

UH: Our Anchor Responsibility

Striving Toward a Culture of Population Health

Roundtable on Population Health Improvement

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New York City

University Hospitals (UH)

- Located in Cleveland, OH
- Non-profit founded in 1866
- 18 hospitals, 40 health centers
- \$4 billion annual revenues
- 1 million unique patients annually
- Nationally-recognized academic medical center
- Second largest employer in Northeast Ohio
- 26,000 employees
- 1,000 residents/fellows trained annually



Dedication to Place: A Call to Action

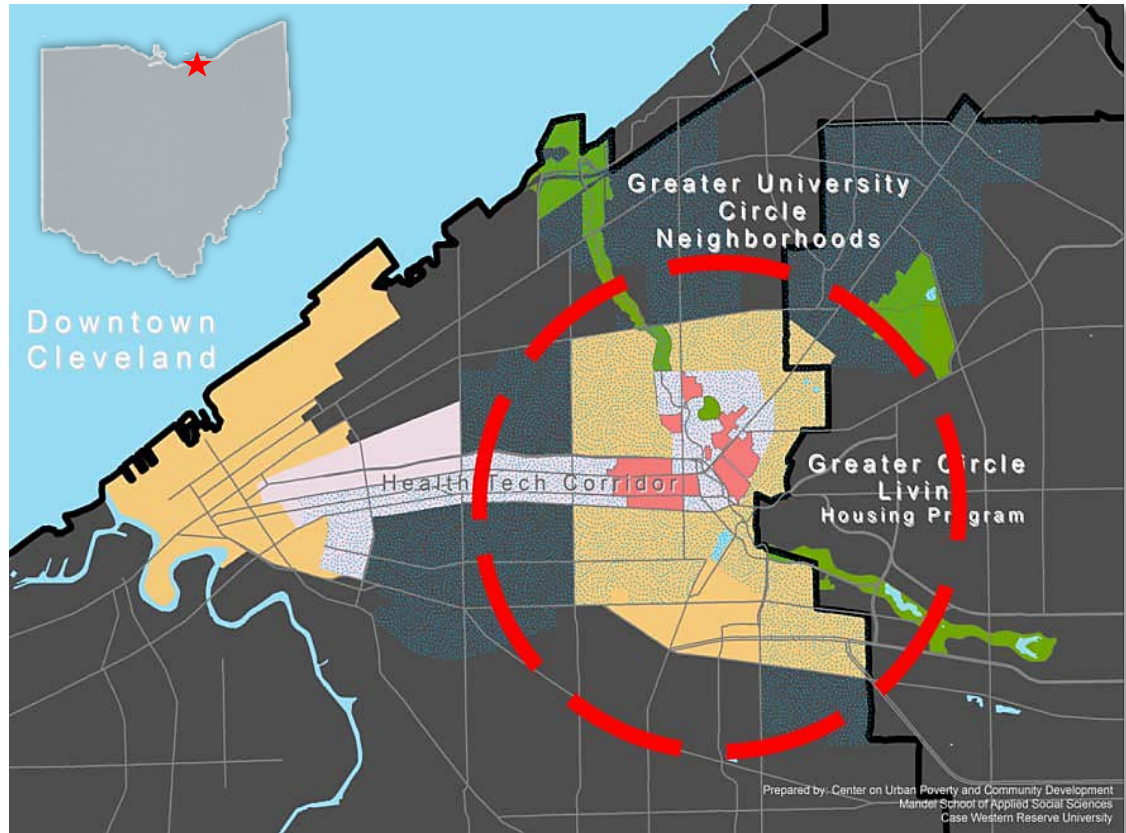
Greater University Circle (GUC)

Socioeconomic Factors

- \$18,500 median household income
- 24% unemployment

Health Outcomes

- Infant mortality = 18.6 per 100 births
(Significantly higher than the Cuyahoga County average of 8.7 per 100 births)
- Significant disparities: African American infant mortality 6x higher than non-Hispanic whites*
- Approx. 11% of children <6 yrs estimated to have lead poisoning
(4X national average)



Greater University Circle Initiative (GUCI)

- **17 major institutions, 60K full-time jobs**
(1/8 of all jobs in Cuyahoga County)
- **University Hospitals (UH)** is one of largest employers in the county
- **\$3B in institutional development** planned in 2005
- Cleveland Foundation convened anchor institutions to create “Greater University Circle Initiative” (GUCI)

How can we leverage economic power of these institutions to build inclusive wealth and healthy neighborhoods in GUC?

