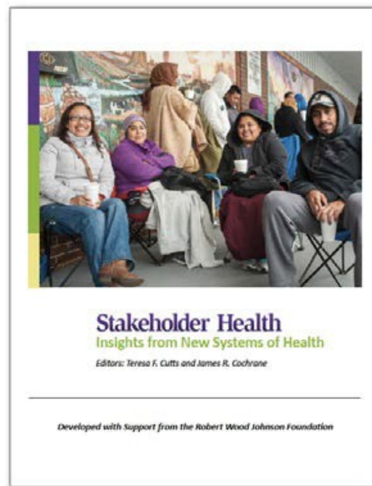
Stakeholder Health

Appendix 3
Updates from the Field



From

Stakeholder Health: Insights from New Systems of Health

Editors: Teresa F. Cutts and James R. Cochrane

Developed with Support from the Robert Wood Johnson Foundation

Order the book Click Here

www.stakeholderhealth.org

© Stakeholder Health, 2016

APPENDIX 3

Updates from the Field

Approaching Social Determinants at the Population Scale by "Sewing Up the Safety Net"- Collaborating with Competitors to Save Infant Lives

The CEOs of four major health systems serving Detroit (Henry Ford Health System, Detroit Medical Center, Oakwood Healthcare System, and St. John Providence Health System) committed their organizations to find enduring, collaborative solutions to reduce the city's infant mortality—among the highest in the nation. In 2008, they commissioned the Detroit Regional Infant Mortality Reduction Task Force, under the leadership of Henry Ford's Kimberlydawn Wisdom, MD, to develop an action plan.

A true public-private partnership, the Task Force represents a range of expertise and perspectives, from clinical to community, and from programmatic to policy, environment and behavior change. The health systems bring the strength and size of their provider networks, and their ability to reach women and families at multiple points across the clinical spectrum. Public health leaders from state and local health departments provide population-based perspectives and a focus on the social determinants of health—racism and its relentless cascade of socioeconomic factors influencing the life course. Agency members provide further policy expertise and links to organizations conducting synergistic work. An equally important cadre of community partners—neighborhood organizations and stakeholder groups —joined the Task Force in designing an innovative grassroots approach.

The result—the $2.6-million grant-funded Sew Up the Safety Net for Women & Children—demonstrates place-based population health management; innovative, sustainable service delivery models; high-tech/high touch social marketing; provider education on the health equity framework; and institutional alignment—even amongst competing health systems.

Sew Up the Safety Net is funded by the Robert Wood Johnson Foundation, The Kresge Foundation, W. K. Kellogg Foundation, PNC Foundation, University of Michigan School of Public Health, and the four health systems.

Infant mortality is known as a "sentinel" health indicator—the infant mortality rate correlates with the health status of the community. In Detroit, infant mortality hovered around 14.4/1000 for the past three years, or about 200 babies each year who do not survive their first birthday. Higher than some developing countries and over twice the U.S. rate, these statistics are cogently painful when the racial health disparity of 15.9/1000 for black babies is compared to 5.6/1000 for white infants for the same period.

According to a 2009 survey conducted by the Detroit Regional Infant Mortality Reduction Task Force, many local programs and services to support women at risk for infant mortality were significantly underused. It was then that the Task Force conceived Sew Up the Safety Net, to tighten this loose web of disconnected medical, social, and community organizations into an accountable network of care.

The project works in three neighborhoods to connect women at risk for infant mortality with community health workers, known as Community & Neighborhood Navigators ("CNNs"), framed by three key objectives:

- The first objective centers on the CNN-participant relationship. Trained as community health workers by a specialist from the Detroit Department of Health & Wellness Promotion with additional education in maternal-child health, the CNNs mentor participants by helping them learn to navigate an array of socially and economically appropriate healthcare services, tailored neighbor¬hood resources, and phone and Web-based information. Moreover, the CNNs provide the vital validation that says “I believe in you” amidst the oft-discouraging, lonely life journeys that many young women in poverty describe facing. In turn, participants become empowered to link their own social networks to similar resources for long-term success and improved health and well-being of women, families (including men), neighborhoods and communities. Over three years, 1,500 women—375 pregnant and 1,125 nonpregnant women of childbearing age—will participate.
- The second objective is providing education on the health equity framework to 500 physicians and other healthcare professionals. Built on a tested, successful Henry Ford healthcare equity CME course, the interactive, challenging workshops are designed to improve awareness of health equity and racial disparities, result¬ing in increased understanding of how life’s difficult circumstances impact health. Resources such as MIBridges and United Way 2-1-1 are shared in a case study approach. A train-the-trainer course also is being offered to expand provider education reach.
- The third objective is to establish technologically relevant products to engage the broader community in promoting good health status prior to and during pregnancy. Social media, a program website and text messaging are being used to connect women to the program, link to related services, and provide a virtual “living room” for sharing and learning. Project planners learned in early focus groups that the name ”Sew Up the Safety Net” was not as relatable for the target population as for health professionals. A CNN proposed the new name, Women-Inspired Neighborhood Network Detroit (WIN Network Detroit) to very positive reception from program members, and it is now used.

