Advancing Health Care and Community-Based Organization Partnerships to Address Social Determinants: Lessons from the Field

August 17, 2018

Please standby, this webinar will begin shortly.

Made possible by Kaiser Permanente Community Health
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Center for Health Care Strategies and Nonprofit Finance Fund

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Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Agenda

- Welcome and Introductions
- Project Overview and Partnership Summaries
- Panel Presentation: Reflections and Key Highlights from Partnership Representatives
- Partnership Tools
- Questions and Answers
Welcome & Introductions
Meet Today’s Presenters

**Anna Spencer**  
Senior Program Officer  
Center for Health Care Strategies

**Nima Krodel**  
Vice President, Consulting  
Nonprofit Finance Fund

**Loel Solomon**  
Vice President, Community Health  
Kaiser Permanente

**Janet Hamilton**  
Deputy Director  
Project Access NOW

**Maryann McLendon**  
Food Assistance Program Manager  
Hunger Free Colorado

**Camey Christenson**  
Senior Vice President  
2-1-1 San Diego
About the Center for Health Care Strategies

A non-profit policy center dedicated to improving the health of low-income Americans
NFF envisions a world where capital and expertise come together to create a more just and vibrant society.

We unlock the potential of mission-driven organizations through:

• Tailored investments
• Strategic advice
• Accessible insights

Guided by our core values

• Generosity of spirit
• Rigor without attitude
• Responsiveness
• Leading by doing
• Equity in action
Project Overview
Social determinants of health (SDOH) significantly impact health outcomes and spending.

Health care and community-based organizations increasingly collaborate to address social needs.

**Project goal:** Build the knowledge base around financial, operational, and strategic considerations necessary to make these partnerships successful.

**Case studies** and **tools** provide in-depth information on effective partnership models and guidance to support partnership development.
C3CAP
Community Assistance Program

Janet Hamilton
Deputy Director
Mission
The mission of Project Access NOW is to improve the health and well-being of our communities by creating access to care, services, and resources for those most in need.

How does C3CAP support the mission?
We connect our clients to the resources they need to regain, maintain, and improve their health.
C3CAP provides a compliant way for hospital systems and Medicaid health plans to provide non-medical support and services for their patients/members.

Hospital systems are focused on a safe and secure discharge that avoids readmissions due to unmet social needs.

Medicaid health plans have ‘waiver’ funds to address social determinants of health. Referred to as health related services.
Hospital Systems:
Safe and Secure Discharge

- First 30 days
- Eligibility Criteria
- Defined list of services
- Maximum Request Limit
- Maximum Lifetime Limit

Metro Area Medicaid CCO’s

- Health Related Services Funds
- Internal Screening/Approval Process

Scope and Services

Closed

- Medication Care Transitions
- Ambulance
- Long Distance Transportation
- Diabetic Supplies
- Taxi Rides
- Meals & Food Delivery
- Hotels/Motels
- RCP
- Trimet Fares
- Muck Outs
- Rental Assistance
- Cell Phone Gym Membership
- Classes Furniture

Project Access NOW
Community | Care | Connection
Impact of the C3CAP Program: 2017

- we received 17,126 requests for service
- we processed over $1.5 million of goods and services
- we served 8,739 clients
- we supported over 420 care providers and coordinators throughout the state of Oregon
- we filled 8,538 prescriptions
- we enabled 7,981 rides
- we facilitated 1,044 temporary housing requests
- we helped our clients avoid over 867 days in the hospital and save ~ $3 million* in unnecessary hospital days

* Kaiser Family Foundation estimated the average hospital stay in Oregon was $3,368/day. (Source)
Addressing Hunger Through Referrals
Maryann McLendon
Our Services

- Connect to food resources
- Applications for WIC
- Applications Supplemental Nutrition Assistance Program (SNAP)
Referral Process

• Identify food insecurity with the client

• Complete the fax referral and send to the secure fax line or capture client contact information and send to Hunger Free Colorado daily/bi-monthly

• Benefit to completing referrals: Outreach increased connection from 5%→85%
Evaluation / Impacts

- Reporting
- Surveying
- Determining Impacts
The Community Information Exchange is an evolving multidisciplinary systems-level network of partners committed to transforming the delivery of health and social services by coordinating care for individuals in the community using a shared technology platform. The technology allows the network to gather shared language and match clients with providers in a resource database. Network partners also benefit from bi-directional information sharing on referrals, program enrollment and outcomes, which allows them to better respond to local needs. The shared risk rating scale evaluates individual wellness along 14 domains using a social determinants of health framework. Network partners add to that record as they provide services, contributing to a single, longitudinal client record of progress toward improved health outcomes using shared language and outcome measurements.
## Impact of Community Information Exchange

