Project Description

Using input from our community, develop social determinants of health curriculum that can be used to educate others and expand this to a framework to address these determinants.

KKV uses its innovative expertise in addressing the social determinants of health to educate and as a draw recognition, support and change in funding and reimbursement strategies based on an expanded paradigm of health and healing.

output-oriented objectives
- Identify funding for project / staff by Sept 2015
- Complete and pilot social determinants of health curriculum by Feb 2016
- Present curriculum to health insurer by April 2016
- Start presenting curriculum to students by May 2016

outcome-oriented objectives
- Renegotiate contract with health insurer by June 2016
- Include education on social determinates of health in affiliation agreements with health profession students
- Expansion in awareness reported by all

Statement of Problem

Kokua Kalihi Valley serves a largely migrant and immigrant population. The majority live below the poverty level financially but have a wealth of sustaining cultural traditions.

Health insurers have a lack of understanding of the social determinants of health (SDH) that our community faces and unrealistic expectations in terms of health outcomes. Current reimbursement models don’t fit.

New Medical/Dental/Behavioral Health providers have some understanding of SDH but not how to address them which leads to less effective care, miscommunication and frustration.

How to design health systems that speak to our community’s needs and view of health and healing?

Outcomes

Outcomes achieved
- Funding sources identified and Health Innovations Coordinator hired in August 2015
- “Expanded Paradigm of Health and Healing” curriculum completed in March 2016
- KKV presenting a series of experiential SDH workshops to HMSA (primary health insurer) in 2015 and 2016 with very positive feedback
- KKV presented curriculum to University of Hawai`i students in March 2016 – “… things you don’t think about; health being impacted by social factors”
- KKV CEO appointed to HMSA Payment Reform Committee in 2015 and meetings are ongoing
- KKV received: $600K grant to support Active Aging! $150K grant to support youth programs

Continuing...

Experiential workshops with HMSA continue – connections have been made and are now focusing on sharing the impact of programs that currently fall outside the health system. Payment reform not yet realized

Our community likes to define quality through story and description – rather than numbers and measurements. Health insurers like numbers and measurements.

Will continue to offer the curriculum to student groups and collect feedback to be used to gauge impact

Lessons Learned

Creating a curriculum that includes experiencing connections with the land, past & future, self, and each other has great power. These experiences lead to healing and to individual awareness which can then lead to individual and organizational transformation.

It is difficult for health insurers to embrace non-traditional payment reform… but they want to. Start with walking with them through experiences so they can learn the lesson without being told what it is. In the meantime, WRITE GRANTS to support programs that aren’t insurance covered

It is essential to go beyond what is lacking (social determinants) to create a culture of abundance using tools the community already has.

My Organization

Kokua Kalihi Valley (KKV) Comprehensive Family Services is a non-profit, Federally Qualified Health Center that started in 1972 from humble beginnings providing home based volunteer medical services. Today, KKV employs 200 staff who speak 26 languages offering services out of 8 program sites. We provide 10,000 Primary Care, Dental and Behavioral Health visits annually to the residents from the Ahupua`a of Kalihi. KKV also addresses the social determinants of health by having innovative social services programs including an evidence based exercise program for elders; several youth programs (tennis, bike, cultural based land/ocean stewardship) a sewing program where Micronesian women can learn to sew and sell their creations, and a Medical Legal Partnership for Children. We lease a 100 acre nature park from the state, Ho`oulu Aina, a welcoming place of refuge where people of all cultures sustain and propagate the connections between the health of the land and the health of the people. Our Roots Cafe is open for lunch two days a week serving organic, healthy foods prepared by our staff. Roots also works to find new opportunities to build health through food, story sharing and connections to the land.

Contact Me

Jo Ayers, MPH
Kokua Kalihi Valley Comprehensive Family Services
(808)791-9413

PLEASE VISIT US IN HAWAII!!!
Community Health Improvement Project (CHIP)
Obesity Weight Loss Program

La Toya Darden, CEO
Central Care Integrated Health Services

Project Description

GOAL
Decrease BMI of obese patients through participation in exercise, education, behavioral health and nutritional programs that will result in healthier lifestyles.

