Moving Upstream

Hospitals’ Strategic Shifts to Advance Community Health

BY: ERIN LANAHAN, MBA
Shifting from “Health Care” to “Health”

Many hospitals are expanding their vision from providing outstanding quality care of sick patients to promoting community health and individual wellbeing. Perhaps this is because, as an oft-cited statistic estimates, eighty percent of health outcomes are attributable to factors other than clinical care—such as social and economic status, physical environment, and health behaviors.¹

Hospital leaders, clinicians, and staff at all levels recognize the negative impact that patients’ unmet social needs have on their health outcomes. As healthcare finances move from fee-for-service reimbursement to value-based care, hospitals are considering how to address patient needs such as housing and food security. Provider organizations are using a host of tactics to grow their partnerships with community-based organizations, including outbound grantmaking to strengthen capacity. At the same time, hospitals are tapping into new revenue sources to support their expanded efforts, including individual and foundation philanthropy and new payer initiatives. Regardless of how programs are funded, meeting patients’ health-related social needs requires consistent screening, data capture, and high-functioning referral loops.

Webinar Series:

Find out the industry trends driving hospitals to address social determinants of health and explore how health systems are shifting their strategy and partnerships to meet these needs.

Learn more

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Hospital executives must carefully define their scope

Many hospital executives use the term “social determinants of health” when they are actually referring to social risk factors or health-related social needs (HRSNs). Using appropriate terminology is critically important, because strategies to inflect social determinants of health differ from those addressing individual social risk factors. For example, hospitals truly committed to improving social determinants of health must incorporate advocacy efforts to tackle structural inequalities.

Despite spending more of its GDP on health than any other nation, U.S. healthcare has worse health outcomes than those of its peers

Many Americans face persistent poverty, unemployment, housing insecurity, hunger, violence, and other ills. These unmet needs and systemic oppression take a significant toll on individual health—and that impact is witnessed by hospitals on many levels. On a national scale, U.S. healthcare spending has grown to $3.6 trillion (2018) and is projected to rise to an astounding $6.2 trillion in 2026. Yet, the United States ranks last when its health outcomes are compared to those of peer nations. Although the U.S. spends more on health care as a share of the economy than

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**Fig. 1: Terminology Relating to Social Determinants, Risk Factors, and Needs**

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Can be positive or negative.

Social risk factors are the adverse conditions associated with poor health (e.g., food insecurity, housing instability).

Social needs are the specific challenges that must be met by an individual.

other OECD nations, it has the lowest life expectancy and highest suicide rates. It also has the highest chronic disease burden, greatest number of hospitalizations from preventable causes, and highest rate of avoidable deaths.

“Health in the United States is often, though not invariably, patterned strongly along both socioeconomic and racial/ethnic lines, suggesting links between hierarchies of social advantage and health.”

- Professor Paula Braverman,

In other words, patients of color and low-income patients are more likely to experience adverse health outcomes. Other groups, such as LGBTQ+ persons, also experience bias that affects their health care experience and outcomes. Additionally, persons of color are more likely to confront poverty than white people.

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**Fig. 2: Social Determinants of Health (Kaiser Family Foundation Frame)**

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
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<tr>
<td>✓ Employment</td>
<td>✓ Housing</td>
<td>✓ Literacy</td>
<td>✓ Hunger</td>
<td>✓ Social integration</td>
<td>✓ Health coverage</td>
</tr>
<tr>
<td>✓ Income</td>
<td>✓ Transportation</td>
<td>✓ Language</td>
<td>✓ Access to healthy options</td>
<td>✓ Provider availability</td>
<td></td>
</tr>
<tr>
<td>✓ Expenses</td>
<td>✓ Safety</td>
<td>✓ Early childhood education</td>
<td>✓ Support systems</td>
<td></td>
<td></td>
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<tr>
<td>✓ Debt</td>
<td>✓ Parks Playgrounds</td>
<td>✓ Vocational training</td>
<td>✓ Community engagement</td>
<td></td>
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<td>✓ Medical bills</td>
<td>✓ Walkability</td>
<td>✓ Higher education</td>
<td>✓ Discrimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Support</td>
<td>✓ Zip code/ geography</td>
<td></td>
<td>✓ Stress</td>
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</tbody>
</table>

**Health Outcomes: Mortality, morbidity, life expectancy, health care expenditures, health status, functional limitations**

Low-income Americans and communities of color experience more social concerns and worse health outcomes

• Health-related social needs are pervasive. In a 2019 Kaiser Permanente-commissioned study of 1,006 U.S. adults, 68% of individuals report unmet social needs, including food security (48%), meaningful relationships (44%), transportation (26%), and housing stability (21%). While individuals across all incomes report some concerns, the incidence of serious issues increases as income levels fall.

