Moving Upstream: Prevention, Resilience and Social Determinants

Thursday, March 9, 3:30-4:45 pm

Hospital Strategies to Improve Healthy Food Access and Community Food Environments
Gary Cohen, President, Health Care Without Harm
Leigh Caswell, MPH, Director, Center for Community Health, Presbyterian Healthcare Services
Eric Kornacki, Executive Director, Re:Vision

Hospitals are increasingly adopting a range of strategies to promote healthier environments to improve the health and well-being of their communities. Food is a key component of a healthy life and an important economic driver to support a healthy community. This session presents innovations for hospitals mobilizing community benefit programming, hospital food service, and community partnerships to improve healthy food access and strengthen local and sustainable food systems. Compelling examples of community engagement demonstrate how hospitals can support community resilience and health equity, promote healthier diets, and reduce risk of obesity and diet-related disease. Health Care Without Harm (HCHW) presents its multifaceted approach to engaging the health care sector to promote healthy, resilient food systems for community health. HCWH discusses its groundbreaking work with its network of over 1000 hospitals to implement food strategies as a core form of preventive medicine.

Next, Presbyterian Healthcare Services (PHS), an 8-hospital health system in New Mexico, showcases its innovative food-related community health programming, including a mobile farmers’ market, a fruit and vegetable “prescription” program, a wellness referral center, a child and adult care meal program, and support for Food Corps. PHS also highlights community collaborations for sustainable financing of community health initiatives.

Finally, Re:Vision demonstrates its work to build a community-owned food system that increases access and affordability to healthy food while creating economic opportunity in one of Denver’s most vulnerable neighborhoods. Re:Vision has created the largest community-led urban agriculture program in the country. Denver hospitals provide community benefit support to Re:Vision’s work with health promotoras to increase SNAP enrollment and provide culturally tailored nutrition education, budget shopping and healthy cooking classes, among other health improvement initiatives. Both case studies identify keys to success for building strong community partnerships and clinical-community interventions to promote healthier food environments.

Learning Objectives:
• Articulate hospitals’ incentives and strategies for promoting healthy food access and healthier, more resilient food systems in their communities
• Describe an innovative health system’s impact in mobilizing food procurement, community benefit programming and community partnerships to improve healthy food access
• Identify keys to success for hospital-community interventions to promote healthy eating and community resilience through health promotoras programs
Thursday, March 9, 5:00-6:15 pm

Health Enterprise Zones: Innovative Strategies for Addressing Determinants of Health
Maura Dwyer, DrPH, MPH, Program Director, Health Enterprise Zones Initiative, Maryland DHMH
Maha Sampath, Director, West Baltimore CARE Health Enterprise Zone, Bon Secours Baltimore Health System
Lori Werrell, MPH, MCHES, Director, Health Connections, MedStar St. Mary’s Hospital

The Health Enterprise Zone (HEZ) Initiative is innovative in its design, approach and timing, and is demonstrating its effectiveness in addressing several of Maryland’s priority outcomes. This session will highlight core components of the HEZs and their approach to addressing social determinants of health, with particular focus on the community engagement and partnership strategies that have enabled their work. An expert workgroup was convened in response to Maryland’s persistent health disparities to investigate strategies to eliminate health disparities. The key recommendation of the workgroup was the creation of the HEZs, defined as contiguous geographic areas where the population experiences poor health outcomes that contribute to health disparities. The HEZs were enabled by the Maryland Health Improvement and Disparities Reduction Act of 2012 and include a range of incentives to attract primary care, behavioral health and dental clinicians to expand or open practices, and to support community-level interventions such as community health workers to broaden the scope of care within a given community and thus address social determinants of health.

The five HEZs, which were designated in 2013, are led by local coordinating organizations and are based in three hospital systems and two local health departments. The HEZs have developed integrated health care systems that are leading health care and prevention efforts in a patient and family-centered manner and with a health equity approach. These systems work with a variety of stakeholders to improve health and decrease costs, expand access, empower communities and reduce health disparities. Further, the HEZs have leveraged health care delivery and payment reforms at the federal and State levels to create a model that aligns systems and incentives. Finally, the HEZ model has realized reductions in Maryland’s priority outcomes, preventable hospital admission and unplanned readmission rates.

