Advisory Board | Population Health Advisor

Addressing Patients' Non-clinical Risk Factors in Ongoing Management

The Role of Community Partnerships to Advance Population Health Management

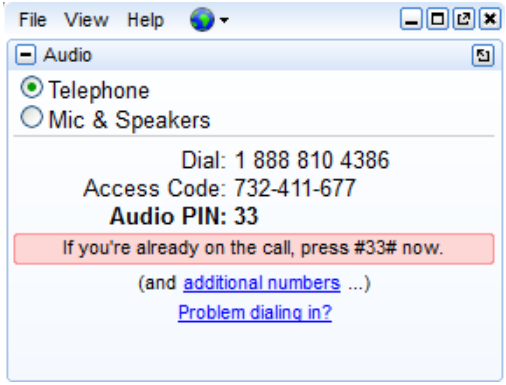
Darby Sullivan
Research Analyst
SullivaDa@advisory.com

Managing Your Audio

Use Telephone

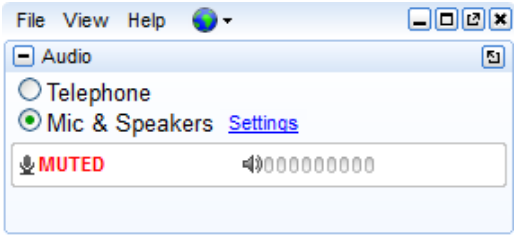
(Recommended)

If you select the “Telephone” option, please use the dial-in phone number and access code provided on your GoTo panel.



Use Microphone and Speakers

If you select the “Mic & Speakers” option, please be sure to check that your speakers/headphones are connected.

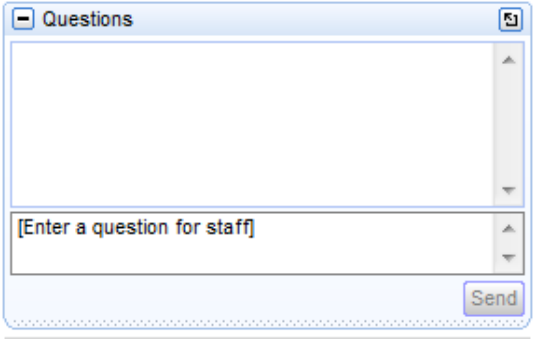


All attendees will be muted during the presentation

Managing Your GoTo Panel

How to Ask a Question

To ask the presenter, please type your question into the “Questions” box on your GoTo panel and press send.



Minimizing and maximizing your screen

Use the orange and white arrow to minimize and maximize your GoTo panel.

Use the blue and white square to maximize the presentation area.

Webconference Survey

Please take a minute to provide your thoughts on today's presentation.

Thank you!

Please note that the survey does not apply to webconferences viewed on demand.

Advisory Board | Population Health Advisor

Addressing Patients' Non-clinical Risk Factors in Ongoing Management

The Role of Community Partnerships to Advance Population Health Management

Darby Sullivan
Research Analyst
SullivaDa@advisory.com

1 The Impact of the Social Determinants of Health

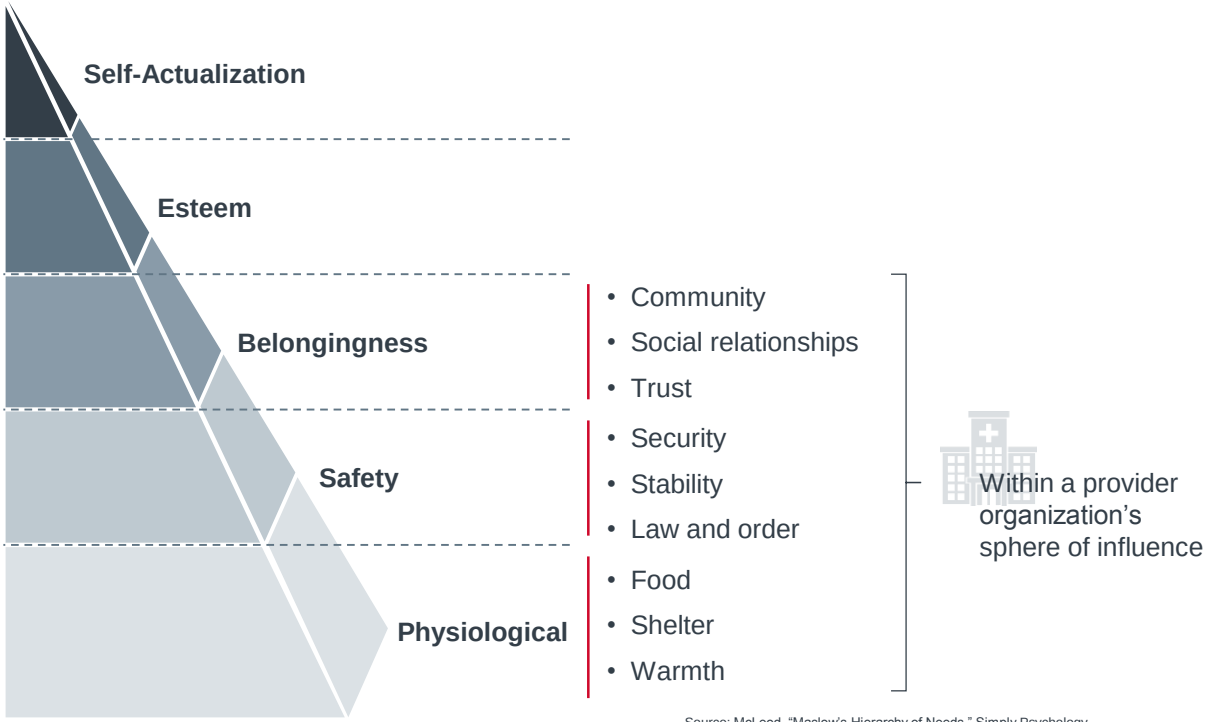
2 The Role of Community Partnerships in Addressing Patients' Non-clinical Risk Factors

