



2017 ABIM FOUNDATION FORUM

# SUMMARY PAPER



<sup>2</sup> Leaders from key organizations across the health care landscape joined together in summer 2017 to consider how they and their peers can improve health and health care by facilitating the delivery of services outside of institutional walls and linking with community organizations. This year's Forum examined how the social determinants of health play a critical role in health outcomes. It also began to define the roles and competencies of clinicians, teams, patients and caregivers to achieve the full potential of an approach to health and health care that goes beyond delivering care in clinical settings.



## WELCOME AND INTRODUCTION

The meeting opened with a discussion between Richard Baron, MD, President and Chief Executive Officer of the American Board of Internal Medicine (ABIM) and the ABIM Foundation, and Elizabeth McGlynn, PhD, Chair of the ABIM Foundation Board of Trustees and Vice President, Kaiser Permanente Research. Dr. Baron began by reflecting on the “chaos and uncertainty” gripping American health care in the midst of continuing debates about the future of the Affordable Care Act, and a growing sense that “our communities and institutions need to lead from where we stand.” He then discussed his experience at an independent medical practice in a residential neighborhood in Philadelphia during a period when there was growing attention to community health. He described how staff at his practice stepped up to lead community activities such as a walking group, and how the practice added a health educator when it obtained additional resources as a certified patient-centered medical home.

Dr. McGlynn discussed her background in researching quality of care at a time when many in health care believed the system faced no serious quality issues. She compared it to today’s discussions about the importance of social determinants of health, when many believe there is a small group out there that suffers as a result of social factors. She said that at Kaiser Permanente (KP), her research group found that the need for social services was quite a bit higher than expected, with one-third to one-half of KP’s members reporting a need for housing, transportation, utility or medical expenses, or for another kind of service. “Part of the conversation we’re having today is realizing the need is deeper than people imagined,” she said. “If you don’t ask, you don’t know.” She said that it is critical to determine which interventions are effective and to define the outcomes that matter. She also said that leaders at KP were primarily interested in addressing social determinants not to achieve cost savings or reduce utilization, but to improve health outcomes for members and, more broadly, the communities KP serves.

Dr. Baron pointed out that large institutions often face challenges in securing trust from the communities where they work and asked how KP addressed that. “The foundation of trust is to start with community needs and not start with ‘We’re smart people,’” Dr. McGlynn said. She described how KP has brought community members into the planning process for decisions such as where to locate new buildings and how to involve community organizations creatively. She said KP also feels obligated to make referrals to organizations and people who will serve the community’s needs and to take mandatory community needs assessments quite seriously.

Dr. Baron asked whether there are unique challenges in evaluating community programs. Dr. McGlynn said that there is often a mismatch between the programs’ desired outcomes and the kind of data that is available, such as emergency department utilization. She stressed the importance of clarity about program goals and expectations. “Disappointment with evaluation often comes from some magical thinking that if we do good things for the world, these other magic things are going to happen,” she said.



## KIMBALL LECTURE: NIRAV SHAH, MD, MPH

After the introductory remarks, Nirav Shah, MD, MPH, then the Senior Vice President and Chief Operating Officer of Kaiser Permanente, Southern California (KP-S.CA), delivered the Kimball Lecture, the Forum keynote address that honors former ABIM and ABIM Foundation President and CEO Harry Kimball, MD.

Dr. Shah began his remarks with a story about an Aetna executive who suffered from two rare diseases and who calculated that in a year filled with dozens of outpatient visits and inpatient days, only 0.08 percent of her time with the medical system was spent receiving treatment for her conditions. For her, and many others like her, time saved equaled quality. Dr. Shah argued that by that metric, our health care system delivers very little quality.

“I like to say that the U.S. has a perfectly designed \$3 trillion health care system,” he said. “It is perfectly designed to deliver more and more health care, not more and more health. The incentives are wrong, and there is no transparency, so costs are a black box. That leads to volume-based solutions as people get on the treadmill of health care.”

