Community Partnership Pilot: Site Profiles

The barriers for health care systems to engage communities and their members are many. These factors can be intensified when seeking to engage populations with complex health and social needs. To better understand this issue, the Center for Health Care Strategies (CHCS) launched the Community Partnership Pilot (CPP). This 18-month initiative, made possible by the Robert Wood Johnson Foundation through CHCS’ Complex Care Innovation Lab, is identifying best practices for engaging community members, particularly those with complex health and social needs, and building effective partnerships between health care systems and the community.

Following are profiles describing the efforts of two competitively selected sites participating in CPP — Hennepin Healthcare and Los Angeles County Department of Health Services’ Whole Person Care program — which are considering a range of evidence-based consumer engagement strategies as part of the initiative.

Los Angeles County Department of Health Services’ Whole Person Care Program: Creating a Reentry Health Advisory Collaborative

Launched in 2016, Whole Person Care (WPC) is a state-wide pilot funded through California’s 1115 Medicaid waiver to better coordinate medical, behavioral health, and social services, and ultimately improve the health and well-being of California’s Medicaid population (Medi-Cal). Los Angeles County is using the Whole Person Care program to develop an integrated health system to deliver coordinated care to Los Angeles County’s highest-need Medi-Cal beneficiaries, including individuals who are: (1) experiencing homelessness; (2) involved in the justice system; (3) high-utilizers of acute care services due to serious mental illness; (4) experiencing substance use disorders; (5) diagnosed with complex medical issues; and/or (6) high-risk pregnant women.

Pilot Patient Population

LA County operates the largest jail system in the world. On any given day, 22,000 individuals are incarcerated in LA County, making the jail system the region’s largest medical and mental health facility. The LA County jail releases between 350 and 500 adults each day with approximately; 10 percent of these individuals are classified as medically high-need based on their acute and chronic conditions; 20 percent diagnosed with moderate to serious mental illness; and 60 percent having significant substance use disorder.

Pilot Focus

The LA County pilot is seeking to engage with formerly incarcerated individuals and their communities to better understand their interactions with the county’s health care delivery system. The pilot is seeking to incorporate this feedback into meaningful policy and programmatic changes that improve service delivery, reduce recidivism, and ultimately, decrease unnecessary health care use among the re-entry population.

To accomplish this goal, the WPC-LA team will establish a countywide Reentry Health Advisory Collaborative comprised of formerly incarcerated individuals from highly policed communities and communities that have been heavily impacted by mass incarceration. The Advisory Collaborative will provide input on: (1) primary, behavioral, and correctional care delivery; (2) local resource allocated for addressing social needs; (3) community assets and regional gaps; and (4) capacity building for and equitable distribution of local revenue funds to community based, culturally competent providers. A human-centered design approach will be used throughout the project, along with other strategies, to facilitate supportive and meaningful engagement and drive community efforts to improve health outcomes for the reentry community.
Key Pilot Features

To effectively work with the community, the pilot will:

- Seek input from community-based organizations, coalitions, faith-based organizations, and other local groups to better understand their perspectives on what needs to be done to improve health care services;
- Use a trauma-informed approach to engage individuals who have experienced incarceration;
- Explore community engagement best practices, such as fair consumer compensation rates and effective facilitation approaches; and
- Employ Design Sprint Sessions, a five-phase process that uses design thinking to identify challenges in health and social service delivery for the reentry population, develop potential approaches to solving identified issues, and build and test solutions.

Hennepin Healthcare: Addressing Behavioral Health Access for Foreign-Born Somali and Mexican Immigrants

Hennepin Healthcare is a Minneapolis-based safety net health system and is a nationally recognized leader in coordinating care for individuals with complex needs. Seventy-five percent of Hennepin Healthcare’s patients are served by either Medicaid or Medicare and the majority are individuals of color. Moreover, Minneapolis has half a million immigrants, with the largest ethnic groups emigrating from Mexico and Somalia. Hennepin Healthcare’s 2016 Community Health Needs Assessment indicated that mental health access was a priority health need, especially for refugee and immigrant populations.

Pilot Patient Population

Within Hennepin Healthcare, access to mental health services by foreign-born Somalis and Mexicans is significantly lower compared to other ethnic groups. Only five percent of Somali patients and three percent of Mexican patients had one or more mental health visits between 2016 and 2018, compared to thirty-seven percent for the rest of the patient population. This may be due to stigma and lack of information about the benefits of mental health care.

Pilot Focus

The Hennepin Healthcare pilot is seeking to increase access to and use of culturally responsive and relevant behavioral health services that will better support community members. The pilot will engage with members from the Somali and Mexican communities to better understand: (1) how each population views on mental and emotional wellbeing; (2) their experiences seeking services; and (3) their experienced and/or perceived barriers to accessing services. Hennepin plans to identify community members with lived experiences, and use a human-centered design approach to develop strategies to increase mental health awareness and use of mental health services.

Key Pilot Features

To effectively work with the community, the pilot will:

- Work with foreign-born Somali and Mexican community members through a four-phase human-centered approach, including: (1) exploring needs and perceptions through focus groups and one-on-one interviews; (2) analyzing research findings and identifying opportunity areas; (3) developing solutions; and (4) implement solutions and solicit feedback.
- Emphasize cultural competency and humility to avoid re-traumatization of these communities and build and maintain trust, particularly given the current political climate related to immigration.
- Partner with Hennepin Healthcare’s Patient Experience and Upstream Health Innovations departments to train hired community members in basic human-centered design techniques so they can help lead the engagement process with their community.
- Engage faith-based organizations — crucial, highly trusted partners among the Somali community.
ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

The Community Partnership Pilot is a product of the Complex Care Innovation Lab, a national initiative made possible by Kaiser Permanente Community Health and the Robert Wood Johnson Foundation, which brings together leading innovators in improving care for low-income individuals with complex medical and social needs. For more information, visit www.chcs.org/innovation-lab/.