3 Key Considerations for Promoting Long-Term Sustainability

Key Drivers of Risk Are Often Non-clinical in Nature

Must Meet Certain Needs Before Care Can Inflect Positive Change

Applying Maslow's Hierarchy of Needs to Population Health Management



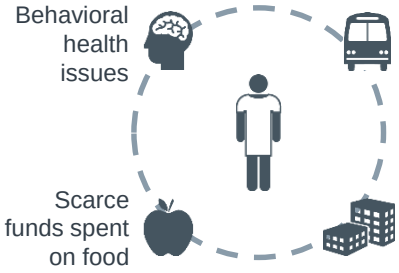
Source: McLeod, "Maslow's Hierarchy of Needs," Simply Psychology, https://www.simplypsychology.org/maslow.html; Population Health Advisor interviews and analysis.

Social Needs Complicate Clinical Challenges

Holistic Approach Critical for Achieving Central Population Health Goals

Surface Underlying Non-clinical Problems Contributing to Worse Health Outcomes

High-risk patient's condition continuing to worsen because patient is not adhering to medication regimen



20%

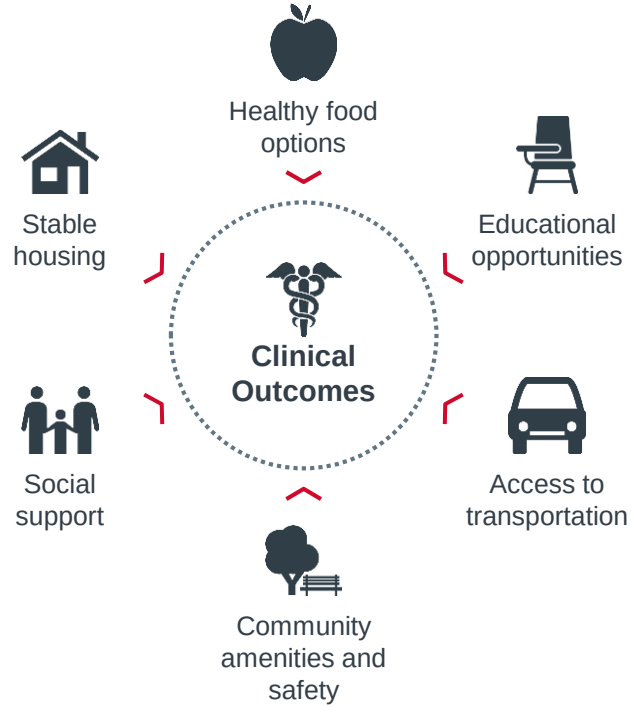
Health outcomes resulting from social and environmental factors

Source: Heiman, "Impact of Different Factors on Risk of Premature Death," Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/; Population Health Advisor interviews and analysis.

High-Risk Patients Face Most Severe Social Needs

Care Teams Unable to Provide Full Range of Services Alone

Interlocking Social Determinants of Health Inform Clinical Outcomes



85%

Physicians reporting that unmet social needs lead directly to poorer health outcomes

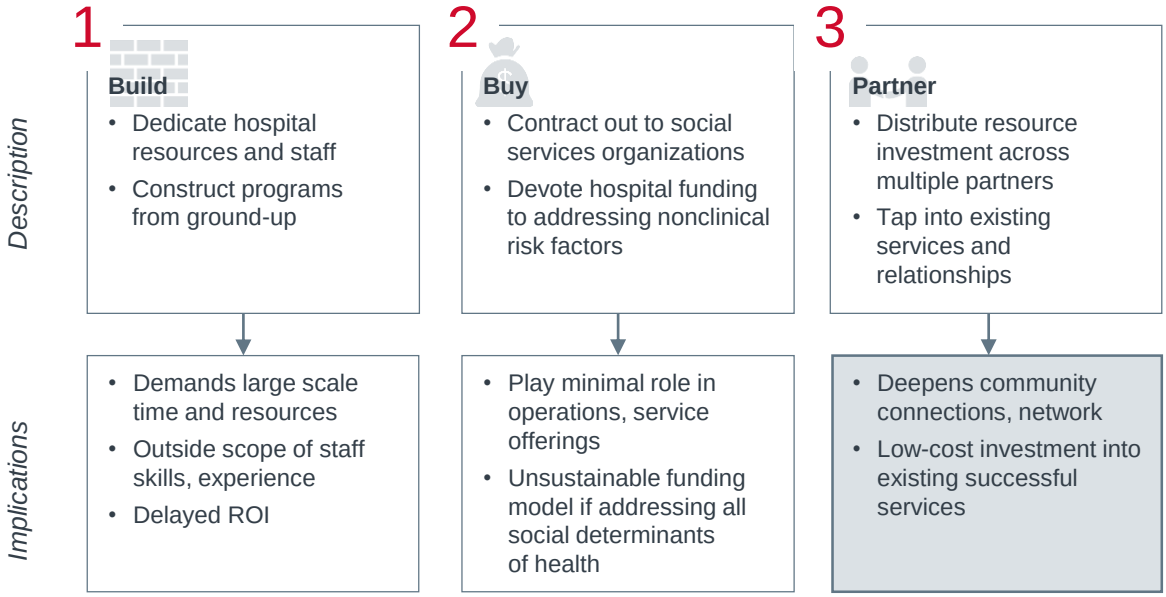
20%

Physicians who are confident in their ability to address unmet social needs

Source: "Health Care's Blind Side," *Robert Wood Johnson Foundation*, http://www.rwjf.org/en/library/articles-and-news/2011/12/health-cares-blind-side-unmet-social-needs-leading-to-worse-heal.html; Population Health Advisor interviews and analysis.