- ***Hire Local, Buy Local, Live Local***



The Anchor Mission

Leverage civic and economic influence to foster community health and prosperity

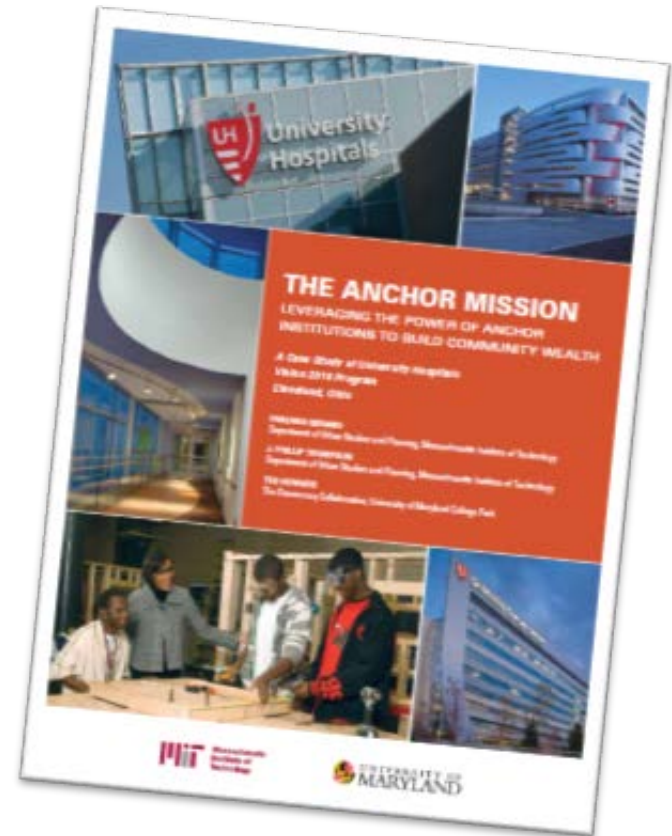
Key areas:

- Invest in our communities
- Revitalize our neighborhoods
- Create jobs and develop skills
- Design and develop multi-institution, city and regional partnerships

Hire Local, Buy Local, Live Local

Full report at:

<https://democracycollaborative.org/content/anchor-mission-leveraging-power-anchor-institutions-build-community-wealth>



Hire Local

Step up to UH

Partnership between community-based organization, workforce intermediary and hospital's HR to create a pipeline for frontline positions from low-income, diverse neighborhoods

