Enhancing the Health of Every Community

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ASCENSION NURSING | Center of Excellence
“You do not have to be me in order for us to fight alongside each other. I do not have to be you to recognize that our wars are the same. What we must do is commit ourselves to some future that can include each other and to work toward that future with the particular strengths of our individual identities. And in order for us to do this, we must allow each other our differences at the same time we recognize our sameness.”

-Audre Lorde
Goals

- Get Informed
- Get Inspired
- Get Uncomfortable
- Get Activated
CommonSpirit Health

20 Million Patients Cared For Annually

18 CINs & 20,000 providers in 21 States

2.5 Million People Cared for Under Value Based Agreements (VBAs)

14 Billion in Total Managed Medical Spend under VBAs
We are a community of healers & leaders across the country committed to driving meaningful, measurable improvement in health and financial sustainability through excellence in value-based care.

Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Values

Compassion
Inclusion
Integrity
Excellence
Collaboration
Know What Affects Health

- 30% Health Behaviors
- 10% Physical Environment
- 20% Clinical Care
- 40% Socioeconomic Factors
Ready to Get Uncomfortable?

a comfort zone is a beautiful place but nothing ever grows there
High (red) values show neighborhoods with the highest disparities among the Social Determinants of Health.

http://tinyurl.com/SDH-Story-Map

Why Should We Care?
What if a 747 crashed every day in the U.S.?
Financial Imperative

Joint Center Health Policy Institute

Found between 2003 & 2006 combined costs of health inequalities and premature death in US were $1.24 trillion

Urban Institute

Projects $337 billion to be spent 2009-2018 on health care related disparities
Time to Get Inspired
The THRBM Universal Screening Model

- Integrate Community Health Workers/Advocates into primary care teams
- Integrate universal screening and referral for unmet social needs into clinic workflow
- Develop robust databases and engaged coalitions of trusted community resources
- Develop standards and methods for practices to conduct regular evaluation of the efficacy of screening, referral and navigation activities
  - to inform improvement within the clinic
  - to inform collaboration with community agencies outside clinic walls
Pioneer Communities

Active CMS Accountable Health Community award service area

Centura Health is a JOA with Trinity Health

MercyOne is a JOA with AdventHealth
## Screening

Over 70,000 screens completed to date

Overall, 1 in 5 patients screened indicate need

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last 12 months, were you worried that your food would run out before you got money to buy more?</td>
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<tr>
<td>Are you worried or concerned that in the next 2 months, you may not have stable housing that you own, rent, or stay in as a part of a household?</td>
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<tr>
<td>In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?</td>
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<tr>
<td>In the last 12 months, did you skip medications to save money?</td>
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<tr>
<td>In the past 12 months, has lack of transportation kept you from the doctor, work, or from meeting other needs?</td>
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<tr>
<td>Are you worried about your physical or emotional safety where you currently live?</td>
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<td></td>
</tr>
<tr>
<td>Do you ever need help reading medical materials?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would you like to receive help with any of these needs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are any of your needs urgent? For example: I don’t have food tonight, I don’t have a place to sleep tonight</td>
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</tbody>
</table>

To date, the most commonly identified needs are food insecurity, financial stress (skipping medications), and lack of transportation.

Originally, nearly half of patients with needs refused assistance; however, this proportion has decreased over time and more patients are engaging with CHWs.
Near Term Outcomes in Pioneer Clinics

- Screening and referral for unmet basic human needs is fully integrated into the clinical workflow in pioneer primary care practices.
- Improved patient awareness of and follow through on accessing resources over time.
- Improved local understanding of actual needs and collaboration to improve referral and support pathways.
- Effective sharing of aggregate health data and experiential findings to support dissemination of this model as a standard of care across CHI.
- Improved Performance Culture Assessments

For more information about the THRM: Elizabeth Evans, PhD (elizabethevans1@catholichealth.net)
Get Activated
Addressing Health Equity

- Establish a Health Outcomes Physician Enterprise Committee to establish and track performance on clinical health equity targets
- Establish an organizational Health Disparities Action Framework to support clinical leaders in achieving Health Equity goals
- Support Community Health in establishing a Health Anchor Institution Framework
- Ensure necessary staff, resources, and operational infrastructure to accelerate health equity progress
- Create health equity analytics platform to define enterprise, care division, and hospital-based health equity metrics
- Heighten health equity activity through push and pull reporting and hospital health equity dashboards
- Create quality improvement initiatives to address health disparity opportunities based on clinical dashboard
- Complete an internal assessment of PE needs and leverage existing programs to support employees
- Enhance employee health equity education opportunities and competencies
- Ensure language accessibility for patients across the enterprise
- Address needs of vulnerable patient populations
- Develop a strategy to recruit diverse providers to represent the patient populations we serve
- Standardize CommonSpirit Health’s REAL/SOGI data collection methodology across strategic combination partners
- Expand Social Determinants of Health assessment and referral infrastructure, education, and resources
- Identify and advance cross-sector collaborations and partnerships that promote Health Equity
- Support and enhance the healthy environment strategy across PE
- Create a social justice advocacy infrastructure to prepare employees and communities for actionable change that improve health outcomes
Health Equity and Data Standardization
REaL and SOGI Data Collection

