



EXECUTIVE DIALOGUE

SOCIAL DETERMINANTS OF HEALTH

Improving Employee and Community Health

PANELISTS



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Hospitals and health systems are doing their part to address social determinants of health when thinking about the patients and communities they serve.

An individual's ability to achieve his or her highest potential for health is influenced by more than just access to high-quality health care. Conditions in the environment in which people live and work affect health, well-being and quality of life. As health care organizations expand wellness programs to improve employee health, it's important to understand the impact of social determinants on the workforce, such as safe neighborhoods, education and access to healthy food. This executive dialogue examines the link between health behaviors and social determinants. It also explores ways organizations can address employee health by designing interventions around social determinants to connect both community and workplace health.

KEY FINDINGS

- 1 Understanding social determinants within the community can help hospitals and health systems, as well as other employers, address barriers to health and wellness in their employee population.
- 2 Physicians and patients often feel uncomfortable discussing social issues affecting their health. Dedicated health coaches and navigators can help to enhance engagement and understanding around social needs.
- 3 The return on investment for wellness programs goes beyond a reduction in the cost of benefits and improved health. A healthy workforce is engaged at work and with their physician – increasing overall satisfaction.

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MODERATOR (*Suzanna Hoppszallern, American Hospital Association*): **How are your organizations addressing the social determinants of health within both your communities and your employee population?**

SUSAN WATHEN (*Hannibal Regional Healthcare System*): Hannibal Regional Healthcare System is an independent system comprising one hospital and about 13 clinics. All of our clinics are in Missouri within about a 90-mile radius of Hannibal, which has a population of about 20,000. The immediate service area includes about 45,000 people, and we encourage our team members to be involved in the community. We provide health screening and support a free clinic in Hannibal by providing the building, and staffing a pharmacist, full-time nurse and office manager. It's helping to improve chronic care management and is cutting back unnecessary emergency department (ED) visits.

MODERATOR: **Are you screening for the social determinants of health in your outreach efforts?**

WATHEN: Yes, we are. Our social services team provides the screenings within the hospital. At the clinic, the nurse provides the screenings. She is passionate about this.

ALISA CULVERHOUSE (*Centura Health*): Centura Health is a 17-hospital system in Colorado and Kansas, and we have a few clinics in New Mexico. We received a Robert Wood

Johnson grant in 2017 to implement a new, innovative model for addressing the social determinants of health. We have deployed five community health advocates at our local clinics throughout Colorado. These community health advocates are using an assessment tool they developed to screen all patients at the clinics, which has been successful. The patients seem more willing to open up and engage with the advocates, more so than they would with their providers. The advocates are reporting positive patient interactions and are able to get to the root causes of the issues that our patients are experiencing. We are excited about this opportunity and we're looking to expand it.

On the employee side, we are self-insured. Our employees are screened for social determinants if their providers are part of a clinic. As we expand, the screenings will expand to our associates. We know that one in 10 Coloradans struggle with hunger and one in six Colorado children lack food stability. It's profound, and one of the biggest challenges we face. And, it is surprising to many because the state's economy has been strong, and they assume we don't have these issues. We are trying to change that by raising awareness. Some people are a paycheck or two away from not being able to pay for food or rent.

GREG MARAS (*Meadville Medical Center*): Meadville Medical Center is located in northwest Pennsylvania. Our main hospital

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is in Meadville, and we have a critical access hospital in Titusville, as well as several clinics. We have used patient data in the past to identify social determinants. Surprisingly, one of the main issues we have addressed revolves around dental health. We were seeing a great number of patients coming to the Emergency Department (ED) with complaints about mouth pain. We linked it to the fact that Meadville did not have fluoride in the water until just a few months ago, and

We have a care coordination team who work with discharged patients who are at high risk for readmission – individuals who may not fully understand how to manage their chronic care.