• Communities of color are especially vulnerable. This disconnect is being driven by unmet social needs and structural inequalities, including systemic racism. For years, these disparities and attendant structural discrimination have translated into unmet health-related social needs and quietly devastating health outcomes. See sidebar.

• Unmet health-related social needs lead to worse health outcomes. In a recent HMS study, individuals reporting concerns about necessities such as food, shelter, and safety were five times more likely to report having poor health.

• Failure to address nonclinical needs undermines effective medical treatment. Time and again, studies demonstrate the link between social risk factors and poor health outcomes, including readmission rates and post-discharge mortality. In a 2014 study, Medicare patients living in high-poverty neighborhoods were 24% more likely to be readmitted after care. In a separate study, having even one of a number of social risk factors almost tripled the risk of 90-day mortality after hospital admission for heart failure. As hospitals move to value-based care, they cannot afford to rely on clinical care alone.

DEVASTATING COVID-19 RATES DRAW NEW ATTENTION TO LONGSTANDING RACIAL HEALTH DISPARITIES

The outsized impact of COVID-19 on communities of color has increased the visibility of health disparities and urgency of remedying them. According to CDC data published in a July 5th New York Times article, African-American and Latinx U.S. residents are three times more likely to become infected with COVID-19 as their white counterparts, and twice as likely to die from the virus.

Although COVID-19 represents an urgent and outsized threat, Black and brown patients have long experienced greater incidence of many chronic conditions and greater mortality from those conditions and other health issues. Persons of color are also less likely to have insurance coverage than white people.

• Black maternal mortality: Data from the Center for Disease Control show that Black mothers die at three to four times the rate of white mothers. Black women are also three to four times more likely to die of the five most common medical complications than their white counterparts. Black women are also more likely to die of cervical cancer and heart disease than white women (71% and 22% respectively).

• The gap between black and white mortality rates from heart disease, breast cancer, and stroke increased from 1990-2005, although the overall mortality rates declined.

• Diagnosis and death rates for individuals with HIV decreased for all U.S. teens and adults between 2013 and 2016, but death rates for Black and Hispanic teens remained higher than that of white people.

• Asthma and diabetes are more prevalent among Black, American Indians, and Alaska Natives than whites.
Industry Trends Pushing Hospitals to Address Social Risk Factors

Recently, executives at many commercial insurance plans have indicated interest in addressing social determinants of health. Trends in commercial and government payer contracts, philanthropy funding, and health technology are also contributing to the case for a broadened health mandate.

Increase in value-based care arrangements incentivizes hospitals to address social risk factors

More hospitals are entering value-based payment arrangements that prioritize their ability to improve health outcomes and patient satisfaction while controlling or lowering costs. A 2018 analysis of most covered U.S. lives linked 36% of healthcare payments to alternative payment models, up 23% from 2015. These APMs include shared savings, shared risk, bundled payments, and population-based payments.

A 2018 McKinsey analysis estimates that by taking greater advantage of existing value-based care programs, most providers can improve their EBITDA, frequently by at least 20 percent. To succeed in such value-based care arrangements, hospitals must overcome many of the same barriers that stand in the way of addressing patients’ social needs:

- lack of coordination and transparency between different departments
- complex program economics that require lengthy time horizons to realize value
- need to participate in multiple programs with different structures
- clinician alignment

MORE PATIENTS EXPECTED UNDER VALUE-BASED ARRANGEMENTS

McKinsey and other organizations estimate that a greater share of patient lives will be covered by government payers in the next two years. This and other market forces—fragmented provider landscapes in some geographies, large employers seeking direct healthcare relationships—will induce hospitals to assume more risk. Medicaid will continue to grow—projected to become a $1 trillion program covering 82 million beneficiaries by 2026. Its ballooning size will only increase the imperative for cost containment, including value-based arrangements.