In tracing how the U.S. health care system reached this point, Dr. Shah went back to Henry Ford’s development of the Ford Motor Company in the early 1900s. Ford broke down a complicated process into components and optimized each, with “managers paid to think and line workers paid to do.” In this system, Dr. Shah said, standardization was innovation, variation was the enemy, and quality was measured by speed. He argued that standardization is completely undervalued in health care.

To support this proposition, Dr. Shah described the standard process for hip replacements in the U.S., which includes three days of hospitalization, primarily so that surgeons can monitor healing through daily rounds. At KP-S.CA by contrast, half of patients go home on the same day as their surgeries through a standard workflow that involves the entire care team, including care coordinators, physical therapists, nurses, pharmacists, and patients and caregivers. This process requires a particular surgical approach that is a bit more complicated but speeds recovery, and standardization of the medical devices used. It has also produced improved infection and complication rates, and very high satisfaction scores from patients.

Dr. Shah argued that too often in health care we start with customization. He argued that while every patient is unique and presents important nuances, starting with what’s common among patients enables the use of template workflows to raise the standard of care to the highest level of evidence-based knowledge. Customization to the important preferences of patients and families is then possible, but it is standardization that drives quality. “Standardization is innovation, which allows for mass customization and improves the velocity of care, a little-heralded measure of quality,” he said.

He said that KP-S.CA’s approach to addressing social determinants of health mirrors its approach to improving clinical outcomes. It began with a community needs assessment based on an open-data platform with 130 indicators covering everything from the location of liquor stores and farmers’ markets to Internet access to climate data and flood zones. This data helped define the top 10 pressing needs of a community, which were prioritized in partnership with the community using a co-design process. He said that once communities select their top priorities, KP provides evidence-based strategies to address them and asks community members to choose from a menu of strategies and tactics, such as working to increase the supply of affordable housing or enrolling people in food assistance programs.

Dr. Shah argued that KP-S.CA's contribution to the communities it serves is encompassed not only by the 4 percent it spends directly on community benefit, but also includes the other 96 percent of the organization as a "force multiplier to achieve improved total health." As an example, he cited KP-S.CA's partnership with Kingdom Causes, an organization focused on homelessness prevention in southeast Los Angeles. When Kingdom Causes adopted a focus on finding jobs for residents with criminal histories and others who were difficult to employ, it created a landscaping company that KP-S.CA contracted with to maintain 11 acres of land at its facilities. KP-S.CA also worked with Los Angeles to develop a neglected 8.7-acre plot of land for a new office building. Collaborating with the community, it created a two-mile walking path and 2.5 acres of green space for community use as part of the project, with 40 percent of contracts awarded to businesses owned by women, minorities and veterans and 48 percent of newly hired construction workers living within five miles of the site.

Dr. Shah then differentiated between complicated and complex systems, in which the number of interactions between components increases exponentially. Referring to Gen. Stanley McChrystal (ret.)'s book *Team of Teams*, he argued that the solutions for complicated systems do not work in complex ones. Among other things, he said McChrystal embraced radical transparency and a flattened hierarchy with empowered front lines. Dr. Shah argued that the "shared consciousness" and "empowered execution" advocated by McChrystal were also required to achieve the next magnitude of improvement in health. For example, he attributed KP-S.CA's success in treating colorectal cancer (five-year survival of 80 percent vs. 65 percent national average) in part to empowering receptionists to counsel patients about testing at check-ins for primary care appointments and publicly recognizing them for doing so, reconnecting them with purpose and meaning in their jobs.

He also talked about the power of data, sharing how nursing home data he made public as New York's state health commissioner was used to find spaces for elderly citizens evacuated from Long Island facilities during Hurricane Irene in 2011. Data about the return on investment for Medicaid dollars invested in fluoridation, nurse-family partnership programs and supportive housing was critical in shaping state spending. "Transparency leads to positive externalities that you can't design for in complex systems," Dr. Shah said. "Henry Ford was wrong—managers shouldn't be paid to think and line workers to do."

