Oregon's Coordinated Care Model Summit:
Inspiring Health System Innovation
December 3-4, 2014
Portland, Oregon

Kelly Hall - The Will and the Way: Integrating Social Needs into Population Health Management

Good morning. Thank you so much for having me here today. You know the theme of this conference is inspiring health system innovation. So I thought it would be fun and interesting to start with talking about an innovator. How many of you recognize the man in this photograph? Anyone? Okay. So for those of you who don't know, that is Doctor Jack Geiger. In 1965, Doctor Geiger, along with a handful other physicians, went to the deep south with the intention of providing medical care to civil rights workers. When he got there, he was so struck by the desperate poverty and profound health needs of the local citizens that he stayed, ultimately opening the nation's first community health center in Mound Bayou, Mississippi.

As he started caring for his new patients in Mound Bayou, what Doctor Geiger quickly realized was that although they were coming to his office with any manner of clinical complaints, the real problem was that many of his patients were simply hungry. So he started writing prescriptions for food. Patients would take those prescriptions to a local grocery store and come out with a bag of groceries to feed their families and send the bill to the clinic's pharmacy. As you can imagine, it wasn't long before the government agency that was funding the clinic got wind of this heresy and sent down a functionary to put a stop to it. When confronted by this outraged bureaucrat who was appalled, appalled that government tax dollars that were intended for prescription drugs were instead going to things like milk and eggs; Doctor Geiger famously replied, "The last time I checked my medical textbook, the specific therapy for malnutrition was food."

These data show what was obvious to Doctor Geiger about fifty years ago. Only ten percent of health outcomes are actually driven by medical care. The remaining ninety percent are tied to personal behaviors, environmental and social factors. In other words, all the things that happen in patients' lives when they are not sitting at their doctor's offices. Frontline clinicians absolutely know this to be true. In a recent survey conducted by the Robert Wood Johnson Foundation, eighty-five percent of physicians surveyed said that patient's social needs are as important to address as their medical conditions. Arthur Gianelli, whom some of you may know is the recent CEO of Nassau University Medical Center in New York, said it best to us when he said, "I can pull every clinical care lever but I know that I'll never be able to deliver the health outcomes or the cost savings that the Centers for Medicare and Medicaid Services wants unless I can get my arms around the realities of my patients outside the walls of our clinic."

421 SW Oak, Suite 775 Portland, OR 97204
Phone: 971-673-3363
Email: Transformation.Center@state.or.us
www.transformationcenter.org

It seems like most people seem to agree that addressing social needs is the right thing to do. But if that's the case then why aren't we doing it? Let me offer some insights from the front lines. Eighty percent of the physicians in that same Robert Wood Johnson survey reported that they don't feel confident in their capacity to meet the social needs of their patients because they lack both the time and the knowledge to do so. Time after time as we go out into the world, we hear variations on the same explanation from clinicians and it sounds something like this. Every day I have patients who come into the clinic. The child has an asthma exacerbation and I prescribe a controller medicine. But the truth is I know there's no food at home. The truth is I know the family is living with twelve other people in a dilapidated mold-infested apartment. I don't even ask about these issues because I know there's nothing I can do. I have thirteen minutes with each patient and more of them piling up in the waiting room. In other words, when it comes to their patients' most basic needs, they essentially practice a Don't Ask Don't Tell policy. Then there's the flip side. If you don't ignore patient social needs you risk being consumed by them.

When we surveyed doctors at Bellevue Hospital in New York City, they reported spending an average of 9.2 minutes of every 15 minutes office visit on patient basic needs. That's obviously not a tenable solution at a time when the number of primary care physicians is declining and the demands on primary care practice are increasing. Still when we talk to health system leaders as well as frontline clinicians, nobody really disputes the importance of addressing patients' social needs. Yet the examples I just shared demonstrate why we're still a long way from doing it reliably and effectively. All of that suggests to me that we don't really have a problem with will; we have a problem with way. Health Leads was born of a desire to find a way. In the clinics where Health Leads operates, physicians can prescribe food, heat and other basic resources that their patients need to be healthy. Patients take those prescriptions to our desk in the clinic waiting room where our corps of well-trained student advocates fill those prescriptions by working side by side with the patients, doing weekly follow-up to access the existing landscape community resources.

Like Doctor Geiger, we started with the prescription pad and asked not what do patients need to get healthy, but what they need to be healthy, to not get sick in the first place. Our advocates in turn provide real-time updates to the rest of the clinic team on whether or not the patient got the resource. Providing valuable information that helps shape the care plan and also frankly providing valuable information back to us to help improve the program. We also armor advocates with a solid technology platform. When our advocates see patients, they enter their demographic information and resource needs into a web-based interface that automatically generates information regarding community resources near where the patients live and work. The best way I can describe it as like a really cool Yelp for community resources. We've been at this work for some time and we always know that we can be doing better, but we're pretty proud of our results.

Last year our corps of nearly a thousand volunteers worked to connect more than thirteen thousand patients and families to basic resources and twenty-two clinics across seven cities. Ninety-five percent of the patients with whom we work either secured a resource or identified Health Leads as equipping them to secure resources on their own. Seventy-one percent of our patient clients reported that they would recommend the clinic they are in because Health Leads is there. So let me pause and say, we believe that Health Leads offers a way but not the only way. That brings us back to innovation again.

