THE COLLABORATIVE TO ADVANCE SOCIAL HEALTH INTEGRATION

What We're Learning About Delivering Whole-Person Care

January 2020

Health Leads

The Collaborative to Advance Social Health Integration

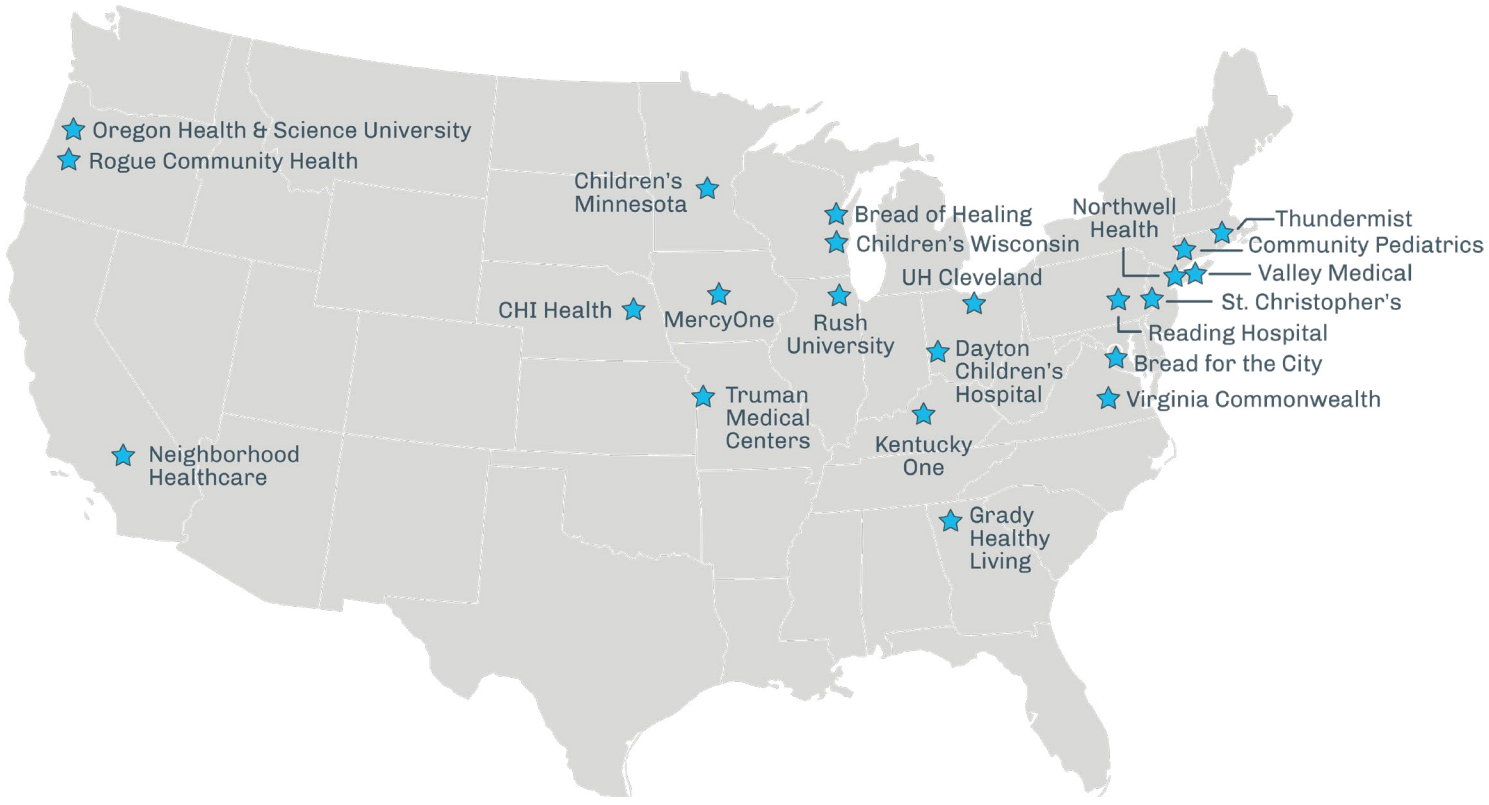
Supported by Health Leads and The Commonwealth Fund, the Collaborative to Advance Social Health Integration (CASHI) was a community of 21 innovative primary care teams and community partners committed to increasing the number of patients, families and community members who have access to the essential resources they need to be healthy. This was accomplished through focused efforts to improve social health practices, spread them to additional sites, and work toward financial sustainability plans.

