
- # Addressing Social Determinants of Health

Essentia Health

September 2021



Storyboard Summary

- Essentia Health is nonprofit, integrated health system serving patients in MN, ND, and WI
- Piloted a screening program for social needs (food insecurity, transportation, and financial strain) in 3 clinics and then expanded to all 70+ locations in 2020
- Developed an interactive dashboard to measure performance
- Engaging patients over MyChart and during clinic visits
- Working with Aunt Bertha
- Aligning stakeholders working together to create an effective solution that works for all

Essentia Health: At a Glance

- Nonprofit, integrated health care system headquartered in Duluth
- 14,700 employees
- 15 hospitals, 75 clinics
- Serving 560,000+ unique patients in Minnesota, Wisconsin, North Dakota NCQA Level 3 ACO



Team Slide



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SDOH Approach

Individual

Addressing immediate, non-medical needs of a patient (example – connecting to food, housing, transportation resources)

Organizational

Develop partnerships to tackle needs beyond the medical setting. Improve communication and coordination between organizations (example – Aunt Bertha/Resourceful)

Community

Impact community conditions that affect health outcomes and risks. Understanding broader context that shapes health in community (example – community contributions, community benefit, CHNA)

Essentia Health's Current Efforts to Address SDOH

- Began routinely screening patients for food insecurity, financial strain, and transportation needs during all primary care and pediatric visits in April 2020
- Started partnership with Aunt Bertha to create a resource referral network and integrate workflows between Essentia Health and Community Based Organizations in March 20201 – www.WeAreResourceful.org
- Developed an interactive dashboard to measure performance
- Engaged patients in clinical settings and over MyChart
- Collaborating with community based organizations, payers, and other ACOS in shared service area
- Funding sources: internal budget, grants, payer contracts



Objectives for the Collaborative



- Understand best practices for establishing effective workflows for SDoH screening and interventions
- Learn from other communities that have successfully built a network of Community Based Organizations ready to serve patients and update referral status, forming a closed-loop network
- Structuring our interventions to be effective at promoting health equity at individual patient care level, and at broader community and structural level
- Developing solutions that work for all: Community Based Organizations, patients, and health system