- Greg Maras
Meadville Medical Center



individuals without dental insurance were going to the ED for their dental problems. We worked with the local government and water authority to bring about this change. At one point, mouth pain was the leading cause for visits to the ED. On top of that, we partnered with Highmark Blue Cross Blue Shield to open a dental clinic to help the underserved in our com-

munity. Mouth pain is not even among the Top 10 reasons for ED visits now.

We also started a community care network (CCN) several years ago to help the organization transition to population health management. Through the network, we have a care coordination team who work with discharged patients who are at high risk for readmission – individuals who may not fully understand how to manage their chronic care. We've partnered with Allegheny College to provide internships to future health professionals who serve as health coaches in our CCN program. The coaches work with patients to make sure they have support to meet their goals. They also ensure that patients take their medications. It's helping to improve the overall health of our community. Another issue of focus is opioid and drug abuse awareness. Like many places across the country, our community is dealing with these issues, and we are trying to make a difference with this challenge. Finally, we've partnered with our local school system and Caring Cupboard, a local organization, to identify and assist families so that children have access to healthy foods and sundries, especially when school is not in session.

BRAD LAWSON (*Interactive Health*): Interactive Health began looking at social determinants a few years ago when we realized that the average employer we work with is a multi-location employer, often with a centralized human

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resources (HR) function that is unaware of what’s going on in the local community. From an analytics perspective, this was an opportunity to help our customers get a better sense of their communities, specifically around social determinants.

When we talk about social determinants of health, many people first think about the underserved population and Medicaid beneficiaries. But these determinants really impact all of us. Often, things like vocation, education and income help drive how communities look and what resources are available to support healthy lifestyles. We’re adding a new dimension to wellness programs so that employers can understand the culture of health in the communities in which they are located. For example, we have a large manufacturer headquartered in Michigan, but it has locations across the U.S., including Mississippi. They were struggling with their wellness program in this community. The data showed that the smoking rate in that county is 34% – twice the national average. In this case, smoking is accepted as a social norm. We are developing programmatic recommendations for the employer around services they should consider to address the smoking rate and other issues in the community that impede healthy lifestyles. We’ve found that even for an employer with one location, it’s still valuable to know in detail what’s going on in the community around them.

We work with a data analytics company and provide community profiles of more than 60 data points, including income



distribution and equity, cost of living, etc. An employer knows what it pays their employees, but often doesn’t take into account total family income and other important information. By looking at nutrition, we’re able to profile communities around things like the density of fast-food restaurants. It’s amazing that, in some parts of our country, the density of fast-food restaurants could be more than twice that of other locations. As you may suspect, a high density of fast-food restaurants is found in low-income areas where the average worker has high commute times and low availability of gro-

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cery stores that sell healthy foods. The result is higher obesity and diabetes rates due to poor nutrition and lack of physical activity. We break the data down into six categories: lifestyle, food and nutrition, physical activity, health care, mental health and finance.

Greg mentioned working with schools. The percentage of kids who receive free or reduced-price lunches is a measure of both financial health and family nutrition. The issue of opioid addiction and drug overdoses is another important indication of community health and wellness, and we are beginning to collect and share that data. Employees spend as much time outside of the work environment as they do inside, so it's important to know what's going on outside. If you are trying to create a culture of health, you have to know the context of where people live.

We are working with a large employer in Missouri. We found that while its employee-base was insured, they weren't using their health insurance in the best way. For example, they had a high ED utilization and the company was planning to change its benefits, increasing the co-pay for using the ED. We worked with the HR team and looked at the community data. One of the data elements is people's perception of their ability to use health care because of cost. When you break that down, it's often not the cost of care, it's the cost of seeking care. People work hourly jobs and are unwilling to take time off during the day to go to the doctor. They aren't concerned about the \$20 co-pay; they are concerned about the \$50-\$100 in lost wages and transportation costs. The ED becomes a solution to this problem. We work with them to increase access, bringing some services into the workplace so people don't have to leave. By focusing on the community-level data, we avoid

profiling individuals and privacy issues. And, we can make a greater impact on health and wellness.