More broadly, CASHI was created to develop implementation guidance in areas where social health integration know-how was limited but critical for effective delivery of whole-person care. We intentionally set an ambitious agenda and chose teams willing to innovate in varied areas of the program. CASHI focused on four core areas:

1. Accelerate practice on key drivers of health equity including patient/community engagement, community health worker (CHW) integration and support, and cross-sector collaboration.
2. Test patient-reported outcome measures (PROMs), which are required to measure social health impact, but difficult to collect and report.
3. Plan for financial sustainability by creating an enduring and practical process for business case development.
4. Move beyond pilots to spread essential resource navigation as an integrated part of care across many sites.

Each team developed aims with specific targets for their organizations and shared progress along the way. Here is what we achieved and learned together.

The CASHI Cohort



Collaborative learning accelerated teams' efforts to develop practices that matter to patients and can be sustained in a variety of contexts.

Informed by their communities, faculty guidance and their peers, teams made important changes to many aspects of their work including screening and assessment tools and approaches, support structures for patients and staff, and strategic partnerships with community-based organizations.

- 90% of teams tested and implemented changes in three or more primary drivers leading to change.
- 70% of teams worked with patients, through patient advisory councils (PACs) or focus groups, to co-develop or improve their social health approach for maximum impact.

	% Teams reporting implementation of one or more change*	Total # of reported changes implemented*	Examples of change
Screening & Assessment	100%	48	Workflows, tools, modality, approach (empathic inquiry)
Community partnership	80%	29	Form new/strengthen partnerships; closed loop referral processes
Financial sustainability	70%	36	Cost analysis, impact measurement, $ modeling
Patient input & leadership	70%	21	PAC, focus groups applied to social health
Workforce training & supervision	65%	33	Hiring, training, support & supervision structures & practices
Navigation & referrals	65%	19	Tech implementaiton, scope of service, hand-offs

**Note: Teams have tested many more changes. This reflects only changes implemented and does not include our measurement innovation work. This is an approximation based only on reported changes in the program learning platform so likely underestimates.*

Early evidence demonstrates a relationship between resource navigation and health confidence, and therefore health.

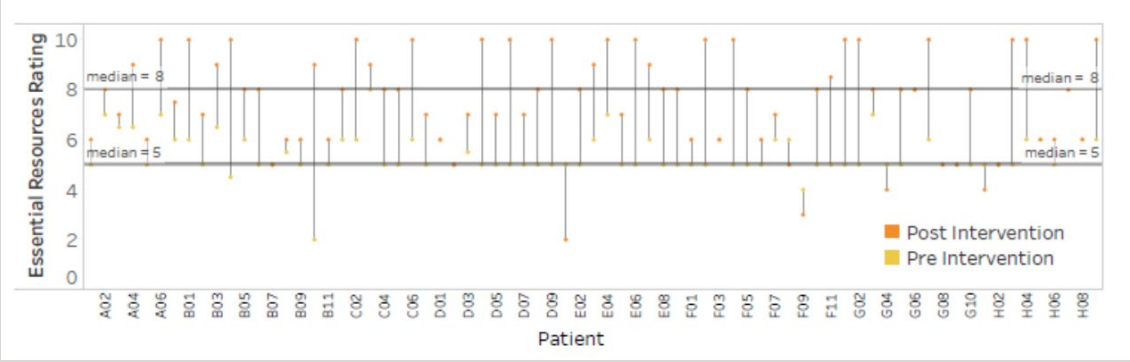
Effective social health integration will ultimately depend on patient-reported outcome measures (PROMs) to adequately understand changes in social or economic status in ways meaningful to patients. While the sector is still learning how best to implement these promising tools for improving care, we learned a lot about their specific application to social health integration.

