ADVANCING PATIENT-CENTERED CARE

Bringing Social Support into the Fold

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The issue of social determinants of health has become a trending topic in health care, and rightly so. The Centers for Medicare and Medicaid Services has stated that achieving health equity and driving improvements for all patients require further investment in tools and approaches to address these determinants and close care gaps. Social factors — including housing, transportation, education and social isolation — affect communities of color in particular and negatively impact access to care and health outcomes.

Even with increased focus on these socially driven health vulnerabilities, efforts to lessen inequities often reach only a fraction of the population — perhaps as few as 2% of all patients, according to CMS.[1] At CommonSpirit, we're committed to doing more and going further. Because we remain rooted in our foundational values of human dignity and social justice, we can put our energy toward determining how to best address social determinants of health, rather than convincing our staff why. It's hard to overstate the impact that one's economic stability, environment, relationships and access to resources has on physical health, and we've long recognized that the most effective care is comprehensive care, which extends beyond anthropometrics and biomarkers, such as blood pressure and weight.

While our mission remains the same, CommonSpirit continues to evolve and refine our approach to deliver the most meaningful and impactful care. Our focus is on operationalizing equity, striking the delicate balance between large-scale standardization, local autonomy and tailored support. In other words, we can implement universal health screenings of social needs across our points of care and also recognize that different regions we serve have prioritized different social needs and therefore have varying levels of support for patients.

ADDRESSING INEQUITY ONE PATIENT AT A TIME

Meaningful social change often starts with personalized patient care inside our own health care systems, which requires understanding each patient's unique social barriers and needs. From offering free language translation services at medical appointments to providing community resource referrals upon discharge from the emergency department, tailored social support is becoming ingrained.

Our Total Health Roadmap model is guiding the way. Launched in 2017 with funding from the Robert Wood Johnson Foundation and the Catholic Health Initiatives Mission and Ministry Fund, the program is grounded in our commitment to create healthier communities and is focused on

building a framework for successful scaling. The roadmap is driven by three core strategies: transforming our roles as providers, expanding our roles as community organizations and strengthening our leadership accountabilities.

At the heart of the program are community health workers, serving as counselors, advocates and front-line links to community agencies and partners. We've embedded 15 community health workers in family medicine practices in select markets in Iowa, Colorado and Kentucky, ensuring they're integrated into the care team and operating under the same roof as our clinical staff.

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We've also ensured community health worker support is accessible to all patients, regardless of insurance status. Every patient is offered the opportunity to participate in the social health screening process, though no one is obligated. Patients complete the screenings during their appointments, and community health workers meet with patients in need of assistance while in the clinic, if possible. They also follow up to determine if needs are being met and establish long-term relationships with many patients.

Over the past three years, screening participation has increased with more than 40,000 screenings in our pilot clinics, a promising metric for a few reasons: we're reaching more and more patients; screenings are becoming a trusted part of the care process; and physicians are providing additional prompts and encouragement to patients to complete the screening — a testament to how much they've come to appreciate the added value of the community health workers. And now we're scaling this approach to additional communities. We still see a significant number of patients who complete the screening but ultimately decline assistance. This is consistent with what other organizations have observed; their responses still give us important insights into the persistence of social needs in each area.

While the Total Health Roadmap aims to serve as a model for our sites everywhere, relying on input from teams in the field and program champions at each center has been a major part of the program's success. And as "warm handoffs" between providers and community health workers become more frequent, our patients are realizing their value, too.

Lisa, whose name has been changed to protect privacy, is one of thousands of our patients whose lives have been touched by the community health workers. Lisa answered "yes" to every question on our screening form, indicating a high level of need. Although she was employed, she and her husband were living in a car with their 2-year-old and 5-month-old children. She indicated that they had been fishing for their food and that her husband struggled with alcohol abuse and post-traumatic stress disorder after his military service. A community health worker assisted Lisa, connecting her to other local organizations to secure permanent housing, benefits from the federal Supplemental Nutrition Assistance Program, and diapers and clothing for the children. They also helped Lisa's husband find a local counselor who could assist with his PTSD and behavioral health struggles and obtained vouchers for gas so that Lisa could make it to work. These were crucial foundational blocks that Lisa needed to build toward a healthier life. And this is just one example of how our passionate, purpose-driven people are changing patients' lives every day.

CLOSING THE CARE GAP WITH DIGITAL TOOLS

As an industry, we've long known that community-based, culturally responsive programs work, but we've lacked the capacity to deliver them in a cost-effective way and to scale them to serve thousands of patients. Today, a technology-enabled approach allows us to drive better outcomes for physicians, strengthen engagement and improve health in the communities that need the support the most. Digital tools such as virtual care, app-based screening and monitoring systems deepen our connections to some of our most at-risk and hard-to-reach patients.