MODERATOR: Several of you mentioned using community health workers to collect social determinants of health. Anecdotal, we hear that patients are less willing to open up to their physicians or other clinicians about social needs. **What are some strategies that you're using to break the barrier and have the conversation?**



Often, things like vocation, education and income help drive how communities look and what resources are available to support healthy lifestyles.

- Brad Lawson
Interactive Health



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CULVERHOUSE: That's a great question, and one we are trying to answer right now. It's a grassroots effort at this point because some physician populations are extremely resistant to having these conversations because of time. They already have a great deal on their plates. The community health advocates are trained and dedicated to going out and having these one-on-one, face-to-face conversations. We share the findings with our physicians. It has helped to shift the mindset of the organization. We don't know what's going on when they come through our doors. We can't continue to make assumptions. The same goes for our employees. We can't assume that things are OK because they work for us. We don't know if an employee's spouse is working, how many children they have and what their situation is, so it's really important for us to just take each individual one by one.

LAWSON: Hospital workers have a higher burden of illness. It's my perception that many are focused on caring for others and they overlook caring for themselves. And, some health care organizations may not realize that they need to stress health and wellness for their employees, because it's the basis for what they do.

WATHEN: I bring this up every two weeks during new-hire orientation. Caregivers often don't take care of themselves. That's my opening into talking about our internal wellness programs. We stress that their wellness is important to us.

MARAS: We look at our claims data to check whether our employees are getting yearly check-ups and mammograms. We're always well above our metrics for preventive services. Crawford County has a higher proportion of cancer than sur-

rounding areas. We don't yet know why, but we do. We have a cancer center and I believe that it has served as a reminder to our employees that preventive care is important. We find that spouses, particularly male spouses, are the ones who do not receive preventive services. That's the group we struggle with because they tend to be obese, have metabolic syndrome and are smokers. It's hard to get them to seek care.

LAWSON: No matter what state in the union, there are going to be ZIP codes and counties that have huge health disparities in access to health care and mental health services, food security, fitness and exercise facilities, etc. There's often a lifestyle factor that contributes to poor health and wellness, such as smoking. I was at a conference recently and Patrick Conway, M.D., pediatrician and former CEO of Blue Cross Blue Shield of North Carolina, spoke. He talked about a sick baby who had been brought to the office one day. They ran every test trying to figure out what was wrong. It turns out it was failure to thrive due to food insecurity. He made note of the fact that they probably spent \$30,000 in tests on that baby in one day, more than enough to feed that family for a year. Overall, North Carolina is a healthy state. But it is a rural state with a high percentage of children and families who go hungry. In every place we go, there are disparities that can be uncovered by data.

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- Susan Wathen
Hannibal Regional
Healthcare System



MODERATOR: As you address the need for caregivers to take care of themselves and drill down into the social determinants of health in your communities, **how do you balance privacy issues while still managing to address the underlying needs contributing to a poor state of health?**

WATHEN: It's difficult, and we probably have some gaps when it comes to asking our team members those questions. We do a lot in the community, but we are not as thorough with our staff. We have health coaches who work with team members

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who participate in our wellness program but do not meet their biometric goals. But it's optional. We can do more.

MARAS: About 70% of our employee base participates in our wellness program. The data we receive from our wellness program participation provides insight into some critical issues that we need to address. We also have health coaches who work with our employees to address health issues. We have struggled with diabetes, for example, and have for years. It's a difficult conversation to have, even with the coaches. How do you have that conversation with somebody who just isn't willing to deal with it? Of course, privacy is maintained. We don't know the names of the individuals, but we do have data to show that it's an ongoing problem. And we use the wellness program data, as well as our utilization review, to understand what services we should offer our employees, such as diabetes education. We offer monthly "Community Conversations," to which the community is invited to a wellness discussion around healthful foods and exercise, and we hope that our employees attend, as well. Smoking is another big issue for us. We don't have a huge smoking population, but those who do smoke, don't want to quit.

