Moving Beyond Walls: From Clinical to Community

Tuesday, March 1 – 3:30-4:45pm

Connecting Clinical and Community Prevention: The Necessary and Complex Paradigm Shifts

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Currently, the United States spends approximately $3 trillion dollars in health care and $1 trillion dollars in social services making them an outlier. Every health system in the nation has begun a conversation around "population health" with very little understanding and and lacking the internal competencies to bridge the community with the traditional and historic role of most acute care hospitals. Both the health systems and traditional public health are in the process of major transformations and the tension between the two entities continues in many communities. Understanding the transitional process and the necessary changes in infrastructure, leadership, and mental models is a critical component in helping every community navigate the necessary changes.

This session will outline the challenges and opportunities in navigating the important conversation with community partners and health systems and highlight the important conversations being held in communities that have begun the journey to creating the health system of the future. A special focus will be given to an area of the inland empire where the majority of the hospitals invested their community benefit dollars into a regional healthy communities initiative. The successes and lessons learned from this 10-year initiative will be outlined in this session.

Learning Objectives

- Articulate the leadership competencies necessary within health care for advocating for community health.
- Identify the political and economic barriers to connecting clinical and community prevention.
- Identify the complexity and collaboration necessary for promoting community-based prevention.

Tuesday, March 1 – 5:00-6:15pm

Community Partnerships to Provide Better Care for Our Patients

Regina McClenton, RN, Associate Director of Population Health, Rush University Medical Center
Christopher Nolan, Adjunct Faculty, Department of Health Systems Management, College of Health Sciences; Project, Manager, Population Health; Chair, LGBTQ Health, Committee, Diversity Leadership Council, Rush University Medical Center
Emily Hendel, CNP, Director of Nursing Services, CommunityHealth
Vidya Chakravarthy, Project Manager, Population Health, Rush University Medical Center

Despite the many benefits of the Affordable Care Act, there are still millions of individuals that struggle to access appropriate, affordable health care services. These individuals are either unable to obtain insurance or are newly insured and new to the health care system. In response to this gap in health care, Rush University Medical Center is enhancing its partnerships to meet the needs of these patients. Rush is working with organizations such as CommunityHealth, the nation's largest free clinic on the near west and south sides of Chicago, and various Federally Qualified Health Centers as

part of the Medical Home Network Accountable Care Organization. Together, this collaboration provides patients with successful transitions of care, warm handoffs between providers, more effective care models, and the best place of service for each patient.

Rush's community partnerships with organizations such as CommunityHealth and the MHN ACO have created methods to improve access to quality, lower-cost, appropriate health care services. Through an integrated, interprofessional approach, Rush identifies how to best approach each patient and successfully transition them based on their insurance status, acuity level, and utilization trends. For instance, if a patient lacks insurance and an established medical home, CommunityHealth offers patients a primary care medical home as well as free medications, specialty, dental, and social work services.

This presentation will detail the process to help the most vulnerable patients best navigate the health care system, how relationships can be enhanced between an academic health system and community providers, and how to create sustainable models to provide individuals with the care they need.

Learning Objectives

- Detail how a partnership of an academic medical center and community clinic can improve the health of the most vulnerable patients;
- Demonstrate the process and complexities of helping the most vulnerable of patients – whether newly insured, uninsured, or uninsurable navigate the health care system;
- Provide other organizations with lessons learned from and the complex needs that arise with transitioning some of the most vulnerable patients to stable medical homes.

Wednesday, March 2 – 8:45-10:00am

Frameworks for Connecting the Clinic and the Community: THRIVE and Community Health Worker Models

Stacey Chacker, Project Director, Health Resources in Action
Heather Nelson, PhD, Senior Research Scientist, Research and Evaluation, Health Resources in Action
Rea Panares, MHS, Senior Advisor, Prevention Institute
Alisa Haushalter, DNP, RN, Senior Director, Department of Population Health, Nemours Children's Health System

This session will present two frameworks for connecting clinical needs with the community. Health Resources in Action will describe the process New England Asthma Innovation Collaborative--a multi-state partnership that includes nine health care providers, six Medicaid payers, and policy makers--is using to engage Medicaid payers, as well results from the evaluation from NEAIC and challenges and lessons learned along the way. Details include: efforts to secure claims data from 6 payers for the cost analysis, an assessment to learn about factors important to payers when considering covering CHW-delivered asthma interventions, results from a NEAIC's March 2015 Payer/Provider meeting, and steps towards sustainability.

