Prioritizing Community Health to Achieve Health Equity

Presenter

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Prioritizing Community Health to Achieve Health Equity

December 18, 2018 Webinar:
Institute for Diversity and Health Equity, an affiliate of the American Hospital Association

Rita Carreon, Deputy Vice President, Health
To live in a world where there are no barriers for Latinos to reach their fullest potential.
A strong America where economic, political and social advancement is a reality for all Latinos, where all Hispanics thrive and our community’s contributions are recognized.
MISSION: WHAT WE ARE HERE TO DO

Build a stronger America by creating opportunities for Latinos
Our Unique Advantage

The nation’s largest Latino civil rights and advocacy organization. Through our unique combination of research, advocacy, programs, we simultaneously challenge the social, economic, and political barriers that affect Latinos in the United States.

We aim to improve Latinos' well-being and access to equitable health care

- Address social determinants of health
- Cultivate leaders in heath
- Build healthier, equitable and resilient communities
Key Health Priorities

addressing social determinants of health and advancing health equity

1. Shape the public narrative
2. Foster leadership and advocacy on key health issues for Latinos
3. Expand where health happens
4. Create and share actionable knowledge
5. Create meaningful and actionable access to health and health care
AHA and UNIDOS US Strategic Alliance

Foster Leadership and Advocacy
thru diversity, inclusion, and health equity
Strategic Alliance to Build Healthier Communities

Advancing Diversity, Inclusion and Health Equity

- Healthy, Equitable, and Resilient (H.E.R.) Communities
- RWJF’s Culture of Health Advisory Council

Trustee Match Program

American Hospital Association
Advancing Health in America
Trustee Match Program

CEO Invitation Letter from Janet Murguia, UnidosUS and Rick Pollack, AHA

UnidosUS
• Identification of Affiliate executives and community leaders – Candidates
• Candidate Profiles and Case Studies
• Readiness Assessment
• Relationship Build Opportunities

AHA
• Identification of engaged member hospitals and health systems - Organizations
• Member Profiles and Case Studies
• Readiness Assessment
• Training of Candidates
• Relationship Build Opportunities
Healthy, Equitable and Resilient Communities

- Educational Sessions
- Webinar Series
- Communications
  - Community Spotlight
  - Podcast
  - Blogs
  - Social Media

AHA/UnidosUS Alliance is Strengthening to Address Youth Violence

Prioritizing community health to achieve health equity

Uninsured rate among nonelderly individuals by Race/Ethnicity, 2013-2016

American Hospital Association
Advancing Health in America
Expanding Where Health Happens

- Combating food insecurity and increasing nutrition programs
- Assessing impact on environment/neighborhood access to healthy foods and beverage
- Target marketing to children on unhealthy food and beverages
- Promoting the National Diabetes Prevention Program

UNIDOSUS
STRONGER COMMUNITIES. STRONGER AMERICA.
**COMPRANDO RICO Y SANO**
(BUYING HEALTHY AND FLAVORFUL FOODS)

UnidosUS’s program—led by community health workers (promotores de salud)—seeks to reduce hunger and instill healthy shopping and eating habits among Latinos through nutrition education and enrollment assistance in the Supplemental Nutrition Assistance Program (SNAP).

**In 2017...**

- **47%↑** fruit intake
- **55%↑** vegetable intake
- **63%↑** healthy meals prepared at home
- **25,636** Latinos enrolled in the Supplemental Nutrition Assistance Program (SNAP)

Across 24 Communities

- **2.5 million** Latinos reached with nutrition and SNAP enrollment messages via news and social media
- **12,871** Latinos participated in cooking demonstrations and grocery store tours
- **73,602** Latinos received face-to-face nutrition education and SNAP information
- **295** promotores received training to implement the program

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**Comprando Rico y Sano Program**
2016 Promotores de Salud Training

**Combating Food Insecurity**
Comprando Rico y Sano

Promotores de salud (community health workers) lead efforts to expand where health happens, promoting a culture of health in the places in which we live, work, learn, and play...