In 2020, CommonSpirit expanded our partnership with Docent Health, a health care technology company focused on personalized patient naviga-

tion, to pair patients with non-clinical navigators who provide them with individualized guidance. Docent Health provides patient liaisons and a technology platform to help patients navigate their health care and to guide patients to the right resources. Docent Health's platform centralizes patient information and creates tools like dashboards and scorecards to illustrate trends and care opportunities based on a health program's goals. A pilot began in 2016, and more recently we've built off the program's success with some maternity and orthopedic patient cohorts in particular. The pilot quantified how the platform's innovative technology and navigator program have successfully improved patient health and utilization outcomes. The model also lowered the cost of care for maternity and orthopedic patients at the three pilot facilities, including vulnerable Medicaid patients. The pilot study included more than 10,000 of CommonSpirit's patients and found new mothers had a 10% shorter average length of stay, Medicaid newborns with complications had a 1.8-day shorter length of stay, and preterm births for mothers on Medicaid fell by 37%. Orthopedic patients had a 45% shorter average length of stay, and 30-day readmission rates fell by 71%.

The program will eventually expand to include more of CommonSpirit's care sites across the country, while the virtual care navigators will improve continuity of care among the health system's hospitals and extend to primary care practices, behavioral health specialists and community-based organizations. Ultimately, this support system allows us to scale services, which is especially critical for vulnerable and underserved populations.

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INVESTING IN HEALTH BEYOND HOSPITAL WALLS

As an anchoring institution in the community, we have a responsibility to invest in our markets for lasting solutions that spark long-term change — a cure versus band-aid approach. CommonSpirit conducts needs assessments and creates implementation strategies every three years to identify and address significant health needs in the communities we serve, and we invest in the continuum of community-driven solutions to social determinants of health: housing, environment, job creation, arts and education, food and nutrition, and access to capital. These investments target key social determinants by funding efforts to develop resources in underserved neighborhoods, revitalizing urban and rural areas in need and empowering people in low-income communities through education, training and sustainable employment.

Since the start of a community investment program in 1990, we've invested more than $277 million in community projects. Today, we have more than 100 projects with close to $107 million in outstanding loans. Without a safe space to live and a stable address, physical well-being is impossible. Therefore, nearly 45% of the current loan portfolio has been invested in housing, from establishing affordable housing projects and revitalizing low-income neighborhoods to addressing and preventing homelessness. Housing is also one of the largest financial strains on patients and a critical linchpin to other social determinants of health. CommonSpirit's Homeless Health Initiative works to co-locate, coordinate and integrate health care, behavioral health, safety and wellness services with housing and other social services. Across California, for example, we have committed to investing at least $20 million through fiscal year 2024 to address housing insecurities and homelessness prevention for individuals and families, as well as to coordinate care and resources for people experiencing homelessness with local community partners and government agencies.

Job creation is another critical need, and people in underserved communities often lack the space and the start-up capital to build their own business. At La Cocina, a nonprofit funded in part by CommonSpirit, women with culinary know-how and a strong entrepreneurial spirit, but little financial capital or business experience, have access to a shared "incubator kitchen" where they

can formalize and grow their own food businesses. Located in the ethnically diverse and economically vulnerable Mission District of San Francisco, La Cocina offers access to kitchen space as well as mentorship opportunities to create business and marketing plans. La Cocina has fostered the development of dozens of new small businesses and paved the way for a more inclusive and equitable food industry.

Many of our community investments are made possible by our Social Innovation Partnership Grants program — funding allocated to up-and-coming technology companies and organizations with transformative approaches designed to increase access to resources and improve health outcomes. To secure grant funding, their solutions must be designed to meet the needs of low-income individuals with chronic physical or behavioral health conditions who lack access to coordinated services and health education. Among this group of innovative companies is One Degree, which has created a website and app that connect users nationwide with resources in their area to help them achieve economic and social mobility. From food assistance and affordable legal counsel to education opportunities and financial services, One Degree's resources touch every domain of the social determinants of health. Since 2017, more than 500,000 people have accessed services through One Degree, using an estimated $20 million in resources they discovered through the platform.[2]

These initiatives have a ripple effect. Access begets access. Resources build self-efficacy. And strong social support enables healthier lives. Health happens everywhere, which means health care can no longer be confined to brick-and-mortar hospitals and clinics. To effectively promote health and well-being for all, the community must be a part of the care plan.

THE POWER OF PARTNERSHIP

No matter where the spark of social change starts, within our walls or out in our communities, one constant persists: the power of partnership. The meaningful impact we have on our patients' lives is made possible by passionate advocates throughout our organization, the collaborative spirit of our care teams who have shared their input and insights and our local champions on the front lines who take ownership of this challenging work. Our deeply rooted connections to our communities prove invaluable. From forging joint efforts with other anchor institutions to fueling innovative social disruptors, our partners allow us to go further, together. As we fully realize the interconnectedness of human health — behavioral, social and spiritual — we must invest in interconnected solutions.

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NOTES

1. For related information from CMS, https://www.cms.gov/newsroom/press-releases/cms-issues-new-roadmap-states-address-social-determinants-health-improve-outcomes-lower-costs.
2. More information about One Degree, https://www.1degree.org/.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, Summer 2021, Vol. 102, No. 3