Achieving health goes even beyond the complex, he said, and requires us to redefine what counts as health care. Dr. Shah described KP-S.CA's review of the one percent of its members with the greatest costs, which included calling them to learn more about their situations. He described a 58-year-old woman living with two large dogs in a rental apartment with steps she could not navigate; she was terrified by the prospect of moving to a new place that might not accept dogs. KP-S.CA, working with partner Health Leads, connected her with a tenants' rights organization that helped her get a \$60 handrail installed. When KP-S.CA called her back, she reported that her chronic stress was gone. "We made the big step of entering her world instead of making her enter ours," Dr. Shah said.

Dr. Shah summarized KP-S.CA's theory of change as embracing bottom-up solutions—supported by evidence, along with the inclusion of and input from community members—to leverage the money in the health care system to improve total health.

Susan Dentzer, AM, LITTD, President and Chief Executive Officer of the Network for Excellence in Health Innovation, asked whether and how work to address social determinants of health can proceed in the absence of senior leaders. Dr. Shah described organic community-driven efforts, such as an asthma control project in Texas, and said we need to support unexpected leaders and give them ownership.



Chris Sinsky, MD, Vice President, Professional Satisfaction at the American Medical Association, asked how we promote “empowered execution” when so many clinicians feel disempowered by technology and other factors. Dr. Shah acknowledged the problems with technology requirements and said we should not necessarily expect physicians to take on and resolve social determinants of health. Rather, he said we can expect them to endorse systems others create for screening and engagement, and that we need to create space for other team members to help solve these problems.

Don Wesson, MD, MBA, President of Baylor Scott & White Health & Wellness Institute, asked about the government’s role. Dr. Shah said government can be extremely helpful and suggested that systems underutilize government because they see it as a regulator. Having been on both sides of the fence, Dr. Shah called for understanding the particular challenges facing government bureaucracy and for health systems to share data with government agencies.

## BARRIERS TO COMMUNITY COLLABORATIVES

After the Kimball Lecture, participants engaged in a thought exercise designed to elicit the steps they would take if they wanted to produce *unhealthy* communities, which resulted in lists of behaviors that they and their organizations would need to stop doing. The discussion helped generate ideas for resolving barriers to promoting health, including:

- Streamlining and simplifying the barriers health plans put in place for those seeking care
- Ensuring that patient interests trump self-interest
- Aligning board certification requirements with the imperative to deliver on population health
- Continually reviewing performance metrics and their impact on care
- Actively confronting ongoing challenges to science
- Including community members on hospital boards
- Broadening the advocacy framework for physician and industry associations to include support for policies affecting the social determinants of health (e.g., increasing the minimum wage)
- Aligning advocacy for access to care with advocacy for improving payment and delivery systems

## INNOVATION SESSIONS

Participants had the opportunity to choose among six innovation presentations to attend during the next session, which began with brief presentations from the innovators.

**100 Million Healthier Lives:** Don Berwick, MD, MPH, President Emeritus and Senior Fellow at the Institute for Healthcare Improvement (IHI), led a discussion of IHI’s 100 Million Healthier Lives campaign, an international multisector campaign with the goal of fundamentally transforming the way the world thinks and acts to improve health, wellbeing and equity.

**From the Memphis Model to the North Carolina Way:** Gary Gunderson, DMIN, MDIV, Vice President of Faith and Health at Wake Forest Baptist Medical Center, described the Memphis Model and the North Carolina Way, partnerships between religious congregations and health systems, as attempts to address social complexities through place-based care. He described how the health systems manage charity care through “proactive mercy,” and shared data about how the partnerships have impacted health care utilization, charity care and readmissions.

