Rural Focus

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Addressing the Social Determinants of Health as They Impact the Cost of Care

By Barry P. Ronan, President and CEO, Western Maryland Health System

Eight years ago, as the Western Maryland Health System transitioned from volume- to value-based care delivery, we anticipated challenges endemic to any new care model. Before this, I never would have imagined one of our first and most significant lessons: social determinants of health would be a critical component of keeping patients healthy and out of the hospital. By necessity, we became the safety net for our region.

As we realized the importance of addressing the social determinants of health, I advised the board of the potential impact on the organization, both financially and from a community health perspective. It supported our engagement but directed the health system's community advisory board to provide oversight in this area. In an effort to keep both boards informed, management reviews progress on all of the social determinants quarterly with the advisory board and twice annually with the governing board. Ongoing education on our key focus areas related to social determinants is also provided to both groups throughout the year.

Identifying Social Determinants of Health and Where to Focus

Several disparate methods were used to ascertain which social determinants were most affecting patient health outcomes: the region's community health needs assessment, overall health rankings for our service area, a series of forums with community partners, and direct interaction with our patients. A careful analysis of available input and data led us to prioritize the needs as follows:

1. Poverty
2. Food insecurity
3. Heart disease
4. Chronic obstructive pulmonary disease (COPD)
5. Diabetes
6. Access to care
7. Substance abuse

We then turned our attention to identifying target populations and locations. Immediately we focused on seniors, the uninsured, and those individuals who were dealing with substance abuse and mental health issues. An analysis of geographic target areas revealed six communities in our service area that were identified as true "hot spots." Hot spots are those areas with the greatest number of residents with chronic illness, multiple comorbidities, high admission and readmission rates, and repeat and unnecessary visits to the emergency department (many of which were related to non-compliance).

Key Board Takeaways

As hospitals and health systems expand their role in addressing the social determinants of health, the governing board should:

- Ensure that the organization's mission and values are being properly applied in addressing the social determinants of health for the area being served.
- Management should identify what social determinants are being targeted and what methodology was used for such determination.
- Understand the costs associated with addressing the social determinants and what the impact is on the total cost of care for the organization.
- Be aware of the many community partners that are assisting the organization.
- Establish an oversight process for the hospital or health system's role in addressing the social determinants of health.
- Determine the frequency of reporting on the continued progress in this area.

Making Improvements through Care Coordination and Community Programs

Investing in a number of highly specialized care coordinators (i.e., RNs and social workers) was

instrumental in addressing social determinants. These staff members, working in the emergency department, inpatient acute care, and observation prior to discharge, identify the needs of our most vulnerable patients. Highly specialized RN transitionists also address social determinants in congestive heart failure and diabetes, following chronically ill patients who may be at risk for readmission within 30 days. Prior to discharge, we have another group, our community health workers, who visit patients to arrange for appointments with their primary care physician, ensure that they have 30 days of medications at time of discharge, and to plan for transportation, if necessary. Transportation for this population can also be arranged for follow-up appointments after discharge.

These same high-risk patients with chronic diseases such as COPD, hypertension, diabetes, and congestive heart failure can receive follow-up care, treatment, and screening to determine what other social needs may be present. This care, treatment, education, and screening takes place in our Center for Clinical Resources where highly specialized staff comprised of a care team including nurse practitioners, registered nurses, respiratory therapists, doctors of pharmacy, dietitians, and navigators. To identify a patient's social determinants of health, the staff performs a 20-question self-sufficiency matrix and, where necessary, appropriate referrals are made to our many community health partners**.** These partners include the county health department, social service organizations, local charities, and the housing authority.

In our previously mentioned hot spots, we established clinics where a team including a nurse practitioner, licensed practical nurse, and a social worker work with high-risk patients or residents. The self-sufficiency matrix is used to screen for the social determinants of health, and arrange for referrals or visits with a primary care practitioner as needed. Individuals can also be enrolled in health insurance coverage through Medicaid and other potential insurers.

To better address the comprehensive care of our behavioral health patients, the health system has been focused on care coordination in conjunction with physician offices and clinics, as well as the social determinants of health for this population.

We have created many programs in our community to improve overall health. We partner with local schools to address obesity, lack of exercise, and unhealthy eating among students. Prizes are awarded to participating schools and students through the Healthy School Challenge. The health system has also brought the Bridges to Opportunity initiative to our region. This evidence-based program empowers individuals to address their poverty through a variety of means, and calls upon strong partnerships with the business community and community partners that are also engaged in addressing the social determinants of health.

One of the greatest needs that exists in our area is food insecurity. We take a very active role in ensuring that no one goes hungry in our region. We discharge high-risk diabetics with 14 days of food, at no charge, with an ongoing plan to obtain healthy meals at a nominal cost through our Food Farmacy. We have seven community gardens with orchards throughout the area for families who may not have access to fresh fruits and vegetables. We also supply the local food bank with extra fruits and vegetables from the gardens. Meals on Wheels has become a mainstay in our community for seniors and those at risk. We provide food to our at-risk children through a weekend backpack program during the school year and lunches at parks during the summer. On the Saturday before Thanksgiving, along with our community partners, we provide thousands who are in need with a traditional Thanksgiving meal. This meal has become a community-wide event with hundreds of volunteers involved in feeding thousands of our most vulnerable citizens. Beginning this summer, we will be bringing fresh foods by van into our pre-determined hot spots, as most of these areas have been determined to be food deserts.

Under Maryland's approach to payment reform, all Maryland hospitals transitioned from a fee-for-service payment model to a global budget model over the last eight years. This transition also resulted in a shift from volume to value. When the transition began, we started targeting patients with chronic illnesses, many of which had multiple comorbidities and numerous social needs**.**[1] In the first year under global budgeting, we had 1,972 patients accounting for $140 million of our costs. In 2014, the introduction of various population health initiatives with a focus on social determinants of

[1] To learn more about Western Maryland Health System's transition to value-based care delivery see Barry Ronan, "Redesigning Healthcare through Value-Based Care Delivery: Are You Ready?" *BoardRoom Press*, The Governance Institute, April 2015.

health triggered a significant drop in those numbers to 1,301 patients accounting for over $80 million of our costs. Today, that number has dropped to 834 patients accounting for $54 million of our costs—a total reduction of $86 million since 2010. By building a culture of health and collaborating to address the social determinants of health, we have dramatically reduced the cost of care, improved the overall health status of our community, improved our regional health rankings, and truly made a difference in the lives of many of our patients and residents throughout the region.

The Western Maryland Health System board continues to pledge its support in addressing the social determinants of health as the overall health status of the area has improved each of the last four years. The board recognizes that our work in addressing the social determinants of health has been an integral component in our region's health status success.

The Governance Institute thanks Barry P. Ronan, President and CEO of Western Maryland Health System, for contributing this article. He can be reached at bronan@wmhs.com.

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