BREAKING DOWN BARRIERS IN HEALTHCARE

ADDRESSING TOP HOSPITAL NEEDS: SOCIAL DETERMINANTS OF HEALTH
Addressing Top Hospital Needs

Perspectives From the Abbott Thought Leadership Network

Many of us went into healthcare because we believed in something bigger than ourselves. We wanted to dedicate our lives to making more than financial gains. We wanted to make a difference. What we found is a vexing environment that undercuts our efforts to help at every turn. Forging ahead and changing the game so that healthcare is accessible and sustainable is more than a business problem to solve. It’s a moral imperative.

Charles Darwin said, “It is not the strongest of the species that survives nor the most intelligent that survives. It is the one that is most adaptable to change.”

Fierce forces are bearing down on hospitals, driving up costs, throttling reimbursement and hampering efforts to deliver quality care. Despite the difficulties, healthcare leaders are pushing ahead with an unwavering commitment to ensure access to high-quality care and the financial stewardship required for long-term viability.

Maintaining the status quo isn’t a viable option to overcome this onslaught of obstacles. Hospitals are being challenged to do more with less, as payers, regulators and patients all demand that they do things differently. However, few providers have the resources to embrace every game-changing solution or place a huge bet on the latest big idea. While innovation can pave a path forward to make the impossible possible, expect skips and hops, not leaps and bounds.

The healthcare system we know today will be different 12 months from now, will be different 60 months from now and will be different 10 years from now. We need to continuously learn and forever adapt at an ever-increasing rate.

To keep pace with our clients’ changing needs, we are reimagining our business. In healthcare, decisions drive costs. We are more than the business of information transactions, pricking fingers and producing lab reports. We deliver data-driven insights that make people’s lives better and providing care easier.
As part of rethinking our business, Abbott is bringing together innovative leaders representing a breadth of healthcare domains and a range of functional expertise to develop and share practical solutions to the most entrenched problems facing the healthcare industry. Working collectively, Abbott’s Thought Leadership Network is focused on three goals:

1. **Establish a network of experts and thought leaders** from across the spectrum of care to gain the 360-degree view needed to solve the dynamic and complex problems that the healthcare industry is grappling with. We are inviting teams to come together across disciplines to tackle their most aggressive problems. The most recent research and opinions will serve as the guiding force of discussions.

2. **Create content and tools that can spark dialogues**, including addressing local challenges that require input from local stakeholders. Whether it’s across the health system or in a particular community, we will work to ignite conversations where they need to happen, from hubs of innovation opportunity to areas ripe for action.

3. **Mobilize and socialize the information** across people and networks to spread the knowledge. The more that people in the industry are exposed to successes and failures, the better healthcare will be. We aim to turn information into insight and insight into action.

We recently facilitated three days of dynamic discussion among some of healthcare’s leading thinkers and innovators, exploring how industry changes are creating and intensifying unmet provider needs related to patient health, quality and efficiency, and strategic priorities. To see past the symptoms, understand root causes and explore solutions, we gathered physicians, academics, mental health professionals, entrepreneurs and C-suite executives from leading hospital systems, mental health centers, payers, consultancies and integrated solutions providers.

Their diverse perspectives, shaped by expertise spanning clinical performance, health policy, patient safety, population health, information strategy and diagnostics, coalesced around the needs summarized below as most critical for hospital leaders to address:

### Top Hospital Needs

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<thead>
<tr>
<th>Top Hospital Needs</th>
<th>Patient Health</th>
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<tr>
<td>- Address the social determinants of health affecting patient outcomes.</td>
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<td>- Empower and engage active patients as core members of their care teams.</td>
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<td>- Provide holistic healthcare to improve patients’ physical, mental and spiritual well-being.</td>
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<th>Top Hospital Needs</th>
<th>Quality and Efficiency</th>
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<td>- Drive resource optimization and efficiency to balance cost containment and quality of care.</td>
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<td>- Foster patient safety through improved information, decisions and operations.</td>
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<th>Top Hospital Needs</th>
<th>Strategic Priorities</th>
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<td>- Improve population health by expanding the boundaries of care beyond your hospital walls.</td>
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<td>- Expand preventive care initiatives to shift your focus from sick care to well care.</td>
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<td>- Align to financial innovations, increasing the risks and rewards of delivering measurable value-based care.</td>
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*Source: Abbott Thought Leadership Network*

To share actionable insights into these unmet needs, Abbott will be releasing a series of articles, presentations and video interviews, as well as facilitating discussions tailored to address our customers’ unique pain points and priorities. We’ll ground ourselves by objectively assessing the severity and prevalence of the problem, unpack the challenges to addressing it, explore how leading hospitals and disrupters are overcoming obstacles, and suggest ways that leadership can begin to take those achievable skips and hops forward.
Social Determinants of Health: Headwinds to Effective Care

One could easily argue that the fiercest headwinds facing hospitals today are social determinants of health (SDOH).