OBJECTIVES
To have 30% of our patients with a BMI over 30 involved in our educational, nutritional and/or exercise program; become self-sufficient in making better food choices; and regularly engaging in healthier eating habits and exercise programs by March 2013.

STRATEGIC OPTION
Enroll 50 obese patients in the developed program by March 2012. Patients who show an active interest in the program through participation show a greater chance of completing program resulting in the desired goal.

FINANCIALS
The budget is anticipated at $60,000. This funding will be attained through community entities and local businesses aligned with the goals of the program.

Statement of the Opportunity

70% of Central Care Integrated Health Services’ patients are obese. Through the existing patient population, there is an opportunity to provide these patients with access to obesity care and become more self-sufficient regarding their health.

In order to achieve this goal, the following issues need to be overcome: an overflow of cheap and accessible fast food restaurants exist in service-area neighborhoods; 30% of patients are 200% below the poverty line; patients either live in food deserts or near establishments that provide the unhealthy food they are accustomed to consuming; and the health center has limited funding to introduce new programs.

To address these issues, a collaboration between the health center, neighborhood schools, churches and grocery stores will be established. This partnership will enlist volunteers to provide nutritional classes (to include use of kitchen facilities) and further the vision of patients seeing the health center as a one-stop-shop for them and their families.

My Organization

Central Care Integrated Health Services (CCIHS) serves various federally designated Medically Underserved Areas (MUAs) and Health Professional Shortage Areas (HPSAs) through six facility locations in the Houston-metro area. CCIHS is a Federally Qualified Health Center that provides accessible, affordable and high quality comprehensive healthcare services to all residents in Harris County, Texas.

Lessons Learned

- Attempting to overhaul someone’s lifestyle requires you to show a true investment in them and demonstrate the investment they are making in their lives.
- Choose team members that are passionate about executing the vision and can contribute a higher level of thinking in order to maximize program improvement and other development.
- Don’t be afraid to shift or adjust the focus of your program if either a more pertinent need arises or resources change.

Contact Me

La Toya Darden
Central Care Integrated Health Services
LDarden@centralcarechc.org
Problem Statement
Lawndale Christian Health Center (LCHC) is a non-profit organization focused on providing healthcare in Chicago’s Westside communities. They provide prenatal care for pregnant women and providers have admitting privileges at two neighboring hospitals, Mt. Sinai and St. Anthony. If an LCHC doctor delivers a baby at Mt. Sinai or St. Anthony, LCHC generates revenue from professional charges incurred during the delivery.

LCHC experienced a small amount of growth within the OB service line and maintained a small market share of deliveries within target areas, including 19% for North Lawndale and 5% for South Lawndale in 2002.

Project Description
The project involved utilizing internal and external data to help explain operational inefficiencies, bottlenecks in service provision, and patient practices in seeking prenatal services. Deliveries take place at either Mt. Sinai, which is a level three hospital and can handle any delivery, or St. Anthony’s Hospital, which can handle only low-risk deliveries. At the time, LCHC employed three OBs, and each prenatal care team included a nurse assistant, a nurse in each hallway of the clinic and case manager. Also, LCHC employed family doctors whose scope include inpatient services.

Goals
Increase Prenatal Users by 20% by 2009
Increase LCHC deliveries by 15% by 2009

Objectives
Create a process analysis to determine capacity & bottlenecks in OB clinical operations.
Create marketing messages highlighting prenatal services.
Enhance hospital services provided to patients through effective collaborations with hospital administrators and OB leaders.
Create marketing messages highlighting OB hospital services.

Recommendations
Numbers
From 2003 to 2007, patient deliveries at non-LCHC admitting hospitals rose from 3.45% to 5.68% respectively.

Key Recommendations
+ LCHC had three clinics within 2.1 miles of each other and bordered North and South Lawndale. However, less than 50% of prenatal patients came from the surrounding areas. Recommended adding additional clinics in other market areas to increase prenatal patients.

+ Expand admitting privileges in additional nearby hospitals.

+ Enhance partnership with affiliated hospitals to improve inpatient experiences.

Lessons Learned
The quality of outpatient prenatal care was impacted patients overall experience with prenatal care. Patients experiences and relationships with staff positively impacted the overall experience.

Conversely, patients commented that cycle times negatively impacted experience.