Financial success in value-based programs require improving the very outcomes that are affected by unmet social needs.
Both Medicare and Medicaid programs have added value-based components that penalize negative outcomes. For example, the Centers for Medicare & Medicaid Services (CMS) Hospital Readmissions Program (HRRP) covers multiple conditions like chronic obstructive pulmonary disease (COPD) and provides a penalty of up to 3% for all diagnosis-related groupings. Conditions like COPD are more prevalent among lower-income populations, who also experience faster disease progression and worse outcomes. In FY2020, approximately 2500 hospitals faced $563 million in penalties relating to this program alone, with an average penalty of 0.71%. This is only one of three mandatory pay-for-performance (P4P) programs under Medicare’s inpatient prospective payment system (IPPS).

In addition, nearly all U.S. states have developed value-based care initiatives, most of them multi-payer efforts.

- Seventy percent of states have a CMS State Innovation Model (SIM) grant including multi-payer reform efforts.
- Medicaid programs in twenty-two states use or are considering accountable care organizations to manage costs and deliver better care.
- In the 39 states with managed care organizations (MCOs), most Medicaid beneficiaries are in an MCO; 27 states encourage or require MCOs to tie contract provisions to alternative payment methodologies. Additionally, these states encourage or require MCOs to screen enrollees for social needs.

**Government programs are expanding to cover social needs**

Increasingly, government programs are also directly incorporating measures and programs relating to patients’ social risk factors and social determinants of health. These provide additional funding or funding flexibility for hospitals to create programs to address social risk factors.

- Medicaid: State agencies are increasingly looking at social determinants of health, particularly within state managed care contracts. Several demonstrations focus on enhancing care coordination and community partnerships to address SDOH. Some include SDOH in the context of new or emerging value-based payment initiatives.
- In April 2019, CMS expanded the scope of Medicare Advantage supplemental benefits to “include services that diagnose, prevent or improve health conditions, or reduce the use of emergency care.” These could include transportation to medical appointments or improving ADA accessibility in a patient’s home.
- Some states (such as New York and Indiana) have created state offices dedicated to SDOH.
Commercial payers are also adding SDOH considerations
Recently, executives at many commercial insurance plans have indicated interest in addressing social determinants of health19. Much like their hospital counterparts, payers are tackling disparities through direct services, partnerships with community-based organizations, and mining data to identify at-risk patients20. According to a recent survey by Change Healthcare, payers are incorporating community programs into their population health programs (42%) and integrating census, socioeconomic data, and clinical data (34%)21.

More payers are also joining forces to address social risk factors, such as the Aligning for Health Coalition and America’s Health Insurance Plans’ Project Link. Many payers are deploying grant programs to experiment with interventions to address health-related social needs.

- In 2020, the Humana Foundation announced plans to invest $7.6 million in eight communities, including $1 million in two New Orleans-based organizations addressing social risk factors
- In 2017, L.A. Care Health Plan made a five-year, $20 million investment in an initiative to secure permanent supportive housing for homeless individuals in Los Angeles County22.

Payers find that partnerships with community-based programs can lower utilization and spending
A 2016 Robert Wood Johnson Foundation (RWJF) study found that a payer program referring 33,000 people to 106,000 community-based programs and services resulted in23:

✓ 17 percent decrease in emergency department use
✓ 26% decrease in emergency spending
✓ 23% decrease in outpatient spending
✓ 53% decrease in inpatient spending

Individual donors and foundations are supporting whole-person care efforts
Grantmaking foundations with an interest in improved health outcomes are expanding their giving beyond direct health care providers like hospitals and community clinics. Organizations such as the Robert Wood Johnson Foundation and the Kresge Foundation have made SDOH the centerpiece of programs like the Culture of Health. The U.S.’s approximately 250 health conversion foundations, such as The California Endowment, the Colorado Health Foundation, and Vitalyst Health Foundation, are centering their giving on projects addressing the root causes of health improvement24.
Foundations are also providing important data to help hospitals, payers, and government agencies measure community need and intervention impact, such as RWJF’s annual County Health Rankings and Roadmaps. Many funders have demonstrated interest in supporting coalitions or partnerships between healthcare providers and community-based organizations. The rigorous evaluation methods used by some funders serve as further impetus to hospitals’ community-based programs to adopt more disciplined and outcomes-focused approaches.

