

9th Social Determinants of Health Summit

Practical Strategies for Sustainable SDOH Programs

**JW Marriott Bonnet Creek
Orlando, FL
October 26–27, 2026**

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Agenda

Day One – Monday, October 26, 2026

7:15am – 8:00am

Conference Registration & Networking Breakfast

8:00am – 8:15am

Chairperson's Opening Remarks

8:15am – 9:00am

Food Insecurity Interventions: From Screening to Medically Tailored Meals

Food insecurity drives poor outcomes and costly utilization, but effective intervention requires moving beyond identifying hungry patients to meaningful programs. Screening tools must match your setting and population, with validated instruments performing better than ad hoc questions. Medically tailored meal delivery, produce prescription programs and food bank partnerships each serve different populations with distinct implementation requirements. Medicaid coverage, grant funding and innovative food bank collaborations create diverse revenue streams supporting sustainability. Calculating ROI, designing referral workflows and building programs surviving beyond pilots demands careful financial planning. Programs connecting patients to food while addressing transportation barriers, cooking skills and nutrition education generate lasting behavior change rather than temporary relief.

Bonnie Morning

Coordinator Operations

Wellstar

9:00am – 9:45am

Beyond the Clinic: Turning Social Needs Data into Better Health Outcomes

Healthcare organizations are collecting more social needs data than ever before, but how can that information be translated into meaningful action and measurable outcomes? This session will explore strategies for integrating social determinants of health (SDOH) data into care delivery, care coordination, and population health initiatives. Attendees will gain insights into identifying high-risk populations, connecting patients to community resources, measuring impact, and leveraging data to drive improved health outcomes, reduce costs, and advance health equity.

Drew Albano, DO, MBA, CPE, FAAFP
Vice President
Atlantic Health & President, Atlantic ACO

9:45am – 10:15am
Networking & Refreshments Break

10:15am – 11:00am
Education Strategies to Advance Social Drivers of Health Screening
Social Drivers of Health (SDOH) screening is becoming an increasingly important part of healthcare delivery, but successful implementation requires more than a workflow change. This session explores practical strategies for educating clinicians and care teams, increasing awareness of SDOH screening, and building confidence in addressing social needs in clinical settings. Drawing from real world health system experience, attendees will learn approaches to training, stakeholder engagement, and change management that support meaningful adoption. Participants will leave with actionable ideas to strengthen screening practices, improve documentation, and connect patients to resources that address barriers to health.

Zaria Johnson, MPH
Program Manager
Northwell Health

11:00am – 11:45am
Advancing Health Equity: Data Strategies and Organizational Change
Health inequities represent one of the most significant forms of untapped economic potential in communities across the country. In Chicago, efforts to close the life expectancy gap were not simply about improving health outcomes—they were about unlocking decades of productivity, opportunity, and community contribution that could no longer be left on the table. Through data-driven program redesign and strategic investments in violence prevention, overdose response, chronic disease management, mental health, housing, and community-based care, Chicago achieved its largest increase in life expectancy in more than a decade while narrowing long-standing disparities in health outcomes. This session will explore the strategies, partnerships, and lessons learned that can help other jurisdictions advance health equity while strengthening community well-being and economic resilience.

Simbo Ige MD, MS, MPH

Former Commissioner of Health of Chicago
Chicago Department of Health

11:45am – 12:30pm

Beyond Hot Spotting: Identifying Underserved Populations Through Data Analytics

Hot spotting identifies high-utilizers needing intensive intervention, but cold spotting reveals underserved populations not accessing care at all despite significant health needs. Combining EHR data, claims information and community-level social determinants creates comprehensive population health pictures showing who's missing. Geospatial mapping visualizes disparities across service areas and guides deployment of limited resources to communities with greatest unmet needs. Community Health Needs Assessments become strategic planning tools rather than compliance exercises when used to identify gaps systematically. Partnerships with public health departments and community organizations enable data sharing and coordinated efforts ensuring resources reach populations most in need rather than just populations most visible. Translating data insights into action separates sophisticated analytics from meaningful impact.

Daniel Rivas

Director, Office of Community Outreach and Engagement
UC Irvine Chao Family Comprehensive Cancer Center

12:30pm – 1:30pm

Networking Lunch

1:30pm – 2:15pm

Beyond Programs: Leading Organizational Transformation to Advance Whole-Person Care

As healthcare organizations increasingly address social drivers of health, many leaders face a common challenge: how to move beyond isolated initiatives and build sustainable models that improve health outcomes at scale. Drawing on experiences leading large community-based healthcare organizations, this session will explore the leadership, operational, and partnership strategies required to integrate whole-person care into the fabric of an organization. Attendees will learn practical approaches for aligning mission, strategy, workforce, community partnerships, and financial sustainability while navigating change in an increasingly complex healthcare environment. The discussion will highlight lessons learned, common barriers, and opportunities to create lasting impact for the communities we serve.