Learning Objectives:
• Describe the core components of a comprehensive approach to addressing social determinants of health
• Identify community engagement and partnership strategies essential to addressing social determinants of health
• Describe new and emerging opportunities within the health care system for addressing social determinants of health related to recent health care delivery and payment reform efforts

Friday, March 10, 8:45-10:00 am

Addressing Social and Legal Needs in Pediatric Hospitals: Insights from Arkansas and Ohio
Jessica Saunders, MPA, Director, Center for Child Health and Wellness, Dayton Children’s Hospital
Chloe Green, Manager, Learning Networks, Health Leads National
LeeAnn Oakley, LCSW, Medical Social Worker, Patient-centered Medical Home, Arkansas Children’s Hospital
Meredith Fay Carpenter, MHA, Medical-Legal Partnership Coordinator, Arkansas Children’s Hospital
Mary Claire Hyatt, JD, Equal Justice Works Fellow, Legal Aid of Arkansas, Arkansas Children’s Hospital

When patients and their families seek medical care, they often are additionally facing critical challenges in their lives – they may have little food, they may not have a job or they struggle to keep up with bills for utilities. Unfortunately, these challenges often affect their health. To address these issues, Dayton Children’s Hospital launched a new program called the Family Resource Connection to screen patient families for unmet social needs – like food, housing and transportation – and connect them with community resources. Leveraging tools, training and consulting from Health Leads, a social enterprise that envisions a healthcare system that addresses all patients’ basic resource needs as a standard part of quality care, Dayton Children’s tailored this program to the meet the needs of its local patients and clinical workflows. In addition to providing important resources to patient families to improve health outcomes, the Family Resource Connection enables clinical staff to work at the top of their licenses while engaging with a variety of students from multiple disciplines to staff the program. The program is staffed by a coordinator with a masters in social work, and more than a dozen students representing multiple local universities, who are familiar with the area and local
services. This session will focus on program design, implementation, measurements and the initial successes of this innovative program addressing the social determinants of health as part of the clinical process.

Learning Objectives:
• Describe a potential process for screening for social needs during a physician visit
• Identify social needs commonly identified by patient families
• Describe a process for connecting and following-up with families to address social needs

Friday, March 10, 10:30-11:45 am
Environmental and Climate Risks Influencing Community Health: A Health System’s Response
Dora Barilla, DrPH, MPH, Executive Leader, Community Investment, Providence Health & Services
Elizabeth Schenk, PhD, MHI, RN, BC, Nurse Scientist, Providence Health & Services
Ellen Tohn, MCP, Consultant, Tohn Environmental

Community benefit investments provide an opportunity to address health priorities while also reducing greenhouse gas emissions that mitigate the health risks of a changing climate. At Renton, Washington-based Providence Health & Services, part of Providence St. Joseph Health, environmental stewardship and the effects of climate on our communities is an important strategic priority. Like many large health systems, the challenge we confront is how to connect this work and resources to our community health improvement and benefit activities. Through collaboration with our caregivers and in partnership with Health Care Without Harm, we are developing new tools and strategies to identify and respond to environmental and climate exposures. Providence is piloting a new community health needs assessment process that integrates climate and environmental assessment practices, creating strategies to identify health practices with climate co-benefits, and cross training caregivers throughout our system. There will be a focus on initiatives in select hospitals and an overview of the collaboration with community groups working on the impacts of climate change.

Learning Objectives:
• Explain the rationale and strategies driving large health systems to address environmental stewardship
• Describe how a health system works with existing and novel community resources to improve health based on environmental risks
• Identify tools to assess environmental and climate risks in CHNA processes and evaluate community benefits for climate co-benefits

Friday, March 10, 2:45-4:00 pm
Project Vision: Working Together to Address Substance Abuse & Build Great Neighborhoods
Sarah Narkewicz, RN, MS, CDE, Director, Community Health Improvement, Rutland Regional Medical Center
Scott Tucker, Commander, Executive Director, Project Vision, Rutland City Police
Ludy Biddle, Executive Director, NeighborWorks of Western Vermont

The plague of opioid addiction was eroding the quality of life in Rutland, VT. As the third largest city in Vermont with a population of approximately 16,495, Rutland is located 20 miles east of New York, and is on the receiving end of a major New York City drug pipeline. It took the tragic death of an innocent, promising high school student to wake up the community and take action. In 2012, the Rutland City Police led the charge to create a community wide approach called Project VISION to address the drug-related challenges facing the community. It is based on the premise that making more arrests will not solve the problem of opioid addiction. The project addresses the underlying issues of substance abuse and its related criminal activity by involving the broader community. Over 100 organizations are involved with the project including health and social organizations, schools, colleges, businesses, the City of Rutland, state and federal probation & parole and law enforcement agencies, faith-based groups, volunteers and neighbors. The effort has a four pronged approach. One is the VISION Center which houses eight embedded community partners that collaborate on responding to those in crisis. Three Sub-Committees address public safety, substance abuse, community, housing, neighborhoods and the culture of a high risk neighborhood.
This collaborative effort is producing measurable results for the Rutland community. From 2013-2015, crimes occurring in the City of Rutland related to drug seeking activities decreased; burglaries declined by 60 percent; robberies, shoplifting and thefts decreased 53 percent, 36 percent and 20 percent respectively. A 2016 community survey shows that people feel safer, are more engaged and are proud to live in their neighborhood. Substance abuse treatment programs serve almost 1,000 patients and expanded through the opening of a methadone clinic and increased Office Based Opioid Treatment.