Partner for Sustainability and Efficacy

Don’t Reinvent the Wheel to Address Non-clinical Needs



Source: Population Health Advisor interviews and analysis.

Broad Range of Partners To Choose From

Clinical-Community Linkages Improve Access to Funding and Services

Sphere of Patient Activity and Interactions

COMMON COMMUNITY PARTNERS

- Public health departments
- County mental health agencies
- School districts and universities
- Faith-based organizations
- Service leagues (e.g., Lions, Rotary)
- Environmental organizations
- Local agencies (e.g., housing and city planning departments)
- Non-profit service providers (e.g., Meals on Wheels, food banks)
- Local businesses (e.g., barber shops)
- Public safety providers (e.g., EMS)

3
Primary partners per project (including hospital)

8
Average total number of partners involved per project

$149K
Average hospital match per implementation site

Source: Population Health Advisor interviews and analysis.

CMS Signals Increasing Interest in Partnerships

Government Joins Payers and Private Companies in Efforts

Program in Brief: Accountable Health Communities Model

- **Overview:** Grant program awarded Fall 2016 to test impact of Medicare and Medicaid beneficiaries' non-medical needs on patient outcomes and total cost of care
- **Key Focus Areas**: Housing instability; food insecurity; utility needs; interpersonal violence; and, transportation needs
- **Eligible Applicants**: Community-based organizations, health care provider practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, and for-profit and not-for-profit local and national entities
- **Use of Funds:** Funds cannot pay directly for any community services (e.g., housing, food) received by beneficiaries, but must be used to fund interventions intended to connect people to those offerings

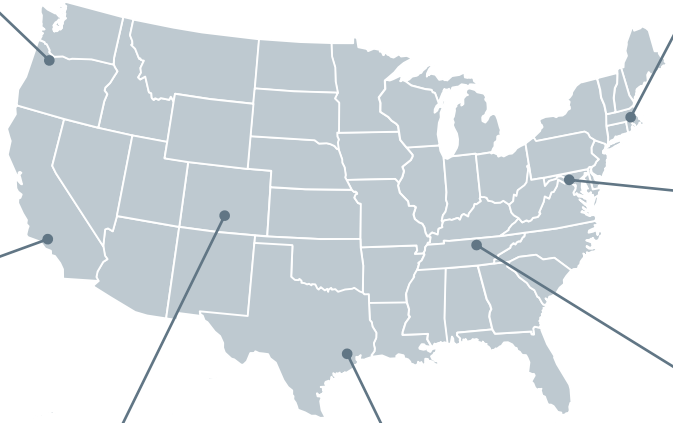
$157M	CMS funding available to bridge clinical care and social services
3 Tracks	Awareness, assistance, and alignment with community service
44	Total awards available to "bridge" organizations
5 Years	Program duration; participants must renew annually
$4.5M	Maximum funding per each of 20 track 3 bridge sites

Source: "Accountable Health Communities Model Fact Sheet," CMS, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-01-05.html; Population Health Advisor interviews and analysis.

Tremendous Innovation Driven by Partnerships

Focus on Determinants of Health Driving Short- and Long-Term Impact

Overview of the BUILD Health Challenge[1] Communities



BUILDing Health and Equity in East Portland

Expanding access to affordable housing, green space, and health food

The Healthy Ontario Initiative

Developing "health hubs" to foster strong bodies and communities

Increasing Access to Behavioral Health Screening and Support

Eliminating health disparities by age five

The Harris County BUILD Health Partnerships

Mitigating food insecurity by redesigning the local food system

Healthy Hill Initiative

Spurring economic development and improving public safety

Healing Together

Empowering youth leaders to stand against violence

Building a Healthy and Resilient Liberty City

Breaking the cycle of violence at all ages

1) The BUILD Health Challenge is an initiative designed to foster and expand meaningful partnerships among health systems, community-based organizations, local health departments, and other organizations that impact health in the community.

Source: Population Health Advisor interviews and analysis.

1 The Impact of the Social Determinants of Health

2 The Role of Community Partnerships in Addressing Patients' Non-clinical Risk Factors

3 Key Considerations for Promoting Long-Term Sustainability

Addressing Non-clinical Needs to Improve Outcomes

Identify Structural Barriers that Contribute to Health Disparities

Map Major Community Health Needs to Partner Organizations With Tools for Success

	Meet Fundamental Needs Critical to Clinical Success	**Remove Barriers to Access Based on Severity of Need**	**Engage Disconnected Patients At-Risk of Clinical Escalation**
Opportunities to Partner	Address baseline needs (e.g., hunger, housing) that must be met before patients can begin to prioritize health care	Increase access to health services, from preventive to specialist care, for patients facing logistical barriers (e.g., work hours, lack of transportation)	Enhance engagement and reduce the trust gap by aligning with community-based organizations serving at-risk, disengaged patient populations
Resources to Achieve Health Equity Aims	• Safe, stable housing • Healthy foods	• Transportation services • Convenient health fairs • Mobile health clinics	• Community health workers • Barbershop screenings • Congregational liaisons

Decreasing resource requirements and severity of need

Source: Population Health Advisor interviews and analysis.