A staggering 80% of patient outcomes are shaped by factors historically considered outside the control of hospitals, such as access to adequate food, housing, transportation, and the financial means to pay for medications, utilities and other services.¹ SDOH play an outsized role in determining a person’s health, dwarfing the 20% influenced through clinical care.

The problem of SDOH hampering patient health is pervasive and not isolated to lower-income communities. Fifty-three percent of patients are dealing with one or more adverse SDOH.² Chances are that when people walk through the doors of your hospital, they are missing a vital component from their lives necessary for good health. A person without access to proper food, housing or a safe community faces double or sometimes triple the likelihood of engaging with the healthcare system.³

Contributing to more than 50% of readmissions,⁴ SDOH can consume a hospital’s resources and hamper its ability to drive sustainable health improvements. It’s a Sisyphean challenge. The way Lee Shulman, Anna Ross Lapham Professor of Obstetrics and Gynecology, Feinberg School of Medicine, Northwestern University sees it, hospitals fix patients; then the world breaks them again. It’s a vicious cycle.

Hospitals have a mandate to provide quality care and to keep costs under control, but the influence of SDOH continues to blow headwinds against their progress. SDOH are top of mind for hospital leaders. They continue to enhance their understanding of these causes and effects to better enable them to achieve their mission. Acknowledging the issue is one thing. Acting on it is another.

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**COUNTY HEALTH RANKINGS MODEL**

- **POLICIES AND PROGRAMS**
  - Physical Environment (10%)
  - Social and Economic Factors (40%)
  - Clinical Care (20%)
  - Health Behaviors (30%)

- **HEALTH FACTORS**
  - Housing and Transit
  - Air and Water Quality
  - Community Safety
  - Family and Social Support
  - Income
  - Employment
  - Education
  - Access to Care
  - Quality of Care
  - Sexual Activity
  - Alcohol and Drug Use
  - Diet and Exercise
  - Tobacco Use

- **HEALTH OUTCOMES**
  - Length of Life (50%)
  - Quality of Life (50%)

**Source:** County Health Rankings Model (© 2014 UWPHI)
SDOH: Forces to Be Reckoned With

Tackling SDOH is a challenge. It means tailoring care plans to each patient’s clinical needs, as well as an array of social and economic issues. It requires gathering data, integrating it into physicians’ clinical workflows, acting on an analysis of potential impact, measuring results and adjusting programs accordingly.

Providers can effectively paint a picture of a person’s health risks based on CPT codes and electronic health records (EHRs). Mining that data for insight into that person’s exposure to adverse SDOH presents much greater challenges. It’s much easier to identify who is at risk for diabetes than to predict whether they have the resources or ability to manage their own care.

Hospitals will need to merge social determinant information with other patient data to identify which SDOH are most likely to undercut their best efforts and adjust treatment plans to mitigate their impact on health outcomes. Clinical workflows must be adjusted to provide relevant information and services at the right time in the right way. Beyond the point of care, they will need to include a plan to measure and monitor results to adjust programs for maximum impact.

Facing myriad challenges in their quest to tackle SDOH, hospitals are learning how to understand and address forces outside their four walls. Early successes of innovative hospitals and nonprovider disrupters offer instructive lessons.

How Leading Hospitals and Disrupters Are Charting a Course for the Future

Hospitals can expand their sphere of influence on patient health beyond 20% through planning, data and commitment to targeted initiatives that address SDOH.

Checking on a person’s SDOH should be as routine as assessing vital signs. In fact, it takes about the same amount of time. Clinicians at Rush University Medical Center only need three minutes to complete an SDOH screening. Many hospitals are actively assessing SDOH using a mix of off-the-shelf and custom-developed screening tools.

Two of the most widely used and readily available screening tools are the Accountable Health Communities (AHC) instrument and the Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences (PRAPARE) instrument. Both are applicable to diverse care settings and capable of assessing multiple overlapping social needs.

Boston Medical Center (BMC) has developed and implemented its own SDOH screener for primary care clinicians to understand potential needs across eight domains: homelessness and housing insecurity, food insecurity, inability to afford medications, lack of transportation to medical appointments, utilities, caregiving, unemployment, and educational aspirations.

But securing information about which patients are at risk means nothing until you mobilize the information and marshal resources to make a difference. Integrating social determinant data into clinical pathways is instrumental. Forward-thinking hospitals are employing software to automatically trigger actions customized to individual patient needs. Automation and integration will enable hospitals to target and scale SDOH solutions.

“Looking at those six or seven [SDOH] factors hasn’t required big data. It’s just required an assessment and changing attitudes.”

Jacques Orces, Chief Medical Officer of the Miami Children’s Health Plan
Here’s how Rush University Medical Center gets from information to integration to action:

Data from the SDOH screening tool feeds directly into the EHR and combines with the patient’s medical history to create a more comprehensive patient profile. Evidence-based algorithms then analyze each profile in context with a database of external support resources to provide a “social services prescription” directly to the patient via email and/or text. The system alerts the social services providers, as well.