- **Schools**
  - “Healthy eating” social clubs for parents
  - Cooking demonstrations for children

- **Workplace**
  - Healthy food at meetings/gatherings
  - Zumba, yoga, and other physical activity classes

- **Neighborhoods**
  - Cooking demonstrations
  - Walking clubs

- **Parks**
  - Family Wellness Days
  - Zumba, yoga, and other physical activity classes

UnidosUS
Advancing Social Change
Creating meaningful and actionable access to health care

- Impact on children’s poverty and health
- Connection between education and health
- Meeting families where they are
- Culturally and linguistically responsive
- Social engagement & communication

*Example: Healthy & Ready for the Future
funding by Comic Relief for Red Nose Day Fund

1,170,684 M
Latino individuals and families reached on importance of oral health and health care services*

25,397 rural children, Primarily ages 2-17, served by MSHS programs and community health centers (2017-2018)*
Leaning In – Community Partnerships

- Utilize multi-stakeholder approach across all social services
- Identify shared values and assets that fosters collaboration
- Enhance role of local community leaders, including community health workers, to support efforts
- Engage with local school health administrators, community leaders, and health care professionals
- Create opportunities for new partners to join local coalitions to advocate for healthy communities and schools
- Advocate for policies to create safer spaces and healthier conditions for all Americans
What Goes into Your Health?
Clinical-Community Partnerships at Sharp HealthCare

Jillian Warriner, MPH
Manager, Community Benefit and Health Improvement
Sharp HealthCare
Learning Objectives

• Describe Sharp HealthCare’s process for engaging community partners in its community health needs assessment (CHNA)

• Discuss how the 2016 CHNA influenced Sharp HealthCare to further engage community partners to address identified community health needs

• Provide examples of Sharp HealthCare/community organization partnerships since the 2016 CHNA

• Describe one specific Sharp HealthCare program model that highlights the impact of clinical-community partnerships to improve community health
Snapshot of Sharp HealthCare

• Not-for-profit serving 3.3 million residents of San Diego County

• Grew from a single hospital in 1955 to an integrated health care delivery system:
  • 4 acute care, 3 specialty hospitals; 2,084 licensed beds
  • 3 medical groups
  • Health plan

• Largest private employer in San Diego:
  • Over 18,000 employees, 2,600 affiliated physicians
  2,000 volunteers

Mission: To improve the health of those we serve with a commitment to excellence in all that we do.
Sharp HealthCare: Pillars of Excellence

The seven Pillars of Excellence are a visible testament of our commitment to making Sharp the best health care system in the universe.
What Goes into Your Health?

- **Socioeconomic Factors**
  - Education
  - Job Status
  - Family/Social Support
  - Income
  - Community Safety

- **Physical Environment**

- **Health Behaviors**
  - Tobacco Use
  - Diet & Exercise
  - Alcohol Use
  - Sexual Activity

- **Health Care**
  - Access to Care
  - Quality of Care
Collaborative San Diego 2016 CHNA Process Map
2016 CHNA Community Engagement

- Behavioral Health Discussions: 3
- Key Informant Interviews: 19
- Community Partner Discussion Participants: 87
- County HHSA Regional Live Well Surveys: 91
- Health Access & Navigation Surveys: 235
2016 CHNA Community Engagement

- **Common health needs/issues**: hypertension, behavioral health, mobility, oral health

- **Challenges for clients**: education, money, stress, time, cultural practices. Poverty big barrier to behavior change

- **Risk factors**: healthy food access; lack of social support

- **Health needs/issues**: behavioral health, blood pressure/cholesterol, obesity, unhealthy diet

- **Challenges to clients/behavior change**: lack of access to healthy food; stress; prioritization of other needs; cultural practices;

- **What can hospitals do?** Improve the inquiry
2016 Collaborative San Diego CHNA: Findings

Top Health Needs

- **Behavioral Health**: Alzheimer’s disease, Anxiety, Drug & Alcohol issues, Mood Disorders
- **Cardiovascular Disease**: Hypertension
- **Type 2 Diabetes**: Uncontrolled diabetes
- **Obesity**: Co-occurrence with other chronic disease

Top Social Determinants of Health (SDOH)

- Food Insecurity & Access to Healthy Food
- Access to Care or Services
- Homeless/Housing issues
- Physical Activity
- Education/Knowledge
- Cultural Competency
- Transportation
- Insurance Issues
- Stigma
- Poverty
2016 CHNA Recommendations

**Strategies** to address the top health needs fell into four major categories:

- Knowledge/education
- Community and cultural competency
- Early identification and prevention
- Care integration and coordination

**Resources** that must be developed or increased to address the top health needs are:

- Community and cultural competency
- Behavioral health services
- Integration health/social services/behavioral health systems
- After hours urgent care
- Worksite wellness

**System, policies and environmental changes** required to support better health outcomes:

- Data sharing
- Increased awareness of available services
- Increased number of psychiatrists and nurse practitioners
- Reimbursement for social and supportive services & care management

