Reducing Health Disparities through Community Partnerships

Session 1 - Overview and Issues

April 8, 2020

The Social Determinants of Health Academy

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In case of technical difficulties – yours or ours – relax!
This session will be recorded and available for you to share with your team.

Please alert Danielle of any technical challenges with Webex through the chat box feature.

About the 2020 SDOH Academy Learning Collaboratives

- **Target Audience:** Staff from health centers, primary care associations, and health center-controlled networks are encouraged to participate.
- **Time Commitment:** Each learning collaborative includes two 90-minute sessions that offer a 60-minute training followed by 30 minutes of office hours, where participants can get coaching and ask specific questions. You can choose to participate in one or both of a collaborative's sessions.
- **Registration:** Use the link at the end of this presentation or in the chat box to register for each session you plan to attend. And yes, you can participate in more than one collaborative!
- **Recordings:** All trainings are recorded and will be available afterward under the "SDOH Trainings" tab on the SDOH Academy website.

SDOH Academy Faculty

The Social Determinants of Health Academy

2020 Steering Committee

National Center for Medical Legal Partnership at the George Washington University

Health Outreach Partners — Healthy People. Equitable Communities.

CSH — The Source for Housing Solutions

National Health Care for the Homeless Council

National Nurse-Led Care Consortium — a PHMC affiliate

2020 Additional Faculty

AAPCHO

acu — association of clinicians for the underserved

Capital Link

Farmworker Justice

Migrant Clinicians Network — MCN

MHP Salud

National Association of Community Health Centers

NCHPH — National Center for Health in Public Housing

National Center for Equitable Care for Elders

NCFH — National Center for Farmworker Health, Inc.

National LGBT Health Education Center — A program of the Fenway Institute

SDOH Academy 2020

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2020 Topics Addressing Social Determinants of Health:

1. **Humanizing Your Enabling Services Data for Patient Care**
   - February 12 and 26: 2 - 3:30pm Eastern Time

2. **Fostering a Health Care Workforce Able to Address Current and Emerging Needs**
   - March 11 and 25: 2 - 3:30 pm Eastern Time

3. **Reducing Health Disparities through Community Partnerships**
   - April 8 and April 22: 2 - 3:30 pm Eastern Time

4. **Equitable Preparedness for Vulnerable Populations**
   - May 20 and June 3: 2 - 3:30 pm Eastern Time

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SDOH Academy Core Competencies Learning Collaborative Series

1. **Improve Access to Quality Health Care and Services:** Health Centers; PCAs; and HCCNs will develop the capacity to improve access to SDOH services and health needs.

2. **Foster a Health Care Workforce Able to Address Current and Emerging Needs:** Health Centers; PCAs; and HCCNs will understand and build the workforce capacity needed to address SDOH.

3. **Enhance Population Health and Address Health Disparities through Community Partnerships:** Health Centers; PCAs; and HCCNs will understand and build capacity to address SDOH through partnerships and system delivery transformation.

4. **Understand Emerging Issues:** Health Centers; PCAs; and HCCNs will obtain a clearer understanding of issues in relation to SDOH.

Today's Session

Presented by:

- **Capital Link**
  - Allison Coleman, *Chief Executive Officer*
- **National Center for the Equitable Care for Elders**
  - Arielle Mather, *Project Manager*
- **National Center for Health in Public Housing**
  - Saqi Maleque Cho, *Director of Research, Policy, and Health Promotion*
- **National Center for Medical Legal Partnerships**
  - Ellen Lawton, *Co-Director*
  - Danielle Rahajason, *Administrative Coordinator*

Meet the presenters!

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Allison Coleman
Capital Link

Arielle Mather
NCECE

Saqi Maleque Cho
NCHPH

Danielle Rahajason
NCMLP

Ellen Lawton
NCMLP

Today's Webinar: Learning Objectives

1. Increase their understanding on how to **build partnerships** in the community that can address SDOH for patients
2. Build capacity on **Integration of Services** to address SDOH within clinic doors
3. Discuss strategies to employ **Delivery System Transformation** including value-based HC for SDOH
4. Explore opportunities to improve **Data Analysis** for population health management, including building competencies around collection, validation, analysis, management, utilization, visualization, and risk stratification segmentation.

