2020 IMPACT REPORT

ProMedica
NATIONAL SOCIAL DETERMINANTS OF HEALTH INSTITUTE®
Dear friends,

Thank you so much for your partnership. What a year this has been!

We at ProMedica’s National Social Determinants of Health Institute are pleased to be able to share a year-end report of the work being accomplished by you, the Institute, and so many partners.

As you’re all keenly aware, it takes all of us working together to truly move the needle on the social issues that will most significantly impact the health and wellbeing of our communities. As we continue pressing forward, we are so incredibly grateful to each of you and to everyone who is so committed to serving our communities. Thank you.

Kate Sommerfeld
President, National Social Determinants of Health Institute
ProMedica

National Social Determinants of Health Institute

Mission:
The ProMedica National Social Determinants of Health Institute creates healthier people and communities by establishing local, regional, and national opportunities to integrate social determinant factors with clinical care and provide a more holistic approach to health and well-being.

Approach:
The Institute accomplishes its mission by creating strong partnerships with health care providers, payers, nonprofits, corporations, civic leaders, and the people we serve to research, test, shape and invest in innovative solutions that improve health outcomes.

Building healthier communities.
Ebeid Neighborhood Promise - Changing Lives

It’s been another busy and life-changing year with the Ebeid Neighborhood Promise!

The ProMedica Foundation, in partnership with Owens Corning, has committed $2.8 million dollars to the Junction Neighborhood to support the areas of basic needs, education and training, health and wellness, jobs and finances, and stable housing.

Launched partnership with JumpStart to support small businesses owned by women and people of color. Click here to discover how Quintin’s Legendary Carpet Care went from a “side hustle” to an enterprise!

The Ebeid Neighborhood Promise received a U.S. Housing and Urban Development (HUD) Secretary’s Opportunity & Empowerment Award

825 COVID Care Kits were distributed to neighbors struggling to cover basic needs

All Scott High School Class of 2020 graduates (+ one respective parent/guardian!) received the HOPE Toledo Promise: full tuition, room, board, fees, and books for 4 1/2 years to help create a two generational approach to mitigate poverty and educational disparities.

Spun off HOPE Toledo from the HOPE Promise incubation into a new 501c3, established to continue the two-generational approach to education, a proven differentiator in future health outcomes.

Community partners rallied together to put a city levy on the ballot to support universal access to pre-K in Toledo. While it didn’t pass, strong momentum continues.

Built deep resident relationships across the UpTown neighborhood to identify at-risk pregnant moms – especially Black and Brown moms who, in Ohio, face more than double the infant mortality rate of white moms – and connect them to care through the Pathways Hub.

Modeled after the Ebeid Center’s Financial Opportunity Center (FOC), helped launch rurally-focused FOCs in Defiance and Fremont, Ohio in partnership with Rural LISC.

2020 Ebeid Neighborhood Promise Snapshot

HEALTH
- 278,499 customers served to date at Market on the Green
- 174 people participated in healthy cooking classes
- 1,000 pregnant moms connected to Pathway HUB

HOUSING
- 35 homeless individuals connected to mental health and housing resources

FINANCES
- 1,900 individuals served through financial wellness services
- 84% returned for additional services
- 30% increased net income
- 32% increased credit score
- 30% increased net worth
- Average increase in credit score = 37 points

JOBS
- 30 Market on the Green job trainees
- 176 New State Tested Nursing Assistant (STNA) training program
- 430 people connected to jobs through Goodwill Job Connection Center
- 246 secured jobs

EDUCATION
- 83 students enrolled at 13 different universities

COMMUNITY ENGAGEMENT
- 533 UpTown residents participated in Ebeid/community events
- $1.3 million invested in community partners

Read the Case Study  Watch the Video

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ProMedica continues to lead the way on reimagining care design to meet the whole needs of patients, members and residents by identifying and solving for social and economic needs.

In all of our care settings patients are asked to self-identify social needs across 14 categories.

- **85%** of patients completed this survey prior to seeing their provider.
- The insights gained from the patient’s answers help the provider to holistically address the patient’s needs, both clinical and non-clinical.
- **43%** of patients identify a social need.
- **16%** of patients have social needs in four or more categories.

Alicia was a single mom with four children living significantly under the 200% federal poverty level. When she first came to the ProMedica Financial Opportunity Center (FOC) she was unemployed and looking for work. She enrolled in the ProMedica State Tested Nursing Assistant (STNA) program, completed the program, and received her nurse aide certificate.

Prior to the last week of classes, Alicia expressed interest in applying for a position with ProMedica Senior Care. Alicia’s financial coach encouraged her to complete the online application and HR contacted Alicia for an interview the next day. She aced the interview and was hired immediately.