LCHC serves a market much larger than the immediate surrounding communities. Only about 44% to 48% of LCHC deliveries come from the surrounding communities presenting opportunities to expand outpatient services.

There was no correlation between distance from the health clinics and the likelihood to deliver a non-LCHC admitting hospitals.

The most powerful reason why patients delivered at a non-partnering hospital was perceived inadequate care.

Outcomes Achieved
+ 3 to 5 sites providing prenatal care.
+ Expanded Midwifery service line at local hospital.
+ 894 deliveries in 2006 to 941 in 2012.

Contact Me
Misty G. Drake
Chief Operating Officer
Piedmont Health Services
drakem@piedmonthealth.org
Community Health Improvement Project (CHIP) Accountable Care Organization (ACO)

Brady Fitzwater, Chief Financial Officer
PEAK VISTA COMMUNITY HEALTH CENTERS

Problem Statement
One of the biggest challenges facing Peak Vista is a heightened level of competition due to payment reform. Health care providers must position themselves to meet the coming challenges of health care payment reforms, as well as Affordable Care Act-driven health care delivery changes.

Providers in the Pikes Peak region of Colorado have historically been highly collaborative in addressing the needs of the underserved population in our community. Additionally, provider organizations, until recent years, have primarily been locally controlled.

- Payment reform and care delivery models are driving changes in how providers interact with each other, our patients, and our communities.
- The two largest hospital systems and several of the largest primary and specialty health care providers have been acquired by larger organizations headquartered remotely.

Project Description
Form an Accountable Care Organization (ACO) with one or more health care entities in our community to participate in the Medicare Shared Savings Program (MSSP).

Goals
- Improve patient health care outcomes while reducing the growth of health care costs in the Pikes Peak Region.

Objectives
- Apply for and be accepted into the Medicare Shared Savings Program and establish baseline data and systems for measuring 33 CMS quality outcomes and patient population costs.
- Meet or exceed the minimum attainment level of 30% of the national quality performance benchmarks on at least 70% of the benchmarks determined by the Centers for Medicare and Medicaid Services (CMS).
- Recognize an average savings rate of 8% or greater per year under the CMS actuarially projected cost growth estimate for our patient population.

Outcomes

Outcomes Achieved

Partnership
Initially partnered with two entities, a sister Federally Qualified Health Center (FQHC) and a specialty practice group local to Colorado Springs (at the time). The sister FQHC subsequently merged into Peak Vista, with the same patient base in the MSSP ACO program remaining. Acceptance into the program granted beginning January 1, 2014.

Baseline Metrics
A historical benchmark cost baseline was determined for our ACO to be $6,700 per Medicare beneficiary per year. The national average benchmark data at the same point was just under $8,500 per beneficiary per year.

Year 1 (2014)
Quality: Achieved quality goals on 83% of measures. Actual expenditures of $7,100 compared to benchmark of $6,700. No shared savings realized.

Year 2 (2015)
Quality: Achieved quality goals on 83% of measures. Costs pending final release by CMS.

Today
Through participation in the CMS MSSP program, we learned that our costs were already well below the national benchmark. In order to achieve savings, a significant decrease in cost growth from our benchmark would be required.

The resources applied to the program have been limited with intentionality, focusing on benchmarking our quality and cost metrics, with the ability to achieve a share of savings limited in a down-side risk only environment.

While we continue to participate in the MSSP program, 2016 being the final year of the initial 3 year term, we are looking to take the lessons learned through participation and apply them toward other payers and other population health models. Our partner in the MSSP ACO is being acquired by a large national group which creates uncertainty as to the future of the partnership.

Lessons Learned

Low starting baseline costs make achieving shared savings challenging without sacrificing patient care.

Data on quality and utilization for our patients in the whole continuum of care is extremely valuable and critical information to achieve the aims of health care reform.

Partnering strategically and with focused objectives is becoming increasingly critical.

While health care is local, it also becoming increasingly global, and how an organization approaches that shifting dynamic can significantly impact future opportunities.

My Organization
Peak Vista Community Health Centers is a nonprofit Federally Qualified Health Center dedicated to providing premier medical, dental and behavioral health care in a collaborative setting for people of all ages. We proudly serve nearly 84,000 patients through 26 outpatient centers in Colorado's Pikes Peak and East Central regions.