Brief Session Evaluation

- Please complete the brief follow up survey that will be **launched immediately following this session** and also will be emailed to participants.

Examples of COVID-19 Response Partnerships

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Capital Link

Goal: Utilize Capital Link's strengths and existing partnerships with NACHC, PCAs and funding sources to identify needs and rapidly develop and deploy financing resources targeted to assist health centers with COVID-19 response

Economic Impact and Financial Data Analysis

- Utilized national database of health center audits and economic impact evaluation tools to estimate revenue and job losses at health centers related to COVID-19.
  - Shared findings with NACHC -> used for federal outreach and education
  - Shared findings with PCAs -> used for state and local outreach and education

Examples of COVID-19 Response Partnerships

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Capital Link

Linking Health Centers to Financial Resources

- Developing a searchable resource to link health centers with available sources of emergency funding/capital to address short-term cash flow needs
- Mobilizing coalition of 25 Community Development Financial Institutions to lend to health centers in need of working capital
- Working directly with funders to develop and deploy emergency loans and other resources to health centers

Examples of COVID-19 Response Partnerships

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HUD's COVID-19 Response

https://www.hud.gov/coronavirus

COVID-19 FAQs for the Public Housing, Housing Choice Voucher (HCV) (including the Project-based Voucher Program (PBV)) and Native American Programs)

HUD announced 3/18/20 it will encourage local PHAs to suspend evictions for public housing residents.

Examples of COVID-19 Response Partnerships

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City of Phoenix Housing Department

PHX HOUSING

Quality Affordable Housing and a Pathway to Self-Sufficiency

- Leasing offices open by appointment only - office numbers are listed below
- Suspension of Notices to Vacate and lease violations for non-criminal activity
- Suspension of evictions for non-criminal activity
- Suspension of routine work orders
- Maintenance staff still performing emergency work orders
- Suspension of housekeeping inspections
- Suspension of late fees
- Suspension of home visits and in-person appointments with caseworkers
- Suspension of all resident activities to include Community Meetings, Tenant Meetings, and Youth Activities
- Transfers, move-ins, move-outs processed on a case-by-case basis
- Existing repayment agreements will be extended
- Recertification deadlines will be extended
- Pest control services will temporarily be suspended in resident's units (excluding health and safety)

Don't know who to contact?

View NCHPH's interactive map to locate the name and contact for the Health Centers located near a Public Housing Authority: Health Centers and Other Health Care Facilities Close to Public Housing Developments.

Examples of COVID-19 Response Partnerships

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City of Williamsburg, VA

Examples of COVID-19 Response Partnerships

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National Center for Equitable Care for Elders

National Council on Aging

https://www.ncoa.org/covid-19-resources-for-older-adults/

https://www.ncoa.org/covid-19-resources-for-professionals/

eldercare locator

MEALS on WHEELS AMERICA

FEEDING AMERICA

FriendshipWorks

http://www.fw4elders.org/

Boston, MA

Reducing social isolation through virtual visits

Examples of COVID-19 Response Partnerships

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National Center for Medical-Legal Partnership

What You're Concerned About

Topic	Details
Remote legal work	- About 80% of comments referenced the challenge of working remotely with clients / lack of technology to work with clients - Impact of court closure on legal work and clients - Difficulty of working with state & federal agencies remotely for both clients and lawyers
MLP fundamentals	- Health care partners are overwhelmed and MLP attorneys can't even be on site – referrals slowed/stopped - What should be prioritized? - Should I try to provide training remotely? - How do I stay engaged with my health partner during this time?
Populations and topics	- Meeting needs of individuals who are homeless, immigrants, DV victims, children - Focus on evictions, public benefits, special education access, unemployment, estate planning
COVID-19 specific topics	- Health care partners asking new and difficulty questions of lawyers - Should we be assisting with advocacy related to PPE or other supplies? - What if hospitals are rationing care – do we have a role? - COVID-19 discrimination
General concern about clients, stress levels, funding, future	- How to manage stress of clients, partners - Fear of losing my job - Law clinic students who can no longer go to health clinics