Rashad A. Collins

President and Chief Executive Officer
Unity Health Care

2:15pm – 3:15pm

Panel: Overcoming Partnership Failures Between Hospitals and CBOs

Effective SDOH work demands genuine partnership between healthcare and community-based organizations, but these collaborations fail more often than they succeed. NEJM Catalyst data confirms poor coordination with community partners as a persistent challenge across health

systems. Panelists will share candid insights about navigating different organizational cultures, aligning mismatched incentives and building trust when historical relationships were rocky or nonexistent. Data sharing, referral coordination and sustaining partnerships when funding landscapes shift require ongoing attention and adaptation. Community health worker programs, wraparound services and integrated care teams that successfully blend clinical and social support offer models worth replicating. We'll also explore overcoming specific barriers participants face and building partnerships designed to last through leadership changes and budget pressures.

Dr. Glenda Francis
DNP, MBA/HCM, CCRN, NEA-BC FACHE, CHE
Wellstar Center for Health Equity
Wellstar Health Systems

Zaria Johnson, MPH
Program Manager
Northwell Health

Jennifer Z. Snow
Vice President, Social Health
The National Center for Clinical and Community Impact
Advocate Health

3:15pm – 3:45pm
Networking & Refreshments Break

3:45pm – 4:30pm
Implementing Systemwide SDOH Screening: Infrastructure, Workflows and Follow-Through
Federal agencies promoting expanded SDOH data collection created incentives for implementation, prompting healthcare organizations to build infrastructure and staffing for systemwide screening. Moving from policy mandates to practice reveals challenges around workflow design, staff training and ensuring screening leads to meaningful intervention. The speaker's implementation journey offers insights from comprehensive evaluation drawing on patient and care team perspectives. Key facilitators include executive sponsorship, adequate staffing and integrated referral systems. Barriers involve workflow disruptions, documentation burden and limited community resources for identified needs. Opportunities emerge around leveraging screening data for population health management and quality improvement. Strengthening communication between clinical teams and social service coordinators prevents screening from becoming performative documentation exercise. Post-screening connections determine whether identification of social needs improves outcomes or just creates data without action.

Katherine Byerly, MPA

Director of Community Health

HealthLinc, Inc.

4:30pm – 5:15pm

Leveraging strategies to increase physician engagement to better influence whole person care.

Physician engagement is critical to effectively collecting and using Social Determinants of Health (SDOH) data because physicians build trusted relationships that encourage patients to share sensitive, non-clinical information. When engaged, physicians can better interpret SDOH insights within the context of a patient's overall health and tailor care plans accordingly. Their involvement also helps integrate SDOH data into clinical decision-making, ensuring interventions address root causes rather than just symptoms. Ultimately, strong physician engagement leads to more proactive, personalized care and improved patient outcomes.

Kelsey Keith, BSPH, PCMH CCE

Director of Population Health

Northeast Georgia Physicians Group

5:15pm

End of Day One

Day Two – Tuesday, October 27, 2026

7:15am – 8:00am

Networking Breakfast

8:00am – 8:10am

Chairperson's Remarks

8:10am – 8:50am

From Compliance to Connection: Building People-Centered Health Systems

As healthcare organizations expand efforts to address social determinants of health, many are discovering that data collection and screening alone do not improve outcomes. Sustainable change requires systems that center trust, dignity, and meaningful relationships. This session examines how cultural humility and behavioral science can support workforce development, organizational transformation, and stronger connections between clinical care and community priorities. Participants will gain practical strategies for moving beyond compliance-driven approaches to create cultures of care that improve both patient experience and community well-being.

Ruaa Hassaballa, PhD, MPH

Health Equity Strategist

American Academy of Family Physicians

8:50am – 9:30am

Advancing Health Equity: Data Strategies and Organizational Change

Health equity practitioners face internal resistance and external barriers when trying to mitigate access obstacles for patients and families. Social inequality, historical biases, contemporary discrimination and organizational apathy all influence outcomes for both patients and equity teams. Collecting and sustaining meaningful data, tracking key organizational moments and building coalitions with departments showing limited commitment require strategic approaches. Demonstrating measurable value through clear metrics helps overcome resistance and secure resources. Staying ahead of events that reveal disparities positions equity teams to respond effectively rather than reactively. Working around skeptics while winning over potential allies demands political skill and evidence-based argumentation.