421 SW Oak, Suite 775 Portland, OR 97204
Phone: 971-673-3363
Email: Transformation.Center@state.or.us
www.transformationcenter.org

Health Leads envisions a health care system that addresses all patients' needs as a standard part of quality care. Honestly we are humble enough to know that we are not going to achieve that vision by providing the world with more and more and more Health Leads. We see ourselves instead as a market catalyst as much as we see ourselves as a service vendor. Our goal is to transform the health care system so that the most creative, most forward-thinking people in the nation, people like you and all the people in Oregon who are doing the amazing work you're doing, are leading the way in thinking about new and better ways to do the critical work of addressing patients' most basic needs.

The great news is there are a lot of examples to learn from. At Boston Medical Center back where I live, they operate the nation's only hospital-based preventive food pantry and demonstration kitchen and also operate the medical-legal partnership which deploys legal services attorneys against wrongful food stamp denials and stubborn landlords. At Parkland Health and Hospital System, they're using predictive software that includes both clinical and social markers to identify patients at high risk for readmission and provide intensive case management. I'm sure many of you know that there's amazing work going on through the Vermont Blueprint for Health to connect patients to community resources. In Hennepin County, Minnesota, they're experimenting with the social ACL model that addresses the needs of some of the most complex patient populations. So to be honest, at Health Leads we don't view that as competition. We view that as absolutely great news. We are a mission-driven not-for-profit. So bluntly, we want you to build a better mousetrap. We need you to come up with solutions so smart and so slick that they motivate us to do better and motivate others to get in the game.

I'm going to go out on a limb here and say that precisely because you in this room are industry leaders, you have actually a unique responsibility to set the bar high and to demonstrate to the rest of the country what excellence in addressing social needs looks like. As you build or buy your own solutions, I challenge you to commit to addressing social needs with the same commitment to excellence that you bring to addressing clinical issues. Let me humbly offer some suggestions as to what excellence might mean.

The first commitment I'm going to ask you to make is to commit to real clinical integration. Let's be honest, the last time I checked, the population in population health management was not limited to patients at high risk for being high cost. It's a great place to start. That shouldn't be where you end. One way to make sure that it isn't is to ensure that whatever work you're doing to address social needs is embedded into your electronic health record. So that addressing patients' social needs becomes as intrinsic to care delivery as taking a blood pressure or ordering a cholesterol screening.

The second thing I'm going to ask you to commit to is developing a workforce that's truly focused on addressing social needs. To do this work well, there has to be a core group of people who come into work every day really jazzed about the idea of addressing patients' social needs. This can't be done on the margins and it can't be tacked on to an already busy job. You know, interestingly, when Health Leads started nearly twenty years ago, we built a volunteer work force. Frankly we didn't see an alternative. If we didn't believe it was possible to put responsibility for addressing social needs on the back of busy clinicians or overburdened social workers, we asked ourselves well then who the heck is going to do the work. One of the more exciting developments I think we've all seen over the past several

been growing acceptance of new workforces and particularly lay workforces in clinical practice. People like community health workers or health coaches and even well trained volunteers like our advocates. As this workforce has grown and become established, we started piloting new ways to offer our technology tools and training to empower them as well as social workers and case managers to do the work of connecting patients to social resources reliably and well. We're really anxious to see what that's going to do to enable transformation even more quickly.

The next thing I am going to ask you to do – you'll find I am very demanding, I have lots of requests – is to commit to giving that workforce the information they need to do their job well. What that really means is giving them an electronic searchable comprehensive resource database. You can't do this work reliably if your sole window into the resource landscape is one of those giant binders with lots of loose leaf pages and yellow stickies. The good news is there is a lot of experimentation going on in this space with everything from open source initiatives to for-profit businesses growing around the need to provide data regarding community resources. So you don't necessarily have to do it on your own.

I'm also going to ask you to commit to follow up. It really isn't good enough to hand an overburdened mother with a sick kid and daycare issues a map to the local food pantry and an application for SNAP. If you're going to do this work there has to be some level of follow-up to find out what actually happened. And to document what actually happened not only for the benefit of the patient but also to ensure that this workforce that you so lovingly developed and empowered with information is actually effective at doing what they need to do.

The last thing I'm going to ask you to do as you plunge into this world is to commit to collecting and analyzing data. The social needs space has been a remarkably, if not data free, at least data light zone. I think some of that is because so many of the initiatives in this area have been funded as special projects or one-time events. The truth is there hasn't been enough emphasis on data and evaluation to really make a solid case for this work. As people who understand the importance of it, we have to commit to collecting comprehensive data to show the impact on a variety of metrics of value from everything from clinical processing outcome, to provider satisfaction, and to for some what's the Holy Grail: utilization impact.

That's a pretty big list of commitments I'm asking you to make and I expect it feels pretty daunting. What we often hear when we are out in the world is, this is really hard. I get it. I spent twenty-two years working in health care systems so I know how challenging it is both to disrupt practice and frankly to disrupt our expectations. Hard is really different from unachievable and I'm optimistic. We are in the midst of a really unprecedented moment in health care. Financial incentives are finally starting to align to make this work possible, and frankly, desirable. Hospital community benefits dollars are starting to align away from sort of traditional free care pools to community health. Mandatory community health assessments are weaving together and alongside community health and health care universes. Most exciting of all, more than 20 million people now have health insurance who didn't. Although many of them are introducing complex social needs to the system. We all have both motive and opportunity to finally solve this. My biggest challenge to all of you, and to all of us, I should say, is to take full advantage at and do the best we can for our patients and for our communities. Thank you.

421 SW Oak, Suite 775 Portland, OR 97204
Phone: 971-673-3363
Email: Transformation.Center@state.or.us
www.transformationcenter.org