**Hennepin Health:** Hennepin Health is a Medicaid managed-care plan that provides medical, behavioral and social services to enrolled individuals and families. Amy Harris-Overby, MA, the Population Health Program Director at Hennepin County Medical Center, described how the plan started with an underlying belief that there had to be a better way to support complex populations, and a burning platform from a state budget crisis that eliminated a previous program serving the Medicaid population. The four partners (a health plan, a safety net health system, a Federally Qualified Health Center and a department of human services and public health) developed a consistent approach that avoided the duplication of resources and connected enrollees with needed services.

**Cincinnati Children's Hospital:** Robert Kahn, MD, Professor of Pediatrics at the University of Cincinnati College of Medicine, described Cincinnati Children's strategic plan to improve child health and health equity at the population level, which includes focusing on reducing the infant mortality rate and disparities in inpatient bed-day rates and improving third grade reading proficiency.

**Mount Sinai Health System Hospital at Home:** Albert Siu, MD, Professor and Chairman of the Brookdale Department of Geriatrics and Palliative Medicine at Mount Sinai, discussed the Hospital at Home program that began in 2014 to provide acute inpatient services at home for selected medical admissions such as community-acquired pneumonia requiring hospitalization. He said the program has offered patients an improved experience and more time at home with loved ones, and that the challenge is now to move to implementation and scaling up the program.

**Oregon Health Authority's Coordinated Care Model:** Jim Rickards, MD, formerly Chief Medical Officer of the Oregon Health Authority, discussed Oregon's approach to delivering and paying for Medicaid services, which relies on coordinated care organizations (CCOs) as community-governed health care plans for its nearly one million Medicaid members, 90 percent of whom are enrolled in and receiving care from a certified medical home. For the five years since 2012, annual cost increases have stayed below 3.4 percent.

## SUMMARY OF THE DAY

Dr. Don Berwick offered closing reflections on the Forum's first day. He said that addressing social determinants of health badly needs attention, and expressed optimism that it was an issue that has a chance of turning a corner. Borrowing from an idea formulated by Tom Nolan, PhD, he said that for large change to occur, three resources are needed: Will, Ideas, and Execution.

He said that we know that social factors are a real problem in harming health, and the knowledge that a problem exists is a strong feeder of will. He also thought the ideas for addressing the problem are strong, with known intervention tactics, although he also stressed the need to be disciplined and maintain skepticism about what does and does not work.

The execution of ideas is the bigger problem, he suggested. As an initial matter, he said that the growth in federal investment and interest in related topics over the past decade is now in doubt. He also raised deep questions about whether there is authentic interest in addressing the social determinants of health in the board rooms and C-suites of delivery systems. He argued that although no CEO or board is going to say that social determinants are immaterial, few may link them to action the way that KP-S.CA has done.



Dr. Berwick stressed the importance of financing that works and an “action platform,” such as the corporate structure at KP that underlies institutional support. He suggested that few organizations—and certainly not community hospitals—could match Dr. Shah’s claim that his full institution was available to address social concerns.

He described two potential paths toward increasing the health care system’s focus on health and social determinants: allocation and reallocation. Under the former approach, new resources would be found to address social determinants; under the latter, resources would be taken from the 18 percent of GDP that is spent on health care currently. He said if you believe in allocation, you will be interested in raising tax rates, and if you believe in reallocation you will be fighting the status quo of distribution.

Dr. Berwick also articulated a tension between community-set goals and evidence-based solutions, something that may become particularly acute in this anti-scientific era. He suggested further consideration about how the model Dr. Shah presented—in which the community sets priorities and health care organizations bring the evidence—would successfully negotiate the tension between shared “democratic” control and control by “experts.”

Finally, he picked up on the idea that in these tumultuous times, silence now constitutes a deed, and a serious impediment to progress with the enormous inertia of the status quo.