At a neighborhood health fair, a CNN recruited “Sonya,” 27, a single mom pregnant with her second child. The CNN learned that Sonya and her 5-year-old son “Derek” are “couch-homeless”—living with various relatives for short periods. Sonya opened up to the CNN about the hardships and disappointments of moving her life from house to house whenever a family member was “tired of having them.” The CNN immediately referred Sonya and Derek to a shelter program that is assisting them with permanent housing. Sonya told her CNN that before her involvement with Sew Up the Safety Net, she felt lost and unsupported. Thanks to her CNN, she said she now “feels hope” and is making plans to become a registered nurse after her second child is born. Meanwhile, the CNN continues to mentor Sonya, connecting her with other needed resources including food, clothing, and a referral to a college counselor. In a sign of her growing sense of optimism and self-efficacy, Sonya has already enrolled in college classes.

While too early for reportable outcomes, as of February 2013, the project had enrolled more than 135 pregnant women and engaged hundreds of women who are pre-pregnancy or between pregnancies. Sew Up the Safety Net is measuring impact around three distinct yet interdependent metrics: 1) no preventable infant deaths among participants—with measures including the effectiveness of community-based referrals, increased social support, and behavior change; 2) knowledge and behavior change on equity-promoting strategies among the 500 healthcare professionals participating in health equity education; and 3) knowledge and behavior change on prenatal care, preconception health, interconception health, and access to community services via the social media campaign.

2016 UPDATE: SEW UP THE SAFETY NET, LATER REBRANDED AS THE WOMEN-INSPIRED NEIGHBORHOOD (WIN) NETWORK: DETROIT, CONTINUES TO SHOW INCREDIBLE OUTCOMES.

- Zero preventable infant deaths amongst program participants.
- Average birth weight of infants was 6.79 pounds with only 12% at low birth weight. 89% had full-term gestation.
- To date, 364 pregnant women and 900 non-pregnant women were enrolled in WIN Network programs.
- As of March 2015, 477 professionals participated in our healthcare equity training; 97% plan to incorporate the information learned in to their respective practices.
- Since launching our website in July 2013, we have had over 12,000 visits, and our Facebook page has grown to over 600 likes, reaching thousands of people in Detroit.
- The Detroit Regional Infant Mortality Reduction Task Force has received numerous awards and recognitions including but not limited to being featured in the University of Kentucky's national study on successful partnerships, the Jackson Healthcare Hospital Charitable Services Award, and a variety of journal, newspaper and television features.

Transforming a Forgotten Community

Bithlo is a semi-rural community in Orlando (FL) that resembles parts of Appalachia. Poverty is the norm for most of its 8,200 residents. The issues that segregate families of poverty in Bithlo are many and complex—and generational. Residents struggle each day with basic survival needs: food, clothing and shelter. Jobs are scarce, and the major industry is junk yards. There is no grocery store, barbershop, library gym, swimming pool, or place to earn a GED. At least 80% of the housing is in dilapidated trailers. Until recently, the nearest bus stop was nine miles along a busy highway with no sidewalks.

Bithlo also faces major environmental issues. Residents rely on well water because there is no public water or sewer. The well water is orange (from iron) and contaminated with known carcinogens from an old gas station and an eight-acre, 25-year-old illegal landfill.

In August 2009, a small 501c3 called United Global Outreach conducted a door-knocking campaign that sparked the "Bithlo Transformation Effort" that focuses on Education, Environment, Transportation, Health Care, Housing, Basic Needs, Building Community, Economic Opportunity and the Arts.

After discussion with UGO leaders, Florida Hospital adopted Bithlo as a local mission project in 2011. The hospital supports UGO's mission of "transforming forgotten communities into places in which we'd all want to live." Most importantly, the hospital committed to supporting UGO's efforts—rather than "taking over" or "doing it the hospital way."

Mitch was a homeless man who came drunk to one of UGO's community suppers. He was belligerent but ultimately begged a UGO volunteer to "please help me." UGO arranged for counseling but Mitch was arrested the next day.

