Community Collaboration – Innovative Approaches to Address Social Determinants of Health and Improve the Health of Vulnerable Populations

Catholic Health Assembly 2017

Kim Luz, MS, CHES
Divisional Director of Community Outreach, HSHS St. John’s Hospital

Tracey Smith, DNP, PHCNS-BC, MS
Director of Population Health Integration, SIU Family and Community Medicine

Community Health Needs Assessment

Data on 100+ community issues

Examined & ranked 22 issues

9 priority areas

3-4 final

1
FY17 CHNA Priorities:

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<th>HSHS St. John’s Hospital</th>
<th>Memorial Medical Center</th>
<th>Sangamon County Department of Public Health</th>
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FY17 CHNA Priorities:

- Access to Care
- Organizational Approach
- Place-based Approach
- Community Driven
- Collective Impact
- Access to Care

Collective Impact
Designing the Strategy

Access to Care

- Place-based Approach
- Community Driven
- Collective Impact
- Organizational Approach

Zip Codes 62701, 62702, 62703
- Pop. 68,750
- 35% of county’s population: 59% of Springfield
- Ranked worst on index
Enos Park Neighborhood

![Map of Enos Park Neighborhood]

Diabetes
Hypertension
Mental Health
Pediatric Asthma

Designing the Strategy

Access to Care

- Place-based Approach
- Community Driven
- Organizational Approach
- Collective Impact
Designing the Strategy

- **Common Agenda**
  - Narrow, deeper dive
  - Proof of concept
  - Collaborate
  - Measurable Outcomes

- **Common Progress Measures**
  - Increase number of people with medical home
  - Reduced ED visits for non-emergent health issues
  - Improve self-sufficiency for program participants
  - Increase access to children’s mental health services

- **Mutually Reinforcing Activities**
  - Provider Council
  - Advisory Council
  - Summer Enrichment Program
  - Community Health Worker Program

- **Communications**
  - Provider and Advisory Council
  - Media Relations
  - Enos Park Neighborhood Improvement Association

- **Backbone Organizations**
  - HSHS St. John’s Hospital
  - Memorial Medical Center
  - SIU School of Medicine
Community Health Worker Model

• Focus on coordination of care:
  – Trust
  – Patient-centered
• Clients referred by churches, service agencies, neighbors, schools, hospitals, self-referred, etc.
• Identify and connect resources:
  – Healthcare - Establish a Medical Home
  – Social - Decrease isolation
  – Activities of daily living - Housing First Model
  – Financial

Who is a community health worker?

“A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.” (2015)

American Public Health Association
Interventions for Increasing Access To Health

• Community:
  – Build a community
  – Identify Workforce Development / Income Potentials
  – Pull agencies together

• Individuals:
  – Decrease isolation
  – Create sense of security / Community
  – Address social determinants of health
    • Provide Transportation
    • Develop new models of housing
    • Connect and train for income potential

• Healthcare System:
  – Build trust
  – Utilize harm reduction and trauma informed approaches
  – CHWs
  – Focus on the patient narrative
  – Flexible schedules
  – Assist patients to decrease no-shows to specialty care
  – Primary Care Home – Continuous care model
  – Coordinate coordinators
Patient Engagement

- A Medical Home was created for 100% of our clients.
- Engagement with primary care providers was high:
  - 409 PCP appointments made
  - 96% of our patients saw a PCP at least once in the past year
  - 83% show rate
- No-show rate decreased to 17%:
  - Two clients resulted in 35% of those no shows
  - If they are removed the rate decreases to 11%

Outcomes

Reached Special Populations:
- 26 people who were parolees
- 15 people who were homeless (87% now housed)
**So what about the clients themselves?**

**Increased:**
- Employment: 50%
- Income: 200%
- Food and Nutrition: 50%
- Healthcare Coverage: 50%
- Lifeskills: 40%
- Mobility: 100%
- Community Involvement: 66.7%
- Physical Health: 25%

**Decreased:**
- Unnecessary ED Use: 38%
- Crime
- Recidivism Rate
- Homelessness
- Police Calls
- No Shows

**Unintended Outcomes**

- New model for housing: 6-units
- Kids love clubs!
- Effect of recidivism: 19% vs 56.7% nationally
- 89% reduction in police calls
- Neighborhood Police Officers collaboration
- Comprehensive Care Clinic
- Work with local agencies to address policy changes
- New United Way Funding Model
- Purpose Built Communities Initiative
Ongoing Challenges

• The overall need is great
• Data access is complicated
• Developing a database is complex
• Integrating Community Health Workers into the healthcare system
• Transient nature of Super Utilizers
• Lack of housing support programs

What They Said!

• “I'm missing a mom, and having someone to call and double check [on me]...Kind of helps me, you know?”

• “I work at a homeless shelter at Inner City Mission. [Shelly] came in and was offering services to our residents...One of things Shelly did was helped our residents find a family doctor.”

• “Getting off the medical card is stressful and it's overwhelming. Not that you want to be dependent on the government for your lifespan, but the transition...without that kind of help, I think it's very difficult.”