CBO Panel
Collaborations that Lead to Better Healthcare

PANEL DISCUSSION

• Carrie Whitwood, Executive Director, Ardent Solutions
• Mitch Gruber, Chief Strategy & Partnerships Officer, Foodlink
• Laura Opelt, Associate Diocesan Director, Catholic Diocese
• Ann Marie Cook, President/CEO, Lifespan of Greater Rochester

• Moderated by Janet King, Director of System Transformation
Mission/Vision

Our Mission
To create synergy within and between systems, organizations, families and individuals that result in a strong culture of health and quality services for our communities.

Our Vision
Working together proactively we will create a healthy, livable community for all.
AUGH!! WHY ARE YOU RIPPING PAGES OUT OF MY BOOK?!

TO MAKE A LONG STORY SHORT.
Our Service Area

Primary/Secondary Service Areas

Allegany County
Cattaraugus County
Chautauqua County
Livingston County
Seneca Nation of Indians
Steuben County
Programs

- Walk with Ease
- Diabetes Self Management
- Diabetes Prevention
- Chronic Disease Self Management
- Chronic Pain Self Management
- Blood Pressure Monitoring
- A Matter of Balance
- Growing Stronger
- ASIST
- CONNECT
  - Safe Talk
  - CPR/First AID/AED
  - Mobility Management
  - Child Passenger Safety
  - Highway Safety
  - CarFit
  - Public Transportation
  - Travel Training
  - Slow Moving Vehicles
- Cultural Competency/Health Literacy
- Clinical to Community Bridge
- Navigation ED
- Navigation PCP
- Professional Development
TWINS

MAYBE YOU SHOULD WAIT UNTIL SPRING TO TRY YOUR NEW TRICYCLE.

WHAT? AND MISS ALL THIS FUN?
System Transformation

Project Goals:
• Screen patients to identify certain unmet health-related social needs
• Provide navigation services to assist high-risk patients with accessing community services
• Encourage alignment between clinical and community services to ensure that community services are available and responsive to the needs of patients
System Transformation Partners

• Human Services Development
• UR/St. James Hospital, Hornell, NY
• UR/Noyes Hospital, Dansville, NY
• UR/Jones Memorial Hospital, Wellsville, NY
• Martin Street Medical, Wellsville, NY
# Social Determinants of Health Intervention Strategy

Martin Street Medical – Preliminary Results

<table>
<thead>
<tr>
<th>Month</th>
<th># Pt Encounters</th>
<th># SDH Screenings Completed</th>
<th># Pts w/Identified Needs</th>
<th># Pts Engaged and Navigated</th>
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<tr>
<td>March 2019</td>
<td>186</td>
<td>146</td>
<td>28</td>
<td>24</td>
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<td>April 2019</td>
<td>215</td>
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<td>31</td>
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<td>May 2019</td>
<td>100</td>
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<td>June 2019</td>
<td>130</td>
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<td>July 2019</td>
<td>130</td>
<td>108</td>
<td>38</td>
<td>20</td>
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<td>August 2019*</td>
<td>73</td>
<td>62</td>
<td>11</td>
<td>4</td>
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<tr>
<td>September 2019</td>
<td>106</td>
<td>82</td>
<td>47</td>
<td>20</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>940</strong></td>
<td><strong>752</strong></td>
<td><strong>260</strong></td>
<td><strong>126</strong></td>
</tr>
</tbody>
</table>
Social Determinants of Health Intervention Strategy
Martin Street Medical – Preliminary Results

March - September 2019

- # Completing the Screen
- # With Identified Need
- # Engaged/Navigated
Social Determinants of Health Intervention Strategy
Martin Street Medical – Preliminary Results

Total = 595

- Dental Services
- Education Assistance
- Employment Assistance
- Family/Community Support
- Financial Assistance
- Food Security
- Health Home Referrals
- Housing
- Insurance
- Mental Health Support
- Other
- Physical Activity Support
- Public Benefits
- Safety
- Substance Abuse Services
- Transportation
- Utilities Assistance

Total = 995
Agendas
October 2018: Poverty & the SDH
December 2018: 211 Helpline/NY Connects
February 2019: HHUNY CHHUNY
April 2019: Transportation (OFA, Public, MAS)
June 2019: Housing (Homeless Prevention, MH, Veterans)
August 2019: Allegany County Community Health Assessment
October 2019: Overview of Behavioral Health Services
December 2019: Behavioral Health Service Providers
February 2020: Allegany Arc
April 2020: ACASA
June 2020: Community-Based Supports
Special Projects

Clinical to CBO
Partnering Practices
• Martin Street Medical
• Canisteo Valley Family Practice
• Tri-County Family Medicine Program- 5 Sites
• Kassas Pediatrics

Accomplishments
• SDH Training
• SDH Screening
• Navigator Referral Process
• Connection to Community Based Organizations

Cultural Competency/Health Literacy
VBP Lessons – Next Steps

• The commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem at scale.