When he was released from jail after a few weeks, Mitch was walking home to his tent in the woods. As he maneuvered along the shoulder of the busy highway that runs through Bithlo, Mitch was hit by a car and died.

Help came in time for another homeless man. James, too, lived in the woods; he is just 45 years old but was blind from cataracts and had lost his job and home. An ophthalmologist donated cataract surgery for both eyes. Today, James is back to his construction job and is a contributing resident of his community.

Helping individuals helps communities. After being an isolated, forgotten community for nearly 80 years, many of Bithlo's issues still loom large. But residents and partners are confident that attention to the root causes of poor health—the physical, built, economic and social conditions—are transforming the Bithlo community into "a place in which we'd all want to live."

AFTER FLORIDA HOSPITAL SIGNED ON, THE PARTNER LIST GREW TO OVER 65 ENTITIES. THE HOSPITAL HAS PROVIDED SOME FUNDING BUT, MORE IMPORTANTLY, HAS LEVERAGED ITS BUSINESS, COMMUNITY AND POLITICAL PARTNERS TO HELP WITH THE TRANSFORMATION EFFORT. SINCE 2011:

- The area's first permanent medical clinic (an FQHC) opened.
- Other medical services include dental care, mental health and substance abuse efforts, vision services, and domestic violence counseling —all free to Bithlo residents.
- The Florida Department of Transportation is widening a dangerous bridge (with an 18-inch pedestrian walkway) in 2014 (instead of 2022).
- The road widening will allow county government to bring clean water to Bithlo.
- Bus service has been restored, and County Government committed to seven miles of sidewalks.
- Florida Hospital provided some dollars, and has leveraged relationships with its construction, fire system and other vendors to donate services. Hospital departments provide hundreds of hours of volunteer time.
- The hospital also serves as the fiscal agent for several grants, a much-needed dental grant that has leveraged over $1 million in dental services for the community.
- UGO operates a 40-student private school for Bithlo children who were not succeeding in public school.

The three-acre "Transformation Village" now anchors a sense of place to Bithlo, with a private school, a hydroponic garden, community meeting space, a library and computer lab, GED classes, social services and Medicaid enrollment, and more. The planned "Dignity Village" will be a small-home community for Bithlo's homeless residents.

PRIMARY CARE ACCESS NETWORK OR PCAN: A STONE SOUP APPROACH

Over 100,000 uninsured residents of Orange County have access to affordable primary and secondary care through a "Stone Soup" model that builds on existing assets and has spawned crucial new services.

The Primary Care Access Network (PCAN) was formed in 2001 as a cost-effective, family-friendly, integrated system of care for the county's uninsured residents. PCAN has 22 safety net providers: three hospitals, county government, 13 Federally Qualified Health Centers (FGHCs), a specialty care clinic, a chronic care medical home, five (free) volunteer clinics, the health department, respite care, and others.

PCAN started with a small indigent clinic serving 5,000 people at a cost of $10,000 per year. Today, PCAN serves 92,000 uninsured people 13 primary care medical homes, and over 10,000 secondary care patients—for just a few more dollars.

PCAN partner agencies bring their assets to the table—much like the children's book "Stone Soup" in which villagers add their own vegetables to a simmering pot of water and stones; the result is a pot of soup for everyone to share.

Like the villagers, PCAN builds on existing assets:

- PCAN partners provide nearly $70 million in donated care (excluding hospital charity care).
- The backbone of PCAN is a network of 13 FQHC medical homes and a strong case management effort.
- County Government puts $13 million per year into the state's Inter-Governmental Transfer (IGT) program, drawing down Medicaid match dollars for the two DSH hospitals.
- The DSH hospitals donate back the dollars through an interagency agreement:
    - Some dollars allow the FQHCs to see "additional" uninsured patients.
    - Other IGT dollars pay for non-volunteer specialty care and help support the free clinics.
    - All three hospitals write off needed surgeries and diagnostics as charity care.
- Other PCAN agencies rely on their "usual" funding sources as well as collaborative grants with other PCAN partners.

As new medical homes open, the hospitals see a drop in non-urgent, self-pay ER visits. In addition, Patients also benefit: the FQHC medical homes have seen a 68% decrease in blood pressure, an 83% decrease in cholesterol, and a 95% patient report of personal health improvement.

Informal "parking lot meetings" have generated new services and millions of additional grant dollars. Examples include the Congestive Heart Failure, Lung, Depression and Anxiety, and Family Medicine Residency clinics as well as chronic disease programs.