Prioritize Needs That Preclude Health Improvement

Review Evidence to Surface Community's Most Pressing Barriers

Lack of housing

- Leads to increased rates of physical trauma, chronic diseases, dental issues, behavioral health problems, and exposure
- Reduces access to primary care and ability to self-manage

26-36 years reduced life expectancy

$44K average annual cost per highest-volume ED patient experiencing homelessness

Acuity:  High

Food insecurity

- Leads to increased rates of chronic diseases, dental issues, behavioral health problems, stress, and hospitalizations
- Influences purchasing decisions between food and: medicine (74%), transportation (67%), utilities (59%), and housing (57%)

$179B annual direct and indirect health-related costs attributed to food insecurity

Acuity:  High

Language barriers

- Leads to increased rates medical errors, infectious disease, and infant mortality
- Reduces access to preventive care, ability to adhere to care plan, and engagement

2x increased likelihood of interpretation errors without use of a professional

60% increased risk of initial ED visit for patients requiring interpretation services

Acuity:  Medium

Social isolation

- Leads to increased rates of behavioral health problems, dementia, hospital readmissions, and mortality
- Reduces ability for the elderly to live independently

26% increased risk of mortality resulting from loneliness

10% increased annual visits to the doctor

Acuity:  Low

Source: See appendix for complete sources; Population Health Advisor interviews and analysis.

Collaborate to Make Big Community Investments

Diversified Housing Offerings Meets Range of Needs with Tangible ROI

UVMMC[1] Develops Housing Portfolio Through Partnership

	Short-Term	Permanent
Infrastructure	**Harbor Place Rooms**: 22 family units, 34 single units with an average stay of 8 days	**Beacon Apartments**: 18 single units across an indefinite stay
Services	**Case management:** UVMMC funds 1 onsite FTE Case Manager from CHC[1] who connects patients to CHC provider and fulfills additional needs (e.g., insurance) **Mental health services**: Howard Mental Services dedicates one case manager to each site (1 FTE), who is reimbursed separately **Additional clinical services** : Various providers (e.g., Visiting Nurse Association, physician house call) visit each site as needed	
Funding	Pay **per diem rate** for patients Guarantees minimum number of nights	**Helped fund purchase and renovation** of motel and pays operations amount per patient
Results	**Decreased inpatient admissions:** Reduced from 95 to 30 stays **Decreased ED utilization:** Reduced from 161 to 94 visits	**Decreased annual cost of care:** Dropped health care from $750K to $250K for permanently housed patients

1) University of Vermont Medical Center.

Source: Population Health Advisor interviews and analysis.

Food, Nutrition Often at Heart of Initial Partnerships

Obesity, Food Insecurity, and Chronic Conditions Inextricably Linked

	1 Connect to Government Benefits	2 Increased Access to Healthy Foods	3 Nutrition Education and Food Literacy
Goal	Empower and support patients eligible for services	Provide assistance to patients who are food insecure and/or living in a food desert	Offer wrap-around support services to build life skills and habits
Primary Services Offered	• SNAP enrollment assistance program • On-campus WIC Office	• Emergency food • On-site food pantry • Discounted produce partnership	• Nutrition/cooking classes • Budget-friendly, healthy recipes • Grocery store tours
Additional Services	• School and senior meal program enrollment		• Community garden • School food service enhancement support

Source: Population Health Advisor interviews and analysis.

Use Existing Resources for Holistic Nutrition Support

Produce from On-Site Farm Supplements Cross-Continuum Education

Lankenau's Health Educators Combat Food Insecurity Across Care Continuum

	Inpatient	Outpatient	Community
Health educator role	Educate CHF patients and families about healthy eating to encourage long-lasting dietary changes	Lead pop-up nutritional classes and provide free produce and recipes in waiting rooms	Offer nutrition counseling at local farmers markets and corner stores; direct patients to fresh, low-cost produce sources
Added support	Fresh, free produce given to patients from onsite farm	Patients referred to community-based services based on results of Social Needs Survey administered in waiting rooms	$10 Philly Food Bucks vouchers distributed to be redeemed at local farmers markets; corner stores host wellness and preventive care sessions

EMR tracks pop-up class utilization, Philly Food Buck usage, harvest volume, and produce distribution

9,596
Pounds of food harvested

1,600
Patients receiving food during first 1.5 years open

1/2
Acre used for harvest

Source: Population Health Advisor interviews and analysis.

Design Program to Address Root Cause of Care Gap

Stabilize At-Risk With Consistent Touchpoints to Health System

Disconnected Patients Face Three Common Access Barriers That Threaten Outcomes

Miss preventive, primary care appointments due to a lack of adequate transport

Unable to access care due to logistical barriers (e.g., appointment timing, clinic location)

Lack key resources to manage health and access care (e.g., housing, economic stability, insurance)

Map Program to Community's Most Pressing Access Barriers and Level of Care Required

1 Arrange Transportation Support to Bring Patients to You

- Coordinate with rideshare companies
- Offer taxi vouchers

2 Create Convenient Care Hotspots

- Launch targeted health fairs
- Integrate staff in community based organizations

3 Bring Full Scale Services to Targeted Locations

- Invest in mobile health clinic for community hotspots
- Set up worksite clinics

Low Provider integration into the community *High*

Source: Population Health Advisor interviews and analysis.

