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## Bree Collaborative | Social Determinants and Health Disparities Workgroup

September 17<sup>th</sup>, 2020 | 8:00 – 9:30 a.m.

Virtual

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### Present

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Cynthia Harris, Family Planning Program  
Manager, Washington Department of Health  
Angela Chien, MD, Obstetrics and Gynecology,  
EvergreenHealth  
Mandy Weeks-Green, Senior Health Policy  
Analyst, Officer of the Insurance  
Commissioner  
Catherine West, JD, Staff Attorney, Legal Voice  
Bob Marsalli, Chief Executive Officer,  
Washington Association for Community  
Health  
Phyllis Cavens, MD, Medical Director, Child and  
Adolescent Clinic, Vancouver  
Ginny Weir, MPH, Bree Collaborative  
Alex Kushner, Bree Collaborative  
Amy Etzel, Bree Collaborative  
Richard Smith, Regional Medical Director,  
Humana  
Alison Bradywood, DNP, MPH, RN, NEA-BC,  
Senior Director, Clinical Quality & Practice,  
Virginia Mason  
Rick Rubin, Chief Executive Officer,  
OneHealthPort  
Yogini Kulkarni-Sharma, AVP, Health Plan  
Quality Improvement at Molina Healthcare  
Tom Green, MD, Orthopedic Surgery, Virginia  
Mason  
Ashley Lile, Director of Training & Technical  
Assistance, Washington Association for  
Community Health  
Laurie Bergman, Quality Integration/Population  
Health/Cm Manager, Confluence Health  
Kevin Conefrey, Vice Present, HR & Corporate  
Services, First Choice Health  
Julie Stroud, MD, MMM, Medical Director,  
Quality & Clinical Services, Northwest  
Physicians Network

Cheryl Berenson, RN, MS, MPH, Public Health  
Nurse, King County Medical Reserve Core  
Mia Nafziger, Senior Health Policy Analyst,  
Washington State Health Care Authority  
Maria Courogen, Special Assistant, Systems  
Transformation, Washington State  
Department of Health  
Karie Nicholas, GC, MA, Epidemiologist, Data  
Analyst, Washington Association for  
Community Health  
Kate McLean, MD, MPH, FACOG, Director of  
Clinical Programs, Quilted Health  
Jessica Martinson, Director of Continuing  
Professional Development, Washington State  
Medical Association  
Abby Berube, Director, Safety and Quality,  
Washington State Hospital Association  
Janice Tufte, Patient Partner, PICORI,  
AcademyHealth  
Christopher Chen, MD, MBA, Medical Director,  
Medicaid at Washington State Health Care  
Authority  
Maggie Bolton, CNM, ARNP, Clinical Program  
Manager, Quilted Health  
Rachel Madding, School Mental Health Program  
Manager, Highline Public Schools  
Yvette McKee, MSW, LSWAIC, Community  
Development & Operations Manager,  
Quilted Health  
Zandy Harlin, MPH, RN-BC, Quality Program  
Manager, Population Health, Kaiser  
Permanente  
Michael Garrett, Principal, Mercer  
Jean Clark, CEO, CHOICE Regional Health  
Network, Cascade Pacific Action Alliance  
Allison Warren-Barbour, Vice President of  
Human Resources, Premera Blue Cross

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### INTRODUCTIONS AND BREE OVERVIEW

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Ginny Weir, MPH, Bree Collaborative, opened the meeting and those present introduced themselves.

- Ms. Weir gave a brief presentation on the Bree Collaborative, reviewing:
  - Roberts Rules of Order, the Open Public Meetings Act, and the Bree's Conflict of Interest form
  - Background on the Bree's founding and mission
  - How recommendations are developed and past workgroups

## GENERAL DISCUSSION

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Ms. Weir began the general discussion on the group's topic of clinical care and the social determinants of health (SDoH).