- We saw a strong association between some teams' interventions and improvements in essential resource access and health confidence, which has been associated with improvements in a range of other health outcomes.[1]
- Some teams using PROMs said they supported better conversations between care teams and patients, consistent with other findings that equity-oriented primary care improves health via improvements in health confidence.[2]
- We found that teams need to have choices about PROMs, like which versions to use and when to administer them. Some chose to modify the wording, rating scales, and/or sequencing of our PROMs based on feedback from their patient leadership. We also found that different outcome measures should be used for different populations, such as adult and pediatric populations.
- Implementing PROMs can be difficult and requires careful workflow design and adequate resourcing.

While not easy, investing in the capacity to collect and use whole-person PROMs can have significant benefits in terms of both demonstrating meaningful impact linked to a range of other outcomes, and enabling that impact by reorienting care team conversations around what matters to patients.

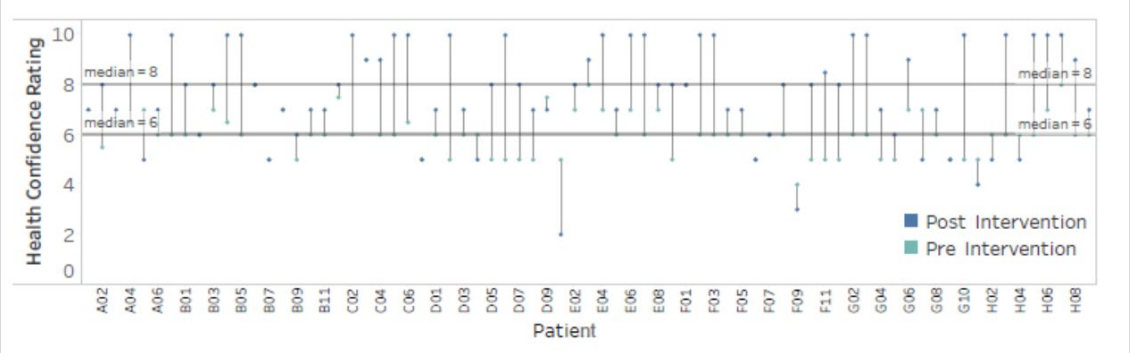
CASHI teams reported monthly on a family of measures, including patient-reported health confidence and access to essential resources. Clinic teams that administered these measures to patients before and after time-limited social health interventions found a strong association between the intervention and improvements in essential resource access and health confidence.

Where are you in having the essential resources to be healthy?
Examples of essential resources include food, housing and transportation.



On average, patients at this site reported a 3-point increase in essential resource access.

How confident are you that you can control and manage most of your health problems?



On average, patients at this site reported a 2-point increase in health confidence.

CHI Saint Joseph Berea pre-post outcome measures data, January-July 2019.

1. Wasson J, Coleman EA. Health confidence: a simple, essential measure for patient engagement and better practice. Fam Pract Manag. 2014 Sep-Oct;21(5):8-12.

2. Ford-Gilboe M et al. How Equity-Oriented Health Care Affects Health: Key Mechanisms and Implications for Primary Health Care Practice and Policy. Milbank Q. 2018 Dec;96(4):635-671. doi: 10.1111/1468-0009.12349.

Effective approaches require increasing patients' influence on design and implementation.

