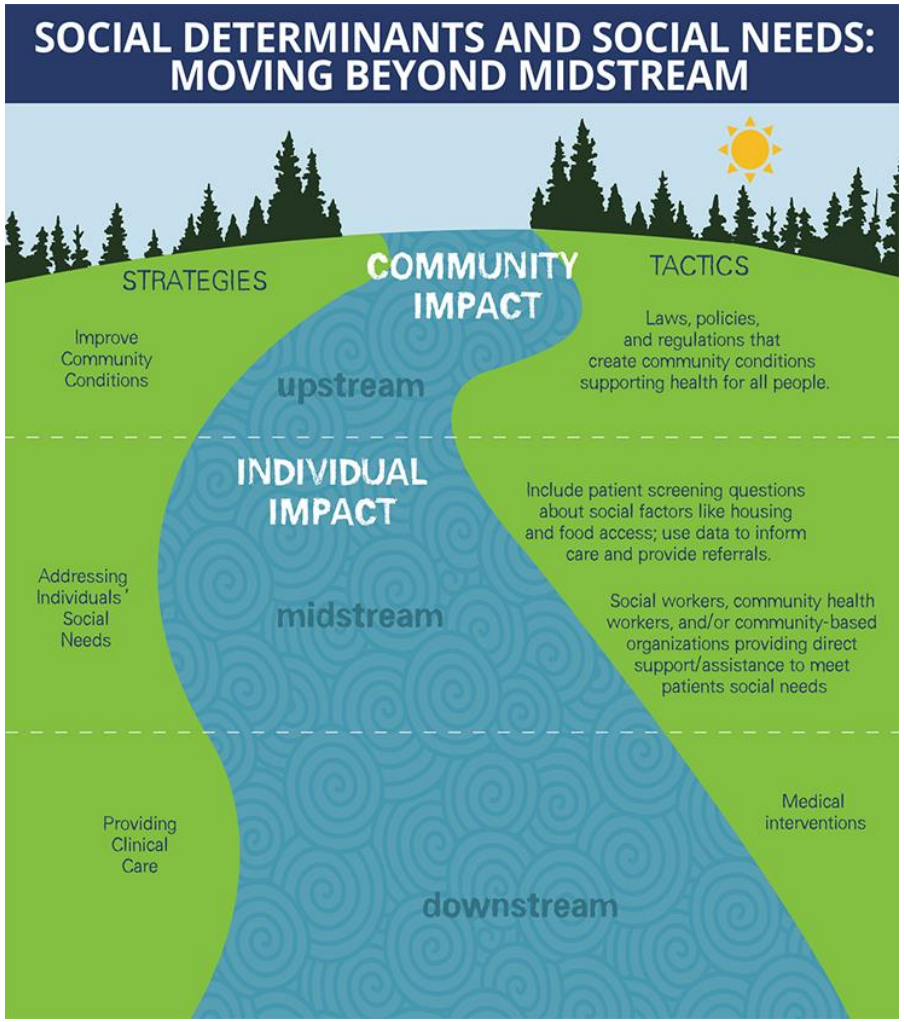
The Contemporary Ecology of Medical Care

The Patients We Don't See



https://www.graham-center.org/publications-reports/publications/one-pagers/contemporary-ecology-2001.html

Catch My Drift?



Moving Health Care Upstream

HEALTH AFFAIRS FOREFRONT

RELATED TOPICS:
SOCIAL DETERMINANTS OF HEALTH | ACCESS TO CARE | COSTS AND SPENDING | SYSTEMS OF CARE

Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health

Brian C. Castrucci, John Auerbach

JANUARY 16, 2019

10.1377/forefront.20190115.234942

"If we, even inadvertently, imply that the social determinants of health can be solved by offering Uber rides to individual patients or by deploying community health navigators, it will be challenging, if not impossible, for public health advocates to make the case for proven policies like alcohol sales control, complete streets, and healthy food procurement."