Impact

- 242 hired
- 80% retention rate



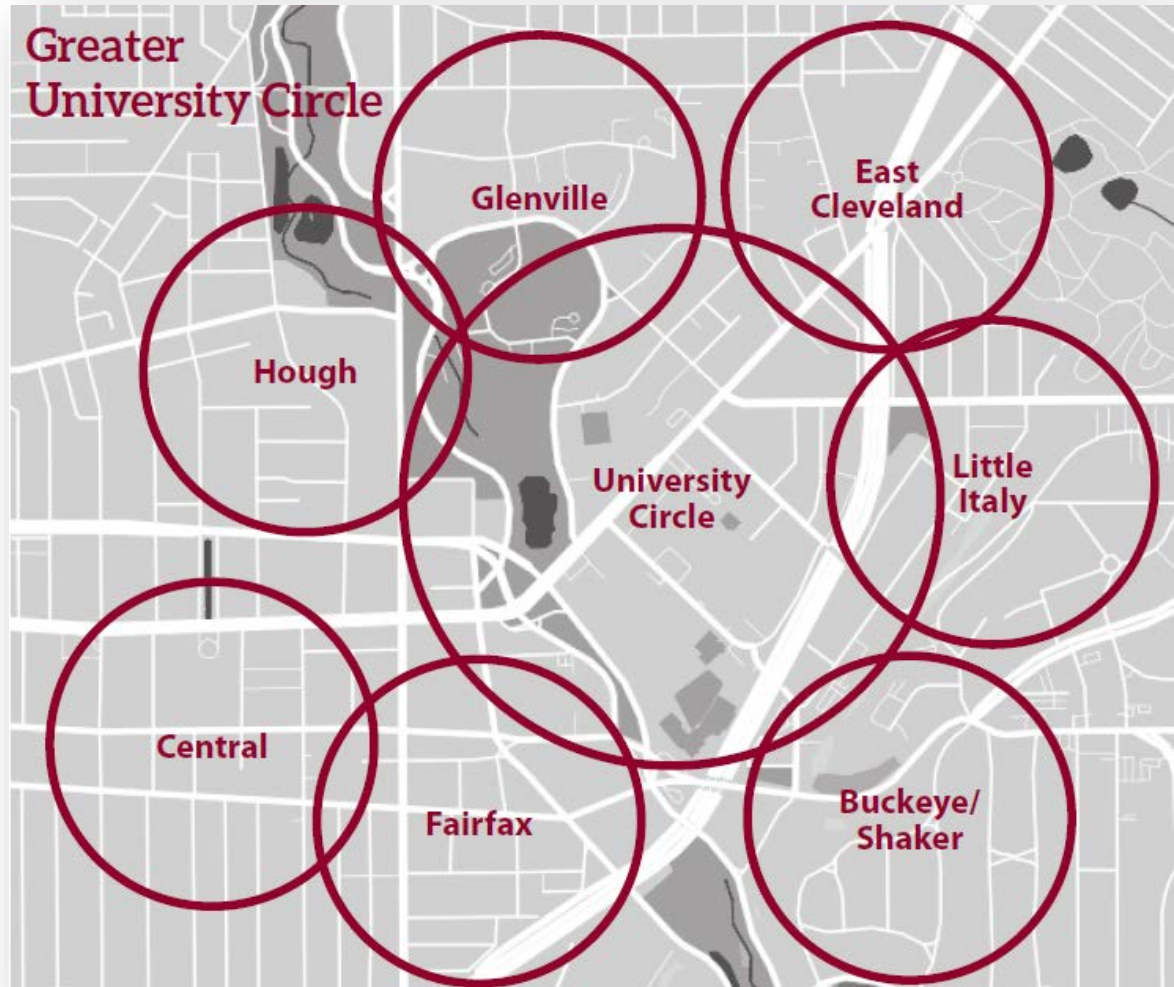
Buy Local

Evergreen Cooperatives: Green City Growers



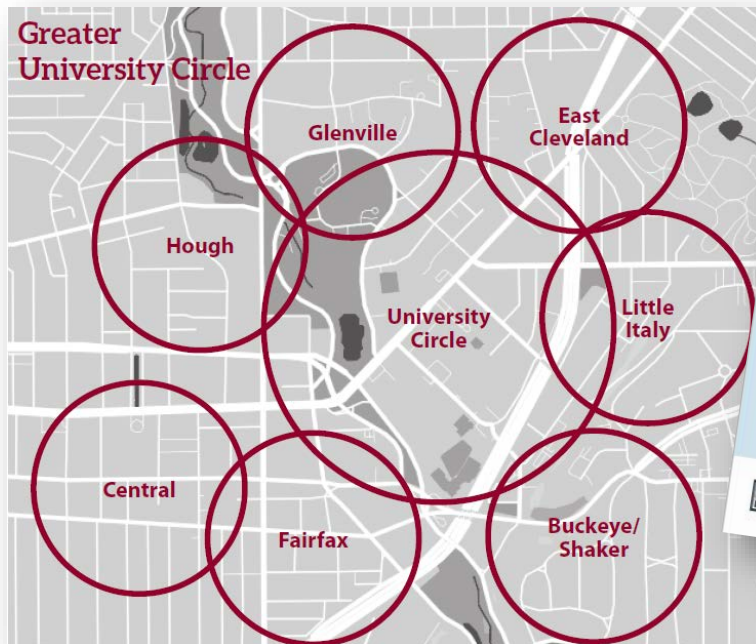
Live Local

Greater Circle Living



Health Local

Place Based Community Health & Wellness



Community Needs Assessments



Assessment Findings

- **Trust** between community and institution
- **Mental/behavioral health** services access
- **Dental** care access
- Access to and knowledge about **healthy food**
- **Inclusion of men**/issues with marginalization of men in the community
- **Multi-generational care**
- **Peer-peer support**
- **Parenting** and education support
- **Groups** – for education, clinical care, support
- **Transportation**
- **Economic opportunity**/workforce development
- Community **safety** and violence prevention

Community Input



Community Advisory Board (CAB)

Collaborative approach to community health

Patients and grassroots community members

Sectors represented:

- Education
- Community development corporations
- Community centers
- Advocacy organizations
- Criminal justice
- Housing
- Mental health agencies
- Faith-based organizations
- Cultural institutions

