



**American Hospital  
Association®**



# **Ensuring Access to Vulnerable Communities**

**An Executive Leadership Series for Urban and Rural Safety-net  
Hospitals**

## **Social Determinants of Health**



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## **AHA Task Force on Ensuring Access in Vulnerable Communities**

# Task Force Background

## Ensuring Access to Health Care in Vulnerable Communities Task Force

- ❖ Confirm the **characteristics and parameters** of vulnerable rural and urban communities by analyzing hospital financial and operational data and other information from qualitative sources where possible;
- ❖ Identify **emerging strategies, delivery models and payment models** for health care services in rural and urban areas;
- ❖ Identify **policies/issues at the federal level** that impede, or could create, an appropriate climate for transitioning to a different payment model or model of care delivery, as well as identify policies that should be maintained.



# Task Force Report

## Task Force on Ensuring Access in Vulnerable Communities

November 29, 2016



### Task Force on Ensuring Access in Vulnerable Communities

Millions of Americans living in vulnerable rural and urban communities depend upon their hospital as an important, and often only, source of care. However, these communities and their hospitals face many challenges. As the hospital field engages in its most significant transformation to date, some communities may be at risk for losing access to health care services. It will be necessary for payers and health care providers to work together to develop strategies that support the preservation of health care services for all Americans.

Recognizing this, the American Hospital Association (AHA) Board of Trustees, in 2015, created a task force to address these challenges and examine ways in which hospitals can help ensure access to health care services in vulnerable communities. The task force considered a number of integrated, comprehensive strategies to reform health care delivery and payment. Their report sets forth a menu of options from which communities may select based on their unique needs, support structures and preferences. The ultimate goal is to provide vulnerable communities and the hospitals that serve them with the tools necessary to determine the essential services they should strive to maintain locally, and the delivery system options that will allow them to do so. While the task force's focus was on vulnerable communities, these strategies may have broader applicability for all communities as hospitals redefine how they provide better, more integrated care.



November 29, 2016

# *Emerging Strategies*



**Virtual Care Strategies**

**Social Determinants**

**Inpatient/Outpatient Transformation**

**Urgent Care Center**

**Rural Hospital-Health Clinic**

**Emergency Medical Center**

**Global Budgets**

**Frontier Health System**

**Indian Health Services**

# *Social Determinants*

**Social challenges often prevent individuals from accessing health care or achieving health goals. Some domains of common health-related social challenges:**

- Housing instability
- Utility needs
- Food insecurity
- Interpersonal violence
- Lack of transportation
- Lack of adequate family and social support
- Low levels of education
- Lack of employment/low income
- Risky or harmful health behaviors



# Social Determinants

This strategy includes:

- **Screening** patients to identify unmet social needs;
- Providing **navigation services** to assist patients in accessing community services; and
- Encouraging **alignment** between clinical and community services to ensure they are available and responsive to patient needs.



# Social Determinants of Health 2017

CHI Health Good Samaritan Hospital/  
UniNet



**CHI Health**

**Good Samaritan**

**UniNet**  
Healthcare Network





**Ken Shaffer, M.D.**  
Medical Director, UniNet  
CHI Health Good  
Samaritan, Kearney, Neb.

**UniNet's** Kearney chapter was formed in 2013, and we've focused on creating clinical initiatives that will help local providers achieve the triple aim: improved health of the population, decreased per capita cost and improved patient experience.

# CHI Health Good Samaritan Hospital

- **CHI Health Good Samaritan is located in Kearney, NE**
  - **Regional referral center with helicopter and ambulance services to central Nebraska and northern Kansas.**
  - **Services include a Level II trauma center, Level II NICU, and full cardiovascular services including cardiovascular surgery. GSH is participating in CMS joint bundle.**
  - **Approximately 60% of our admissions are from outside of Kearney and Buffalo County.**
  - **Physician staff include both salaried and private practice.**

# UniNet 2017

- **UniNet is a physician-driven, clinically integrated network (CIN).**
- **UniNet was formed in 1998 and is a partnership of independent and employed physicians, facilities, ancillaries, collaborating hospitals, and post-acute care providers working to improve patient outcomes while lowering the overall cost of care.**
- **UniNet has more than 3,000 providers with chapters in Kearney, Grand Island, Lincoln, and Omaha, and 36 hospitals.**
- **UniNet has 2 MSSP/ACO products, one Tract 3 in Omaha, value based contracts with the Medicaid MCOs in NE, and value based contracts with BCBS beginning 7/1/17.**