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NATIONAL ACADEMIES Sciences Engineering Medicine

Minorities More Likely to Receive Lower-Quality Health Care, Regardless of Income and Insurance Coverage

News Release | March 20, 2002

WASHINGTON -- Racial and ethnic minorities tend to receive lower-quality health care than whites do, even when insurance status, income, age, and severity of conditions are comparable, says a new report from the National Academies' Institute of Medicine. The committee that wrote the report also emphasized that differences in treating heart disease, cancer, and HIV infection partly contribute to higher death rates for minorities.

Little Progress Has Been Made in Closing Racial and Ethnic Gaps in U.S. Health Care; Federal Government Should Act to Fix Structural Inequities

News Release | June 26, 2024

WASHINGTON — The U.S. has made little progress in advancing health care equity over the past two decades, and racial and ethnic inequities remain a fundamental flaw of the nation's health care system, says a new report from the National Academies of Sciences, Engineering, and Medicine.

Goal 1: *Generate accurate and timely data on inequities.*
Goal 2: *Equip health care systems and expand effective and sustainable interventions.*
Goal 3: *Invest in research and evidence generation to better identify and widely implement interventions that eliminate health care inequities.*
Goal 4: *Ensure adequate resources to enforce existing laws and build systems of accountability that explicitly focus on eliminating health care inequities and advancing health equity.*
Goal 5: *Eliminate inequities in health care coverage, access, and quality.*