I. Developing Cross Sector Partnerships

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Health Disparities

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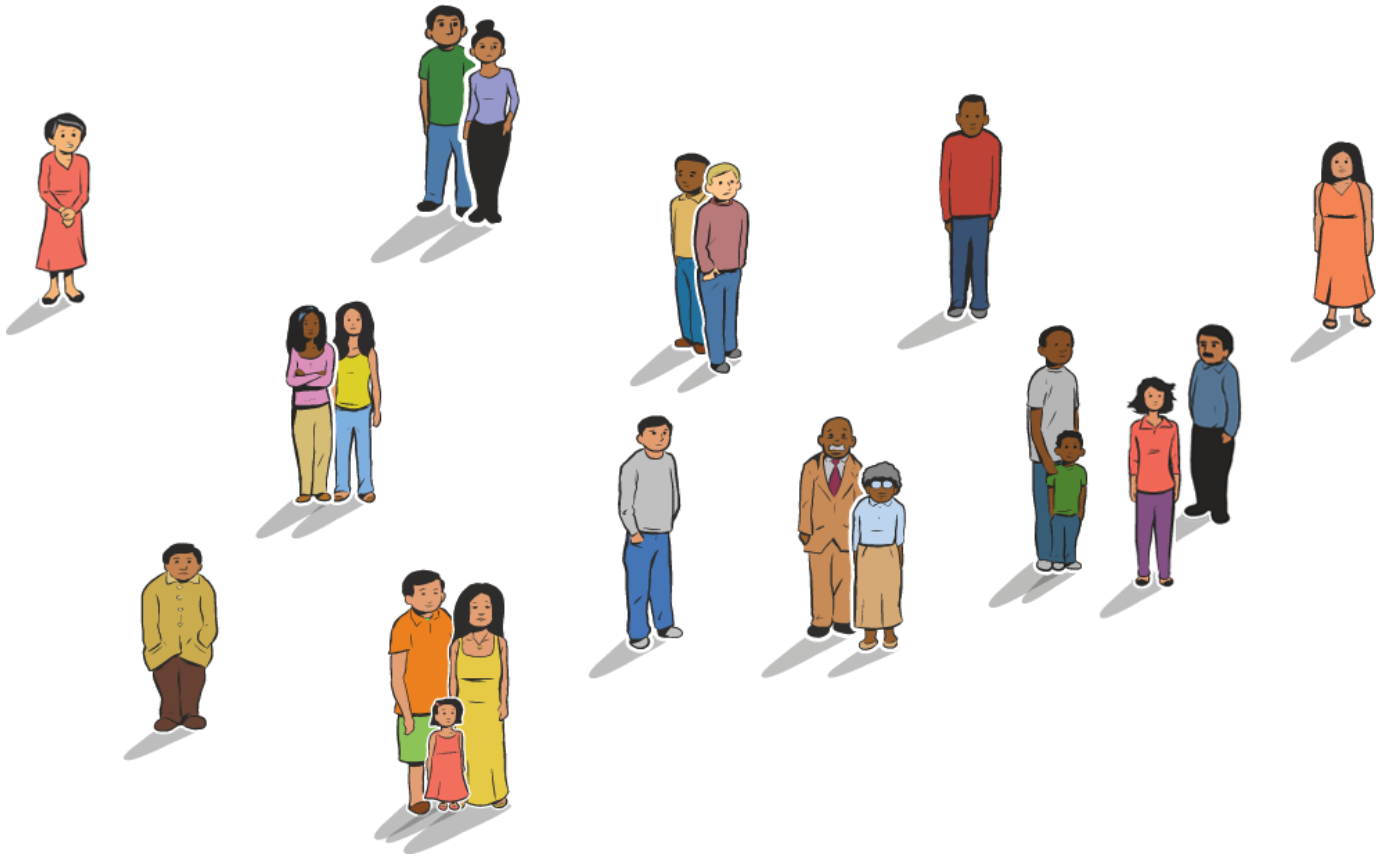
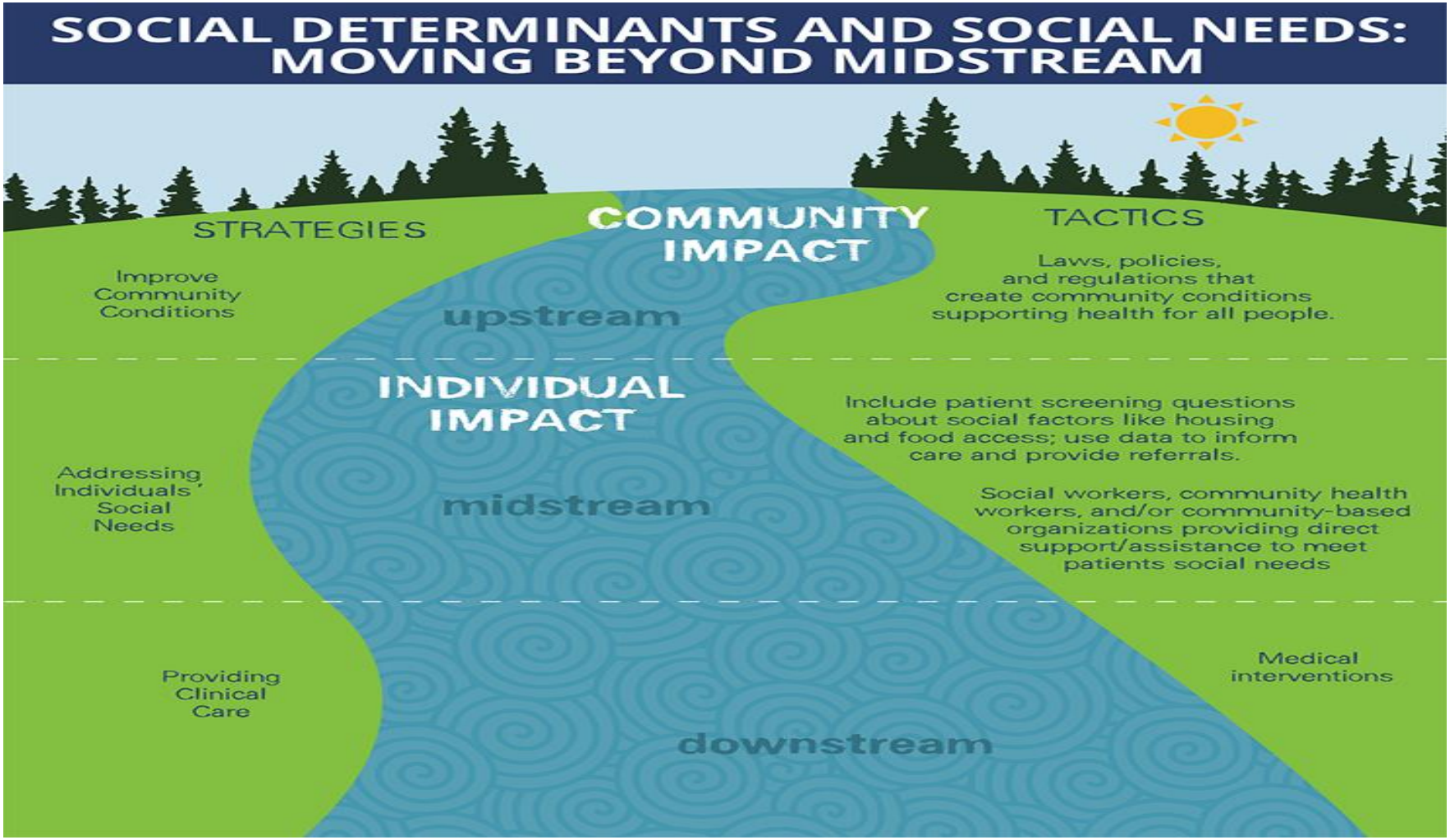