We don't hire anyone who tests positive for nicotine. It's hard, from a recruitment standpoint, but it's the right thing to do.

- Alisa Culverhouse
Centura Health



On a positive note, we are beginning to see some improvement in our metrics for diabetes. It means that our employees are trying to make lifestyle changes. But there are still many folks who haven't been able to make that change. We are a smoke-free campus, but people always find a way around it. I recently received an email from a community partner stating that our employees were smoking in a parking lot of a neighboring business and would like for that to stop. Smoking is still prevalent in western Pennsylvania.

WATHEN: Our community health needs assessment shows that, as a community, we have a higher smoking rate than even the state benchmarks.

LAWSON: Do any of your organizations test for nicotine?

CULVERHOUSE: Yes, we do. And we don't hire anyone who tests positive for nicotine. It's hard, from a recruitment standpoint, but it's the right thing to do.

WATHEN: We also screen for nicotine. If an employee tests positive, he or she pays more for health insurance. We will hire someone who tests positive for nicotine. If we didn't, we would have a difficult time filling some of our positions.

LAWSON: This is one of these issues that still shocks me when we profile communities. About 17% of the population smokes, but there are regions where the rate is much higher. Here's another example of where culture and social norms play an important role. When we look at the data on the number of people who self-report that they avoid receiving care, we find that just having health insurance isn't enough to get them to the doctor. There's a cultural issue at play. They don't believe they need to go to the doctor unless something is broken and bleeding. They avoid care, even when they've been diagnosed with a chronic condition like type 2 diabetes. Type 2 diabetes patients can, for the most part, go for a while before it becomes critical. As employers, you are impacted by these social norms and that's what we're trying to uncover. What are the cultural norms around health in the community and what are the disparities? If the population is obese, and there is a high density of fast-food restaurants, then you need to do something about nutrition. You could have an on-site farmers market, for example, and provide more healthful options in the cafeteria.

MARAS: One of the challenges we've faced is making sure that information that we gain from participation in our wellness program gets to the employee's primary care providers. We get a good deal of information and it was going nowhere. We now have contact information for all primary care physicians (PCPs) in our area. When employees participate in the program, with their permission, we fax the findings to their PCPs.

CULVERHOUSE: For our wellness program, employees have to go to their own PCP for their biometrics.

LAWSON: Are most of you tracking how many of your employees have a PCP or, in some cases, an OB-GYN relationship?

WATHEN: Yes, we do, and the number is high. We made a change last year in our wellness program. The biometrics are

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done by our health team and internal lab. But employees must make a follow-up appointment with a PCP afterward to get the screening results. When we started this, some employees didn't have a PCP, but that changed. And we know anecdotally that the follow-up visits have identified a few serious health conditions that needed immediate attention.

MODERATOR: Susan, were you able to share that with your broader employee population? I know privacy is a concern, but sharing that may be powerful.

WATHEN: Yes, we did share those stories without revealing names. They are success stories.

MODERATOR: Alisa, what kinds of results are you seeing with your employee population?

CULVERHOUSE: We have similar success stories. But one of the challenges we face is that some people are still willing to skip the biometrics and pay more for insurance. It's unfortunate, especially when some cannot really afford to pay more. We continue to encourage participation and try to find ways to engage employees who choose not to participate.

MODERATOR: Do you think they're worried about confidentiality and privacy?

CULVERHOUSE: I believe some are afraid. When we became a smoke-free campus and stopped hiring smokers, there was pushback. We've focused on educating people on how it impacts their health and productivity. We didn't terminate employees who smoked. We couldn't, legally. But we have offered smoking-cessation programs and other resources to encourage them to quit.

MODERATOR: Did any issues emerge that surprised you or that were troublesome in terms of moving toward a greater health awareness? For those who are reluctant to get care, is smoking the major one? Are there other challenges?