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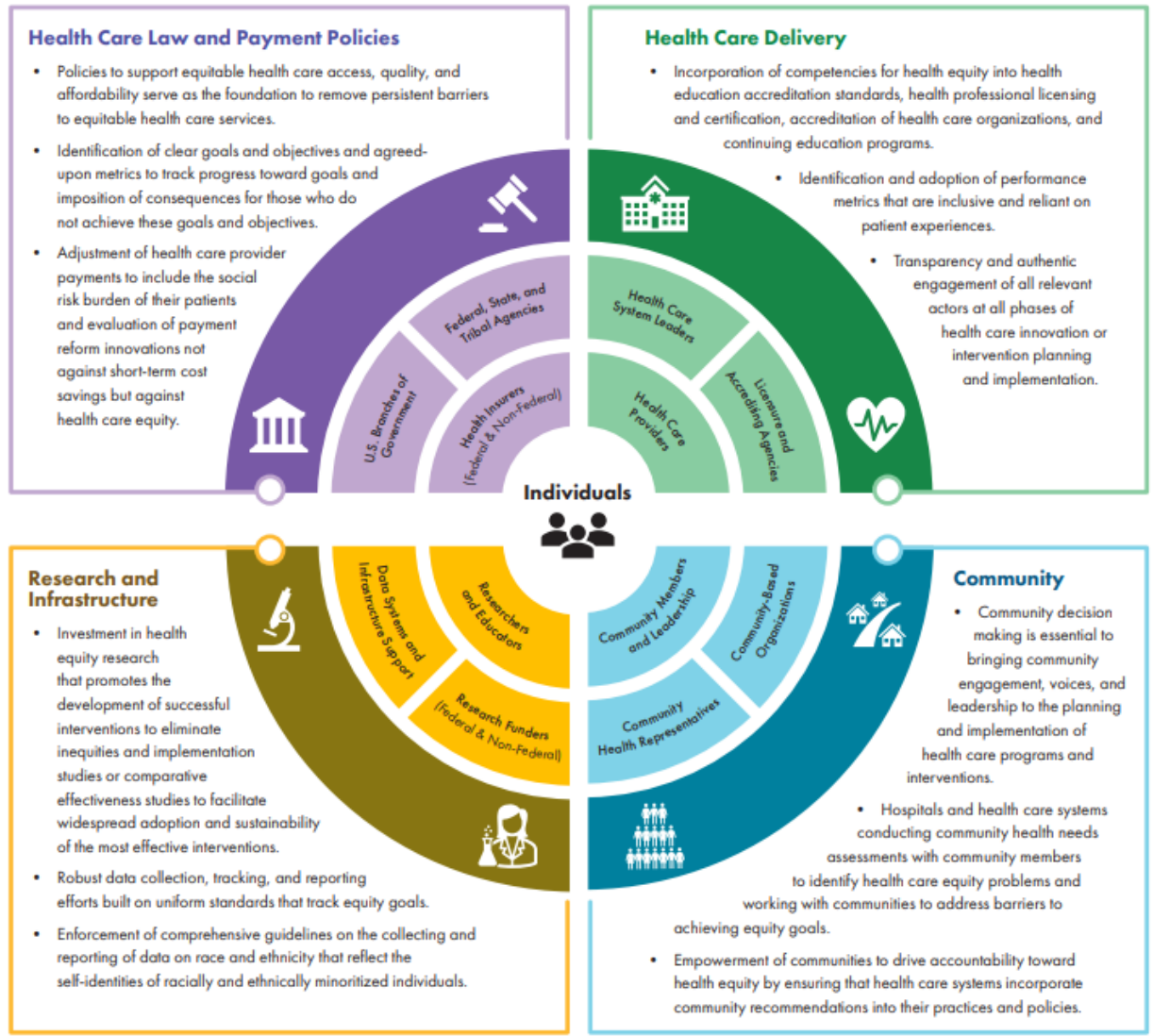
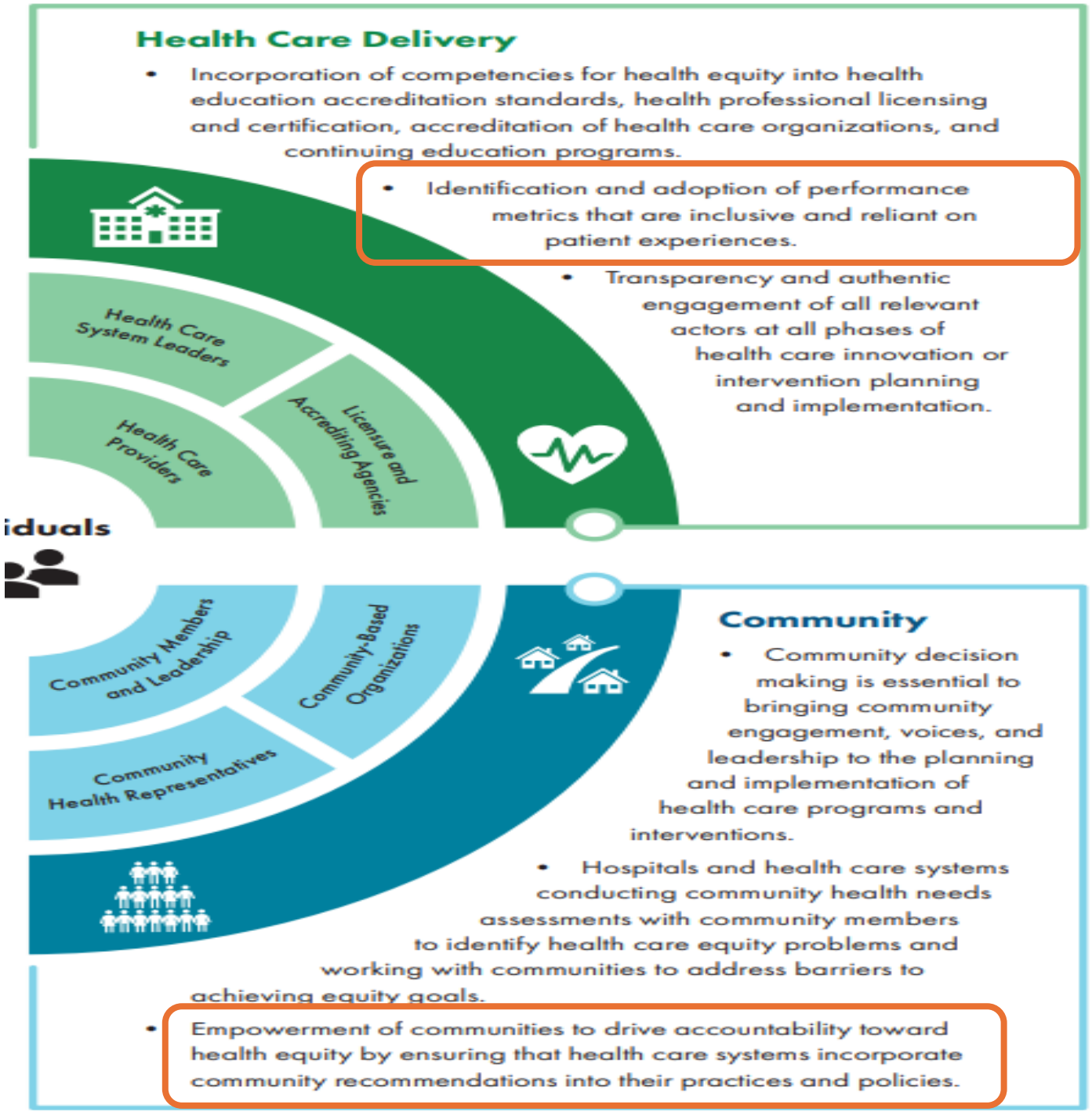