Alicia is studying to take the state test that is required for the position and once she passes the test and has obtained her STNA, her monthly income will increase by more than $1,800. The additional income will give her the ability to negotiate a settlement and pay off her collection accounts, ultimately improving her credit score. Alicia plans to continue to grow her credit by working with her coach, applying for a twin account, and saving money each pay period to purchase a vehicle.

Check out our [50 Changed Lives report](#) to read more stories like Alicia’s.
Clinical SDOH Screening, Interventions, and Outcomes

As an organization, ProMedica is committed to addressing the holistic needs of our patients, which moves beyond those who are typically identified in the clinical setting. Integrating non-clinical needs such as food, housing, and financial strain into plan of care discussions is integral in our approach to helping our patients connect with resources to allow them to focus on their health. Screening patients for social needs is the first step, but connecting them to that next partner in care is a critical part of the process. Our community care hub, social workers, and care navigators work with our clinical partners to connect patients to resources and establish a plan to allow the patients to not only address their socioeconomic needs, but also focus on their health and well-being.

Interventions

As need is identified, patients are connected to ProMedica and community partner supports and programs.

- Nearly 120,000 screenings by our patients, members, and residents.
- More than 18,000 connections were made to our food clinics, financial coaching, social programming, educational opportunities, and other various interventions.
- Launched grocery delivery program for oncology patients to decrease risk of COVID-19 exposure.

Financial Wellness:
1,900 individuals supported with financial wellness services

27,000 people were served in the food clinic impacting 8,357 households and providing 67,535 days’ worth of food to our community

Nearly 7,000 individuals living in rural communities received fresh produce

2020 Core SDOH Identified Risks in Primary Care Settings

- Food Insecurity 15%
- Social Isolation 34%
- Employment 5%
- Education 5%
- Domestic Violence 5%
- Transportation 5%
- Housing 6%
- Financial 22%

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Racial Disparities in COVID-19

Analyzing our data to identify risk and racial disparity will allow us to address social need gaps and vaccine skepticism as we take steps to emerge from this pandemic. Our data tells us that SDOH risk is a compounding factor for COVID-19.
National Leadership

ProMedica has already blazed a number of social determinants of health trails: integrating screenings into the clinical setting; the launch of the Ebeid Neighborhood Promise including the opening of Market on the Green in a food desert; the first health system to operate a financial coaching model; and helping lead the way in the Anchor Institution movement among other innovations.

2020 brought these new exciting developments:

The launch of the ProMedica Impact Fund, a $1 billion effort to transform America’s healthcare system by demonstrating at scale how social needs and social determinants of health interventions improve health outcomes while reducing utilization.

The birth of Resourceful, a partnership with Kumanu to design an essential needs commercial solution for employers.

Supported a Federally Qualified Health Center (FQHC) in Marion, Ohio, to open a grocery store.

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Thought Leadership

The ProMedica team continues to be regularly featured in national interviews and podcasts about the direction of social determinants of health. Here are a few highlights:

Healthcare Equals Outcomes (Article)

Equitable Access to Healthy Food Options: A Public Health Issue (Article)

Five Numbers That Could Reform Healthcare (Video/TedTalk)

How ProMedica prioritizes data to address social determinants of health (Podcast)

Social Determinants of Health: Lead or Partner (Article)

In addition, the team launched its own blog series this year, Beyond Screening, with more content to come in 2021.

Beyond screening: Integrating social support into clinical practice

Reducing infant mortality and improving infant vitality

COVID-19 Relief: Meeting our neighbors’ basic needs

The critical role of employers in addressing the social determinants of health

Equity in Education: Delivering hope to Toledo’s students

Equitable Access to Healthy Food Options: A Public Health Issue

FIVE NUMBERS THAT COULD REFORM HEALTHCARE

TEDx Watch the Video
Passage:

Data Sources:
Pilot Data from 1/31/2017 - 7/31/2017; Wellopp Data from 8/1/2017 - 8/1/2019; Epic Normalized Survey Data from 5/31/2019 +

Notes:
This report uses the Screen Date and not the Encounter Date for the date range of the report. Also, Total Risk within Epic excludes Activity, Alcohol, Stress, and Education when calculating the medium and high risk levels. Total Risk within Wellopp excludes only Activity, Alcohol, and Stress (3 new domains in Epic.) The Depression screen changed from PHQ2 to PHQ8 on 10/12/2018, resulting in a decrease in the high risk Depression scores after this date. The Social Connections scoring logic changed with the implementation of Epic in June 2019, which resulted in higher social isolation risk.

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