What Matters Most in Driving Cross-Sector Partnerships for Complex Populations

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Robust online resource center offering the latest knowledge on evidence-based and promising practices for people with complex health and social needs

Provides practical how-to guidance to inform health system leaders, payers, policymakers and others on strategies to improve care for high-need, high-cost populations

Coordinated by the Institute for Healthcare Improvement and the Center for Health Care Strategies through support from six leading national health care foundations: The Commonwealth Fund, The John A. Hartford Foundation, Milbank Memorial Fund, Peterson Center on Healthcare, the Robert Wood Johnson Foundation, and The SCAN Foundation

BetterCarePlaybook.org
Share Your Successes on the Playbook

- Have you established a promising practice?
- Have you published a study about your complex care program?

The Playbook welcomes content submissions to help spread best practices in complex care.

BetterCarePlaybook.org
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Community Integration
Executive, Adventist Health
5% of the population accounts for 50% of the cost

16 Domains of Care, only 4 or 5 are “medical”

- Education & Employment
- Mental Health
- Food & Nutrition
- Provider Relationships
- Medication & Medical Supplies
- Reproductive Health
- Official ID & Vital Records
- Health Maintenance
- Substance Use Disorder
- Family, Personal & Peer Relationships
- Legal
- Benefits & Entitlements
- Advocacy & Activism
- Transport
- Shelter
- Other
- ?
What Matters Most...

- **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

- 40%
- 30%
- 20%
- 10%
Wellbeing

Self Care, Help-Seeking

Family Life, Community Connections, Support Networks

Trauma, Crime, Domestic Violence, Abuse & Neglect, Addiction

Social Determinants of Health, Housing, Nutrition, Income
Underneath the Surface

Social Determinants of Health

• Housing
• Transportation
• Food Insecurity

• Social Isolation
• Legal Issues
• Health Literacy/Language
• Safety

System Barriers

• Access
• Disorganized Services
• Disconnect between medical/social/behavioral services
• Complex Health Problems – fragmented treatment silos
Change Happens When Patient Stories are at the Center
Key Features of Cross-Sector Partnerships

What does it take to establish partnerships that work for patients, providers, health plans, community-based organizations and government?
Bringing it All Together
Tools for Building Cross-Sector Partnerships
Shared Mission & Aims
Asset Mapping
Data Sharing and the Value of HIEs
Data Sharing with Limited Resources

A tricky balance between goals and dreams versus resources.
Addressing Friction
Tools for building cross-sector partnerships: shared outcomes
the four quadrant outcomes

Cost
Medicaid shortfall, appropriate fee-for-service outpatient revenue, capitation surplus retention, community services

Utilization
Lengths of stay, appropriate and specialty care, emergency transports, emergency department visits

Quality Improvement
Readmission rates, disease management, preventative care

Patient/Provider Story
Vulnerability, sustainable housing, disease management, morale, retention, mental health
Collaboratives and partnerships at work: Project Restoration
Adventist Health Clear Lake
Lake County, California
- Ranked last in health outcomes
- 75% of county burned in wildfires of the past 5 years
- High rates of poverty and substance misuse

Project Restoration
- County-wide cross-sector collaborative (Police, Fire, EMS, Criminal Justice, Mayor, Health, Social Services, Education)
- Shared data
- Process improvements to change root cause
Utilization

Hospital Reduction (ED & IP) 44% ↓

Community Services
Police, EMS, Jail 83% ↓

Cost Reduction 71% ↓

Patient Experience
Access to Care and Safety

Primary Care Visits: 133%
Housing: 93%

Cross-sector partnerships: Four lessons learned
“Receptive, flowing people are the ones who change the world and transform history. Their possibilities are limitless because they do not let any seeming barriers stop their path. ‘Be like water’ is a good piece of advice.”

Father Richard Rohr
2. constraint

“Great things are done by a series of small things that are brought together.”

Vincent Van Gogh
“The two words ‘information’ and ‘communication’ are often used interchangeably, but they signify quite different things. Information is giving out; communication is getting through.”

Sidney J. Harris
"If the tide is left unchecked, if those who would strive for equality and justice cannot unite in the recognition of shared goals and common perils, then no group will escape in the end. None will be able to gather up enough crumbs to make any sort of a meal."

New Paradigms for a New Century: Rethinking Civil Rights Enforcement
Q&A How will you partner across sectors?
Save the Date:
Putting Care at the Center 2019

November 13 – 15, 2019 | Memphis, Tennessee
www.centering.care

This year’s conference will be co-hosted with Regional One Health
LinkedIn group hosted by the National Center
Opportunity to share resources, opportunities, and questions among peers.

Join today!
Want to Learn More?

https://www.nationalcomplex.care/

https://www.bettercareplaybook.org/

https://www.nationalcomplex.care/our-work/blueprint-for-complex-care/
Publications


- A Hands-On Guide to Cultural Integration in Community Health Partnerships and Alliances was recently released at the California Health Care Foundation
Thank You!

National Center for Complex Health and Social Needs
An Initiative of the Camden Coalition of Healthcare Providers
www.nationalcomplex.care

The Playbook: Better Care for People with Complex Needs
www.bettercareplaybook.org/