Learn more: National Partnership for Action to End Health Disparities TOOLKIT FOR COMMUNITY ACTION



Source: https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/

Importance of Partnerships

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Formal partnerships involving hospitals and/or health systems, public health departments, and other stakeholders who share a commitment to improving the health of the community they serve have an important social role. These partnerships can serve as ***effective vehicles*** *for* ***collective action****.*

-Robert Wood Johnson Foundation

Source: https://www.rwjf.org/en/blog/2015/02/the_secret_to_succes.html

Partnerships that can reduce health disparities for older adults

Links to social services:

- Support and Services at Home (SASH) Program
- Naturally Occurring Retirement Community Supportive Service Programs (NORC-SSP)
- Program for the All-Inclusive Care of the Elderly (PACE)
- Senior Network and Activity Program (SNAP)
- Benefits Enrollment Center

Addressing transportation barriers:

- Dial a Ride
- Mobile Health Services
- Peninsula Volunteers partnered with the Sequoia Healthcare District and the Lyft Concierge Service to provide low-cost, fast rides to seniors

II. Building and Sustaining Community Partnerships

Medical Neighborhoods

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Medical neighborhood “maps” can take a variety of forms but should be created in written format so that all members of the health center care team can identify "neighbor" organizations and link patients to community resources.

Medical neighborhood maps could look like:

- Circle diagrams with the patient/population in the center and partners listed on spokes
- Excel lists of partners with relevant contact information
- Noted on patient care plans in the EHR
- A bulletin board in the health center

Medical Neighborhoods

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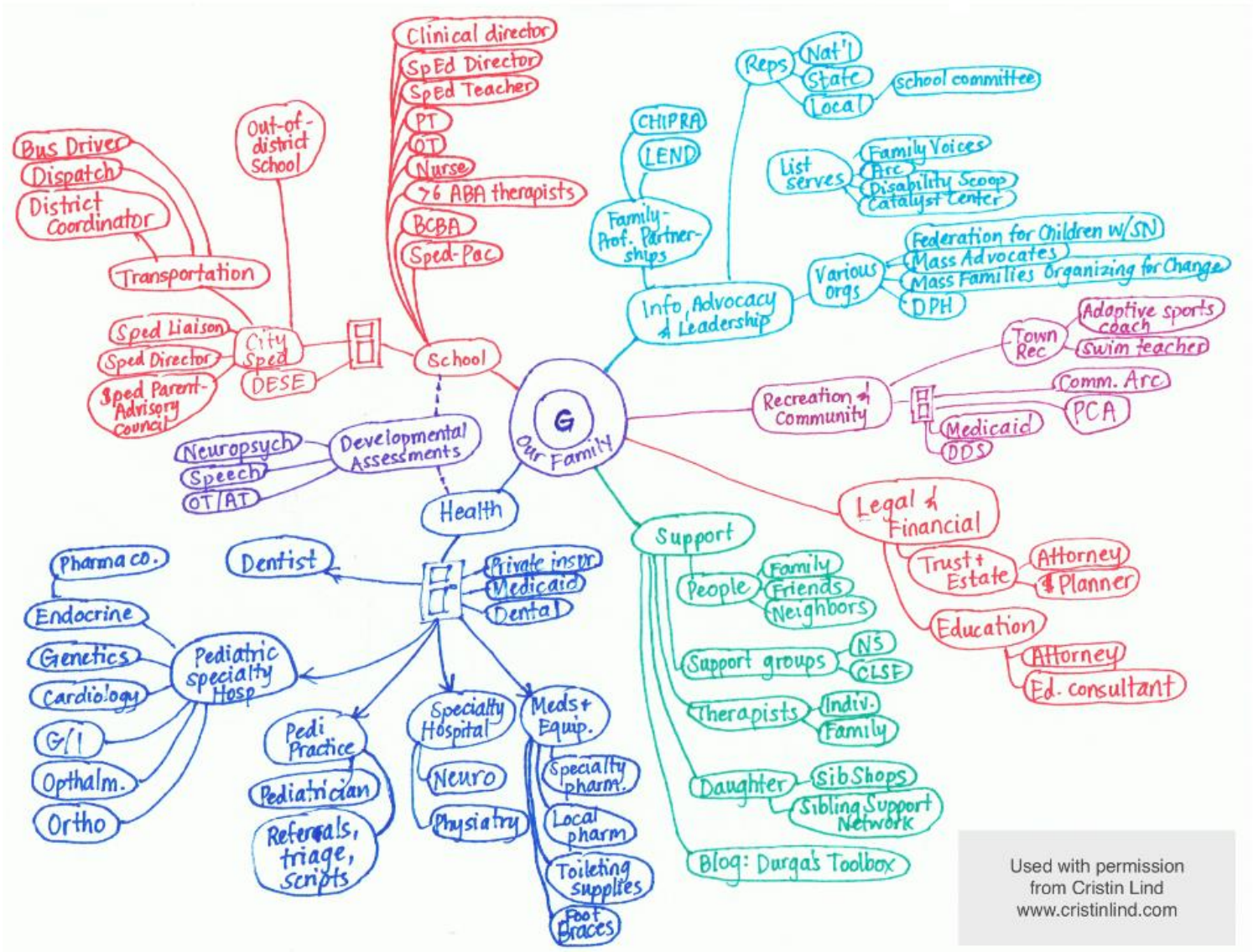