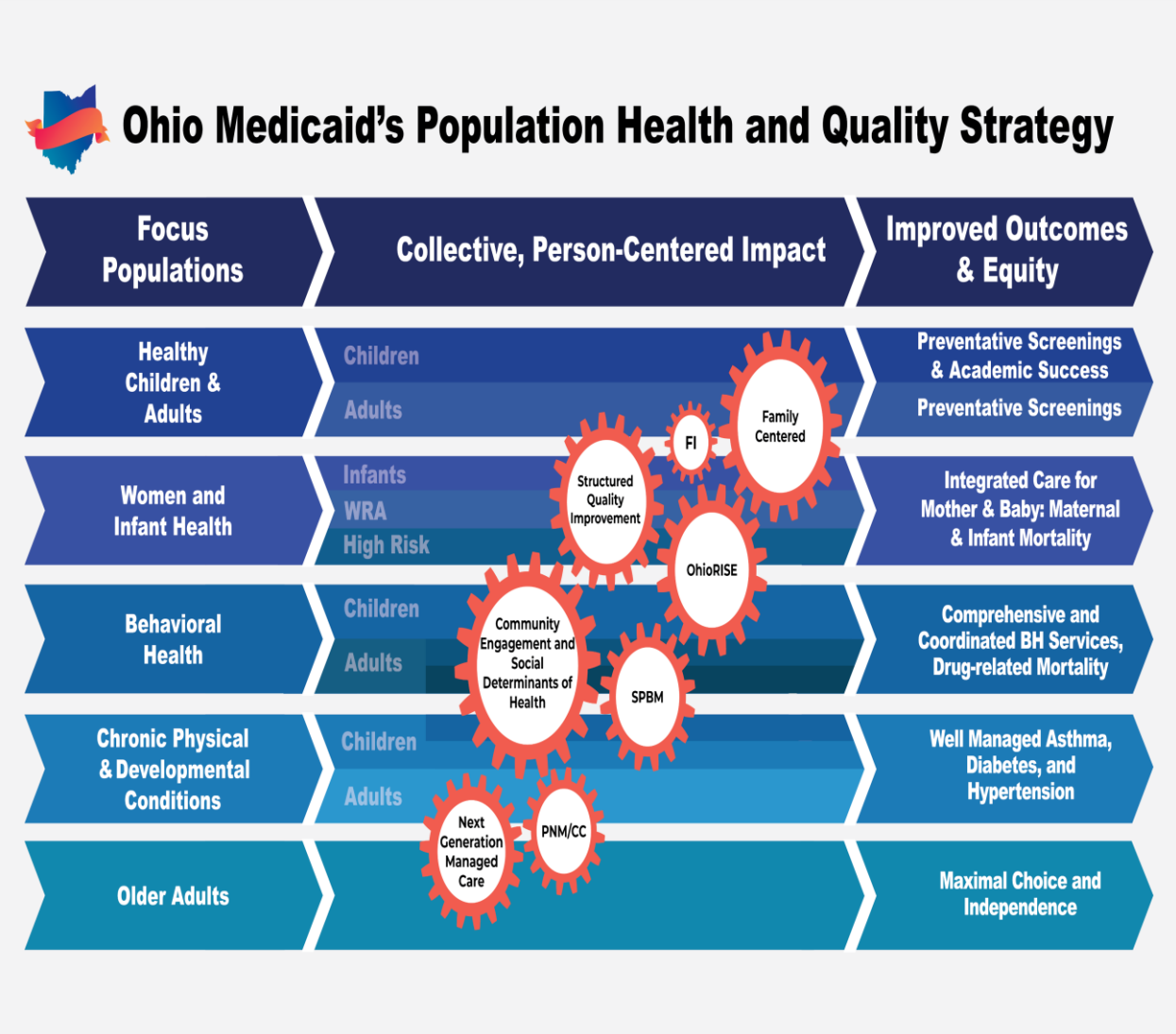
What Might Accountability for Health Equity Goals Look Like?