## DAY TWO: MOVING TOWARD COMPETENCIES

The Forum’s second day began with a panel discussion reflecting on the previous day’s discussions. James Jerzak, MD, Physician Lead, Team-Based Care at Bellin Health, talked about how Bellin redesigned its practice structure and the office visit to enable more contact between physicians and patients (by having staff document visits) and to use extended-care team members for population health management. Ziva Mann, a consultant and Patient Lead for Cambridge Health Alliance (CHA), discussed how CHA integrates patients into multidisciplinary care teams. In her role as faculty at IHI, she helps build capacity for communities to address their own problems, including by building cross-sector coalitions. This could entail, for example, enlisting someone who uses the services of a food bank to help work on food insecurity. “You want to see the shape of the problem from all angles, and find opportunities to have impact,” she said.

Moderator Jackie Judd, a journalist and communications consultant, asked panelist Julian Harris, MD, MBA, Senior Vice President for Operations Strategy and Localization at CareAllies, about the impact of payment systems on efforts to design care to improve community health. “The challenge for providers and systems is having feet in both boats [fee for service and value-based payment regimes] at the same time,” Dr. Harris said. He said that he advises clients to move as much of their revenue to value-based payment as possible and suggested that reaching the 25–40 percent level is sufficient to catalyze broader change.

A few of the panelists talked about the importance of physicians surrendering control. For example, Ms. Mann said that patients may feel more comfortable speaking with non-physician members of the care team, who may feel more like peers, about social factors affecting their health. Ms. Mann challenged Forum participants to “trust enough that health care takes a back seat to health, and health really belongs to the community.” Dr. Harris acknowledged a sense of “mourning and loss” among physicians regarding changes to their roles in the health team, but called for physicians to “derive joy from helping other members of the team practice to the top of their licenses.” He also suggested that helping to address social determinants of health might reduce burnout among physicians, as it could reduce guilt about their inability to help complex patients suffering from social factors.



## PLENARY SPEAKER: KAREN DESALVO, MD, MPH

After the panel, Karen DeSalvo, MD, MPH, former Acting Assistant Secretary for Health at the U.S. Department of Health and Human Services and former National Coordinator for Health IT, delivered a plenary address about lessons learned from the response to the devastation of Hurricane Katrina, which destroyed the “entire health continuum” of New Orleans. She described how, with standard clinical settings unavailable, she and her fellow clinicians saw patients at card tables set up in the street. “When you don’t have patient documentation, or the walls that divide us, we want to work in teams, meet patients where they are, and think holistically about patient needs,” she said.

When it was time to rebuild the system in New Orleans, leaders devoted considerable thought to the health status of New Orleans residents and disparities within the region, including a 25-year difference in life expectancy between neighborhoods within the New Orleans metropolitan area. Thus, the first lesson from the Katrina experience was the need to move health services upstream, ending what had been a heavy reliance on Charity Hospital to care for the most vulnerable patients and improving community health access and quality through financing changes. Dr. DeSalvo noted, however, that this was only a partial solution. “Re-engineering the health care system was important, but fixing life expectancy was going to take more than primary care clinics,” she said.

The second lesson Dr. DeSalvo drew was that providers in New Orleans were unprepared to go upstream. Most physicians lacked the necessary population health competencies, and had a limited understanding of opportunities to assess and address patients’ social needs. She said that in addition to population health competencies, physicians need digital competencies and meaningful inter-professional training. She also suggested that maybe physicians are not the best-positioned professionals to address social determinants—“maybe it needs to be tools and teams and not placing more burdens on physicians,” she said.

The third lesson was that paper records were insufficient. She described how medical records were destroyed in the flooding, and how electronic records made it possible to collect and analyze population health data and determine what programs and supplies are most needed.

The fourth lesson Dr. DeSalvo offered was the importance of how physicians are paid. Innovation was possible in New Orleans thanks to philanthropic and federal support that enabled a capitated model of care. When that support ended, a section 1115 Medicaid waiver sustained innovation but required seeing more patients and eliminating some staff positions focused on social determinants; this return to fee-for-service payment was a downgrade for the functioning of the delivery system.