- Ms. Weir walked through a short slide presentation that covered:
  - Clinical care only determines about 20% of a person's health.
  - Race impacts many of the social determinants of health.
  - USPSTF is currently assessing the role of SDoH in primary care prevention—this group will be looking at their materials as they are released.
  - The group needs to make sure to think about the unintended consequences of any of its recommendations.
- Ms. Weir displayed a slide with the questions that HCA MCOs ask clients with special needs, and Christopher Chen, MD, MBA, Medical Director, Medicaid at Washington State Health Care Authority spoke about the HCA's work in the area of SDoH.
  - The HCA currently asks about three main areas for their Medicaid clients: food insecurity, housing instability, and transportation access.
  - Dr. Chen added that effective, useful screening requires a high level of standardization and data capture.
- Janice Tufte, Patient Partner, PICORI, AcademyHealth, spoke about the importance of affordable housing given the number of Americans currently facing eviction. Clinicians need to ask people if they are in the process of getting evicted or uncertain of their housing during housing screening questions.  
**Ms. Tufte to send more notes on housing screening to Ms. Weir.**
- One attendee spoke about clinicians' reluctance to screen for SDoH if they do not have solutions to offer their patients.
- Another attendee suggested thinking about the language we use to talk about social determinants of health—what types of language helps patients and what types of language alienates them?
- Another issue that was discussed is screening for undocumented people. There is a barrier to screening and care for undocumented people who are fearful of being deported or harassed by the government when presenting for care.
- The group agreed that, if we are recommending screening, we also need to provide suggestions for next steps that clinicians can take to help their patients.
- Alison Bradywood, DNP, MPH, RN, NEA-BC, Senior Director, Clinical Quality & Practice, Virginia Mason, spoke about how Virginia Mason is conducting SDoH screening currently:
  - They have found that they already had the necessary resources to help patients in SDoH related areas, but they were not doing as well as they could in connecting patients with those resources.
  - Safety and comfort are important: they get better responses when they let patients self-report rather than be interviewed.
  - They use the Core 5 tool (out of Ohio) because it hits many of the important domains and is brief. Their team added two more questions to the Core 5: availability of caregiver and financial impact of obtaining medications.
- Ms. Weir asked attendees to discuss the best and worst case outcomes from this group's work.
  - One attendee voiced that failure would be no standardization of any type in SDoH screening. This would make it difficult to track people along their lifetime of care. The best case would be a framework, but one which is not so rigid as to dictate the exact questions that would need to be on a screening exam.
  - Creating a framework also helps the state understand where funding needs to go.
  - Attendees also advocated for the integration of medical providers and social service providers.
  - There is ROI for investing in SDoH even in a FFS system—it can reduce extended hospital stays and re-hospitalization, for example.

- The group agreed that, of those in attendance at the meeting, there was a distinct lack of community partners, and this is a possible failure point that should be addressed. Need transportation, food banks, etc. invested in this work.
- The group also discussed the importance of addressing systemic racism in terms of SDoH. The group may need more diversity in its membership to do this effectively.

**Action Item: Ms. Weir asked everyone in attendance today to think about who else could be invited to the group and to send her suggestions or connect her with those people.**

- Ms. Weir asked attendees to think about the ACHs as a way to fill the gap between the clinical and community spaces.
  - Each of the 9 ACHs are going about SDoH work differently, but they are all focused on it.
- Michael Garrett, Principal, Mercer, mentioned the importance of clinicians collecting Z codes during care and being able to communicate out the answers to community groups. He also mentioned a need to think about intersectionality in our work, as well as physical accommodations for patients.
  - Another attendee added that we should also think about digital accessibility of care as well as physical—not everyone has an internet connected device. Accessibility is an important equity issue.
- The group discussed the national Gravity project. This is a national project run by SIREN. The group is formed of community members coming together to talk about the language of social determinants of health and coding that language in a standardized way. The three main domains of discussion right now are housing, transportation, and food insecurity.

#### **CLOSING COMMENTS**

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Ms. Weir thanked all for attending. The meeting adjourned.