Metrics: Longitudinal Patient/Caregiver Survey



Responsive Patient Population

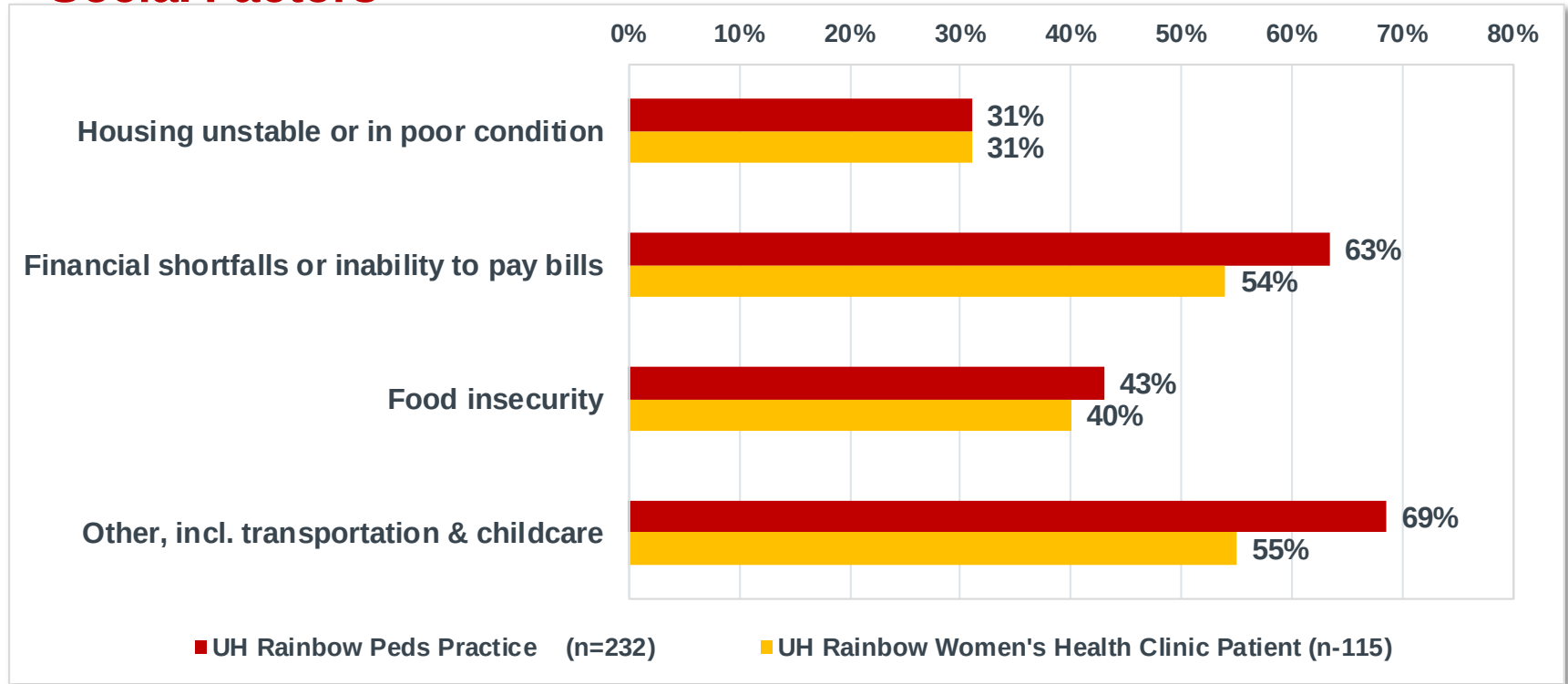
- Presented as an opportunity to contribute to our future planning
- 80% of those asked agreed to participate
- 81% of enrollees completed the survey (n=347)
Half of respondents utilized both practices

UH patients (and their caregivers) report:

- Substantial community and health care-related needs
- Significant stress due to unmet needs
- Poorer self-reported health status than expected
Compared to national and regional benchmarks

Respondents Reporting Unmet Needs

Social Factors



Role of the Medical Practice



Nearly half of respondents believe it is important their medical home meet their community-based needs

80+% of respondents want their medical home to provide navigation to outside resources, including:

- Identifying community agencies
- Making appointments for them at the appropriate community agencies
- Introducing them to someone at the appropriate agencies
- Interceding with the agency on their behalf