Developed by Prevention Institute with support from the Office of Minority Health, THRIVE (Tool for Health and Resilience in Vulnerable Environments) is a framework for understanding how structural drivers play out at the community level to impact community determinants, and consequently, health and safety outcomes, and inequities in outcomes. The Delaware Public Health Institute and their partners at the Nemours Foundation introduced THRIVE across a diverse assembly of agencies and perspectives, engaged a variety of stakeholders to align health priorities, increased the capacity of the health care community to implement THRIVE in their work and Community Health Needs Assessments and began integrating THRIVE with Delaware's State Health Improvement Plan process through follow-up trainings and quarterly evaluation. In this session, participants will hear about the work in Delaware, as well as how THRIVE can be used as a framework and tool in their own states, communities and organizations.

Learning Objectives

- Describe the process used to engage payers a multi-state collaborative to promote sustainable financing for CHW asthma home visiting.

- Explore challenges and potential solutions to promoting sustainable (and interim) financing for CHWs, be it from Medicaid payers or from Accountable Care Organizations, using NEAIC and their own projects as a learning laboratory.
- Demonstrate an understanding of THRIVE as a framework and tool for community-clinic collaboration to address social determinants of health and promote health equity.
- Identify opportunities to use THRIVE as a framework and tool in their states, communities and organizations.

Wednesday, March 2 – 10:30-11:45am

Effective Community Care Design for High Risk/High Utilizer Patients

Irene de Jesus, JD, RN, Regional Director, Community Care Program, Florida Hospital
Jill Piazza, Vice President, Care Integration, Florida Hospital

In this session, attendees will be guided through the business planning process of community care proof of concept, program design and structure, funding requirements and performance measures utilized to launch and replicate throughout Florida Hospital East Region's health care systems. We will also demonstrate first- and second-year learning that identified and showed improvements in both clinical outcomes and cost metrics.

Challenges addressed:

- Connecting the associated members, patients, physicians and caregivers to commit to a new delivery model;
- Key players involved: physicians, social workers, ED staff, transition care coordinators, executive management, allied health professionals in university settings, community leaders;
- Steps or processes implemented: Building both a clinical and financial plan; partnerships with local universities;
- Relevant outcomes achieved: Creating an outcome driven statement of goals for year one that include reducing ED visits, reducing avoidable readmissions, reduce total cost of care, improve vulnerability scoring of patients, increase patient satisfaction; and
- Success factors and/or prerequisites: Adjusting goals and directives from new learning; effective and regular communication to stakeholders; inclusion of support resources in all aspects of planning and execution.

Learning Objectives

- Identify essential elements that contribute to launching community care program for high risk patient populations
- Understand the importance of visualizing and establishing clinical and financial goals over 3-5 years and how those metrics address specific improved patient outcomes, appropriate and regular care interventions that provide reduced costs of care
- Learn how to sustain and grow improvements: Treating the whole patient improves the health of the community
- Addressing the areas of mental, spiritual, physical, emotional and social needs that impact this patient population

Wednesday, March 2 – 2:45-4:00pm

Identifying the Intersection of Community Health Needs and Health Care Utilization

Colleen Milligan, Senior Manager, CHNA Project Manager, Baker Tilly
Christina Cool, Senior Consultant, Baker Tilly

Hospitals, Public Health, and other social service providers can better identify community health disparities and design interventions to improve community health by understanding how consumers are using the health delivery system. Conversely, health care delivery is improved when it is tailored to meet the specific needs of high risk or disparate populations by understanding the socio-economic factors that influence health. Because CHNAs have historically focused on "external" community or public health data, we've missed an enormous opportunity to better understand health care usage and align population health management strategies with community health priorities.