The fifth lesson Dr. DeSalvo offered was that New Orleans is not alone. She said that the life expectancy gap within the New Orleans area was present in locations across the country and constituted a “social disease.” She argued that addressing this crisis will require not only addressing health-related social factors—which payers are moving to do—but also having health systems take steps such as leveraging their hiring and spending decisions to support local communities. More broadly, she said that the solutions require societal action, not just action by physicians and health systems. She called for more social spending to alleviate current inequalities.



Don Wesson, MD, MBA, asked about the health outcomes of the changes to care in Katrina's aftermath. Dr. DeSalvo said that although evaluation data is somewhat limited, the primary care clinics demonstrated improved rates for mammography and diabetes testing and that the New Orleans region had improved in Louisiana's health ratings each year.

In response to another question about health systems' role in improving health, Dr. DeSalvo commented that there is some reason to be concerned about "medicalizing social determinants and running roughshod over existing agencies already dealing with these problems." She also noted that there is a surprising amount of interest among venture capitalists in ideas to address social determinants.

## INNOVATION SESSIONS

Participants then attended one of six new innovation sessions, which included:

**Boston University Geriatrics Services Home Care Program:** Sharon A. Levine, MD, Director, Medical Education Innovations at Boston University School of Medicine, discussed two innovative programs to provide primary care to seniors at home through physician- and nurse practitioner-led care teams.

**Comprehensive Care Community and Culture Program:** David Meltzer, MD, PhD, Fanny L. Pritzker Professor at the Pritzker School of Medicine at The University of Chicago, presented about a clinical trial at Chicago comparing outcomes for patients at increased risk of hospitalization who receive both inpatient and outpatient care from the same comprehensive care physician (CCP) with outcomes for patients who receive inpatient and outpatient care from different physicians. He also discussed an enhanced version of the CCP program that seeks to bridge sectors to address social determinants of health, seeking to meet the needs of the 30 percent of patients who did not engage in the original program.

**Honor:** Kelsey Mellard, MPH, Head of Health System Integration at Honor, described the company's aim to deliver high-quality home support for older adults. Ms. Mellard said that Honor focuses on the individual preferences of care recipients and their families, and provides training and higher pay to the workforce than is standard in the home care industry.

**Housing to Improve Health in Los Angeles County:** Mitchell Katz, MD, Director of the Department of Health Services for Los Angeles County, and Va Lecia Adams Kellum, PhD, President and CEO of St. Joseph Center, discussed their collaborative effort to move more than 2,000 people from clinical settings into supportive housing.

**Medicine for the Greater Good – Johns Hopkins Bayview:** David Hellman, MD, Aliko Perroti Professor of Medicine and Vice Dean at Johns Hopkins Bayview Medical Center, led a session on an initiative to help medical trainees become "physician citizens" who can improve population health and reduce health disparities that afflict many of Bayview's patients. The program includes a didactic curriculum on health disparities and a structured, mentored project by individual trainees to address local or global health disparities. More than 180 trainees have completed the program.

**Neighborhood Health Education Learning Program at Florida International University:** John Rock, MD, Founding Dean and Senior Vice President for Health Affairs at Florida International University Herbert Wertheim College of Medicine, presented about the school's curriculum, which is designed to address the health needs of the communities it serves, emphasizing social accountability and inter-professional education. Students conduct home visits (more than 7,000 since 2010) and a majority of graduates choose primary care residencies.

## COMPETENCIES

Participants then worked in small groups to develop lists of competencies needed to effectively address community needs and the social determinants of health. Suggested competencies included:

- Advocacy skills
- Creativity
- Nonjudgmental facilitation skills
- Ability to reduce/handle complexity
- Negotiation skills
- Authenticity
- Knowledge of communities
- Ability to build and sustain communities
- Understanding of cognitive behavioral therapy/ motivational interviewing
- Understanding of how to promote patient and family involvement
- Listening and conversational skills
- Ability and willingness to collaborate
- Understanding of systems
- Willingness to take risks
- Humility
- Respect

## CLOSING REMARKS: DAY TWO

Mary Naylor, PhD, RN, Director of NewCourtland Center for Transitions and Health at the University of Pennsylvania School of Nursing, closed the Forum's second session. She began by saying that the most pressing priority issue is to figure out how to integrate health and social services, noting the extraordinary changes in the patient population as a result of increases in life expectancy.