Peak Vista's mission is to provide exceptional health care to people facing access barriers through clinical programs and education.

Contact Me
Brady Fitzwater, CPA
Chief Financial Officer
Peak Vista Community Health Center
brady.fitzwater@peakvista.org
(719) 344-6188
Community Health Improvement Project (CHIP)
INTEGRATING HIV TESTING INTO PRIMARY CARE

Regina King
Chief Clinical and Community Engagement Officer, Hamilton Health Center, Harrisburg PA

Statement of Problem
Pennsylvania HIV act 148 prevented clients from receiving HIV testing without a signed consent. Hamilton Health Center Inc. (HHC) struggled with testing clients due to the stigma of HIV and adding a consent form further increased the reluctance of receiving this test. HIV, if diagnosed early increases the life span of those infected as well as preventing the spread of this disease to others. In January 2009 HHC in collaboration with Department of Health and Hershey Medical Center decided to initiate an “Opt-in” pilot study which would increase HIV testing at HHC’s Adult Medicine department. The goal was to increase HIV testing by 50% by June 2011.

Outputs & Outcomes

Outputs achieved
- HHC increased testing from 213 test in 2009 to 1046 by June 30, 2011 exceeding our goal of 50%
- Decreased stigma regarding HIV testing.
- Expanded “Opt-in” testing to Woman’s Health Service on March 2010. Increased HIV testing by 25%
- Improved Medicaid reimbursement for HIV testing.

Expected outcomes
Provide HIV testing as a part of routine primary care reducing the stigma of HIV services. This will be accomplished through comprehensive shared collaboration and strategic planning between Hershey Medical Center and Pennsylvania Department of Health. Increase testing by 50% by June 2011.

Where are we now...
As of January 2016 HHC has implemented routine testing in our Adult Medicine and Women’s Health Center departments accounting for over 3,500 test a year.

HHC currently provides Sexually Transmitted Infection (STI) screening at the local high school. In January 2016 HHC was given permission by the Department of Health and Harrisburg School Board to include HIV testing into our STI clinic. This is the first time this testing has been offered in a high school in the Pennsylvania region.

My Organization
Hamilton Health Center is a Federally Qualified Health Center (FQHC), a non-profit community based health organization. HHC provides comprehensive primary care, dental and mental health services to persons in all stages of the life cycle. The center also assists clients to access specialty and hospital care services not available at the center. Hamilton operated under a Board of Directors comprised of at least 51% of Hamilton clients and functions under the supervision of the Bureau of Primary Health Care. HHC provides comprehensive health services to the medically underserved to reduce the client load on hospital emergency room. We bring primary health care services to the underserved, underinsured and uninsured people of Dauphin county including migrant, and non-citizen visitors and guest.

Services Provided:
- Adult Medicine
- Pediatrics
- Women Health Service (OB/GYN)
- Dental
- Family Planning
- Mental Health
- HIV/AIDS
- Immunization Services
- Laboratory
- Podiatry
- Radiology
- Pharmacy
- Healthy Start
- Baby Love
- Teen Resource Center
- Benefit Coordination
- Care Coordinators

Contact Me:
Regina King
Chief Clinical and community Engagement Officer
717-230-3946
rking@hamiltonhealthcenter.com
Community Health Improvement Project (CHIP)
EXPANDING ACCESS TO INTEGRATED CARE IN NORTHERN COLORADO

MARK E. WALLACE, MD, MPH
CEO/CMO, NORTH COLORADO HEALTH ALLIANCE & BOARD CHAIR, SUNRISE COMMUNITY HEALTH

**Statement of Problem**

The North Colorado Health Alliance, through four of its main partner organizations, set the goal in 2004 of expanding and integrating the safety net to provide 100% access to comprehensive physical, behavioral, oral, and population health care for the underserved in northern Colorado by December 2009.

The worst met safety net access needs in 2004 were for adults in the areas of primary care, specialty care, and behavioral health. By December 2014, Sunrise Community Health, North Range Behavioral Health, Summit Stone Health Partners, and the Weld County Department of Public Health will have expanded integrated care services to over 135,000 patients registered in their shared community electronic health record - representing a 285% increase over baseline and representing access to comprehensive by at least 95% of those living in poverty in the shared service area.