MARAS: Addressing behavioral health issues is a challenge. We screen for behavioral health issues through our voluntary, online self-assessment. We work in a high-stress environment, and stress can adversely affect physical health, among other things. We are focusing on the whole person – his or her physical, mental and financial health, etc. We know that having a chronic illness affects the individual and family dynamic as well as work performance.

MODERATOR: Given the sensitivities of mental health issues, along with privacy and confidentiality, how are you educating employees about what's available to them if they need these services?

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CULVERHOUSE: We address it through our employee assistance program (EAP).

MARAS: We do, as well.

CULVERHOUSE: Through the self-assessment, we are able to see the percentage of employees who report mental health issues. We try to connect folks with appropriate services. It's all confidential, of course. We're looking at how we can provide more assistance.

LAWSON: We are seeing employers do direct outreach, via a health coach, if they give an indication of having a behavioral health issue. The feedback has been positive. It's tough, though, because of the stigma that still surrounds behavioral health issues. People don't want to discuss or acknowledge it. But there is growing recognition that you can't separate physical and emotional health. As we address social determinants, we look at behavioral health and related community issues like high crime rates, excessive alcohol consumption and drug overdoses. Poor access to behavioral health resources exacerbates the problem. The EAP is a valuable service, but it's passive. We need to be more proactive in addressing behavioral health issues.

One large employer with whom we are working conducts follow-up calls with employees who report behavioral health concerns. Instead of telling them to call the EAP, the EAP is part of the initial phone conversation between the employee and the health coach. It gets them engaged. They make the connection and start the process. Many employers with whom we work report that their behavioral health utilization rates are low. The PCPs are writing the prescriptions, and there are concerns that employees aren't receiving the right kind of care. We can't treat this as a passive issue anymore. If it's left to the employee to initiate the conversation, it likely won't happen. There are some who won't answer the phone calls. They won't participate. But the majority will, and it's a benefit for everyone involved.

One of the challenges is lack of access to behavioral health services within the community. That's occurring across the country. Telepsychiatry services are helping to ensure access to the necessary care. Again, behavioral health issues have a big impact. It's not just chronic depression or anxiety. Employees may be going through divorce, financial stress, or a death in the family. That impacts overall health and well-being and it impacts work performance. Many people suffering from chronic condi-

tions often have underlying behavioral illness, which can impact compliance. They may not be able to follow care plans. It's a good starting point to address some of these challenges.

MODERATOR: How are you measuring the effectiveness of these programs and interventions?

MARAS: One of the metrics we look at is our utilization rate. Our utilization rate and our health insurance costs have been flat for the last four or five years.

WATHEN: We look at the cost of claims per person, as well as the biometric screening results. Is our wellness program improving outcomes from high risk to medium risk, or going the other direction?

MARAS: When we conduct our engagement survey, we ask about satisfaction with benefits. More than 90% responded positively until last year when we increased the deductibles and some co-pays. You know, those are the things that kicked that back. Our costs have remained flat, and if they would look at the cost of their health insurance compared to that of other organizations, they would see that they have great coverage. One reason our costs have been flat is because of our wellness program. Those who participate are becoming healthier and our participation rates continue to rise. That's good stuff.

LAWSON: One of the challenges in our industry is misinformation. There was a Journal of the American Medical Association study published this year that followed employees at one company for one and a half years. The study found no significant changes in health for participants over the time period nor did it find a significant change in health care costs. But when we are working with individuals with chronic conditions, it takes more time to move the needle. The program referenced in the study was pretty basic. Several of you have discussed how difficult it is for certain populations to make the changes necessary to improve their health. It's not an overnight thing. It's a multiyear investment. Greg was talking about the challenges of addressing employees with diabetes. Each year, they are building on their efforts and finding new ways to reach employees and educate them. The value of a healthy workforce goes way beyond a reduction in health care costs. A healthy employee is an engaged employee. A healthy workforce positively impacts real business metrics for an organization.



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