Ensuring Access in Vulnerable Communities
Ensuring Access to Health Care in Vulnerable Communities Task Force

- Confirm the **characteristics and parameters** of vulnerable rural and urban communities by analyzing hospital financial and operational data and other information from qualitative sources where possible;

- Identify **emerging strategies, delivery models and payment models** for health care services in rural and urban areas;

- Identify **policies/issues at the federal level** that impede, or could create, an appropriate climate for transitioning to a different payment model or model of care delivery, as well as identify policies that should be maintained.
To learn more about the work of the AHA Task Force, please visit [www.aha.org/ensuringaccess](http://www.aha.org/ensuringaccess)
Emerging Strategies

- Virtual Care Strategies
- Social Determinants
- Inpatient/Outpatient Transformation
- Urgent Care Center
- Rural Hospital-Health Clinic
- Emergency Medical Center
- Global Budgets
- Frontier Health System
- Indian Health Services
Ensuring Access in Vulnerable Communities

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The Relentless Pursuit of Better

- Using change as a strategic and competitive advantage
- Optimizing change effectiveness
- Building a culture that leads through effective change
Community Health Needs Assessment

- HIV and other STDs
- Mental Health and Substance Abuse
- Obesity
- Overuse of Emergency Departments
- Barriers to Healthcare
- Cancer
- Diabetes
- Heart Disease and Stroke
- Negative Lifestyle/Behaviors
- Vulnerable Populations
Efficiency & Access are Return on Investment

**Cost Per Patient Day Decreases 58%**

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost</th>
</tr>
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<tbody>
<tr>
<td>EKL 2011</td>
<td>$4,137</td>
</tr>
<tr>
<td>OLOL 2014</td>
<td>$1,819</td>
</tr>
<tr>
<td>OLOL 2015</td>
<td>$1,690</td>
</tr>
<tr>
<td>OLOL 2016</td>
<td>$1,750</td>
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Able to leverage the existing operations and efficient systems without many new fixed costs. All incremental costs for the additional patients are spread across Our Lady of the Lake’s already effective cost structure (business model).
Urgent Care

Annual Visits in 2 Urgent Care Clinics

| Year 1 | 29,419 |
| Year 2 | 29,521 |
| Year 3 | 51,528 |

Prior to closure, EKL annual ER visits = 30,000
Partnering for a healthy community

https://www.youtube.com/watch?v=pQQkPondzIY
Transforming Healthcare Delivery
Improving Population Health

Carolinas HealthCare System Anson
To significantly improve the health status of Anson County by offering an innovative, community-focused care delivery model.
Our Commitment: Future State

- **Community Profile** serve as the guiding principles for future state
- **Enhance Patient and Community Outcomes** through personal and virtual connectivity of Carolinas HealthCare System’s network of specialized services
- **Provide and Support a Team of Healthcare Professionals** for primary and preventive care
- Enhance the availability of **Specialist Physicians**
- Provide improved access to appropriate services, through **Telemedicine Applications and Other Services**
- Develop a **Flexible, Cost-Effective New Facility** for the evolving care needed to service the community
• Outcomes focused
• Wellness and prevention
• Triple Aim: transforming to provide value (cost/quality/access)
Our New Model – Patient Flow

Patient seeks medical care

Provider screens for needs

Patient is treated in the most appropriate setting

Patient Navigator coordinates care and connects patient to community services

Care Team follows up with patient

Community health advocates update primary providers
Care Coordination Team

- Family Practice Physicians
- Mobile Clinic
- Social Workers
- Acute Care Hospital
- Behavioral Health
- Clinical Pharmacist
- Home Health (CAP) Personal Care
- Faith Based Services (Advocate)
- Tele Monitoring
- Registered Nurses
- Educators
- Dietician
- Care Coordinator
- Patient Navigators
- Care Provider
- Virtual Care
- Advanced Care Practitioner (ACPs)
- Health Quest Pharmacy Assistance
Primary Goal: Access to Care (Medical Home)
Site Opportunities: New Facility • Mobile Unit • Virtual Care • Satellite Space

Key to Improving Community Health: Ongoing Education
Community Health Talks • Screenings • Messaging • Benefit Bank

Health Priorities
- Chronic Disease
  - NDPP
  - Pre-D
- Behavioral Health
  - MHFA
  - Online
- Children’s Health
  - Teen Pregnancy
  - Childhood Obesity

Community Entry Points
- Faith Community
- Schools
- Community Groups

Support Areas for Program and Service Development:
- Chamber
- Focus Groups
- Board
- Coalitions
Doing Different Things in Different Ways

Innovative Mobile/Virtual Collaborative Data Informed

Patient Engagement
ADDRESSING THE ROOT CAUSE OF HEALTH
AHA TASK FORCE ON ENSURING ACCESS IN VULNERABLE COMMUNITIES
CASE STUDY: SOCIAL DETERMINANTS

Kate Sommerfeld
Corporate Director of Advocacy & Social Determinants
ProMedica
AHA Task Force on Ensuring Access in Vulnerable Communities
EMERGING STRATEGIES