**Project Description**

Integrate and expand access to the safety net through formal corporate partnerships, coordinated strategic planning, and clinical collaboration.

**goal**

Each 100% access to comprehensive care for the underserved in our shared northern Colorado service area by 2009.

**output-oriented objectives**

- Complete fundraising for a new 40,000 square foot Sunrise Community Health integrated primary care/behavioral health clinic by July, 2006.
- Complete architectural design and construction of 3 new integrated clinical pods in expansion facility by December, 2006.
- Secure funding and enroll first class of professionals in academic Center of Excellence to train behavioral health specialists in new model of care by 2007.
- Open Kids Care Clinic on school campus by August, 2006 as part of school-based health center access plan.

**outcome-oriented objective**

- Double integrated primary care access infrastructure by December 2009.

**Outputs & Outcomes**

- **outputs achieved**

  $7.2 million raised to build new 40,000 square foot facility by July, 2006.

  Open 3 new primary care clinical pods (30,000 square feet) fully integrated with behavioral health specialists trained in new model of care by August, 2007.

  School board approval and $300,000 in funding secured for comprehensive school-based health center on campus of district’s largest elementary school with highest percentage of children in poverty by August, 2005.

  Fully developed plans for specialty service, information management, capital and operating financials, facilities, and shared governance by April 2005 to support goal of 100% access to comprehensive care.

- **expected outcomes**

  Comprehensive shared strategic planning and resource allocation through a formal health alliance will ensure access to comprehensive integrated primary care for at least 95% of those living in poverty in the shared service area by December of 2009.

- **looking forward…**

  Disciplined fostering of trust-building to support ongoing shared governance, strategic planning, and clinical operations will sustain access to comprehensive health homes as Colorado expands Medicaid and coverage through a state-run insurance exchange.

- **Leaders of successful collective impact initiatives have embraced a new way of seeing, learning, and doing that marrying emergent solutions with intentional outcomes.**

  - John Kania and Mark Kramer, SSIR

**Lessons Learned**

- Integrating health care services doesn't happen by chance; it requires tremendous ongoing discipline and attention to trust building, shared vision, and selfless sharing of credit for success.

- Be bold in vision and practical in implementation; stay focused on the end game even when timelines to achieve outcomes take longer than planned or desired.

- Corporate self interest amongst partners isn’t a deal-breaker; these interests, and the associated resources to achieve them, can still be aligned to achieve the shared vision of an increasingly integrated health neighborhood.

- Don’t underestimate the need for C-suite leaders to continuously re-engage around the shared vision; managers’ focus on implementation and operations is necessary but not sufficient.

**My Organization**

The North Colorado Health Alliance (NCHA) is a non-profit formal collaborative composed of public and private organizations committed to collectively generating health across northern Colorado as the foundation of thriving communities and economic vitality. Founded in 2002, NCHA exists to leverage synergy between its member partner organizations that include: Sunrise Community Health, North Range Behavioral Health, Summit Stone Health Partners, Banner Health, Kaiser Permanente, Weld County Public Health & Human Services, Centennial Mental Health, Colorado Access, University of Northern Colorado, United Way, and Northern Colorado Medical Society. NCHA partner organizations collectively generate health by expanding access, eliminating disparities, improving quality, controlling costs, improving experience, managing care, and focusing on population outcomes. We envision becoming the healthiest region in the healthiest state in the nation by serving and supporting thriving families in thriving communities.

**Contact Me**

For more information, contact me:
Mark E. Wallace, MD, MPH – CEO/CMO
North Colorado Health Alliance
mwallace.alliance@nocoha.org
(970)350-4674
Community Health Improvement Project (CHIP)
IMPROVING SENIOR CARE IN INDIANA

Beth Wrobel
Chief Executive Officer, HealthLinc

Problem Statements
- Reduction in the number of private practitioners who take Medicare and Medicaid
- Valparaiso has an aging population
- Lack of oral health care for seniors, since Medicare does not pay for oral health services
- Long wait for mental health services
- HealthLinc’s existing building is not “senior friendly”
- Our seniors have multiple chronic diseases and need care coordination

Goals
HealthLinc will be the model of excellence for senior care in the state of Indiana.