"Mary" has health insurance. A routine mammogram picked up a suspicious mass (so small it could not be felt) in her left breast, and Mary's family doctor referred her to a surgeon.

The surgeon ordered a diagnostic mammogram, followed by an ultrasound-guided biopsy that determined that the small mass was only pre-malignant. But the surgeon said that the lump needed to come out. Before surgery, he referred her for a breast MRI and then, for implantation of a single radioactive seed. Mary then went to pre-admission testing and finally, outpatient surgery where the seed and the mass were removed.

The co-pays for the five radiology procedures, three physician visits, pre-admission testing and surgery came to $3,700 – with insurance. What if Mary had not had insurance?

The PCAN specialty care clinic cares for women like Mary every day. For many of them, the cost of care frequently means delays in care and, sometimes, their conditions are more urgent and outcomes are not as good. PCAN partners know that their "stone soup recipe" nurtures thousands of low-income, uninsured people in Orange County, Florida.

ADVOCATE CHRIST MEDICAL CENTER & CEASEFIRE PARTNERSHIP: HOSPITAL-BASED VIOLENCE REDUCTION PROGRAM

Advocate Health Care provides a quarter of trauma care for Illinois, mostly unreimbursed. At Advocate Christ Medical Center, a Level 1 Trauma Center, physicians and staff began to recognize patients who were being admitted multiple times and partnered with Chicago-based CeaseFire, which has been effective in reducing community violence rates. The partnership offers services to trauma patients, their families, and communities, within an hour of a violent incident. Conversations happen when patients are willing and able to reflect on the import of retaliation and the cycle of violence they are caught up in. In Chicago, violence is a leading causes of death for people between 15-34 years. The majority are male, low income, young and minorities. This deadly violence is concentrated in communities with high unemployment rates, few business opportunities and limited social service resources. Repeat violent injury patterns are common. According to one study, after being victimized once, a person's risk of being violently re-injured is 1.5 to 2.4 times greater than an individual who has never been victimized. In communities where violence is an accepted method of resolving conflict, victims and their families are also highly susceptible to retaliation. In 2005, Advocate Christ Medical Center, a Level 1 Trauma Center, partnered with CeaseFire to develop the region's first hospital-based gun violence prevention project. CeaseFire, which works in five 'hotspot' communities that overlap with Christ Medical Center's service area, employs trained 'violence interrupters' and 'community-based outreach workers.' The violence interrupters—individuals who may previously have been in street gangs—use cognitive-behavioral methods to mediate conflict between gangs, and intervene to stop the cycle of retaliatory violence that threatens after a shooting. Professionally trained and credible, they are able to work effectively with highest-risk individuals to change thinking around violent behavior. The communitybased outreach workers provide counseling and services to high risk individuals in communities with high violence rates. The program builds on the strong role of chaplains already working in the Emergency Department as part of the trauma care team. When a gunshot victim is admitted, an Advocate chaplain alerts the hospital response coordinator, who is available 24/7, to their pending arrival. Hospital responders immediately work one-on-one with the victim, and family and friends, to diffuse tension and reduce the risk of retaliation. Responders are street-savvy individuals (many are ex-offenders) with strong community ties to the high-risk population. They leverage their network of contacts with CeaseFire 'violence interrupters' to mediate conflicts and squash retaliations. Dante, previously in a gang, forged a strong bond with the hospital case manager, whose own 'street history' allowed Dante to confide about serious family and social issues he faces in his transition away from the street activity. In the course of these conversations, the hospital case manager supported Dante, encouraging him to seek clinical care from a licensed therapist. Due to the stigma associated with mental health issues and treatment within his community, it would have been very difficult for another intervener to successfully connect Dante with the services needed. In 2011, the Christ CeaseFire Violence Prevention Project responded to a total of 580 incidents of violent injury and connected 298 patients to community-based violence interrupters. While unable yet to assess actual impact on costs, Advocate Christ Medical Center invested $120,000 in 2013 to support the case manager role.
The program's success has led to its replication at two other Chicago trauma centers.

2016 UPDATE:

Interrupters in the Christ CeaseFire Violence Prevention Project responded to a total of 868 incidents of violent injury and made community-based resource referrals for 766 patients in 2015. Even though some patients were not immediately connected to an interrupter in the hospital, many of them end up working with the case manager later through the trauma clinic. While unable yet to assess actual impact on costs, Advocate Christ Medical Center invests $120,000 each year to support the case manager role. The program's success has led to its replication at trauma centers around the country.