Patient input ensures resources are well-used, but few in the field are taking action to involve their patients to design and improve their social health efforts. We call this patient leadership rather than patient engagement, which often refers to patients who are active self-managers. Rather, we asked CASHI teams to develop patient leaders as co-designers of their social health integration approach. In this context, 70% of CASHI teams implemented approaches to gather patient input.

> We save so much time, effort, and money when we simply ASK patients for feedback and create from there, instead of guessing what patients want, failing, and having to keep guessing and adapting.

CASHI Organization	Approach to Patient Leadership	Sample Impacts on Social Health Integration
TMC Truman Medical Centers	Patient and Family Advisory Council and Patient Champions (patients active on interdisciplinary committees and projects), as well as patient interviews and surveys	Increased trust via clear language on "why social needs screening" Ensured location of a new on-site food pantry was optimal for patients
VCU Health OHSU Health	Patient and Family Advisory Councils where patients evaluate and direct updates on aspects of program (e.g. screening, measures)	Improved screening tools and processes (e.g. better questions and icons, ensured medical assistants not overburdened) Updated patient reported outcome measure language to increase patient receptivity
Bread of healing clinic	Patients as Advocates, Outreach Workers and Board Members	Aligned center leadership on the importance of investing resources in certain social domains (e.g. utilities)
Bread for the City helping people	Patients participating in human-centered design and innovation	Working with patients to understand how food insecurity presents and then design a scalable solution (e.g. a "food home" at the clinic) that better meets their food and health needs

Cross Sector Collaboration

Progressive alignment of resource navigation infrastructure and investment across sectors is key to improving community health.

Teams are maximizing impact by building trust and sharing resources, data and decision-making with community partners. Some are supporting spread by strengthening partners' capacity or adding community partners to their care coordination networks.

Children's Minnesota

Reviewed program data and invested their community benefit dollars in their top referral partners.

Engaging CBOs in long term planning.

Invested significant effort in creating standard and streamlined MOU process for Community Connect-CBO partnerships.

CHMN meets monthly with its "tier 1" partners - with memorandums of understanding - and reviews common goals and data (# referred, # reached, % connected) to reflect on effectiveness of their work

Rogue Community Health

No-wrong-door community hub where they are a member alongside CBOs.

Community building and shared visioning with each of the partners in the hub; routine meetings among partners at all levels (Front-line staff up to exec).

Shared tech platform for direct referrals between partners reducing intake burden for members and entering goals in patients' own words.

All case managers from participating agencies are trained together on trauma-informed care, implicit bias, customer service, crisis de-escalation, health and system literacy. This builds camaraderie, understanding of each others' work, and a common language at a community-level.

Northwell Health

Funding more staff and training at CBO partners that can provide more support closer to patients' homes who require deeper support.

Expanding the reach of their Medical Legal Partnership (MLP) into community-based locations towards more of a hub model. This allows more CBOs in catchment area to refer to MLP and ensures that healthcare (Northwell) is not the gateway to services.

Providing backbone support for a multi-sector collaborative using community-based research and shared-decision making to address housing insecurity. 15 CBOs and many community members involved will apply for funding at neighborhood level and collaborate to execute.

Sustainable work environments for CHWs require a trauma-informed and racial equity lens.

In CASHI, CHWs and navigators led improvement efforts with impacts ranging from improved patient activation through strengths-focused assessments to strengthening community partnerships to honing measurement approaches. When CASHI teams surveyed patients on their overall experience of working with their CHW or navigator, the average rating was 9.7 out of 10! But despite their impact, CHW burnout is a real problem - it's very difficult to do this work on the front line, and it's often undervalued in a variety of ways. Identifying ways for practices/systems to make it more sustainable is going to be critical to the long game of transformation. Insights include:

- Teams are creating space for storytelling, case support and creating compassionate boundaries, as well as increasing CHW influence on and leadership of design and improvement work.
- Teams are hungry for and welcoming guidance on practical ways to address power imbalances on care teams and ensure social health integration improves racial equity more broadly.