As observed by Accordant Health Principal Consultant Amy Dorrill, FAHP, CFRE, individual major donors can also be excellent partners in supporting population health efforts. The most sizeable gifts to healthcare have always been predicated upon a larger vision—for example, an ambition to eradicate cancer. Burgeoning partnerships between hospitals and community-based organizations can actually draw in donors with giving interests that have historically lain outside the hospitals’ four walls, such as stable housing or secure food.

**Digital health’s as-yet unmet promise for underserved populations**

Hospital executives have also observed an explosion of digital products promising increased engagement with patients in their own care, as well as real-time monitoring to allow clinicians to intervene earlier. However, too often, these products disproportionately benefit individuals of higher socioeconomic status (SES), who are typically earlier to adopt them. Few products—even those aiming to reach underserved populations—incorporate perspective from low-income communities or communities of color. In their current state, these products risk exacerbating existing health disparities.
Hospitals Working More Expansively To Address Risk Factors, Improve Health Outcomes

There is a large opportunity for hospitals to better meet their mission while improving their sustainability through a better margin. Many hospitals are expanding their vision of themselves and their partners; these organizations are more often identifying and addressing social risk factors of individuals patients and determinants of health for broader communities.

MOST COMMON HOSPITAL TACTICS FOR ADDRESSING SOCIAL RISK FACTORS OR SOCIAL DETERMINANTS OF HEALTH

- **Screening patients for health-related social needs.** Hospitals engaging in multiple value-based care arrangements are more likely to screen patients for social risk factors.
- **Incorporating health-related social needs into their CHNAs.** The Affordable Care Act outlines more mandates relating to assessing and addressing community health needs.
- **Capturing health-related social needs in EMRs.** This is most often noted in free text fields; though specialized ICD-10 Z codes exist, few clinicians deploy them to date.
- **Coordinating among hospital teams and departments to offer improved care of the whole patient, particularly for patients requiring complex care.**
- **Establishing or expanding partnerships with community-based organizations (CBOs), government entities, payers, funders, and others to address complex broader needs.** Successful hospital-CBO partnerships allow organizations to build on complementary skill sets and tackle structural disparities.
- **Increase direct investment (including grantmaking).** As the Affordable Care Act and Medicaid expansion resulted in more covered lives, most hospitals have seen declines in charity care spending. This is one factor spurring organizations to consider effective, highly visible ways to support their communities.
- **Referring patients to community-based resources to address needs such as housing, food, transportation.** Increasingly, hospitals are using electronic tools to identify resources and make referrals. The UCSF Social Interventions Research & Evaluation Network (SIREN) has published a guide of such platforms.
- **Offering hospital-based programs to change knowledge, attitudes, and behaviors of patients and community members and promote healthy lifestyles.**
- **Offering direct resources such as transportation vouchers.**
Some hospitals are considering new approaches to truly effect change
A subset of major health systems are moving beyond this list to more fully leverage their role as community anchors. In thinking about positively inflecting their community, they are considering the following three levers:

1. Hiring
2. Sourcing
3. Investing

A recent Health Affairs analysis found approximately $2.5 billion in hospitals’ public commitments towards directly addressing social determinants of health such as housing, food security, and job training (from 2017-2019). These investments included grants to community agencies, reallocating existing spending to focus on local hiring/contracting programs, and investments that would address social needs while generating return (e.g., constructing affordable housing units).

Different teams and different tools for addressing patients’ social needs
Several hospital teams have a role in addressing upstream factors to improve patient outcomes. Two of the most central—and disparate—are population health management and community benefit. Although these teams work with some of the same patients, they frame their goals in distinct ways and use different tools to achieve them.

THE ROLE OF POPULATION MANAGEMENT
Population health management is a framework for achieving reduced costs, improved quality, and better patient experience. Typically, population health managers use three categories of tactics to meet these goals: increased prevention, improved quality and patient safety, and better care coordination. Their team includes clinicians, contracting, quality improvement, and others.

The population health manager asks, “how can I achieve the best outcomes and highest patient satisfaction for the most efficient cost?” Population health managers often deploy big data analytics to define patient cohorts, stratify members by risk, create interventions for specific groups, and report on outcomes. They have a clear linkage to the business case for the hospital as well as its quality imperative.