For example, along with instructions for follow-up and self-care, diabetic patients with SDOH barriers to meeting their nutritional needs might also get dietary guidance that can be met at a recommended food pantry.

Tracking the use and relevance of its program, BMC has screened more than 57,000 patients for SDOH, identified 28% with at least one need to address, and received requests for assistance from 19%. Going forward, collecting outcomes data will provide visibility into the program’s effectiveness.

Already reporting results, the Veterans Health Administration showed a 19% reduction in emergency department use and a 34.7% reduction in hospitalizations for patients enrolled in its Homeless Patient Aligned Care Team program over a six-month period.

Nonproviders are stepping in as disrupters to address social determinants. Optum, which is owned by UnitedHealthcare, developed and launched a social determinants program that drove a 52% reduction in the cost of care for targeted patients by identifying and assisting homeless veterans.

**How to Start Addressing SDOH at Your Hospital**

1. **Focus on prevalence and relevance.**

   What adverse social and economic factors are prevalent among your patients and are creating the greatest headwinds to improving outcomes for relevant health conditions? For example, approximately 1,374,000 people in Pennsylvania, or 12% of the adult population, have diabetes, and one in nine central Pennsylvanians struggles with hunger. Patients of the Geisinger Health System who are identified as having HbA1c levels greater than 8% and as being food insecure are given a referral by their primary care physicians for the Fresh Food Farmacy. Like Geisinger, start by focusing on a narrow set of social determinants most relevant to your service area and the health outcomes to improve. Use any lessons learned and savings to fuel the program’s expansion.

2. **Know your patients**

   Next, prioritize which determinants to track and the screening method that makes the most sense, given your resources. Cultivate the mindset that SDOH are vital signs like any others, monitored as standard operating procedure and integrated into clinical workflows. Combining clinical and SDOH data provides a more holistic view of your patients to help pinpoint the most draining determinants and to guide decisions that optimize your resources and improve patient care.

“If you’re going to fail, fail fast, and redirect and readjust. But if you are fearful that you’re going to fail, innovation will never take place. And if you fail to innovate, the organization suffers the consequences and dies.”

**Khosrow R. Shotorbani, MBA, MT (ASCP) Founder, CEO, Lab 2.0 Strategic Services**
3. **Turn information into actionable insight.**

All the information in the world means nothing if you can't get it into the right hands at the right time to drive the right actions. The success of SDOH initiatives depends on hospitals distributing information across the continuum of care. It's not enough for your technologists and data scientists to collect and present the information. Your medical director and his or her team must define and refine the clinical pathways to create value at the point of care.

4. **Create and cultivate partnerships.**

Collaboration with community partners can help address the social determinants outside of your direct influence. For example, health systems across the country have agreements with ride-sharing companies to bring patients to their providers for follow-up and preventive care. Other hospitals are helping members of minority groups with high rates of particular chronic illnesses by connecting with community leaders in churches and schools.

5. **Measure, analyze and adjust.**

The success of any journey depends on knowing your starting point, choosing a destination and knowing when to course-correct. Similarly, you can use historical data or a control group to establish a baseline and measure progress against it. With limited benchmarks available, you may face uncertainty when setting your initial goals. That's okay. Based on your best judgment, ensure that the goals are SMART (specific, measurable, attainable, realistic and time-bound). This enables you to create a process to capture the right performance measures and adjust your targets or program, as needed.

You might find that referrals for housing assistance may be most impactful on health costs for some conditions while addressing transportation needs may improve outcomes for others. You also may find that you're just not moving the needle and have to treat that small failure as a larger opportunity to course-correct.

6. **Embrace change.**

Addressing SDOH with scalable, consistent initiatives takes more than good planning and tools; it requires commitment, execution and culture change. Responding to SDOH starts at the top, but it will also require a bottom-up approach. Some hospitals are already putting in place C-level executives responsible for SDOH and population health initiatives. Ultimately, your hospital's success depends on inspiring doctors and other clinicians to make these initiatives part and parcel of how they care for patients. John Fox, MD, MHA, Associate Chief Medical Officer, Priority Health, offers a five-step approach for physician engagement:

a. Convince doctors that the initiative will improve patient outcomes and experience.

b. Pay them fairly for what you are asking them to do.

c. Get them home at 5:00 p.m.

d. Keep their staff happy.

e. Make them feel like they own the change.
Conclusion

Only by defining your health system to include the societal and lifestyle factors shaping your patients’ health will you be able to have more than a 20% influence on their outcomes. Leaders in this space have shown how to push the conventional boundaries of clinical care to effectively address powerful social determinants of health. Choosing the right tack into the headwinds of SDOH can accelerate your efforts to contain costs and improve patient outcomes. Hospital executives are poised to have more influence on SDOH than they realize. In some select cases, they already do.

SOURCES

8. Health care that includes meeting basic needs: Rush care providers prescribe and track non-medical services using high tech. Rush University Medical Center. Chicago, IL (May 23, 2018): https://www.rushu.rush.edu/news/health-care-includes-meeting-basic-needs.