Virginia Commonwealth University Hospital

CHWs reflect on their work using a voice recorder on their phones while in the field.

This technique, as well as the specific reflection prompts, allow CHWs to go beyond "just the facts" to more organic storytelling, how they are feeling, and what they are noticing about their own skill development.

Their supervisor remarks how valuable it is to be able to hear "what they are saying and what they are not saying" in their tone in the recordings, so they can offer additional support where needed.

Bread for the City

Created and tested a trauma-informed racial equity supervision toolkit to ensure consistent and high-quality supervision for staff across the organization.

When rolling out their standards for trauma-informed and equity-grounded supervision, they found that supervisors needed more hands-on guidance.

Bread for the City is now offering a group support series for supervisors where they teach core supervisory skills live and discuss cases. The impact is enhanced capacity within the organizaiton and consistently improved supervision, including stronger professional development plans for staff.

A practical approach and tools support teams' ability to make the case for continued funding and expansion.

Analyzing current costs and benefits inform future decisions about funding, programmatic design, and the sustainability and spread of social health integration.

- Financial sustainability is supported by developing a comprehensive view of value. This means considering what benefits accrue to varied stakeholders and focusing business case development on where those sources of value align. In addition to cost and outcomes, teams looked at sources of value such as growth in new patients and/or patients with a payer source, provider satisfaction, productivity, and mission/qualitative patient impact.
- A strong grounding in the cost of social health integration enabled teams to plan for spread more effectively and efficiently through better capacity forecasts and consideration of how to integrate roles well. It also enabled PMPM cost calculations to support funding conversations.
- Detailed cost analyses also forced teams to focus intervention decisions on what drives value. One free clinic found that 59% of their costs lied in follow-up workflows, and then analyzed and honed their scope of service based on what drove the most value for patients.
- Many teams' data collection efforts were hindered by difficulty "closing the loop" with resource providers, both due to capacity on both sides and the lack of data sharing infrastructure. Rogue Community Health, which has such a data system in place, noted that it saved their CHWs time, allowing them to invest more in relationships.

Sample Business Cases

- ✓ New revenue generation from increased referrals from community partners
- ✓ Better payer contracts due to better primary care utilization and lower total cost of care
- ✓ Decreased total cost of care in an ACO setting
- ✓ Decreased uncompensated care at the community level through services that include resource navigation and insurance enrollment
- ✓ Increased patient and provider satisfaction

CASHI Business Case Technical Assistance Approach

Analysis of current costs, funding and benefits to inform and justify future funding asks to spread and sustain the work

Value Proposition

Hypothesis for the value you will demonstrate and to whom (must include those who will pay)

Total Cost

Analysis of funds required.
What drives cost?
Potential efficiencies?

Funding & Revenue Sources

How you will cover your costs.
Who will pay and what do they need to see?

Measures & Data Collection

How to demonstrate the value (measures, data collection & analysis)

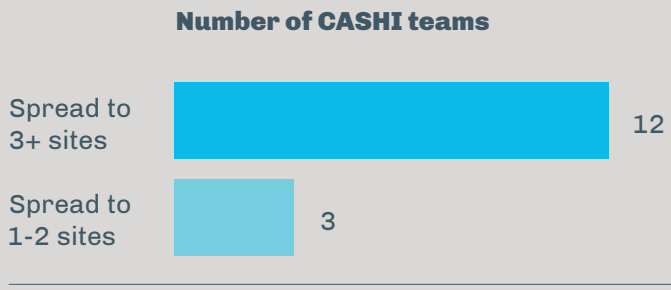
Engage Stakeholders. Use Champions.

Significant spread of social health practices throughout institutions and cross-sector partnerships.