- Race Ethnicity & Language; Sexual Orientation & Gender Identity
- Meet the needs of our diverse patient populations
- Collecting meaningful patient data and reviewing the data to identify inequities in the provision and utilization of health care
- Assess the impact of interventions to improve care for patients
- Key to success:
  - Develop equity scorecard to report on performance
  - Education and communication across the system
  - Consistent and accurate documentation in EMR
### Social Determinants of Health

#### Hunger Vital Signs
- **Within the past 12 months we worried whether our food would run out before we got money to buy more?**
  - Often
  - Sometimes
  - Never
- **Within the past 12 months the food we bought just didn’t last and we didn’t have money to get more?**
  - Often
  - Sometimes
  - Never

#### PREPARE

##### Personal Characteristics
- **What language are you most comfortable speaking?**
  - [Dropdown]
- **At any point in the past 2 years, has seasonal or migrant farm work been you or your family’s main source of income?**
  - Yes
  - No
  - I choose not to answer this question

##### Family & Home
- **What is your housing situation today?**
  - I have housing
  - I do not have housing
  - I choose not to answer this question
- **Are you worried about losing your housing?**
  - Yes
  - No
  - I choose not to answer this question
- **How many family members, including yourself, do you currently live with?**
  - [Dropdown]
Health Equity Operations
Docent Health Navigation Services

**What**
- **Docent Navigation Services:** Provide a comprehensive blanket of navigation services for maternity and orthopedic journeys
- **Scale Best Practices:** Enterprise collaboration to standardize and scale best best practices
- **Partner Locally:** Coordinate with local leadership and community resources to meet local market needs

**Why**
- Continue commitment to the patients and communities we serve and strengthen our services through health outcomes initiatives for the most vulnerable populations
- Reduction of health disparities through innovative technologies and approaches
- Partner with innovative companies and scale best practices

**Program Goals**
- Improved health equities across all patients
- Improved health and utilization outcomes
- Measure, learn, improve
- Address SDOH by connecting patients to resources

**How is Docent Health Supporting CommonSpirit Patients**

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Services</td>
<td>1,401</td>
</tr>
<tr>
<td>SDOH</td>
<td>799</td>
</tr>
<tr>
<td>Patient Preparation</td>
<td>598</td>
</tr>
</tbody>
</table>
Connected Community Network

Patient Journey

Community (CCN)
- Patient engages in community (work, school, resident area)
- Patient understands they're pregnant
- Patient connects to needed community resources (eg. food, utilities assistance)
- Patient enrolled in prenatal education classes and social support groups
- Patient calls 211 to find a ride to get to GC
- Patient returns to their community and entered into MCC/Gris and childcare assistance programs

Clinical (Docent)
- Screen patient for social needs
- Encourage patient to register for tours and prenatal education classes
- Educate patient on car seat installation and support
- Encourage selection of obstetrician before delivery
- Confirm OB/Exp/MD/Examination for delivery
- Delivery patient assessed for post discharge needs

For more information about CCN: Ji Im, (JI.Jim@DignityHealth.org)
Vulnerable Population Council

The overall goal of the Vulnerable Populations Council (VPC) is to set the strategy for CommonSpirit Health Vulnerable Populations and execute programming focused on health equity and taking care of our vulnerable populations. The VPC will serve in an *advisory capacity* and report to Physician Enterprise Senior Leadership.