THE ROLE OF COMMUNITY BENEFIT
Community benefit focuses on the role of the hospital in meeting its mission, particularly within the geography, history, organizations, and traditions in which the hospital or health system is situated. Community benefit managers conduct regular research into surrounding geographies, known as community health needs assessments (CHNAs), and create plans to address specific pain points. Community benefit teams are key to a hospital living its mission and being more than a “good neighbor.” Increasingly, they are being called to help hospitals control costs and improve outcomes.
Historically, hospitals have tackled community health issues through direct services such as mobile health vans, health education fairs, and school-based wellness programs. Many hospitals have offered philanthropic sponsorships for fundraising events of local nonprofits. Across the healthcare industry, community benefit teams are applying increased rigor to their community work and adding new tactics to improve community health. These approaches include additional investments in capacity-building of essential local community-based organizations such as homeless shelters and federally qualified health centers, often through grantmaking programs. Hospitals are also deepening their partnerships with local nonprofits and government agencies.

As community benefit teams develop metrics to determine the effectiveness of their interventions, their tools—dashboards, surveys—increasingly resemble those of population health. Leading-edge hospitals are expanding their vision statements to include elevating the health of their communities. Community benefit managers retain their responsibilities to create and maintain flourishing relationships with local nonprofits.

**THE ROLE OF DEVELOPMENT**

For hospitals to be maximally effective in addressing social risk factors and social determinants of health, they need consistent funds to support their efforts. Philanthropy is essential in allowing hospitals to realize their expanded vision. Just as gift officers have historically met with clinical leaders to determine strategic campaign priorities and flesh out the case for support, they should now include community benefit and population health managers in their efforts. Gift officers must understand the specific populations, interventions, and partners that their organizations are working with to address social risk factors and community needs. Gift officers should also cultivate community health champions.

In addition to the teams creating the strategies to address population health, it is important to consider which hospital staff are tasked with meeting patients’ health-related social needs on a day-to-day basis. A recent Deloitte survey of 284 hospitals found that hospitals overwhelmingly rely on nurses (88%) to address patients’ social needs. Yet, effectively addressing health-related social needs often requires a team-based approach—and incorporate partners throughout and outside of the hospitals’ four walls. This disconnect between ambition and day-to-day operationalization is a major factor in preventing hospitals from realizing their community health goals. Clearly, community benefit and population health teams have distinct and complementary skills and resources; unfortunately, these groups rarely unlock these powerful synergies because each too often operates in its own domain.

**QUESTIONS DEVELOPMENT STAFF SHOULD ASK WHEN MEETING WITH COMMUNITY BENEFIT AND POPULATION HEALTH**

**How will this intervention ...**

... better the patient experience for all individuals?

... help our organization meet the needs of the most vulnerable?

... help contain healthcare costs?

... incorporate partner efforts and leverage existing community coalitions?

... meaningfully include the perspectives of patients being served?

... improve healthcare outcomes? What specific measures are being used (quality measures, readmission rates, etc)?

... align with our existing institutional priorities and areas of excellence?

... address community needs?
MOST HOSPITALS ARE FOCUSING ON SUBSETS OF THE POPULATION

When crafting strategies to address patients’ health-related social needs, one of the most challenging issues hospitals must address is determining which patient populations will receive special focus. Sometimes, there is a disconnect between the business and community benefit sides of the house. CHNAs typically uncover needs across large geographic areas, including primary and secondary service areas, but few (if any) hospitals have the resources to address issues at this scale—especially if tackling them alone. As a result, the size of the ultimate intervention is often on the order of a few dozen patients or community members, while the needs may affect tens or hundreds of thousands across the hospital’s service area. Measuring the impact of interventions is also impossible without carefully defining the target population.

Most hospitals focus their interventions and efforts on one of more of the following groups:

- **Patients with complex care needs:** Sometimes referred to as “high utilizers” or “super utilizers,” these patients repeatedly cycle through multiple healthcare, social services, and other systems without sustained improvement. Health expenditure data has suggested that 1% of patients account for 23% of total health expenditures and that half of all health expenditures are attributable to just 5% of patients. These patients typically have both multiple clinical comorbidities (including behavioral health issues) and social risk factors such as financial stressors.

- **Patients covered by managed care contracts, especially through Medicaid and Medicare.** In multiple studies, Medicaid status has been found a powerful predicator of avoidable hospital readmissions; Medicaid covers nearly 20% of U.S. lives. Medicare patients also include vulnerable populations; about 14 percent of adults age 65+ live below the federal poverty level. Approximately half of Medicare enrollees over age 65 have incomes of $25,000 or less and are most likely to have health conditions.