**Collaborations** that could improve community health outcomes:

- Warm hand-offs and information sharing between health providers & community based organizations
- Increased internship and workforce training programs with local educational institutions
- Partnerships with community collaboratives & intergenerational partnerships
- External support for providers through the use of technology
- Collaboration between provider and community
SDOH and Health Outcomes

**Food Insecurity**
- Chronic diseases
- Negative impacts on growth / development
- Behavioral health risks across the lifespan

**Transportation:**
- Health care and other needed services:
  - Rx and follow up care
  - Food

**Housing (substandard/unstable):**
- Chronic and infectious diseases
- Lead poisoning
- Injuries
Post-CHNA: Sharp Program Implementation

Food Insecurity (Hunger and Health)

- Medical group food insecurity screening and referral programs
- Hospital Outstation (HOS) Program
- Sharp Senior Health Centers & San Diego Food Bank Senior Nutrition Program
- Advocacy support – San Diego Hunger Coalition
- Sharp CME food insecurity education initiative
Post-CHNA: Sharp Program Implementation

• Southwestern College/International Rescue Committee/Sharp Acute Care Certified Nursing Assistant Training Program

• 2-1-1 Community Information Exchange (CIE)

• Sharp Grossmont Hospital Care Transitions Intervention (CTI) Program
Sharp Grossmont Hospital
Care Transitions Intervention (CTI) Program

Partners: Sharp Grossmont Hospital, 2-1-1 San Diego, Feeding San Diego, Grossmont Hospital Foundation

Shared Goal: Bridge gap between social services and health in discharge patients transitioning home

Outcome measures:
- Percent of individuals readmitted into hospital (readmission rate)
- Number and percent who decrease vulnerability of social determinants on risk rating scale
- Client patient satisfaction and ability to better manage health
Sharp Grossmont Hospital: Community Served
What is the Sharp Grossmont CTI Program?
CTI Partner: 2-1-1 San Diego

- Traditionally Information and Referral Network
- Resource Database
- Multiple Languages offered
- 24/7 365 days a year
- Moving towards navigation & care coordination
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<td>FINANCIAL WELLNESS &amp; BENEFITS</td>
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Navigation for Social Needs:

Bridging gaps between social and health services
Partnership: CTI and 2-1-1 San Diego

1. 2-1-1 receives fax referral via ECIN and social worker/discharge planner case notes
2. Health Navigator assigned to case and sends e-mail confirmation with Health Navigator assignment to social worker
3. Health Navigator begins case planning based on social worker/discharge planner case notes and patient information
4. Health Navigator connects with patient within one business day of referral receipt to complete assessment and identify care plan and schedule follow-up appointment
5. Health Navigator will follow-up with client on care plan with frequency based on need
6. Continued communication and outcome information will be provided to social worker/discharge planner via encrypted e-mail, on a bi-monthly to monthly basis
CTI and 2-1-1 San Diego: Evaluation

FOOD & NUTRITION
Long-term and sustainable access to nutritious foods and to support services to maintain access

CRISIS
- Less than One Day Supply of Food

CRITICAL
- 1-3 Day Supply of Food

VULNERABLE
- Ability to Maintain Food Supply up to 30 Days

STABLE
- Adequate Food

SAFE
- Nutritious Food

THRIVIN

IMMEDIACY

KNOWLEDGE AND UTILIZATION
- No Access or Knowledge of Resources
- Some Access (Food Banks & Food Pantry)
- Connected to a Limited Number of Short Term Resources (CalFresh, WIC, Supplemental)
- Knowledge to Buy and Prepare Nutritious Food
- Practices Healthy Eating and Wellness

BARRIERS AND SUPPORTS
- Limited Supports and Lack of Transportation, Finances
- Some Barriers (e.g. Lack Access to Grocery Stores) and Limited Friend or Family Supports
- No Barriers (Supports to Food Preparation and Finances)

FOOD INSECURE WITH HUNGER

FOOD INSECURE WITHOUT HUNGER

FOOD SECURE
CTI: Outcomes

- Reduced readmissions: 9.6%
- Improved care coordination: 97%
- Improved SDOH vulnerability: 91%
- Improved ability to manage health: 92%
CTI: Lessons Learned

• Resource linkages must be client/patient centered
• Health care setting connection is key to resource access
• Organization champions are essential
• Flexibility is crucial to partnership evolution
• Outcomes tracking – short and long term – are critical

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