# CHI Health Good Samaritan/UniNet

- **Inpatient care management and utilization review staff, across CHI Health, became employees of UniNet in 2016; thereby promoting better coordinator of care and services across our care team.**
- **UniNet supports primary care practices' outpatient care management by training care managers and PMPM payments if possible.**
- **Communication between care managers of needed and provided services across the care team is provided by TAV Connect, a cloud based service.**
- **Actively developing post acute care networks in each of our chapters.**

# CHI Health Good Samaritan/UniNet

- We believe the social determinates in a patient's/family's life are critical in the success of the engagement and care of the patient.
- Even more important is making sure the entire care team, inpatient, outpatient, post acute care, etc. communicates!!!!
- The success of value based care, which is driving payment reform, will depends on a community of integrated providers caring for the patient. (similar to it take a village to raise a child)

# **American Hospital Association**

## Addressing Social Determinants of Health

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June 20, 2017

# Yale New Haven Health Representatives

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**Augusta Mueller**  
Community Benefits Manager

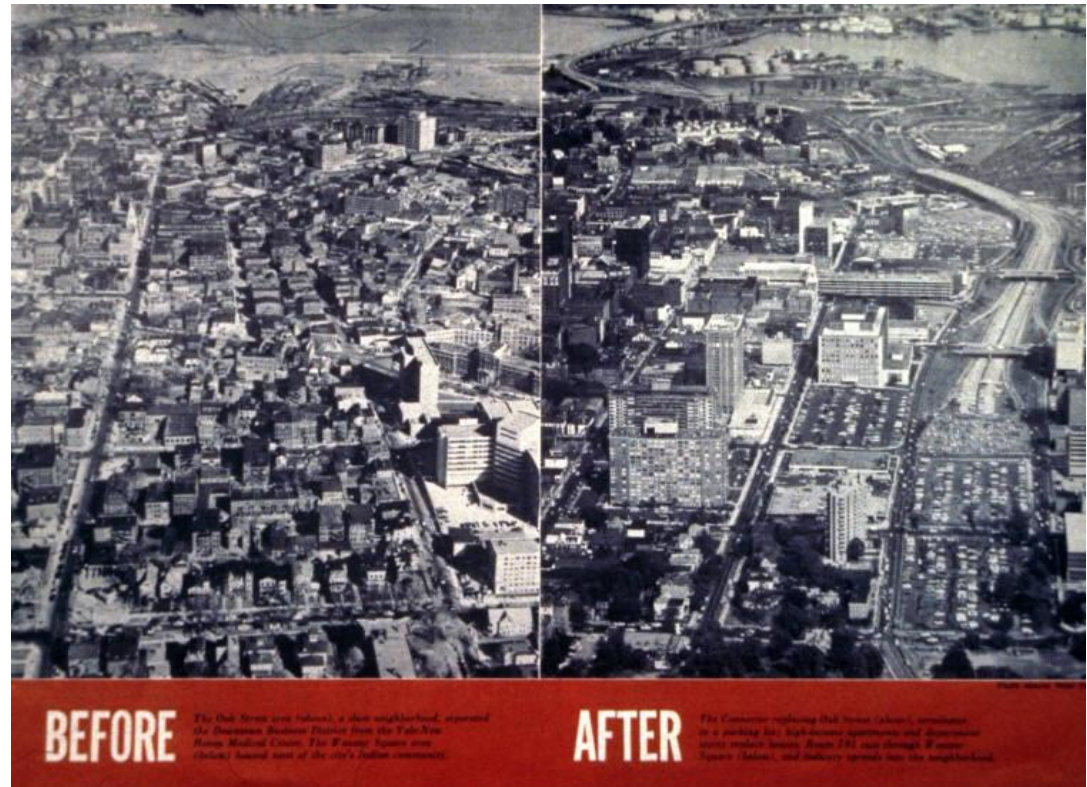


**Andrew Orefice**  
Program Coordinator



# Historic Perspective

- The Hill was historically a thriving residential and industrial neighborhood
- Home to many immigrants
- Low income but with jobs
- New Urbanism in 1950's: "highway to nowhere"
- Industry closed or left
- Population became isolated





# Current Condition

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- 42% do not feel safe enough to go for walks in their neighborhood at night
- 25% of residents are unemployed, the highest among all of New Haven's low-income neighborhoods
- 22% home ownership rate
- 69% are low income, 43% at or below poverty

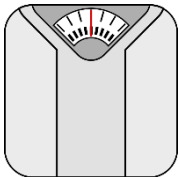


# 2015 Health Status

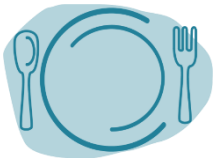
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15% of residents report “excellent” health compared with 28% statewide