- **Patients facing specific social risk factors, such as housing instability or food insecurity.** Patients experiencing homelessness or with housing vulnerabilities are often marginalized. They are more likely to have complex needs that require coordination and resource investment than other patients, and are also more likely to be readmitted the hospital within 30 days. To truly serve these patients, hospitals must develop referral pathways and true partnerships beyond their four walls.

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What Does This Mean for Philanthropy?

Currently, as a recent Advis survey showed, most hospitals are funding these programs themselves (57%)\(^3\). However, a significant percent of organizations also use funding outside grants (44%) and private philanthropy (41%). Different types of interventions appeal to slightly different funders. For example, payers may have a greater interest in funding programs that address patients with complex care needs whose repeated hospitalizations imperil their own health outcomes and drive outsized costs. Payers may also be willing to fund programs that address health behaviors. In contrast, many foundations and individual donors are interested in programs that emphasize effective partnerships between the hospital and community-based organizations. Fundraisers must now understand not only how their organization serves its own patients, but how it helps other community nonprofits.

Considerations For Hospitals

There is great promise and great urgency for initiatives that integrate clinical and social risk factors. Restrictions to federal program eligibility and funding pressures may place additional burdens on hospitals. Both moral and margin imperatives dictate that we embrace this challenge.

Considerations for Hospitals Seeking to Address Social Risk Factors and Social Determinants of Health

1. Define the population(s) your organization will address.
2. Consider how far upstream your hospital is prepared and positioned to go. See Figure 3
3. Decide what role your hospital will play—advocate, funder, convener, care partner, etc.
4. Assemble a team of internal and external allies. Clearly define roles within those teams and organizations. Bring together hospital teams such as population health, community benefit, and philanthropy that may be developing parallel and disconnected processes.
5. Map community assets, including community collaboratives.
6. Adopt one or more screening tools to uncover patients’ unmet health-related social needs. Make clear how the data will be captured, tracked, and used.
7. Select a combination of process and outcome measures to track the effectiveness of interventions.
8. Don’t adopt a “colorblind” strategy—consider the role of systemic racism and bias in the health system and related fields.
9. Incorporate the patient voice. Seek their input at regular intervals, including initiative development, launch, stasis, and evaluation. Embrace interaction.
10. Avoid over-reliance on technology (including apps) that may actually exacerbate disparities.
Blackbaud Grantmaking™ can help streamline processes and clearly track outcomes as you work with organizations in the community.

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About the Author

Erin Lanahan has 15 years of health care philanthropy experience and specializes in advancing community health through strategic visioning, partnership building, grant making, and health system philanthropy. She also brings experience in social determinants of health, grateful patient fundraising, development performance management and trends in health strategy.

Through 2018, Erin served as Associate Director of Cedars-Sinai’s Community Benefit Giving Office which she helped to launch in 2013. In partnership with community and hospital leaders, Erin developed and implemented a proactive grant making strategy that included the flagship Community Clinic Initiative, a capacity-building endeavor for 35+ community clinics serving over 800,000 patients annually.

Other portfolios include elevating community-based behavioral health, advancing funded programs addressing under-insured patients and expanding medication-assisted treatment (MAT) for opioid-using persons. In the past year, Erin has facilitated sessions on social determinants of health for a variety of health systems, Los Angeles-based organizations, and the California Improvement Network.

Prior to Cedars-Sinai, Erin spent seven years at the Washington, DC-based Advisory Board Company, a best practice research firm. There, Erin served as the chief research expert for the Philanthropy Leadership Council, where she supported chief development officers at 750+ hospitals and health systems. She was recognized as a national expert on grateful patient fundraising and performance management.

Erin has served as a member of the speaker committee and a judge for the Awards of Excellence at the Association of American Medical Colleges’ Group on Institutional Advancement. She currently serves on the advisory board of the Institute for High Quality Care and is a member of Coro’s Women in Leadership fellowship. She recently completed a two-year fellowship for senior-level grant makers in Southern California. Erin has authored publications on planned giving, grateful patient fundraising, performance management for development officers and sustainable fundraising strategies and is a nationally-recruited speaker.

Erin received an MBA from University of California, Los Angeles, where her graduate capstone project focused on exploring the market for liquid alternative investments for retail investors. She received a BA in History from Yale University. She speaks fluent French, conversational Italian and is currently learning Spanish.

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