Used with permission from Cristin Lind
www.cristinlind.com

Building Your Neighborhood

1. Creating care maps for patients/populations

- A care map is a comprehensive snapshot of the medical and social supports in place to promote patient and family wellness.

- Care maps should be created in consultation with patients and families, with the patient/population at the center.

- The map should change based on evolving patient needs and should incorporate all the social determinants of health at play in a patient's life.

Building Your Neighborhood

2. Identifying the community organizations that play a role in patient/population care maps

- Identify a point of contact at the organization
- Create a contingency plan for turnover

Building Your Neighborhood

3. Operationalize partnership by creating a shared protocol or memorandum of understanding (MOU)

Health centers can use a MOU to:

1. Identify purpose
• *Example:* To facilitate individuals' consistent participation in health-enhancing activities
2. Identify principle
• *Example:* Focus on patient and family needs
3. Defining common terms (*elderly vs older adult*)
4. Define funding and duration – how could the partnership continue if the original funds are depleted?

Neighborhood Outcomes

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Short-term

- Improved care coordination
- Improved patient safety
- Improved patient experience

Long-term

- Improved clinical outcomes
- Reduced costs through reduced duplication and waste
- Improved population health management

Levels of Partnerships

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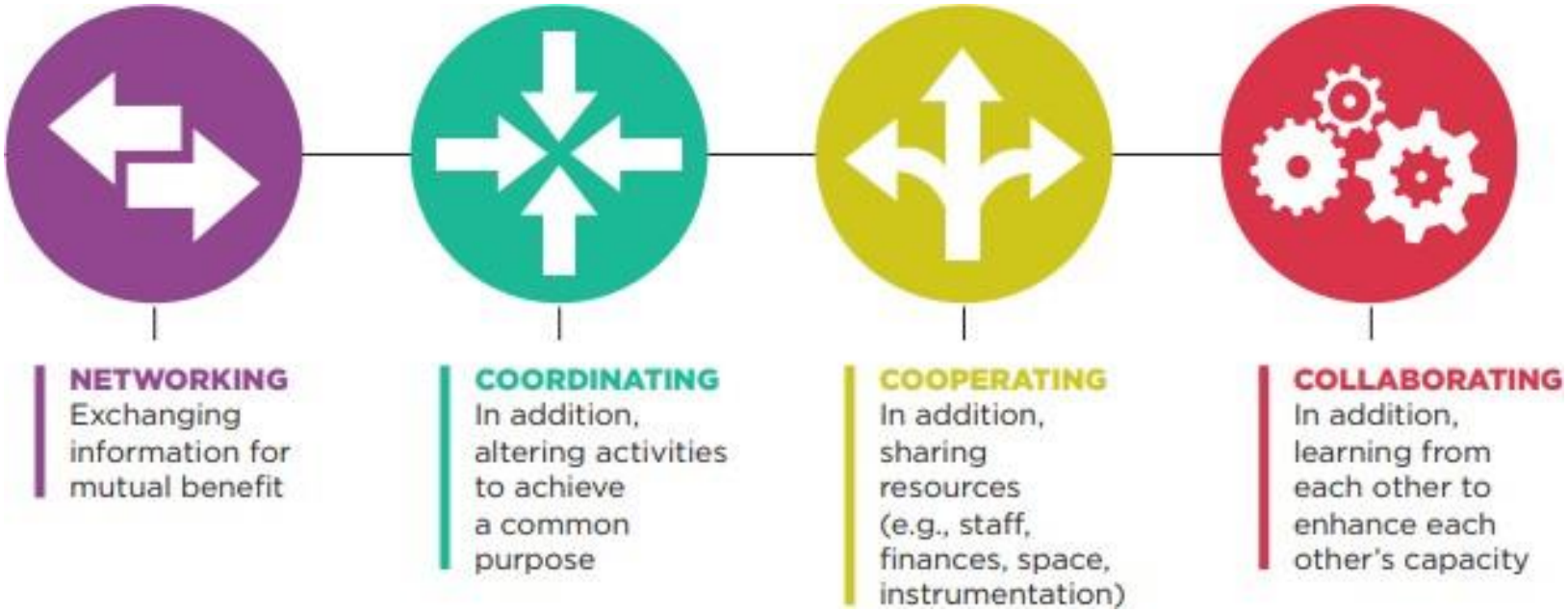