Racial and ethnic inequities in health care have persisted despite numerous efforts to address them over the years. A 2024 report from the National Academies of Sciences, Engineering, and Medicine examined the major drivers behind these inequities, provided insights into successful and unsuccessful interventions, and made recommendations to advance health equity goals. To ensure those goals are met, accountability is needed across multiple sectors, including all levels of government, individual health care systems, public and private payers, and other entities involved in health care. Some measures for accountability are listed below.




Health Care Delivery
• Incorporation of competencies for health equity into health education accreditation standards, health professional licensing and certification, accreditation of health care organizations, and continuing education programs.
• Identification and adoption of performance metrics that are inclusive and reliant on patient experiences.
• Transparency and authentic engagement of all relevant actors at all phases of health care innovation or intervention planning and implementation.
Health Care System Leaders
Health Care Providers
Licensure and Accrediting Agencies
iduals
Community Members and Leadership
Community-Based Organizations
Community Health Representatives
Community
• Community decision making is essential to bringing community engagement, voices, and leadership to the planning and implementation of health care programs and interventions.
• Hospitals and health care systems conducting community health needs assessments with community members to identify health care equity problems and working with communities to address barriers to achieving equity goals.
• Empowerment of communities to drive accountability toward health equity by ensuring that health care systems incorporate community recommendations into their practices and policies.

Multisector Community Partnerships: **Payors**



Programs Inclusive of Medicaid MCOs

- Comprehensive Primary Care
- Comprehensive Maternal Care
- QI Hub
- Cardi-OH

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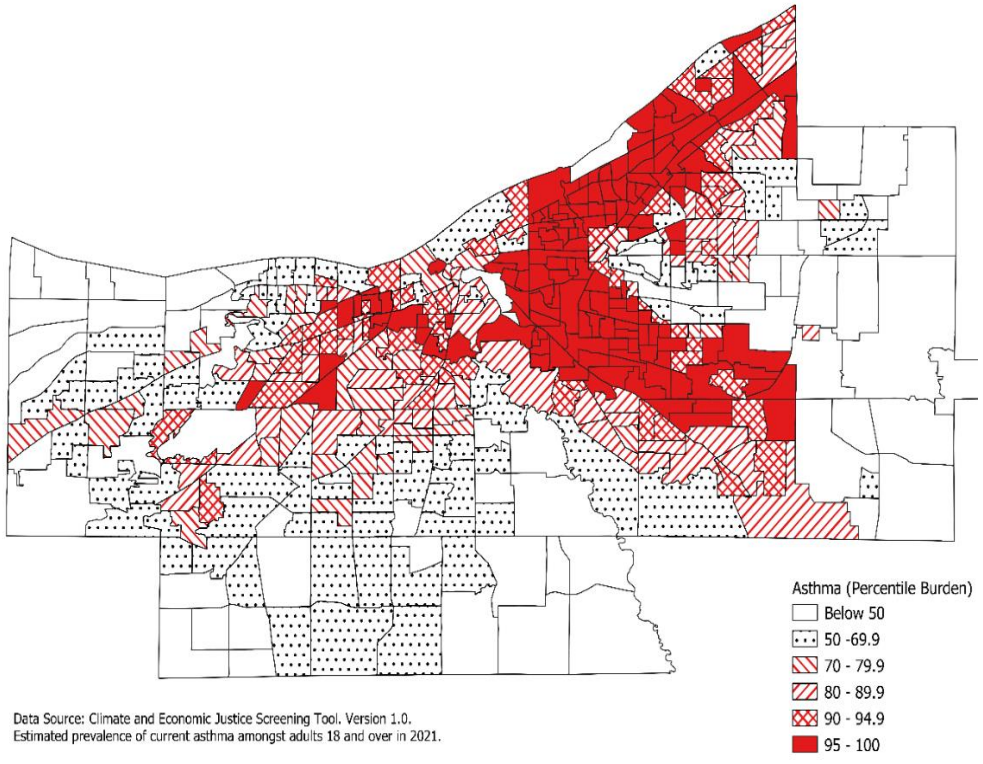
A Current Project