74% of residents are overweight or obese compared with 62% statewide



38% of residents report food insecurity (highest in the city) compared with 12% statewide



38% of residents report daily smoking (highest in the city) compared with 26% statewide



20% of residents have asthma compared with 13% statewide

# Habitat for Humanity

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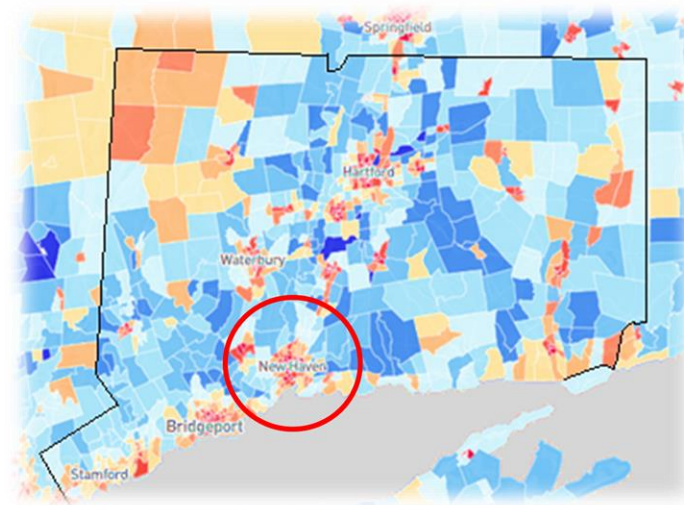
- Relationship initiated in 2008
- Nine builds to date, most in the Hill
- Hundreds of volunteers and thousands of hours
- Concentrating on Vernon Street: one block at a time



# Lead Poisoning & Regional Treatment Center

- Started in 1992
- One of two lead programs in CT
- Over 4,000 visits annually
- Results: From >1,200 annual visits to <120

CT Cities Ranked by Childhood Lead Poisoning Prevalence



1. New Haven
2. Bridgeport
3. Waterbury
4. Hartford
5. Meriden
6. New Britain
7. Stamford
8. Norwalk
9. Norwich
10. Torrington

\*Covered by YRLTC

75% of the Connecticut housing stock is built before 1978 – the year in which lead-based paint was banned from residential homes

# Home Ownership Made Easy (H.O.M.E.) Program

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- Recently celebrated H.O.M.E. 10<sup>th</sup> anniversary
- Up to \$10,000 in forgivable, 5-year loans
- \$200/month mortgage subsidy for homes in challenged neighborhoods around medical campus
- 140 first time homebuyers



# Rowe Residences

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# Contact Information

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# Tools

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## Paving the Way: Addressing Transportation as a Social Determinant of Health for Rural Residents

Research center: [University of Minnesota Rural Health Research Center](#)

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## Social Determinants of Health Among Minority Populations in Rural America

Research center: [South Carolina Rural Health Research Center](#)  
Phone: 803.251.6317

Lead researcher: [Janice C. Probst, PhD](#)

Contact: [Janice C. Probst, PhD](#), 803.251.6317, [probst@mailbox.sc.edu](mailto:probst@mailbox.sc.edu)

Project funded: September 2015

Anticipated completion date: August 2017

Topics: African Americans, American Indians and Alaska Natives, Hispanics, Minority health, Rural statistics and demographics

Rural Health Value

UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

StratisHealth

RUPRI  
RURAL POLICY RESEARCH INSTITUTE  
Center for Rural Health Policy Analysis

## Understanding the Social Determinants of Health

### A Self-Guided Learning Module for Rural Health Care Teams

GOALS

This tool is designed with two goals in mind:

- Learning:** To help people who work in (or are concerned with) rural health learn more about the concept of social determinants of health.
- Acting:** To enable rural health leaders and care teams to act to improve health outcomes in their communities by addressing factors that contribute to the social determinants of health.

## ADVANCING HEALTH IN AMERICA

### THE PATH FORWARD

**Our vision:** A society of healthy communities where all individuals reach their highest potential for health.

**Our commitment:**

- Access:** Access to affordable, equitable health, behavioral and social services
- Value:** The best care that adds value to lives
- Partners:** Embrace diversity of individuals and serve as partners in their health
- Well-being:** Focus on well-being and partnership with community resources
- Coordination:** Seamless care propelled by teams, technology, innovation and data



# Discussion



**We invite your questions and comments.**

# Contact Information

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