Objectives
- Create the health infrastructure that will improve the health of our community seniors
- Leverage a newly formed group in Valparaiso, Indiana, called “ElderStyle” that establishes a welcoming community
- Create a facility that is “senior friendly”
- Increase the number of Medicare patients served by HealthLinc

HealthLinc’s Mission
HealthLinc improves its communities by expanding access to exceptional health care.

HealthLinc’s Vision
Patients consistently perceive the HealthLinc experience as one of exceptional quality and satisfaction. Without hesitation, they refer families and friends. Those committed to improving health and reducing disparities see HealthLinc as a valued partner in the communities we serve. Employees choose to work at HealthLinc and are engaged because of the care we give patients, the team collaboration, and the servant leadership demonstrated throughout the organization.

This is the vision we live every day.

Outcomes
Outcomes Achieved

Numbers
Since attending the UCLA/J & J Health Care Executive Program, the total number of patients has grown from 3,424 in 2007 to 26,882 in 2015. The number of Medicare patients has grown from 137 to 2,688, as shown in the chart below.

Partnership with ElderStyle
Created a senior resource center in the lobby of our Valparaiso Clinic. During the school year, we have social work students available to help our seniors find the resources they need. (Figure 1.1)

Recognized Patient-Centered Medical Home (PCMH)
All our sites are recognized by NCQA as a Level 3 PCMH. The Valparaiso Clinic has been re-accredited to the 2014 standards. (Figure 2.1)

Quality Drive
Monthly reports on the quality indicators that are published by HealthLinc overall, individual site and provider. Overall goals by indicator and site developed, and employees’ bonus incentive are tied to the outcomes.

Additional Services
Added optometry and expanded dental access and services. Onsite integration of behavioral health into primary care. (Figures 3.1 and 3.2)

Infrastructure
Valparaiso’s new 22,000-square-foot building replaced the multi-story building. New building integrates behavioral health into primary care and added optometry, onsite pharmacy, and large patient education rooms. Last, but not least, a shuffleboard court that is the only shuffleboard court in NW Indiana. (Figures 4.1 and 4.2)

Today
HealthLinc continues to grow in our understanding of the needs of our senior population. Our greatest advertisement is word of mouth!

Lessons Learned
- It takes time to achieve the outcomes. We needed the new building, and this CHIP is a work in progress.
- We have adjusted our hours to respond to the needs/wishes of our seniors (in some cases, we open at 7 a.m.).
- As with any change, Board/Staff Leadership/staff needed to be told the “why” before we could get their buy-in.
- HealthLinc is in the process of exploring and learning the social determinates of health for our health center patients, including our seniors.

My Organization
HealthLinc services include primary and preventive care services; health and wellness education; chronic disease management; prenatal care; women’s health services; men’s health services; wellness checks and immunizations; services to treat depression, anxiety, and many other behavioral health conditions and disorders; comprehensive dental services; pharmacy services; and optometry services.

The National Committee for Quality Assurance has recognized HealthLinc as a Level 3 Patient-Centered Medical Home.

Contact Me
Beth Wrobel
CEO, HealthLinc
951 Transport Drive, Valparaiso, IN 46383
bwrobel@healthlincchc.org, (219) 465 - 9500

Outcomes Achieved

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>3,424</td>
</tr>
<tr>
<td>2010</td>
<td>5,293</td>
</tr>
<tr>
<td>2014</td>
<td>20,408</td>
</tr>
<tr>
<td>2015</td>
<td>26,882</td>
</tr>
</tbody>
</table>

Numbers

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Medicare Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>137</td>
</tr>
<tr>
<td>2010</td>
<td>396</td>
</tr>
<tr>
<td>2014</td>
<td>2,262</td>
</tr>
<tr>
<td>2015</td>
<td>2,688</td>
</tr>
</tbody>
</table>

Today
HealthLinc continues to grow in our understanding of the needs of our senior population. Our greatest advertisement is word of mouth!
Community Health Improvement Project (CHIP)

IMPROVING SENIOR CARE IN INDIANA

Beth Wrobel
Chief Executive Officer, HealthLinc

Figure 1.1, Partnership with ElderStyle

Figure 2.1, Recognized PCMH

Figure 3.1, Optometry

Figure 3.2, Dental

Figure 4.1, Valparaiso Clinic’s New Building

Figure 4.2, Shuffleboard