Figure 2: Distribution of Asthma Burdens in Cuyahoga County



Translate »

erage Asthma Burden and Air Pollution Exposure across Cuyahoga County Communities

Figure 3: Rates of Asthma Hospitalization & Emergency Department Visits, Cuyahoga County Adults

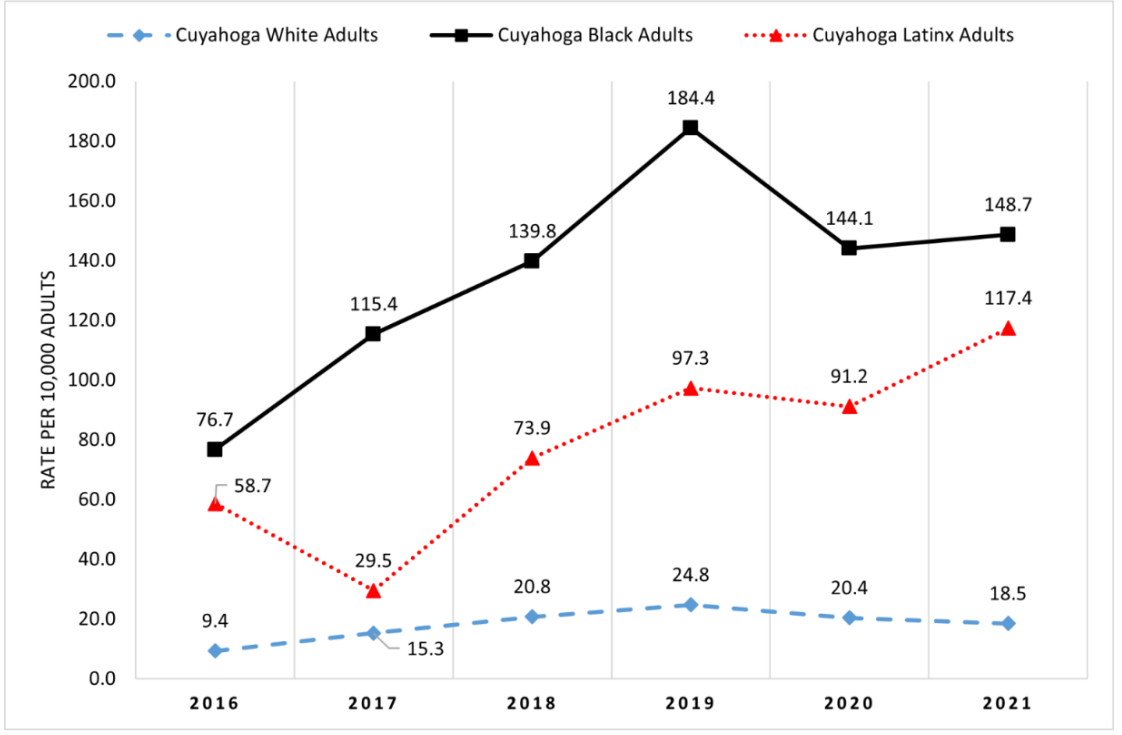


Table 2: Rates of Asthma Hospitalization & Emergency Department Visits, Cuyahoga County Adults

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Multisector Partnerships

MetroHealth Receives $17.2 Million Grant to Improve Air Quality for People with Asthma

working with seven community organizations that will coordinate the upgrade work for the 1,200 homes in Cleveland, East Cleveland, Euclid, Newburgh Heights, Garfield Heights, Maple Heights and Warrensville Heights.