By incorporating health care utilization data into our clients' CHNAs, Baker Tilly has been able to demonstrate the impact of social determinants on health care utilization, tracking the highest percentage of chronic disease and behavioral health

back to the most disparate populations within our communities. Clearly showing this relationship has helped our clients bridge the gap between their "external facing" community health improvement strategies and "internal facing" population health management process improvements, while measuring ROI through public health measures, as well as impact on health care utilization.

The culmination of the data integration is developing an implementation plan that includes strategies for partnership in the community to enhance prevention and education to high risk populations and incorporates CHNA findings into hospital strategies to improve care transitions, patient engagement, staff competency, and performance measures.

Learning Objectives

- Learn what hospital utilization data is most valuable to incorporate in CHNA
- Learn how to develop concurrent strategies that drive and measure community health improvement and population health management initiatives
- Learn tactical steps to develop internal work teams to integrate community health and population health management strategies

Wednesday, March 2 – 4:30-5:45pm

Collective Impact & Community-Centered Health Homes: Promising Healthcare Models for Addressing Social Determinants and Equity

Tiffany Netters, Program Manager, Louisiana Public Health Institute
Nora J. Bailey, President of the Board, the Partnership for a Healthy Community and President of Strategic Management Initiatives
Chandra Smiley, Executive Director, Escambia Community Clinics, Inc.
Rea Panares, Senior Advisor, Prevention Institute
Sandra Veronica Serna, MPH, Program Manager, Gulf Coast Healthy Communities
Jessica Riccardo, Interim Clinical Transformation Portfolio Director, Louisiana Public Health Institute

This session will provide real world examples of how health care organizations are implementing two promising models within communities that address social determinants of health and equity. Participants will gain an understanding of the key characteristics of robust partnerships that enable the successful implementation of the Collective Impact Model. Presenters will address strategies for sustaining collaboration and engaging unlikely partners. Participants will also gain a clear understanding of the Community-Centered Health Home Model and hear about lessons learned regarding its implementation in clinical settings and health center capacity to engage in community-centered practice.

Thursday, March 3 – 9:15-10:30am

Transition to Success: A National Standard of Care to Treat Poverty

Marcella Wilson, PhD, President and CEO, Matrix Human Services
Nancy Combs, Director, Community Health, Equity, and Wellness, Henry Ford Health System

Transition to Success is a standard of care to treat the condition of poverty, a condition that affects over 45 million individuals in the United States. TTS addresses the social determinants of health by coordinating care across health, human services, government, and education. This standard maximizes existing funding streams and integrates uniform protocols based upon best practices of care management, volunteerism, financial literacy and peer mentoring.

TTS utilizes a 19 domain reliability tested tool to assess and measure outcomes related to the social determinants of health. TTS is based on a continuous quality improvement model with uniform standards of practice, creating consistency in care, measurement and evaluation.
With extensive experience in health care administration, Ms. Wilson brings a health care lens and methodology and presents how a standard of care creates consistent practice to maximize all services to address social determinants and improve health outcomes.

A standard of care to treat poverty aligns with the critical needs of the medical field across the nation: to recognize and respond to the social determinants of health. In partnership with Henry Ford Health System, including the regional, multi-sector collaborative, Women-inspired Neighborhood Network: Detroit to reduce infant mortality, Matrix is directly addressing the social determinants of health with uniform care protocols.

This presentation integrates evidence-based best practices, collective impact, and a model to improve outcomes for those most in need. Participants will experience a paradigm shift in understanding heath equity, poverty in America, and its pervasive nature that affects an individual's physical, emotional, developmental and behavioral health, impacting communities at large. TTS is a dynamic first step in unifying, organizing, and evaluating the complex system of care for children and families living in poverty.

Learning Objectives:

- Understand a paradigm shift for poverty as a treatable, environmentally-based condition and not a character flaw;
- Develop knowledge of evidence-based treatment methodologies and analytics designed specifically to respond to social determinants of health; and
- Learn of current pilots across health, human services, government, and education programs, promising outcomes and impact, and a continuous quality improvement process for the treatment of poverty.