• Diversity of the actors as well as the scale. Not only involve people from a clinical background, providers and insurances, need to be much broader than that: transportation, social services, social supports.
CURBSIDE MARKET RX

Mitch Gruber
Chief Strategy & Partnerships Officer,
Foodlink
Food insecurity and poor diet compromise our region's health and burden the healthcare system.

Over 150,000 people in our region struggle with food insecurity every year.

In a survey of households who visited emergency food programs, 66% reported making the choice between paying for food and paying for medical care.

By using food as medicine and overcoming issues of healthy food access, together we can improve health and save costs.
We make it easy to "prescribe" fruits and vegetables.

**Patients are identified.**
GRIPA identifies patients with food insecurity that may benefit from adding healthy foods to their diet.

**Healthy foods are eaten.**
Patients prepare and eat healthy foods with their families. Providers continue to discuss how healthier eating choices can continue to improve health outcomes.

**Curbside Market Rx is prescribed.**
Enrollment teams engage patients and discuss how healthier eating can improve health. Patients are enrolled directly into the Curbside Market Rx portal by their provider.

**Curbside Market Rx is redeemed.**
Patients are given a Curbside Market Loyalty Card with $30 each month to use to buy anything on Curbside Market, at any of our 90+ locations.
HEALTHY MOMS AT UNITY ST.
MARY'S HOSPITAL
ROCHESTER, MONROE COUNTY

Model 1: High-touch, change management program in an urban setting.
• Services include: pregnancy education, mental health counseling, care management, job training, leadership, and smoking cessation.

EASTERN REGION AMBULATORY CARE MANAGEMENT

WAYNE, ONTARIO, & SENECA COUNTY

Model 2: High-risk, ambulatory care management in a rural setting.
• Care includes: practice, community and home based visits and telephonic support
Lessons learned

Patient enrollment, behavior change takes time

Sustainable partnerships involve investment

Participant buy-in ensures success

Tech transformations require capacity

Participant and market stand.
**IMPROVED HEALTH OUTCOMES**
Increased access to healthy foods results in improved health outcomes and chronic disease management.

**LOWRED HEALTHCARE COSTS**
Healthy food access decreases food insecurity and lowers healthcare expenditures.

**IMPROVED CLINICAL EXPERIENCE**
A trusted, reliable resource for providers to refer their patients and encourage healthy eating.

**IMPROVED PATIENT EXPERIENCE**
A positive food shopping experience that celebrates making healthy choices.
FLPPS Progress

Laura Opelt
CCS Service Priority

### Kinship Family & Youth

**ABOUT KINSHIP FAMILY AND YOUTH**
The Kinship Family and Youth service priority for Catholic Charities of Steuben helps families develop the capacities for healthy family functioning and promotes healthy child development.

- **Child Development Services**
  - Bath Community Child Day Care
  - Healthy Families Steuben
  - Kids Adventure Time
  - Laker Kids

- **Family Preservation Services**
  - Healthy Families Steuben
  - SHAPE
  - Therapeutic Foster Care

### Substance Free Living

**ABOUT SUBSTANCE FREE LIVING**
The Substance Free Living service priority for Catholic Charities of Steuben reduces the prevalence of substance abuse and its negative consequences in the population of the area served.

- **Home and Community Based Services**
  - Empowerment Services-Peer Supports
  - Prevention Services
    - Bath Area Hope for Youth
    - Impaired Driver Program
    - John Southard Youth Recreation Program
    - Steuben Council on Addictions

- **Residential Services**
  - Community Residence
  - Supportive Living

- **Coalition Leadership**
  - Steuben Prevention Coalition

### Turning Point

**ABOUT TURNING POINT**
The Turning Point service priority for Catholic Charities of Steuben alleviates the effects of social injustice by stabilizing families in economic crisis, and supporting them as they strive for self-sufficiency.