Getting Patients To, Rather than Through, the Door

MedStar Teams Up with Uber to Bring Qualifying Patients to Appointments

Case Managers Use Uber to Help Patients Overcome Transportation Barrier

Case manager identifies qualifying patient at-risk for no-show

Case manager calls patient up to 90 minutes before appointment

Patient indicates no-show due to lack of transportation

Case manager schedules ride through UberCENTRAL

Patient makes appointment

3.6M People miss medical appointments due to lack of transportation, annually

11-30% Average clinic no-show rate

25% Of low-income patients report missing appointments due to lack of transportation

Average daily revenue capture <100%

Source: Syed, Samina T., Ben S. Gerber, and Lisa K. Sharp. "Traveling Towards Disease: Transportation Barriers to Health Care Access." Journal of community health 38.5 (2013): 976–993. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/. Population Health Advisor interviews and analysis.

Create Convenient Care Hotspots in the Community

Bring Screening Events to Unconnected Groups

Annual Health Fair for Upper Manhattan's Taxi Drivers

Engage Target Population

Livery Cab drivers, adult males of all ages

Pinpoint Specific Health Needs

Sedentary 12-16 hours a day, do not receive regular preventive care

Remove Barriers to Attendance

Lack of parking for cabs, lack of awareness and time

Targeted Outreach Strategy

1. Taxi cab dispatchers direct drivers to the annual health fairs; NYP posts marketing flyers at cab bases
2. Taxi drivers are provided with free parking for their cabs
3. Medical home staff provide HIV, blood pressure, diabetes, cholesterol, prostate, and vision screening
4. Patients receive on-site counseling based on screening results

Source: Population Health Advisor interviews and analysis.

Supporting Team Efforts with Minimal Resources

System Staff Volunteer at Health Fair

Before Health Fair

Outreach Nurse and Coordinator

- Plans and coordinates health fair
- Enlists volunteer providers
- Liaises with taxi dispatchers

During Health Fair[1]

Provider Volunteers

- Conduct all patient screening during health fair
- Provide in-the-moment counseling

After Health Fair

Outreach Nurse

- Follows up on patients with high clinical indicators or positive tests

NewYork-Presbyterian's Regional Health Collaborative Driving Results

20% Portion of a single full-time employee's time dedicated to this initiative

500 Number of patients seen annually at taxi driver health fairs

1) All education and screening efforts made possible by inter-departmental collaboration and community partnerships.

Source: Population Health Advisor interviews and analysis.

Clinic Brings Care to CBOs[1] Serving the Homeless

Eliminate Transit Barriers that Impede Access to Care and Medications

HOMES[2] Program Addresses Needs of Patients Experiencing Homelessness During and After Visit

Clinical Care

Mobile clinic staff provide acute and chronic disease care, education, check-ups, immunizations, mental health counseling, and dental care for children and adults

Psychosocial Services

Supplemental services vary by site and population need (e.g., staff health educator, interpreter, psychologist when visit domestic violence shelter)

Medication Access

Pharmacy supplies 35 medications for patients free of charge to enable patients to start regimen immediately

Referrals to Other Programs

Staff connect patients to other programs (e.g., specialty clinics, housing support)

Specialty, Emergent Care

22-person shuttle loops around central business district to Parkland main campus for additional care (e.g., x-rays, ED care, Class A pharmacy)

9,377	78%	$5M
Patients served in 2015	Patients uninsured	Annual program budget

1) Community Based Organizations.
2) Homeless Outreach Medical Services.

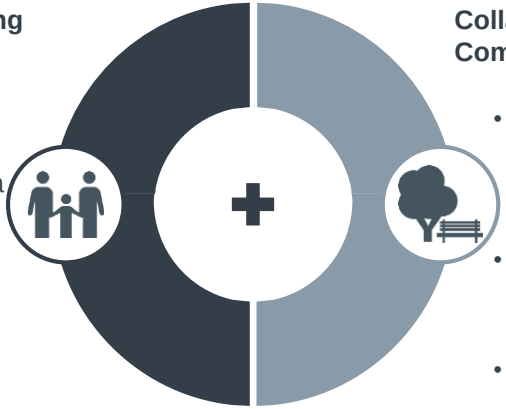
Source: Population Health Advisor interviews and analysis.

Select Trusted Partners with Deep Community Ties

Supplement Programs with Partner Expertise to Jump Start Engagement

Devote Staff to Strengthening Community Relationships

- Build a longstanding relationship by catering to the specific needs of a particular population
- Promote top-of-site utilization by connecting patients with appropriate services
- Embed a health system staff member in the community to build patient loyalty



Collaborate with Trusted Community Partners

- Choose partners based on existing positive relationships with target population
- Augment partner expertise with health system resources
- Build rigorous partnership agreements based on joint principles of collaboration

Time, resource commitment

High — Health system control — *Low*

Source: Population Health Advisor interviews and analysis.

Use CHWs[1] to Capture Disconnected Patients

Bridging the Physician-Patient Communication Gap

Patients in the Community

- Poor access to health care services
- Poor health status
- High disease burden

Promotoras: Community Health Workers

- Navigate patients through health and social services
- Educate patients on healthy behaviors and prevention
- Help patients understand physician advice
- Help physicians understand patient's cultural values, beliefs

Physicians in Clinics

- Access to care, self-management support
- Engaged in goal setting
- Care plan reinforced via peer-to-peer support

Academic Research Supports the Case for Leveraging CHWs

2.28:1
ROI of running a CHW program

25%
Decrease in inpatient visits after contact with a CHW

79%
Frequency of positive outcomes associated with CHWs

1) Community Health Workers.