Source: http://www.teaglefoundation.org/Teagle/media/GlobalMediaLibrary/documents/resources/CollaborationContinuum.pdf?ext=.pdf

Nurturing Partnerships

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- **Define clear roles for all**
- **Build trust through open communication**
- **Value diverse perspectives**
- **Use a common language**
- **Be present & stay engaged**

Maintaining Partnerships

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- **Have clear ground rules**
- **Maintain strong core leadership**
- **Ensure on-going support (diversify funding)**
- **Manage conflict (and discomfort)**
- **Give opportunities for feedback**
- **Keep trying! (Nobody's perfect)**

Evaluating Partnerships

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- What targets do you want to reach? By when?
- Re-visit objectives, look at progress over time
- ALL can participate- no matter how formal!
- Often not about anyone claiming exclusive "credit"
- Share what you learn!

III. Case Examples

Casa Maravilla- Senior Center

- Public- Private Partnership
- Senior Housing- 73 units; age 55+
- Benefits Enrollment Center- 2,400 seniors annually
- Monthly Wellness Programs

"It's been a remarkable experience, one of the things that it enables us to do is to talk to people in the community and young people about this line of work and how rich the variety is and how meaningful and fulfilling it is to work with older adults."
Alivio Program Manager

Partnership Timeline

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Resources

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The BUILD HEALTH Challenge®

Improving Health Through Innovative Collaborations

By strengthening partnerships between local nonprofit organizations, hospitals and health systems, and local health departments, we are able to improve community health and well-being.

https://buildhealthchallenge.org/resources/

Resources

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Community Care Connections: Rochester, NY

Article: Working Across Sectors To Improve Health For Older People: The Community Care Connections Program

Pilot Project Report: Community Care Connections Final Report

Questions?