… community partner organizations are

- Community Housing Solutions
- Rebuilding Together Northeast Ohio
- Metro West Community Development Organization Tremont West Development Corporation
- Old Brooklyn Community Development Corporation Slavic Village Development and
- Ohio City Incorporated

October 09, 2024 11:04 AM

MetroHealth to create ‘playbook’ for community health workers with national nonprofit

- Ongoing review of our job descriptions and challenging inflated education and experience qualifications

- Creating career pathways and professional development opportunities to advance into careers that lead to higher family sustaining wages

- Educating and providing employees with tools and resources that promote financial wellness and wellbeing

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Government & Politics

Cleveland invests in $100M fund for affordable housing development

Ideastream Public Media | By Abbey Marshall
Published September 30, 2024 at 8:45 PM EDT

MetroHealth Collaborates with Cleveland Clinic, Western Reserve Land Conservancy to Advance Health Equity

Cleveland, OH, September 24, 2024

The MetroHealth System Partners with CMSD and Integrated Health to Open Three In-School Clinics for District Students, Families and Staff

Cleveland, OH, February 12, 2024

UWGC and BHP Team Up to Deliver Workforce Development for Guiding Coalition

BY BETTER HEALTH PARTNERSHIP | APRIL 18, 2024

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The Sound of Ideas

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By Rachel Rood

Published October 10, 2024 at 5:00 AM EDT

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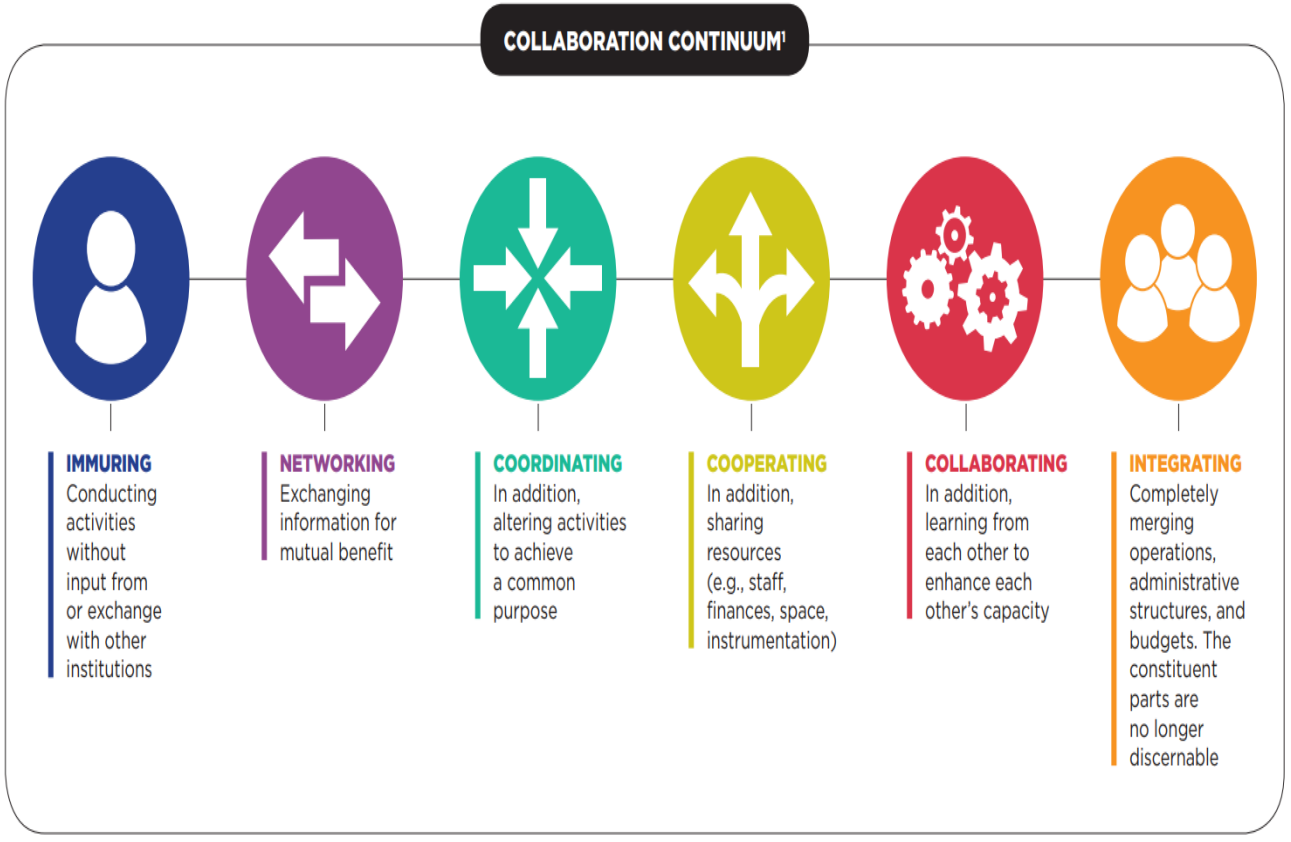
Multisector Partnerships – Whose Lane Is It Anyway?