Source: Bodenheimer, T., "Building Primary Care Teams: 15 Case Studies," *California HealthCare Foundation,* 2007; Dower C, et al., "Advancing Community Health Worker Practice and Utilization: The Focus on Financing," National Fund for Medical Education, https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/6.%202006-12_Advancing_Community_Health_Worker_Practice_and_Utilization_The_Focus_on_Financing.pdf; Population Health Advisor interviews and analysis.

Embed Targeted Health Literacy Approach with Rigor

Initiating Effort with Rx Adherence Goals to Achieve Trackable Success

Improving Health Literacy Necessitates Standardized, Community-Inclusive Process

Develop culturally-relevant and evidence-based **health literacy curriculum**

- Incorporate community input on unit topics
- Use data from needs assessments or studies

Perform individual **patient interventions** across all partner organizations

- Perform teach-back
- Provide visual and written educational materials

Train **health and community leaders** to use effective health literacy techniques

- Medical center staff (e.g., pediatricians, residents, and family support/ community health workers)
- Staff from seven participating CBOs[1] (medical students, volunteers)

Repeat research process as necessary to **adapt curriculum** with changing community needs

1) Community Based Organizations.

Source: Meyer D, "The Health Education and Adult Literacy (HEAL) Program," Healthy Tomorrows Partnership for Children Program, http://mchlibrary.jhmi.edu/downloads/file-7146-1; "Heal - Health Education and Adult Literacy Program," NewYork-Presbyterian, http://www.nyp.org/clinical-services/ambulatory-care-network-programs/heal---health-education-and-adult-literacy-program; Population Health Advisor interviews and analysis.

Leverage Community as Program Design Lab

Columbia University's Three Step HEAL[1] Curriculum Based on Research

Shape Curriculum According to Community-Sourced Needs and Provider-Led Analysis

Provider role

- Community pediatrics unit initiated health literacy program targeted towards parents
- Staff researcher performed an observational study on communication quality between patients and providers
- Included patient exit interviews

Community role

- Key nonprofit partner gathered 22 community members to form three focus groups in Spanish and English
- Groups offered input on patient communication with providers, medication use, and home remedies

Health literacy curriculum

- Seven-unit course developed on a 5th grade reading level and a train-the-trainer manual
- Spanish versions created by speakers native to countries represented by patients
- Unit topics include:
  - Doctor's appointment preparation
  - Over-the-counter medications
  - Prescription medications
  - Home remedies
  - Medication management
  - Upper respiratory infections
  - Antibiotic use

1) Health Education and Adult Literacy.

Source: Meyer D, "The Health Education and Adult Literacy (HEAL) Program," Healthy Tomorrows Partnership for Children Program, http://mchlibrary.jhmi.edu/downloads/file-7146-1; "Heal - Health Education and Adult Literacy Program," NewYork-Presbyterian, http://www.nyp.org/clinical-services/ambulatory-care-network-programs/heal---health-education-and-adult-literacy-program; Population Health Advisor interviews and analysis.

Results Indicate Improved Health Literacy is Viable

Incorporate Applicable Lessons Into Nascent Efforts

83%

Patients approached in waiting rooms indicating interest in program

61%

Increased knowledge/attitude score for parents receiving upper respiratory infection education

145

Pediatric faculty, residents, and family support workers trained at CUMC[1] clinics

Key Lessons To Guide Health Literacy Programs

Base Program on Explicit, Quantifiable Goals

Strong vision for health literacy intervention (e.g., improved medication adherence) spurs metric tracking to prove efficacy and sustain funding

Leverage Networks of CBOs[2] to Build Course

Local social services and nonprofits can connect providers with community representatives who help guide topic development

Inform Clinical Staff of Proven Best Practices

All patient-facing staff should be aware of and trained on health literacy best practices to improve communication protocols

Use Partners to Expand Program Reach

Extend health literacy programming outside the health system into community health clinics and social service organizations

1) Columbia University Medical Center.
2) Community Based Organizations.

Source: Meyer D, "The Health Education and Adult Literacy (HEAL) Program," Healthy Tomorrows Partnership for Children Program, http://mchlibrary.jhmi.edu/downloads/file-7146-1; "Heal - Health Education and Adult Literacy Program," NewYork-Presbyterian, http://www.nyp.org/clinical-services/ambulatory-care-network-programs/heal---health-education-and-adult-literacy-program; Population Health Advisor interviews and analysis.

Pillars of Community Can Help Breach the Trust Gap

MedStar Brings Care to Barbershops to Reach the Disconnected

Staff Perform Screenings Through the "Hair, Heart and Health" Program to Identify African-American Men At-Risk for Hypertension, Diabetes

Barbers trained to promote diabetes and hypertension screening, provide health education

- Receive 8-hour training on informed consent, measuring height and weight, and collecting data

Health navigators conduct blood pressure and blood glucose screenings on-site

- Present in rotating, high-traffic barbershops from 2-7pm five days/week

RN, Dietician, Diabetes Educator perform follow up appointments on-site

- Do not travel for regular screenings

Surfacing Undiagnosed Health Issues

54%

Previously undiagnosed participants with hypertensive or pre-hypertensive BP readings

19%

Participants with uncontrolled BP referred to and tracked for follow-up care

9%

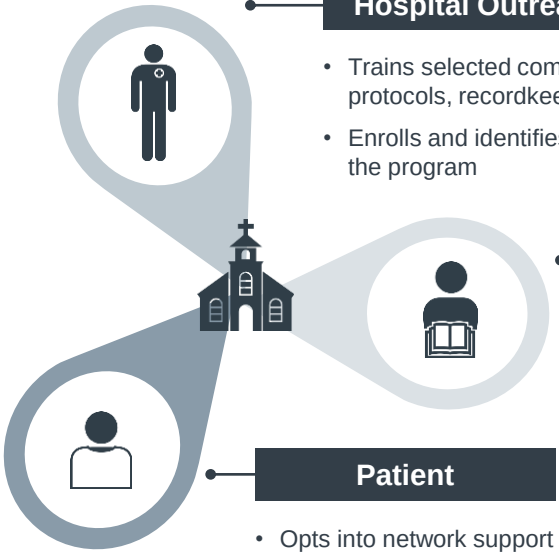
Previously undiagnosed participants with elevated blood sugar

Source: Population Health Advisor interviews and analysis.