Virtual Care Strategies
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Inpatient/Outpatient Transformation
Urgent Care Center
Rural Hospital-Health Clinic
Emergency Medical Center
Global Budgets
Frontier Health System
Indian Health Services
PROMEDICA

- 332 sites
- 27 counties in two states (OH and MI)
- 4.7-million patient encounters system-wide
- 12 hospitals
- 334,000+ lives covered by Paramount insurance
- More than 900 providers/ProMedica Physicians with 1.6-million annual patient visits
- 2,300+ physicians with privileges
- 1,400 ProMedica Health Network members
- Six ambulatory surgery centers
- 15,000+ employees
- 2,700+ volunteers
- 40+ boards, committees/councils, foundations
- 400+ volunteer board members
- 400+ ProMedica Continuum Services beds
- 2,350+ licensed inpatient beds
- 90,000+ inpatient discharges
- 71,000+ surgeries
- 8,200 births
- 392,000+ ER visits
- 220,000+ home care visits
- 425,000+ rehabilitation therapy encounters
- $14.5 million raised through philanthropy
- More than $198.7 million in community benefit (2015)
20 percent of health and well being is related to access to care and quality of services

Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014
ProMedica’s Anchor Institution Model
Healthy Individuals: Healthy Communities
HUNGER AS A HEALTH ISSUE

Hunger Screening Research Study
2016 statistics

| Screened: | 57,244 |
| Screened positive: | 2,243 |
| Average age: | 50 |
| Number of new food pharmacy clients: | 1,100 |

More than 1 in 5 families with children experience food hardship in Toledo

Of 4,000 Medicaid patients completing screen and food pharmacy referral:
- Reduced ED usage (3%)
- Reduced readmission rates (53%)
- Increased primary care visit rate (4%)
EBEID INSTITUTE

• Food market – 1st Floor
• Teaching kitchen – 2nd Floor
• New Call Center – 3rd Floor
• Job training/career skills
• Financial literacy classes
• Parenting classes
• Nutrition counseling
• Diabetes education
• Block by block community empowerment/improvement
FINANCIAL OPPORTUNITY CENTER

- Casey Foundation Center for Working Families Model
- FREE financial coaching & education
- Debt management, Credit building
- Employment readiness training
- Housing

- 208 served, 40 ProMedica Employees
- 52% has seen coach 5 times or more
- 48% increase in net income
- 15% increase in credit score
- $88,190.00- Approved Income Supports
- $195,413.00- Federal Tax returns
- 9 opened savings or checking account
- 10 purchased a new car, 3 with cash and 7 approved loans
- 21 approved for credit card (to build credit)

- Settled student loan & major medical debt
Housing Continuum

Green & Healthy Homes
- Integrate health and housing providers to ensure healthy housing.
- Model ROI: 70% fewer asthma-related client hospitalizations, 76% fewer asthma-related client ED visits

Central City Home Ownership
- Partnered with Key Bank, LISC, National Equity Fund
- Stabilize 700 LIHTC affordable units
- 200 residents to homeownership
- Employee Assisted Housing- 30 Families

Lead Paint
- 3,433 Toledo children are predicted to have lead poisoning
- Photo of 18 month old boy, DJ, seen for a routine well visit at CHS
- 0-3.5 micrograms per deciliter is CDC acceptable range
- DJ-52.5 mcg/dl lead level
THE ROOT CAUSE COALITION

• New 501(c)3, formed October 2015
• Founding members: ProMedica and AARP Foundation
• Goals: Research, Advocacy, Education
• 20+ Members
• National Summit – Louisville, KY October 9-10, 2017
New Downtown ProMedica Campus

Downtown revitalization

- ProMedica Headquarters - $40 million
- Colony Area - $120 million (120 room hotel, 200+ apartments, 100 bed assisted living and memory care unit)
- Marina District - $30 million (370 apartments, restaurant)
- Marriott Renaissance - $31 million (240 rooms, 125 employees)
- Fort Industry Square - $50 million (89,000 usable sq ft)
- Tower on the Maumee - $30 million in phase I (100+ construction jobs)
- Chop House - $2.5 million (100 jobs)
- Metro Parks – $3.7 million in site development
- Lathrop – TBD (6,000 sq ft, moving 40 employees)
- Hart – TBD (20,000 sq ft, moving 60 employees)
- Convention Center – TBD
QUESTIONS FOR HEALTHCARE LEADERSHIP

• What do we believe our role/obligation should be in addressing the social determinants of health?
• What are our key priorities within our four walls/outside our four walls?
• How might local human services and health programs partner with health systems to achieve improved coordination of care, lower costs, and improve community health?
• Have we aligned our philanthropy efforts/community benefit with the issues that are most pressing to our patient population and/or the broader community?
• How do we measure success?
COMMUNITY HEALTH IMPROVEMENT

http://www.viddler.com/v/418af1e2
Clinically Integrated Systems of Care:
  • Central to value based care strategy and efforts to eliminate disparities

Transportation:
  • Lyft Partnership

Food Insecurity:
  • Multi-pronged approach, focused on measureable outcomes
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