Evolution of the Anchor Strategy

UH Rainbow Center for Women & Children

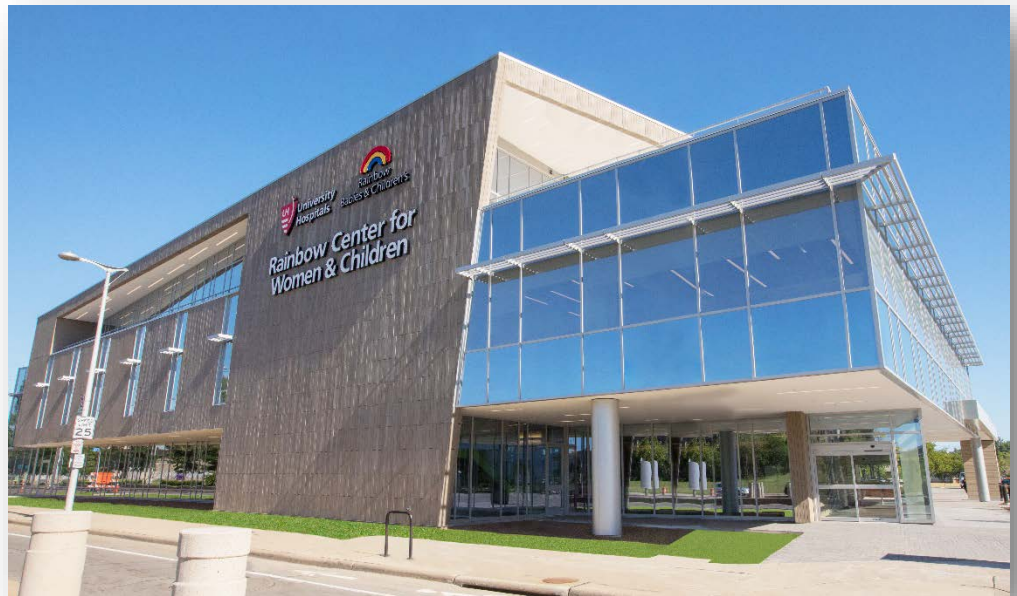
Newly-constructed facility of UH Rainbow Babies & Children's and UH MacDonald Women's hospitals with 100% capital funding attained through philanthropy and new market tax credit allocation

Located in a **federally designated medical/dental underserved area**

Aims to be a **highly-accessible medical home with wraparound services**, within an academic center of education and research

Services include:

- Primary Pediatrics and OB/GYN
- Centering Pregnancy/Parenting
- Maternal Fetal Medicine & Imaging
- Integrated mental health and addiction services
- Optometry
- Dental
- Pharmacy
- Women/Infants/Children (WIC) Office
- Medical/Legal Partnership
- Social needs navigation



Social Needs Navigation Program

Rainbow Connects

Social needs navigation program provided by UH that addresses all patients' basic resource needs as a standard part of quality care

Increases access to health and healthcare services by addressing the social and economic factors that contribute to illness

- Housing
- Food
- Utilities
- Clothing
- Legal concerns
- Related patient needs

Create models for integrating patient socials needs into care using a full spectrum of tools, including the Rainbow Connects resource desk

Clinicians “prescribe” basic resources (ie. food, heat) and trained advocates stationed in the clinics **work side by side with patients to “fill” those prescriptions** by accessing community resources and public benefits in attempt to reduce the cost of healthcare and improve the care that is received







From Healing in the Hospital To Healthy at Home: A new narrative for value

Framework for Exploring Population Health

- How do you define population health and what are goals, measures
- What population(s) serve
 - Those we employ, those we insure, those we care for, those we life with
- What roles(s) to play for each population you serve
 - Access, care, value, social determinants, economic well being
- What is your responsibility for each role
 - Primary, partial, limited
- What are other stakeholders framework and how do you collaborate to ensure you meet population health goals

Checklist for Optimizing Value for those we Insure

Global Measures

- CDC Healthy days
- % of care in network
- Annual TCOC

Stay well,

- Obtain annual wellness exam and close gaps
- Support healthy habits,
- Provide recommended preventive care, wellness, immunization

Get well, optimize health for people with chronic disease

- Is disease diagnosed,
- Is patient treated with recommended therapy,
- Is patient activated and able to use therapy,
- Is their physiology controlled,
- Is their utilization of ED, hospital admissions and readmissions improved

Manage acute condition: for any condition anywhere in care continuum

- Is care coordinated with PCP,
- Is the therapy beneficial and appropriate
- Is care being provided in highest value sight of service,
- Is care provided by a high value provider that uses EBM