Embed Staff in Community to Optimize Transitions

Empower Community Liaisons to Support High-Risk Patients

Outreach Coordinator, Liaison Provide Face-to-Face Patient Support in Community



Hospital Outreach Coordinator

- Trains selected community liaisons on privacy protocols, recordkeeping, and health leadership
- Enrolls and identifies patients who may benefit from the program

Community Liaison

- Coordinates volunteer community caregivers for post-discharge support
- Provides mental health first aid, hospital visitation, and spiritual care for terminally ill patients

Patient

- Opts into network support upon inpatient admission
- Participates in health education courses

20%

Reduction in readmissions among program participants

$4.1 M

Aggregate cost savings from decreased utilization

Source: Population Health Advisor interviews and analysis.

ROAD MAP

1 The Impact of the Social Determinants of Health

2 The Role of Community Partnerships in Addressing Patients' Non-clinical Risk Factors

3 Key Considerations for Promoting Long-Term Sustainability

Providers Can't Afford to Ignore Non-Clinical Needs

Documented Impact of Addressing Specified Patient Need

Need	Reduces Cost	Rightsizes Utilization	Improves Quality	Improves Access	Improves Satisfaction[1]
Language barriers	✓	✓	✓	✓	✓
Behavioral health	✓	✓	✓		✓
Housing instability	✓	✓	✓		✓
Socioeconomic status[2]	✓	✓	✓	✓	
Food insecurity	✓	✓	✓		
Lack of transportation	✓		✓	✓	
Social isolation		✓	✓		✓

1) Includes staff and patient satisfaction.
2) Includes insurance status and financial status.

Source: See appendix for complete sources; Population Health Advisor interviews and analysis.

Best Partnerships Require Rigorous Standards

Success an Iterative Process Requiring Buy-In, Focus, and Care Integration

Prioritize Initial Focus: *Determine what services to start with*

1. Who are the most vulnerable members of my community?
2. What are their greatest non-clinical needs?
3. Who is identifying these needs at the level of the individual?
4. Are assessment results being shared across partners?
5. Are we adequately serving those who may be disconnected from the health system? If not, how will we reach them?

Engage Leadership: *Communicate the business case, resource needs*

1. What is our business case for expanding community engagement/collaboration efforts?
2. How will we measure and track partnership success?
3. What kind of resource commitment can we offer? What resource commitments do we need from others?

Design Standards: *Outline screening, referral protocols and contributions*

1. Which partners can support us in providing these services?
2. How many patients do we aim to treat through this initiative?
3. What will each party contribute?
4. How will we share data and communicate regarding progress?

Source: Population Health Advisor interviews and analysis.

Value to Patients, System Must Be Critically Assessed

Partner Relationships a Two-Way Street, Success Not Guaranteed

Hallmarks of Effective Relationships

Enthusiastic buy-in from leadership and frontline staff

Sustainable infrastructure for stakeholder engagement, feedback

Clear metrics for measuring ROI, transparency, accountability

Aligned back office capabilities for data transparency, continuity

Shared mission and culture

Community Partner Checklist:

- ☐ Provides high quality services valuable to Medicaid population
- ☐ Conveniently located near crowded, high-Medicaid system EDs
- ☐ Articulates clear value to system, with demonstrable ROI
- ☐ Maintains open, transparent communication channels
- ☐ Willing to meet clinical standardization expectations
- ☐ Willing to progress toward risk-based arrangements

Source: Health Care Advisory Board interviews and analysis.

Many Opportunities for Engaging Staff with Partners

Communication Strategy Depends on Resource Availability

Investment Required

Develop Community Resource Guides

- Community resource guides assist in identifying community organizations for assistance
- Universal referral forms improve exchange of patient information

Leverage Volunteers and External Resources

- Volunteers support either within the organization or in the community to connect patients to community resources
- Community members can be leveraged for health screenings or health education and coaching

Employ Community Resource Specialists

- Community Resource Specialist handles non-clinical patient issues that interfere with clinical outcomes
- Forges relationships with local organizations and fields patient requests

Source: Population Health Advisor interviews and analysis.

A Few Lessons from Experienced Peers

Advice from BUILD Leaders Helps Efforts Start Strong

Define key terms upfront. For example, there may be multiple concepts of "community" even within a single institution (e.g., metro region, adjacent neighborhoods, specific zip codes)

Balance accessibility with meaningfulness of data. Useful measure sets should capture both community conditions (e.g., whether housing is affordable and people are healthy) and institutional effort (e.g., dollars spent, staff hired)

Partner with community groups to collect data. While hospitals have robust clinical data, other partners have ready access to other helpful data points such as home environment

Include a mix of process and outcome metrics. Demonstrating outcomes can be slow given the pace of work and long-tail of certain interventions, so ensure metrics provide helpful guideposts for progress in the interim

Aim for "good enough." There are no perfect metrics or perfect methods for isolating impact in interventions with multiple partners and confounding factors

Building the Business Case for Community Partnership

Four steps for building effective community partnerships to extend care team reach and improve cost and quality. *Access it here*

Source: Population Health Advisor interviews and analysis.