She described Karen DeSalvo's remarks as a challenge to re-envision the social contract to help the most vulnerable while rethinking how we create health for all. She said the innovation sessions demonstrated that a major transformation in care delivery is occurring at the local level, and that it is occurring through co-creation with community members, including those who need services and whose voices are often silent. She urged that we consider as a competency the ability to think about problems from the perspective of those people being served. "They're seeking a seamless care system and access to care that is very much grounded in trusting relationships," she said. At the same time, Dr. Naylor noted that we face a challenge in re-energizing physicians, nurses and social workers who currently feel overwhelmed.

Dr. Naylor suggested two questions that should be benchmarks of success: (1) Are we improving the health of communities? and (2) Are we improving the health of the most complex individuals? She suggested using a learning health system framework to assess successes and failures and quickly scale evidence-based strategies.

Dr. Naylor closed by calling for a commitment in all sectors, and the employment of multiple strategies inside and outside of health care institutions, to improve health. "We will be defined as a society by how well we care and meet the needs of those counting on us, not by how well we deliver health care," she said.





## DAY THREE

The final day of the Forum began with participants engaging in small-group discussions about the circumstances that can drive paradigm shifts, such as refocusing health care on promoting community health, drawing on stories from their own work. Responses included:

- The passion of the person driving the change
- Conviction and persistence
- Persuasiveness
- Determination
- Ability to forge alliances
- Willingness to let go of long-held beliefs and mental models
- A burning platform
- Courage to admit failure
- Courage among leaders to set direction, make difficult choices and motivate

The participants then proposed strategies for improving how health care organizations and clinicians could shape the health of the communities they serve, and developed them through small group work. After the groups completed their work, participants voted on which strategies displayed the greatest promise. Those groups were:

- **Training of Health Professionals and Students about Social Determinants of Health and Their Impact on Health Quality:** This group discussed how best to disseminate information about social determinants to practicing clinicians and to trainees with the aim of improving health quality. The group members believed that many resources had already been developed but thought some new tools could potentially be useful. They defined success as changing the knowledge, skills, attitudes and behavior of clinicians and trainees, and ultimately improving care for patients.
- **Expose Organizational Leaders to the Experiences of Community Members as a Result of Their Current Practices:** This group's aim was to put community needs "front of mind" for organizational leaders making decisions. Group members proposed co-creating a playbook or template with community members of authentic, deep experiences that would have an impact on leaders, and having such experiences on an annual or semi-annual basis. They said success could include having such exposure to the community be part of how leaders are evaluated.
- **Geographic-based Maps of the Prevalence of Diseases and Risk Factors in Communities Served by an Entity:** This group called for the creation of an open-source, open-data-access platform that would provide information about the prevalence and incidence of diseases and data such as education and graduation rates and environmental data. This would help interested parties pick target areas where community work would have the greatest impact, and would enable community organizations to see what peers in other areas are working on. The ultimate goal would be to improve health outcomes, with intermediate measures of how widely the data was being used.
- **Find Out from the Community What Their Needs Are and Meet Them:** This group called for health systems to engage with community organizations such as faith-based communities and civic and community groups to develop mutual trust and gain a deeper understanding of community priorities. Group members said an important measure of success would be whether the community is participating and trust is being developed.