Mallory Yung, MPH, PMP

Director, Health Impact Alliance

The Health Management Academy

9:30am – 10:00am

Networking & Refreshments Break

10:00am – 11:40am

Community-Based Health Partnerships: Faith Communities and Trusted Networks

Health begins in neighborhoods, families and faith communities shaping daily lives long before clinical encounters occur. Partnerships with churches and community organizations create trusted health educator networks addressing challenges medical advice alone cannot solve. Training volunteers from within communities generates culturally appropriate outreach that institutional providers struggle to replicate. These collaborations improve screening access, encourage healthier lifestyles and foster trust between institutions and communities they serve. Examples from pandemic-era initiatives demonstrate how resilient, adaptive outreach saves lives while reducing hospital costs. Population health improvement and cost efficiency pressures make these community-rooted models increasingly compelling. This session will explore how connecting clinical care to community support creates lasting networks rather than episodic interventions.

Nicolette Wise, MPH

Director, Social Determinants of Health

TennCare

10:40am – 11:20am

Leveraging Alternative Payment Structures to End the Syndemic and Promote Whole-Person Health for Individuals Living with Substance Use Disorder

With Medicaid changes looming, how can we strategically insulate safety-net substance use disorder treatment programs from impending budget cuts, while simultaneously improving the quality of care and expanding the scope of services provided? With a little bit of wizardry, and a lot of zeal, county health administrators have teamed up across agencies to create a value-

based payment system for SUD treatment services and to integrate additional physical health services into these behavioral health treatment programs. In this talk, the speakers will share their concerns, dreams, successes, and challenges in their quest thus far to promote whole-person health for people living with substance use disorder in their county.

Jillian Irwin

Public Health Physician and County Medical Director
Allegheny County Health Department

David Loveland

Director of Substance Use Services
Allegheny County Health Department

11:20am – 12:00pm

Scaling Social Health Impact: Leveraging Technology and Workflow Design to Build Sustainable, Enterprise-Wide Screening and Referral Systems

This session focuses on how health systems can scale social health screening and referral programs without proportionally increasing staff. It covers how to embed standardized workflows into the EHR, use technology to automate and prioritize referrals, and build closed-loop tracking systems that reduce manual burden on clinical teams.

It also highlights how data can be used to target high-risk populations, improve coordination with community partners, and measure impact, while aligning teams across settings.

Overall, the goal is to move from fragmented efforts to a scalable, sustainable model that integrates technology, workflow design, and partnerships to expand capacity and improve outcomes.

Jennifer Z. Snow

Vice President, Social Health
The National Center for Clinical and Community Impact
Advocate Health

Cherelle Rozie, MPH, CHES

Associate Vice President, Social Health & Community Health Workers
Advocate Health

12:00pm – 12:40pm

Leading Initiatives That Advance Upstream Systemic Change for Health Equity, Justice, and Accessible Education for All

Health equity for all is not possible without justice, where the social determinants of health (SDOH), including the social, environmental, physical, and mental health of communities, are acknowledged and addressed. Brewing Public Health is one of the initiatives I founded that models health equity, justice, and accessible education for all. Achieving truly equitable care requires upstream systematic and sustainable change that transforms how organizations, institutions, and leaders provide care for diverse and marginalized populations. Equitable, patient-centered care needs to go beyond the clinical definitions and also be rooted in justice, reflect the SDOH, and be community-driven, notably empowering and uplifting the very

populations it seeks to serve. This session will explore innovative, cross-sector models that provide long-term, equitable care and showcase how cultivating justice-centered leadership that reflects the values, voices, and dignity of communities is crucial to building healthy generations.

Hiba Elkhatab, MPH

Founder

Brewing Public Health

12:40pm

Conference Concludes

12:45pm – 2:45pm

Workshop: Building Your SDOH Referral Network and Resource Directory

Most health systems screen for social needs but struggle with what happens next when patients need housing assistance, food support or transportation help. This workshop will explore building effective community resource directories and referral workflows that actually connect patients to services. Attendees will learn how to identify key community partners, develop referral protocols, create feedback loops to track completion and build sustainable relationships with community organizations. The workshop covers vetting resources for quality and availability, training clinical staff on when and how to refer, managing tracking without overwhelming workflows and measuring impact. You'll leave with a starter resource directory template, referral workflow diagram and partnership outreach plan ready to implement.

You'll develop:

- Community resource directory with contact information and eligibility criteria
- Referral workflow and staff training plan
- Tracking system for referral completion and outcomes
- Partnership development strategy for your priority social needs

Ellen Grant PhD, LCSW-R

President

First Advantage Consulting

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