First Steps Can Be the Most Challenging

Tactics for Identifying Community Health Disparities

Next Webconference

Advancing Health Equity: Surfacing Disparities in Outcomes and Care Delivery

Thursday, February 1st, 2018 • 3:00p.m.

Join us again in February to discuss how to identify your community's most pressing social determinants of health. This collaboration from Population Health Advisor and Health Disparities Initiative will outline best practices for surfacing health disparities on a community- and patient-level.

Register for the webconference here.

Source: Population Health Advisor interviews and analysis.

Webconference Survey

Please take a minute to provide your thoughts on today's presentation.

Thank you!

Please note that the survey does not apply to webconferences viewed on demand.

Appendix

Sources Cited, Page 16

Lack of Housing
"Health Problems of Homeless People," NCBI, (1988), https://www.ncbi.nlm.nih.gov/books/NBK218236/; "Health Care and Homelessness," National Coalition for the Homeless, http://www.nationalhomeless.org/factsheets/health.html; "The Cost of Homelessness Facts," Green Doors, http://www.greendoors.org/facts/cost.php.

Food Insecurity
Aungst, "Food Insecurity and Health Impacts," Michigan State University Extension, http://msue.anr.msu.edu/news/food_insecurity_and_health_impacts; "What are the Connections Between Food Insecurity and Health?," Hunger + Health, https://hungerandhealth.feedingamerica.org/understand-food-insecurity/hunger-health-101/; Cook, J et al., "Estimating the Health-Related Costs of Food Insecurity and Hunger," Bread for the World Institute, http://www.childrenshealthwatch.org/wp-content/uploads/JohnCook_cost_of_hunger_study.pdf.

Language Services
"Language Barriers in Health Care: Select Findings from the Literature," Robert Wood Johnson Foundation, https://www.rwjf.org/content/dam/farm/meetings_and_conferences/speeches_and_presentations/2008/rwjf26940; Foden-Vencil, "In the Hospital, a Bad Translation Can Destroy a Life," NPR, https://www.npr.org/sections/health-shots/2014/10/27/358055673/in-the-hospital-a-bad-translation-can-destroy-a-life; Njeru J, et al., "Emergency Department and Inpatient Health Care Utilization Among Patients Who Require Interpreter Services," *BioMed Central*, 15, no. 214 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4448538/.

Social Isolation
Seegert, "Social Isolation, Loneliness Negatively Affect Health for Seniors," Association of Health Care Journalists, https://healthjournalism.org/blog/2017/03/social-isolation-loneliness-negatively-affect-health-for-seniors/; "Threat to Health," Campaign to End Loneliness, https://www.campaigntoendloneliness.org/threat-to-health/; Gerst-Emerson, "Loneliness as a Public Health Issue: The Impact of Loneliness on Health Care Utilization Among Older Adults," *American Journal of Public Health*, 105, no. 5 (2015): 1012-1019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4386514/.

Source: Population Health Advisor interviews and analysis.

Sources Cited, Page 42

General: Bachrach D, et al., "Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment," *The Commonwealth Fund*.

Language barriers: Njeru J, et al., "Emergency Department and Inpatient Health Care Utilization Among Patients Who Require Interpreter Services," *BMC Health Services Research*, 15, no. 214 (2015); Foden-Vencil K, "In The Hospital, a Bad Translation Can Destroy a Life," NPR; "Speaking Together: National Language Services Network," Robert Wood Johnson Foundation; Jacobs A, "The Impact of an Enhanced Interpreter Service Intervention on Hospital Costs and Patient Satisfaction," *Journal of General Internal Medicine*, 22, (2007): 306-311; Population Health Advisor interviews and analysis.

Behavioral health: "Behavioral Health Management Guide," Population Health Advisor, Advisory Board; Population Health Advisor interviews and analysis.

Housing instability: "How to Close the Housing Gap Through Strategic Partnerships," Population Health Advisor, Advisory Board; Population Health Advisor interviews and analysis.

Socioeconomic status: "Teaching Uninsured Patients to Self-Administer IV Antibiotics at Home," *NEJM Catalyst, (*2016); "Goods for Guns," UMass Memorial Medical Center; Samuel LJ, et al., "Does the Supplemental Nutrition Assistance Program Affect Hospital Utilization Among Older Adults? The Case of Maryland," *Population Health Management*, (2017); Sommers B, et al., "Health Insurance Coverage and Health — What the Recent Evidence Tells Us," *NEJM*, 377, (2017): 586-593; Population Health Advisor interviews and analysis.

Food insecurity: "Provider-Led Strategies for Addressing Food Insecurity," Population Health Advisor, Advisory Board; Population Health Advisor interviews and analysis.

Lack of transportation: Care Delivery Innovation Reference Guide, Population Health Advisor, Advisory Board; Population Health Advisor interviews and analysis.

Social isolation: Dickens A, et al., "Interventions Targeting Social Isolation in Older People: A Systematic Review," *BMC Public Health*, 11, no. 647 (2011); Gerst-Emerson K, et al., "Loneliness as a Public Health Issue: The Impact of Loneliness on Health Care Utilization Among Older Adults," *American Journal of Public Health*, 105, no. 5 (2015): 1013-1019; "Threat to Health," Campaign to End Loneliness; Population Health Advisor interviews and analysis.

Source: Population Health Advisor interviews and analysis.

Advisory Board

2445 M Street NW, Washington DC 20037
P 202.266.5600 | F 202.266.5700 | **advisory.com**