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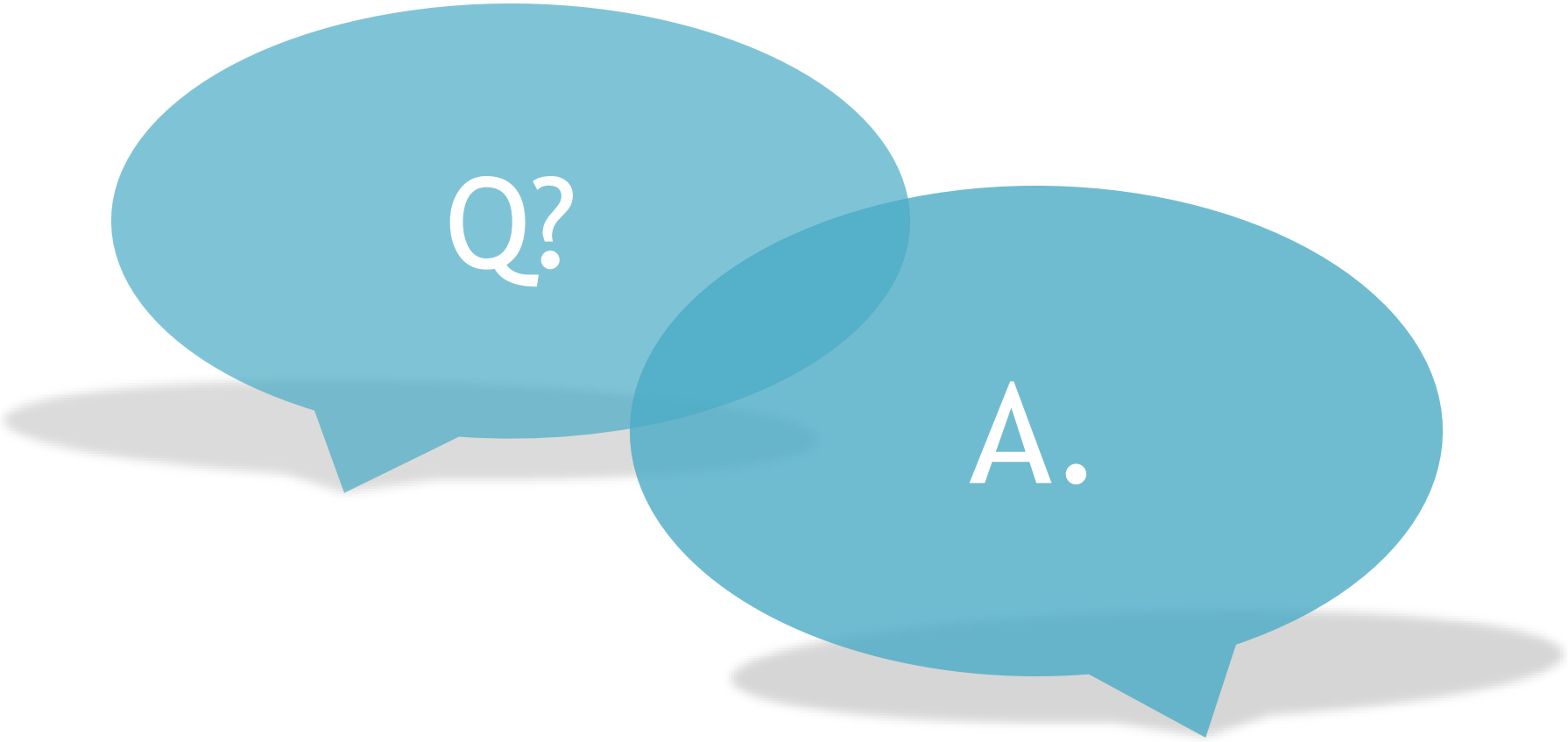

Teaser!

Join us next week for in-depth applications

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Health Center / Grocery Store Collaboration

In 2015, Brockton Neighborhood Health Center and Vicente's Tropical Grocery teamed up to develop adjacent sites to house a 13,600 SF health center and a 40,000 SF grocery store—through a $22 million combined investment financed through NMTC

Teaser!

Join us next week for in-depth applications

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Context - Brockton, MA

- African American, Latino and immigrant community
- Unemployment rate 2x MA rate
- Diabetes rate ~10%
- 25% poverty rate
- Food desert

Teaser!

Join us next week for in-depth applications

Features of the Collaboration

- Wide variety of fresh foods from all over the world
- Nutritional guidelines and labels on shelves
- Focus on improving health of diabetic patients
- Teaching kitchen, staffed by dieticians and health workers
- Food preparation demonstrations and educational events
- Rewards system to encourage healthy choices
- City commitment to building new sidewalks and housing

Join us for the *"Deep Dive" on implementation strategies!*

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Next Session – April 22nd

- **Addressing SDOH Core Competencies: Reducing Health Disparities through Community Partnerships**
- Session 2 – Implementation Strategies
  - Wednesday, April 22, 2020 @ 2:00 – 3:30 PM EST
  - Register here: https://register.gotowebinar.com/register/1488961249876648460

Brief Webinar Evaluation

- Please complete the brief follow up survey that will be launched immediately following this session and also will be emailed to participants through Webex.

Contact Us

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Thank you!

https://sdohacademy.com/collaboratives

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Office Hours

30 minutes

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What concerns would your health center like to address through community partnerships?

What feels most challenging about maintaining partnerships?

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How does your health center currently use data in collaborations?

THANK YOU!!