- **Basic Needs Services**
  - Advocacy
  - Financial Assistance
  - Food Pantry
  - Mobile Outreach
  - Referrals
  - Transportation

- **Support & Development Services**
  - Community Navigation
  - Education
  - Mobile Outreach
  - Nutrition Outreach and Education
Collaborations/Partnerships: Community Navigation

**Successes:**
- Community referrals to doctors- Navigation refers to the function of linking patients and family members with essential health and community services.
  - 1,112 individuals connected with Primary Care
    - Of these, 254 had not been to a doctor in over a year
  - 1,327 individuals accessed health plans through direct connections to Fidelis
  - 887 individuals were surveyed through Patient Activation Measurement (PAM), helping to measure the person’s level of involvement with their own health care and identify opportunities for referrals and coaching
  - 16,150 trips provided through bus tokens and gas cards
    - Of these, 6,783 trips provided linkages to health care
  - 1,089 people were navigated to 3 medical appointments, on average

**Challenges:**
- Providers with limited capacity unable to take new patients
- Scheduling appointments during the day
- PAM surveys not always an accurate representation due to fear, embarrassment, limited understanding of questions, etc.
- Complex and limited public transit system
Collaborations/Partnerships: Max Work

• **Successes:**
  – Partnerships – Arnot Ira Davenport /Keuka Family Practice
    • Connect high utilizers to proper supports to reduce cost to health care system
      • Getting alerts for high utilizers
    • Address social determinants of health across all ED patients, as able
    • Provide support to Keuka Family Practice for identified patients
    • Develop model for integration of CCS into health care system that can be replicated
    • Improve health outcomes for patients
    • Calculate cost savings for IRA Davenport
    • Make case for Value Based Payments from Ira or similar setting
    • Not a finish product

• **Challenges:**
  – Sustainability
  – Transportation. Bus tokens are more cost effective vs medical travel, but the bus does not run routes to and from the hospital.
  – Integrating workflow while also maintaining individual policies and procedures for each agency.
  – Multiple data collection/management systems in use with no interfacing.
Collaborations/Partnerships: BHCC
“Your Health Partners of the Finger Lakes”

• **Successes:**
  - Electronically connect patients to clinical and social services providers
  - Track patient progress and receive automated feedback
  - Collaborate with community-side “care teams”
  - Collect data including structured patient outcomes
  - **Unite Us as a key partner in this effort, CCS will be working directly with Unite Us to:**
    - Electronically connect patients to both clinical and social service providers
    - Track patient progress and receive automated feedback from partners to ensure care and services are received
    - Collaborate with community-wide “care teams” ensuring providers are on the same page regarding their shared patients’ progress; and
    - Collect data including structured patient outcomes to measure the network’s impact.
  - We also have the benefit of any grants, through the BHCC, covering infrastructure development, potential hands-on assistance in the development of a Steuben Collaborative, Data Analytics assistance via the NEXO group, and potential revenues via BHCC Collaborative work.
  - Ira Arnot is also a partner in our BHCC.

• **Challenges:**
  - Key partners are part of other BHCCs
  - Rural vs Urban
Collaborations/Partnerships: Fresh Farmacy

• **Successes:**
  - Developed business agreement with 8 practices/providers
  - Connected families (not just patient) to fresh fruits and vegetables
  - Provided additional beneficial services to the families
  - Improved health outcomes for patient
  - Use of Peers. Peers are certified by both through OASAS and OMH. They are working primarily in supporting Fresh Farmacy and helping people get to their PCPs or other appointments. They are helping people with paperwork if they are struggling. They are supporting Hornell, Bath, and Painted Post.

• **Challenges:**
  - Getting data for proven outcomes
  - Aligning with future funding
  - Fresh Farmacy in high demand
  - We are service the whole family which many not be covered by VBP.
  - Expansion to other providers is being requested. The longer we provide services for free, the harder it will be to get payment for it later.
  - Mind Shift – Fresh Farmacy is NOT a Fruit and Vegetable Prescription Program!
Lifespan of Greater Rochester Inc.

Ann Marie Cook
President/CEO
Lifespan of Greater Rochester Inc.


Community Care Connections
Integrates Lifespan’s community-based aging services with health care systems to breakdown siloes.

The right care, at the right time, at the right place.
Community Collaboration

Steering committee:

• Representatives from the two local health systems.
• Office for the Aging.
• Health insurers.
• Monroe County Medical Society.
• FLPPS
• Rochester RHIO
• Accountable Care Organizations (ACOs).