<table>
<thead>
<tr>
<th>Impact</th>
<th>Improvement in Health Indicators</th>
<th>Advance Quality of Life</th>
<th>Address inequities (Race, Gender, Cycle of Poverty)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcomes</td>
<td>Social Network Collaboration</td>
<td>Change from domain specific work to whole person care</td>
<td>Change in intervention and interaction with people helping people</td>
</tr>
<tr>
<td>Outputs</td>
<td>Look-ups</td>
<td>Sharing Data</td>
<td>Client Consents</td>
</tr>
</tbody>
</table>
Stakeholders

Data Governance:
Advisory Board, CIE Network Partner Meetings and Workgroups

14 DOMIANS
- Housing stability
- Primary care and prevention
- Health management
- Nutrition and food security
- Financial wellness and benefits
- Activities of daily living
- Social and community connection
- Legal and criminal justice
- Safety and disaster
- Utility and technology
- Transportation
- Education and human development
- Personal care and household goods
- Employment development
Panel Presentation: Reflections and Key Highlights from Partnership Representatives
Key Takeaways

- **Building Community Ecosystems**
  - Partnerships are an integral component of a “community ecosystem”
  - Leverage existing community capacity
  - Expand information sharing
Key Takeaways

- Managing Through Partnership Evolution
  - Evaluating outcomes and processes
  - Financing and sustainability
Key Takeaways

- Building the Case
  - Provider buy-in
  - Mutual benefit
  - Reducing stigma
Partnership Tools
Resources to Advance Collaborative Efforts

- Integrating to Improve Health: Partnership Models between Community-Based and Health Care Organizations

- Value Proposition Tool: Articulating Value Within Community-Based and Health Care Organization Partnerships

- Health Care and Community-Based Organization Partnership: What Does It Cost?
RESOURCES TO ADVANCE COLLABORATIVE EFFORTS

Partnership Models between Community-Based and Health Care Organizations to Improve Health Outcomes

<table>
<thead>
<tr>
<th>SERVICE MODEL: how services within a partnership function and relate to each other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong></td>
</tr>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td><strong>Examples</strong></td>
</tr>
</tbody>
</table>

FINANCIAL RELATIONSHIP: How partnership funding and services are funded

PARTNERSHIP EFFECTS: How partnerships benefit individuals served
RESOURCES TO ADVANCE COLLABORATIVE EFFORTS

Articulating Value Within Community-Based and Health Care Organization Partnerships

Value Proposition Framework

WHAT challenges your partner’s ability to achieve desired outcomes?

HOW can you help address this through partnership?

WHY is this approach more effective than alternate approaches?

Your organization:

Partner organization(s):

WHAT challenges your partner’s ability to achieve desired outcomes?

Blue fillable text boxes are for notes.

How does this impact your partner? What outcomes are not being achieved? Why is this challenge of concern to your partner?

Consider:
- How does this affect service delivery, health and social outcomes, staffing, revenue, and cost?
- What external factors – such as a community health needs assessment, participation in an Accountable Care Organization, contractual requirements, care quality standards – make this a relevant concern?
**RESOURCES TO ADVANCE COLLABORATIVE EFFORTS**

**Health Care and Community-Based Organization Partnership: What Does It Cost?**

![Graphs showing cost breakdowns for different years and expenditures.](image)

### Total Cost of Partnership

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>Personnel</th>
<th>Non-Personnel</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization Name 1</td>
<td>$10,000</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Organization Name 2</td>
<td>$7,000</td>
<td>$4,000</td>
<td>$11,000</td>
</tr>
<tr>
<td>Organization Name 3</td>
<td>$9,000</td>
<td>$6,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Organization Name 4</td>
<td>$8,000</td>
<td>$5,000</td>
<td>$13,000</td>
</tr>
<tr>
<td>Organization Name 5</td>
<td>$10,000</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Total Cost</td>
<td>$40,000</td>
<td>$21,000</td>
<td>$61,000</td>
</tr>
</tbody>
</table>

### Personnel vs. Non-Personnel Costs

<table>
<thead>
<tr>
<th>Year</th>
<th>Personnel</th>
<th>Non-Personnel</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>30%</td>
<td>40%</td>
<td>$12,000</td>
</tr>
<tr>
<td>Year 2</td>
<td>27%</td>
<td>50%</td>
<td>$11,500</td>
</tr>
<tr>
<td>Year 3</td>
<td>25%</td>
<td>70%</td>
<td>$15,000</td>
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</tbody>
</table>

### One-time vs. Ongoing Costs

<table>
<thead>
<tr>
<th>Year</th>
<th>One-time</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>$5,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Year 2</td>
<td>$4,000</td>
<td>$2,500</td>
</tr>
<tr>
<td>Year 3</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

### Cost per Unit

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Cost per Unit</th>
<th>Ongoing Cost per Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>$2,500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Year 2</td>
<td>$2,750</td>
<td>$1,250</td>
</tr>
<tr>
<td>Year 3</td>
<td>$3,000</td>
<td>$1,500</td>
</tr>
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</table>
Question & Answer
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For more information, contact:

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Thank you and stay in touch!

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