Learning Objectives:
• State the collaborative proactive and evidence-based approaches developed by law enforcement that has reduced crime
• Describe the multifaceted changes that have improved the quality of life in a targeted neighborhood
• Outline the growth of the collaborative model addiction treatment services and supports that has reduced the wait time for services

Friday, March 10, 4:30-5:45 pm
How a Hospital-Community Partnership Helps Children Thrive
Robert Kahn, MD, MPH, Professor of Pediatrics, Associate Chair of Community Health, Cincinnati Children’s Hospital Medical Center
Chara Fisher Jackson, Executive Director, Greater Cincinnati Urban League

Cincinnati Children’s Hospital has been a leader in providing quality pediatric care for over a century. Cincinnati LISC has worked for decades to revitalize neighborhoods by implementing solutions that address the needs of families and children for housing, education, jobs and income, nutrition and safety. Most often health care and community development organizations are working in the same cities, but on separate tracks. In Cincinnati, these two community institutions are increasingly working together to realize a common vision: helping Cincinnati’s children to thrive.

This session will share best practice and lessons learned from this partnership, including: how a hospital can partner with community development and other community-based organizations to address the social and economic factors that influence children’s health and wellbeing; the resources, tools and techniques used in a community development-driven collective action approach that has been effective in building local nonprofit capacity and bringing a wide range of community-based service organizations to the table to collaborate with the hospital; the use of improvement science and learning networks in multiple neighborhoods to understand the needs of parents and children, and identify ways to remove barriers to children’s health and create system-level and policy changes that can help all children thrive; and how a community development organization can use its financing and real estate development expertise to help inform and target a hospital’s neighborhood-level investments.

Learning Objectives:
• Learn about an emerging, effective partnership between a children’s hospital and a community development organization that uses improvement science to remove barriers and create systemic change to help children thrive.
• Understand the tools and resources used by community development to build the capacity of neighborhood based nonprofit organizations
• Become aware of how a learning network can drive system-level changes and inform neighborhood-level investments to improve children’s health
Saturday, March 11, 9:00-10:15 am

Putting Health Equity First in Chicago and Cook County
Laurie Call, Director, Center for Community Capacity Development, Illinois Public Health Institute
Christopher Nolan, MPA, Manager, Community Benefit and Population Health, Rush University Medical Center
Paula Meyer Besler, JD, CDM, Director, Community and Health Relations, Advocate Lutheran General Hospital

Through the Health Impact Collaborative of Cook County, over 25 hospitals are working with diverse partners across sectors and across communities to improve health equity, wellness and quality of life in Chicago and suburban Cook County. This session will feature presentations from three of the collaborative’s steering committee members, representing two member hospitals and the “backbone organization.” The presenters will discuss how the Health Impact Collaborative is working to implement its overarching community health priority – Addressing Social, Economic and Structural Determinants of Health to Reduce Inequities. Hospitals and other members of the collaborative are working together to develop collaborative infrastructure to implement upstream prevention, work on policy and systems issues, and achieve greater collective impact. Hospitals are also strengthening relationships and partnerships in local communities most impacted by inequities.

A presenter from Rush University Medical Center will describe how the health system is approaching its anchor mission, deepening community partnerships and focusing on communities most impacted by inequities; the opportunities and challenges of sitting at the table for community-based cross-sector initiatives; and working collaboratively with other health systems and community partners to design programs and systems related to screening for social determinants, housing and workforce development. A presenter from Advocate Lutheran General Hospital will discuss how to leverage relationships with education and business partners to start to address root causes of health and ways to build partnerships between hospital staff and community organizations to understand and address unique health and social needs in diverse immigrant communities. The session will be interactive including opportunities for participants to share from their experience building collaborative community health initiatives. Our goal is to leave participants inspired and challenged to continue improving cross-system, multi-sectoral, and community-driven efforts to address social determinants of health and improve health equity.

Learning Objectives:
• Examine how to effectively partner with community stakeholders to advance work on social determinants and health equity at multiple levels—local, regional and statewide
• Describe lessons learned from collaborative planning for action on social determinants of health, involving 25+ hospitals, seven health departments, and nearly 100 regional and community stakeholders in Cook County
• Discuss specific ways for hospitals to begin to engage in work on youth development, food access, housing, community-based workforce development and supporting educational success