Referral partnerships: 70+ physician practices & certified home care agencies.
Social Work Care Navigation

Ongoing home visits
Geriatric Wellness Assessment
Care plan development

Connects clients to:
Housing
Financial benefits
Transportation
Respite
Socialization
Mental health intervention
Caregiver supports
Chronic disease management workshops
Geriatric addictions intervention
Caregiver supports
Home safety modification
Elder abuse intervention
+ other social supports

Community Care Connections Team

Healthcare Coordination:
LPN’s and Community Health workers supervised by an RN

Access to Preventative Health Screens
Complete Medication reconciliation at every encounter
Healthcare Coordinator & Patient
Schedule medical appointments and transportation
Health Education Training - increase self-management
Accompany to medical appointments - ensure understanding and advocacy

+ other social supports
Healthcare Provider Perspective

I’m no longer spinning my wheels trying to help somebody.

...Just the idea that somebody who is skillful and understands the population – where they are, and where they’re living, and what life looks like for them – when that’s being handled, the benefit is that the patient can come in and talk to us about their health and to know that they have a [CCC social worker] for X amount of days, months, working on something with them.

It helps us to focus on good primary care when the patient’s in the office.

- Health Care Provider
90-DAY PRE/POST ANALYSIS:
PERCENT CHANGE IN HEALTH CARE UTILIZATION BY SERVICE CONNECTION

<table>
<thead>
<tr>
<th>Service Connections</th>
<th>N</th>
<th>Hospitalizations</th>
<th>ED visits</th>
<th>Observations</th>
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<tbody>
<tr>
<td>Case Management</td>
<td>1051</td>
<td>-33%*</td>
<td>-30%*</td>
<td>-22%*</td>
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<tr>
<td>Caregiver support</td>
<td>339</td>
<td>-37%</td>
<td>-12%</td>
<td>-8%</td>
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<td>Financial Benefits Counseling</td>
<td>328</td>
<td>-54%*</td>
<td>-37%*</td>
<td>-9%</td>
</tr>
<tr>
<td>Home Health Aid/Personal Care</td>
<td>199</td>
<td>-23%</td>
<td>-39%</td>
<td>-30%</td>
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<tr>
<td>Medicaid</td>
<td>186</td>
<td>-28%</td>
<td>-8%</td>
<td>-27%</td>
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<tr>
<td>Health insurance counseling</td>
<td>182</td>
<td>-57%*</td>
<td>-32%</td>
<td>-6%</td>
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<tr>
<td>Durable medical equipment</td>
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<td>-26%</td>
<td>-19%</td>
<td>-18%</td>
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<tr>
<td>PERS</td>
<td>163</td>
<td>-39%</td>
<td>-29%</td>
<td>-25%</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>153</td>
<td>-56%</td>
<td>-41%*</td>
<td>-10%</td>
</tr>
</tbody>
</table>

Services presented here are those to which clients were most frequently referred
* p<0.05
### 90-DAY PRE/POST ANALYSIS: HEALTH CARE UTILIZATION

Rochester Regional Health Information Organization (RRHIO) provided ED & hospitalization encounter data for pre- and post-intervention comparisons. New York Academy of Medicine evaluated the effectiveness and ROI.

**Average number of hospitalizations, emergency department visits, and observations per client decreases** after 90 days of CCC program participation.

<table>
<thead>
<tr>
<th></th>
<th># of CCC Clients (N)</th>
<th>Pre CCC</th>
<th>Post CCC</th>
<th>% Change</th>
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<tbody>
<tr>
<td>Hospitalizations</td>
<td>1,225</td>
<td>.097</td>
<td>.069</td>
<td>-29%*</td>
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<tr>
<td>ED Visits</td>
<td>1,225</td>
<td>.392</td>
<td>.281</td>
<td>-28%*</td>
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<tr>
<td>Observations</td>
<td>1,225</td>
<td>.176</td>
<td>.135</td>
<td>-23%*</td>
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* = significant at $p < .05$

### RETURN-ON-INVESTMENT

Every dollar spent on the CCC program is associated with an estimated **$3.04** in reduced costs related to hospitalization and ED visits (using a 90-day analysis).
Results led to additional demonstration grants and contracts from foundations, an ACO and an insurer.

Continued evaluation will provide results and cost analyses broken down by funders’ population of interest.

Working to transition demonstration partnerships to a sustained payment model including value-based contract agreements.