With the right people, resources, planning and supportive community, spread of these critical approaches is possible. Fifteen teams spread to 70+ new sites during the 18-month program. Supportive factors were very consistent with the IHI Spread Framework[3]; a few notable enablers:

- **Active leadership.** Beyond resources and creating capacity, leaders connected the work to strategic priorities like health equity initiatives and preparation for value-based reimbursement.
- **Thoughtful sequencing.** Many teams spoke to starting where there were champions, and increasingly moving to where the need was highest based on social or economic indicators.
- **Multi-disciplinary teams.** This allowed members to fan out to peers as they spread. Teams also increased CHW visibility to showcase their impact across roles and levels.
- **Adding staff and clarifying roles.** Teams hired additional navigators, volunteers, and CHWs to support the additional patients at spread sites.
- **Effective will-building.** Teams used shadowing and storytelling to support learning and build excitement. They created communities of practice and shared dashboards and success stories.
- **Data tracking.** They used data to support accountability and reviewed regularly (monthly or biweekly) to observe quickly if any gains were back-sliding.
- **Mix of standardization and adaptive strategies.** Many teams saw value in standardizing roles, training and implementing tech platforms or iPads to standardize screening and data collection. On the other hand, one team spread to 15 sites by adapting roles and experimenting with ways to integrate the work into existing (vs new) FTEs.
- **Significant investment in socialization** (culture change to support social health integration) and **training** around specific changes to screen for and address patients' resource needs.

15 teams have spread to 70+ new sites in the past 18 months



Description of Spread Progress

Teams have spread to 70+ sites in total; primarily to other primary care sites with a few exceptions

Teams spread screening, referrals and navigation as capacity allowed; very few new "screening only" sites

Some teams supported spread by strengthening their community partners' capacity with FTEs, $, and data

Due to capacity constraints, 2 teams are spreading slowly through a provider-to-provider to allow time to socialize changes on care teams and monitor caseloads

Other forms of spread include sharing best practices within a multi-org partnership, and adding 29 partners to a "no wrong door" community hub model

These teams were either unable to spread due to organizational constraints or chose to stop spread based on changes in their social health strategy (e.g. desire to pursue operational efficiencies first, or resource solutions instead such as improving access to food)

3. http://www.ihi.org/resources/Pages/Tools/SpreadPlanner.

Looking Ahead

Demand among CASHI teams is high for continued learning to deepen impact and keep supporting the spread of successful practices. The "All Teach, All Learn" environment we created resulted in a supportive and resilient community of innovative practitioners. As a result, teams made significant institutional and community-level changes, and they now have the foundational elements in place to deepen impact that improves health equity – including structures like patient advisory councils, know-how around PROMs, CHW integration and support, and deep relationships with community partners supported by shared resources, data, trust, and decision-making.

Reflections From the CASHI Community

"We have gotten a tremendous amount out of the collaboration. I have a framework to help me push my work forward in such a tricky situation."

"CASHI has been a transformative experience for me- something I'm going to keep with me."

"We were coming off a three-year pilot when joining CASHI. CASHI helped inform where we were and where we wanted to go to next- especially in terms of sustainability."

"We came in as a successful pilot and we are leaving with a system-level strategy."

"We came in with hope and we are now confident – thank you CASHI."

"We came in with a small-town vision for collaboration and we are now happy to have made meaningful relationships on the national level."

"We have learned so much together and are hitting our stride. We are collectively addressing big questions in the field."

"We are all gaining significant ground now. We are establishing some really good relationships with one another and there is great opportunity within this group to innovate and not only spread, but also deepen the impact of this work!"

ABOUT HEALTH LEADS

Health Leads is a national non-profit organization working toward a vision of health, well-being and dignity for every person in every community. For over two decades, we've worked closely with hospitals and clinics to connect people to essentials like food, housing and transportation alongside medical care.

Today, we're partnering with local organizations and communities to address systemic causes of inequity and disease — removing the barriers that keep people from identifying, accessing and choosing the resources everyone needs to be healthy.

For more information visit www.healthleadsusa.org, or email info@healthleadsusa.org.