Other topics that were explored in the small-group sessions included:

- Having all health system participants read Matthew Desmond's book *Evicted*
- Developing health strategies focused on a health system's own employees
- Continue and increase efforts to draw undergraduate and medical students from underserved and socioeconomically disadvantaged communities
- Bring community leaders onto health system boards

Following these small-group sessions, participants reconvened to discuss what they plan to do as a result of the discussions at the Forum. Responses included:

- Explore the possibility of worker-owned not-for-profit companies taking over aspects of charity care from hospitals
- Incorporating community input into medical school curriculum redesign
- Calling for a national initiative on heart failure rates among African-Americans
- Applying mapping strategies to a health system's own employees to analyze social determinants affecting their health
- Advocating for payment models that not only move away from fee-for-service but also incentivize addressing social determinants
- Advocating for integrating primary care and population health
- Scaling local efforts to address social determinants to the statewide level

## CLOSING REMARKS

Robert Wachter, MD, Professor and Chairman of the Department of Medicine at the University of California San Francisco (UCSF), delivered closing remarks that embraced the impulse to address patients' social needs but raised questions about whether health systems and physicians were well-positioned to do so. He began by characterizing the subtext of the meeting as questioning why the United States spends so much on health care when it is only a small determinant of health. He suggested we can all agree that you might not design such a system from scratch, but argued that that does not answer the question of whether and how we would change the system we now have.

Dr. Wachter outlined a range of attitudes one could take toward social determinants, from an acknowledgment that they are important to a declaration that health care organizations and physicians are responsible for addressing them. He said that he was persuaded that health care organizations should at least partner with organizations that address social determinants, but that he was unsure that resources currently devoted to health care should be reallocated to tackle social problems.

He imagined that a rational decision-maker at a health system, answerable to a broader array of individuals and concerns than may have been present at the Forum, might actually choose to do little about social determinants. He said that this likely wouldn't be a matter of decision-makers not caring about the state of homelessness or public education. Rather, they would believe that investments of time and resources in these areas would have less obvious payoffs than investments in more traditional areas (such as improving health care access or quality). Moreover, he said they would likely—and correctly—question whether the health system possesses the competencies to make sound investments in areas so far afield from their core business.



Dr. Wachter considered the questions raised by the Forum through a health economics lens, and the decisions our system makes about health spending that carries only small benefits. He contrasted the individual perspective traditionally embraced by physicians—in which you provide all care that offers a benefit, no matter how small or costly—with the societal perspective that you provide care of limited value only after all care with superior cost/benefit ratios has been funded. He said one could argue that the funding spent on care delivering limited benefits could also be reallocated toward housing and education, but that this would create conflict. He thus questioned whether characterizing such spending as “health” spending was “a politically astute way to prompt ‘reallocation’” of funds currently spent on health care while sidestepping that conflict.

He also considered the success of Kaiser Permanente in addressing social determinants. He suggested that it is rational for KP to address social determinants due to its structure and payment model, which enable it to achieve a return on investment on social spending. He questioned, however, how applicable KP’s experience is for organizations with different payment models and incentive structures.

Dr. Wachter said he was “wowed by the innovations and passion” he heard at the Forum. He said, however, that he was uncertain whether we really know how to address social determinants, pointing to the experience of San Francisco, which is filled with liberal will but suffers from a tremendous homelessness problem. He also cautioned against minimizing what he called the “just one more thing” issue, in which we ask clinicians to add one additional element to their duties, such as in well-meaning calls to “just ask these two–three additional questions on hospital admission to assess patients’ social determinants.” With multiple priorities, he suggested that these “one more things” add up quickly.

He concluded by suggesting that there are many other priorities on which health care systems could spend surplus dollars, from improving quality, patient experience and value to funding infrastructure and innovation. He said rational decision-makers should work to cut waste, teach about social determinants, and partner with organizations that can make a difference, but that he does not think they should spend their marginal dollars on tackling social problems over other imperatives. He said he did support pushing for payment systems that promote the population perspective and the reduction of low-value care, building on growing competencies in change management and building bridges that help patients find needed services.

The ABIM Foundation hopes that the Forum provided the background necessary for participants to appreciate how they might engage to promote the health of the communities they serve. We would be very interested in learning about any such engagement that participants may have in the coming year; we look forward to hearing from you.