The VPC will:
• Evaluate clinical and social analytics
• Leverage clinical evidence-based and community models
• Connect system resources
• Inform advocacy and policy platforms to better serve our vulnerable populations
• **Support system Health Equity Roadmap**

The VPC will leverage the knowledge and expertise of health system clinical and operational leaders to ensure a coordinated and comprehensive approach.
Transformative Strategy for Vulnerable Populations

Core Programs

**Physical Well-Being**
- Prevention
- Episodes
- Chronic Disease

**Behavioral Determinants**
- Mental Health
- Substance Use Disorders
- Resiliency

**Social Well-Being**
- Social Determinants
- Social Justice
- Community Health
PE Leaders:
• Please share any best practices with us
• Please identify clinical champions that represent our vulnerable populations
• Distribute Toolkits once received

COVID-19 Vaccination Hesitancy in Vulnerable Populations
Messaging Recommendations/Guidance

Goal: National studies, statistics, and real-time reports from the field, show that a disproportionate number of vulnerable populations/people of color (African American, Indigenous, Hispanic/Latino, and Asian populations) are expressing hesitancy towards COVID-19 vaccination. [COVID Collaborative] Proactive and culturally competent education and awareness is needed for our CommonSpirit Health (CSH) internal staff, providers, patients and communities we serve. What follows is a framework to support the larger, systemic CSH messaging and ensure alignment with what is occurring within the local markets.

Message: CSH will provide culturally competent, health literate, impactful messaging, driven by evidence-based medicine and inclusive of the lived experience of communities, in a multitude of channels to overcome historical distrust of the healthcare system, address barriers to obtaining the vaccination, and spread awareness in our communities.

The message(s) should be provider, patient and community facing and:• At the national, regional, and local level with consistent themes to ensure trust
• Engage community voices in crafting the message, utilizing their feedback, co-branding with trusted local partners
• Be tailored to diverse populations, generations, geographies, languages (i.e. common vernacular), culture (i.e. preserving a tribe’s language) data-driven, heart and mind focused.
• Acknowledge and validate topics of vaccine hesitancy, structural racism and historical trauma
• Align with existing campaigns, public health departments community, other health systems, and national organizations following federal guidelines

Messengers: It is crucial that we utilize various messengers to have the greatest impact and can related to their respective audience(s).

Messengers we should consider:
• Peer-to-peer networks
• Community based organizations, hospital partners and grantees of our funding programs
• Businesses
• Faith Community
• Elected officials/civic leaders/local advocates
• Informal leaders in communities
• Sports figures (leverage sponsorships, affiliated universities, and other relationships)
• Entertainment figures
• Providers within the respective populations (Physicians/APPs/Nurses/Social Workers)
• Medical and research leaders
• Have a campaign where an “influencer is convinced” and is spreading education and awareness.

Deliverables for dissemination: Emphasize importance of material being culturally nuanced and translated into multiple languages. Include a diversity of faces/stories/geographies in video, print and call campaigns.

• Prepare various ways to share (i.e. church, different generations, informal channels/social media, urban vs. rural) and encourage patient/community participation/engagement
• Patient testimonials
• Provider/leadership/partner testimonials
• Utilize existing Physician Enterprise toolkit
• Engage community partners, tribal clinics, FQHCs, local market advocates/influencers
• Peer to peer campaign, (i.e. HumanKindness, focused on CSH employees showing that they are getting vaccinated, create hashtags (i.e. #GotVaccinated))
• Dynamic messaging/toolkits that reflects changing and regional/state guidelines (CDC COVID-19 Vaccination Communication Toolkit)

Future State: CommonSpirit Health knows that the message is just the first step to widespread vaccination deployment, other factors to be considered:

• Reaching homeless and migrant populations
• Overcoming historical barriers (SDOH, structural racism, etc.)
• Equitable vaccine distribution
• Partnering with public venues for greater vaccine distribution
• Disseminate message(s) in service lines that have a high percentage of at-risk/vulnerable populations
• Support markets in these efforts
• Provider learning modules/resources to equip providers with the resources and knowledge they need to build trust and address vaccine hesitancy
• Identify national efforts can CSH contribute to and join?
• Leverage CSH communication channels to provide real time information on vaccine availability

CSH Population Health- I&P Facilitated Workgroup
01/22/2021
Communications Guidance Document

How to Use This Document

Framework for communicating about the COVID-19 vaccine with providers and patients (specifically tailored to patients of color).

https://commonspiritpophealth.org/population-health-initiaves/vaccine-information/
Health Equity Metrics of Success

How to we build health equity measurement into frameworks that already exist?

Quality Measures
Patient Safety
Patient Satisfaction
Employee Satisfaction
Leadership Goals
3 Takeaways

1. Poverty, unequal access to health care, lack of education, stigma, and racism are underlying, contributing factors of health inequities.

2. Important to look beyond behavioral factors and address underlying structural and institutional issues.

3. Silos need to be broken, it’s not just an issue for the healthcare field, it requires all sectors to be at the table, including patients and caregivers.
What Can You Do?

"Start where you are. Use what you have. Do what you can."

Arthur Ashe

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CommonSpirit