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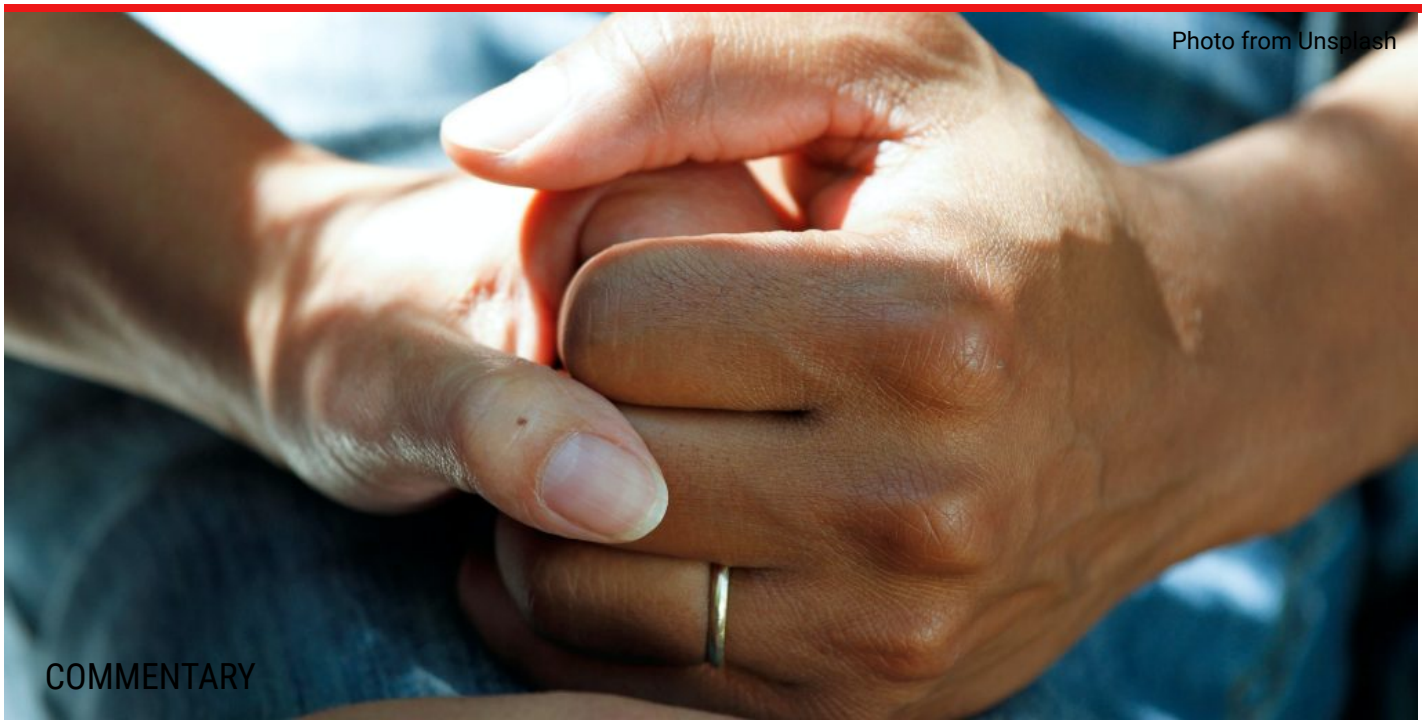

Governance matters: Managing environmental and socioeconomic factors to improve health outcomes

Written by Larry Morrissey 10th August 2021

A person's zip code has a far greater impact on their health than their genetic code. Mayors and municipal leaders who take into consideration these local, environmental and community factors, known as the social determinants of health, are uniquely positioned to make lasting health

improvements for their communities. My own experience as the mayor of Rockford, Ill., illustrates how investing in actionable tools to solve community health issues can lead to lasting impact and large dividends.

Homelessness was a priority issue when I was first elected mayor of the City of Rockford in 2005. But despite the creation of a plan to end chronic homelessness, numerous investments in technology, and incredible efforts by front-line workers, by my third term in office we had made little progress. In fact, I felt like our annual point-in-time homelessness count became a ritualistic reminder of our failure rather than a useful diagnostic or management tool.

So, when I was approached late in 2014 to take up the White House Challenge to End Veteran Homelessness, I was resistant and cynical. The City of Rockford had been through so much. We had limited resources. What would be different this time? Fortunately, I was working then with a HUD team leader, Lynnette, who was embedded in my office as part of the White House Strong Cities, Strong Communities (SC2) initiative. She assured me that this time would be different. But we needed my leadership as mayor to make it happen. With Lynnette making a strong case, and with the remaining optimism I could muster, in December 2014 I accepted the challenge on behalf of our community.

The social determinants of health: The importance of connecting community care and clinical care

Social determinants of health research validate something that many local government leaders know intuitively—that one's home address is a greater predictor of health outcomes than the quality of the clinical care they receive. In fact, according to research by the World Health Organization (WHO), medical care accounts for only 10 to 20 percent of health outcomes with 60 percent or more attributed to environmental factors known as the social determinants of health. Local government leaders and their frontline workers see this in practice every day.