"Listening to local voices is crucial because those closest to injustice are those best able to identify solutions to that injustice."

Philip Alberti, PhD
AAMC Center for Health Justice founding director

> "Move at the speed of trust. Focus on critical connections more than critical mass —build the resilience by building the relationships." - Adrienne Maree Brown

Mashek,D. (June, 2015). Capacities and Institutional Supported Needed along the Collaboration Continuum. A presentation to the Academic Deans Committee of The Claremont Colleges, Claremont. C

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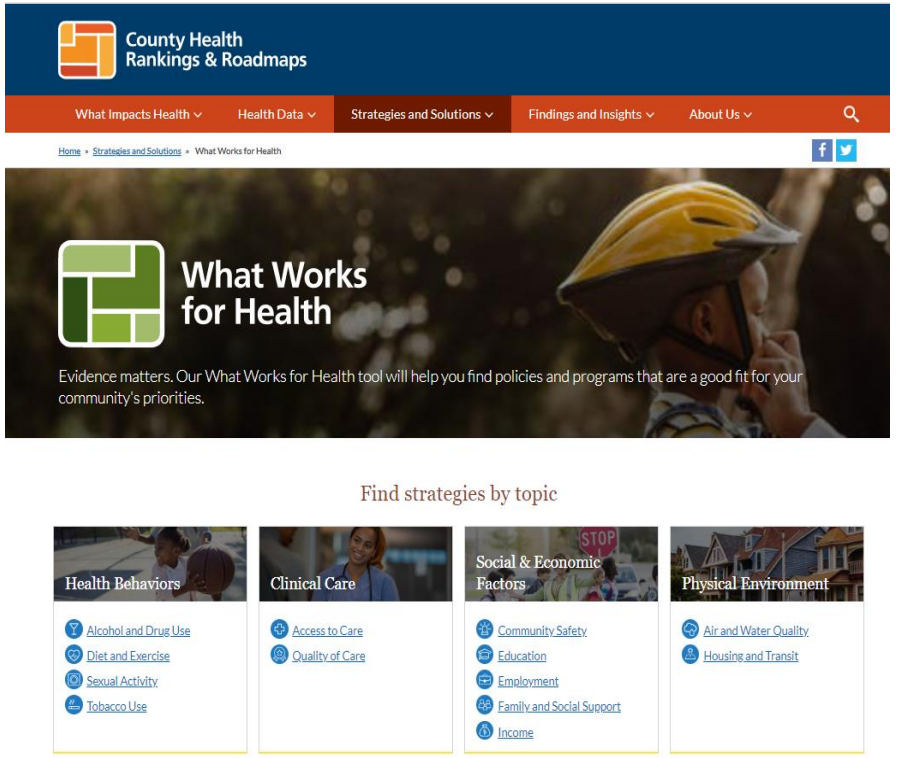
"Every system is perfectly designed to get the results it gets."

- Paul Batalden



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“Should the child of a poor American family have the same chance to avoid a preventable illness or receive care for a given illness as the child of a rich American family?” – Uwe Reinhardt

“People and communities can structure our society so that everyone benefits. We can work across our differences and build solidarity by understanding the root causes of our problems and collectively addressing them. Though history has shaped the rules we live with today, we write a new history every day for which we are all responsible.”

– County Health Rankings

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6. Moving Health Care Upstream
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8. Common Health Coalition | ChangeLab Solutions

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Q & A

Better Health Partnership