Our 911 centers highlight "hot spots" for various health emergencies ranging from cardiovascular disease, diabetes and hypertension to domestic violence, drug overdoses and mental health crises. Local governments operate at the health crossroads of an individual's environmental and social circumstances and clinical intervention. While social workers, paramedics and law enforcement officers play a vital role in these community health interventions, we historically lacked an effective manner for connecting our vital work with that provided by clinical care organizations like hospital systems and other health care providers. Perhaps no challenge illustrates this more clearly than homelessness.

A city's homeless population can encompass a complex mix of health and socioeconomic challenges like housing affordability and availability, job training and opportunities, drug and alcohol addiction, mental health services, domestic violence, health care costs, health insurance and health provider access. And the web of partners and resources designed to address homelessness can be equally challenging with a wide spectrum of providers ranging from large hospital systems, human and social service agencies, managed care case managers, police and fire personnel, faith-based organizations, emergency shelters, jails and correctional facilities, etc.

Navigating this complex web can be difficult for anyone dealing with a health or social challenge, let alone someone who is homeless. Taken together, the mass complexity of problems, providers, payers and places was impossible for us to solve. But by December of 2015, that's precisely what we did, reaching "functional zero," effectively ending Veteran Homelessness in our community. What did we do differently?

Population health approach: By-name lists

Our epiphany came in February of 2015 when our team attended a HUD Region V training in Chicago. That's where we learned the core lesson that led to our success. Rather than trying to solve every causal factor and abstract problem or find the perfect technology, we learned that communities were finding success by taking a population health approach to solving the problem: identifying each homeless veteran, creating a "by-name" list, and building a multidisciplinary operations and governance model to work the list.

For our homeless veterans, our population health approach ensured that unique solutions were being generated and executed for each individual on the list. Case managers, social workers and other partners then met monthly as a team in HIPPA compliant meetings to share details on outreach and develop solutions to address the specific needs for each homeless veteran. We then connected that operations level work with my policy team through monthly, public review meetings analyzing aggregated de-identified data to help us stay on track and provide policy-level support and resources as needed.

As we were building our population health approach to support our homeless population, our fire department was taking a similar approach in developing a Mobile Integrated Health (MIH) program to support frequent users of our 911/EMS system. We analyzed our data and identified specific individuals who were heavy users of our EMS resources. We then worked to enroll those individuals into our program and then work with our partner hospitals to address the needs of those individuals proactively, helping to reduce emergency calls, improve outcomes for patients and reduce health care costs. Coincidentally, at this time we also began taking a similar population health approach to support our own employees and their family members.

Population health for public employees

One of the things that helped me believe that our population health model would work for homeless veterans was my realization that we had already adopted a similar approach for improving the health of our own employees. In 2014, we opened our own advanced primary care health center for our city employees and their family members and adopted a population health model to support their care.

The social determinants of health don't just impact low-income households. Every individual must cope with a complex mix of environmental and social factors that impact their health outcomes, regardless of economic condition and clinical care resources. By opening our own health center, the City of Rockford built a foundation for supporting personalized health solutions for each member of our organization.

The city's health center partner manages a HIPAA compliant process, building patient lists, identifying individuals with chronic health conditions, and working those lists to support positive engagement and interventions. Clinicians work to identify the needs, goals and resources for each patient and build a personalized approach designed to address their unique circumstances. The result is more personal, humane, relationship-based care that leads to improved patient experience, better health outcomes and lower costs. After six years operating under this model, the City of Rockford has experienced savings of more than $23 million compared to its prior trend.

Lessons learned: Improve governance to improve outcomes

Our historic barrier to progress with a complex problem like homelessness did not arise from lack of resources or good intent. We simply did not have an effective governance model to connect the many financial, organizational and cultural silos between providers, payers and programs at the local, state and federal level. We started experiencing success when we shifted our governance approach to a population health model informed by the social determinants of health.

A social determinants informed approach recognizes the complex environmental and socioeconomic factors that impact health outcomes for our citizens. The approach validates the importance of local governments that employ the workers that most closely connect with community members. It recognizes the unique ability that local governments have in supporting outreach to these community members, literally and figuratively meeting them where they are on their health journey. It appreciates the unique needs and goals of every community member and builds a customized approach to connect everyone to the care and resources that will best support them on their journey.

After finding success combating homelessness, building MIH models within fire/EMS systems, and supporting the health of city employees and their families, similar population health approaches have emerged to take on other complex community challenges such as opioid overdoses, violent crime interdiction and co-responder programs to support citizens experiencing mental health crises. Several common characteristics typify these efforts.

These initiatives involve multidisciplinary tactical efforts of frontline personnel from both community care and clinical care organizations. They provide operations level review and support over the work of the tactical teams. Policy leaders then provide oversight, accountability and resource allocation to support the enterprise.

Communities that adopt these types of proactive and holistic population health approaches that connect community care with clinical care are improving the service experience, improving health outcomes and lowering costs—leading to a healthier, more prosperous and more resilient population.

This is the last of a three-part series by Larry Morrissey, former mayor of Rockford, Ill., and current vice president of government affairs for Marathon Health, that examined three major factors affecting local governments' ability to tackle health care challenges and save money on their health care spend and the implications it has for their constituents and employees.

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