POPULATION HEALTH: From Planning to Action

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Cottage Health
Santa Barbara, CA

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MISSION

To provide superior health care for and improve the health of our communities through a commitment to our core values of excellence, integrity, and compassion.
COTTAGE HEALTH FRAMEWORK
Data Collection and Community Benefit

- CHNA Survey
- Listening Tours
- CHNA Results
- 2016-19 Community Benefit Implementation Strategy
• Collaboration is lacking.
• Some of our own employees struggle with very poor health.
• In general, participants felt population health could play an important role in facilitating collaboration to address root causes of poor health in Santa Barbara County.
More collaboration needed.

- Cottage Health can fill the roles of facilitating, convening and coordinating.

- Housing insecurity, mental health and food insecurity were mentioned time and time again.

- Underlying economic and racial/ethnic inequalities make this work more complicated.
<table>
<thead>
<tr>
<th><strong>Exceeds HP 2020 Target</strong></th>
<th><strong>Below HP 2020 Target</strong></th>
<th><strong>HP 2020 Target NA</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall good health</td>
<td>Insurance status</td>
<td>Housing insecurity</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>Primary care provider</td>
<td></td>
</tr>
<tr>
<td>Physical Inactivity</td>
<td>Cost as barrier to care</td>
<td></td>
</tr>
<tr>
<td>Oral health</td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>Food insecurity</td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td>Depression</td>
<td></td>
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</table>

BRFSS Data Collection
On average, California and Santa Barbara are healthy, but that is not the whole story . . .
<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>Santa Barbara</th>
<th>California</th>
<th>Hispanic</th>
<th>White</th>
<th>No HS Diploma</th>
<th>&lt;$35K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall good health</td>
<td>81</td>
<td>82</td>
<td>72</td>
<td>87</td>
<td>59</td>
<td>71</td>
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</table>
Five Priority Areas

- Behavioral Health
- Chronic Conditions
- Access to Care
- Food Insecurity
- Housing Insecurity
Who needs help to be healthy?

What is the need? What is the cause?

What is the pathway to health?

Cottage Population Health Approach

Population
- SB County overall
- Population segments

Health
- Measurable outcomes
- Mental, social, physical well-being

Programs
Research, partnerships and initiatives to address health disparities
Population Health Initiatives

- Behavioral Health Initiative
- Social Needs Programs
- Medical Respite Program
- Behavioral Health Collaborative
COMMUNITY PARTNERSHIP GRANTS:
Behavioral Health Initiative
## History of Community Partnership Grants

<table>
<thead>
<tr>
<th>BEFORE 2014</th>
<th>AFTER 2016</th>
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</thead>
<tbody>
<tr>
<td>• Broad-based</td>
<td>• Focused</td>
</tr>
<tr>
<td>• Reactive</td>
<td>• Data-driven</td>
</tr>
<tr>
<td>• Limited accountability</td>
<td>• Evidence-based or best practice</td>
</tr>
<tr>
<td>• Individual Programs</td>
<td>• Capacity to evaluate outcomes</td>
</tr>
<tr>
<td></td>
<td>• Multi-sector collaboration</td>
</tr>
<tr>
<td></td>
<td>• Potential for sustainability</td>
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</tbody>
</table>
Grant Selection Process
Community Health Coordinating Committee

- 29 Grant application requests
- 19 Grant application submissions
- 11 CHCC review process
- 9 CHCC recommendations
Child Abuse Listening Mediation
Santa Barbara Resiliency Project

Partnership
• Santa Barbara Neighborhood clinics

Intervention
• Assisted in funding Wellness Navigators, a lead pediatrician, CALM mental health clinicians, and UCSB research and evaluation
• Implement ACEs screening at well-child visits for 0-3 year olds and their parents. Clients randomly assigned to 3 interventions.

Reach
• 44 children screened, 16 (36%) eligible for the study
• 1 home visit, 8 families are receiving ongoing care from a therapist
Partnership
- Santa Barbara Unified School District

Intervention
- Expand school-based counseling services to high school students by funding 1.2 FTE Marriage & Family Therapists

Reach
- 205 referrals across 3 high schools in the first semester—89 at Santa Barbara HS, 56 at San Marcos HS, 60 at Dos Pueblos HS
- Individual counseling has been expanded to 5 days a week per high school
HEALTH LEADS
SOCIAL NEEDS
SCREENING PILOTS
START

Employees access Social Needs Screening Tool

Employees answer social needs questions

Employees screen positive for social need

START END

YES

Screen positive for food, transportation, and/or behavioral health needs

Employee asked if they want to be connected to Resource navigator – telephone, web or in person

NO

Screen positive for housing needs

Employee receives list of resources

YES

Resource Navigator contacts employees who request support

NO

Outcome and process metrics tracked for evaluation and continuous quality improvement
EVERY PATIENT, EVERY TIME

Goleta ED Pilot Concept

START

Admitting administers screening for social needs (food, transportation, housing)

ED patient completes screening and returns to Admitting

YES

Unit Coordinator calls Social Worker to meet with patient

NO

ED volunteer scans negative screening results to Family Service Agency (FSA) to enter into REACH

NO

ED volunteer provides warm handoff and scans positive screening results to FSA to enter into REACH

YES

Social Worker available to meet with patient

NO

Social Worker meets with patient to discuss needs and provide a warm handoff to Resource Navigators

YES

Patient receives follow-up communication from resource navigator until referral is completed.

(Documented in REACH)
Santa Barbara County has 1,400 homeless individuals

South Santa Barbara County has 900

On average at Cottage Health hospitals:

- 155 homeless patient visits/month
- 2.57 inpatient visits/homeless patient/year
- 3.90 ED visits/homeless patient/year
- $10,602 – direct cost/homeless inpatient visit
- $611 – direct cost/homeless ED visit
Conducted phone calls with and site visits to Hope of the Valley in Mission Hills and Illumination Foundation

Reviewed 23 CA programs described in National Health Care for the Homeless Council’s 2016 Medical Respite Program Directory

Consulted with National Care for the Homeless Council on medical respite models
Reduce ED and inpatient use for program participants

- CH ED utilization rates and costs
- Inpatient utilization rates and costs

Community referrals offered and utilized

- Patients with established care plans
- List of referrals offered or appropriately identified
- Successfully completed referrals

Document-ready for housing

- Patients discharged to temporary housing (e.g., SB New House, PATH program beds, family reunification)
- Patients that are document-ready for housing
Medical Respite Sustainability

- Philanthropy
- Reimbursement
- Cost Savings
- Community Benefit
BEHAVIORAL HEALTH COLLABORATIVE
Collaborative Approach

- Key community health care players met for first time: public health, large medical group, FQHC, community health care system, medical benefit provider, and community foundation.
- Shared health data
- Defined priority as behavioral health
- Agreed to work together to ensure individuals with mild to severe mental health and substance abuse needs are able to access timely and appropriate care in Santa Barbara County.
• Improving behavioral health care access is a shared goal.

• County has strong culture of collaboration and accountability to the community.

• Challenges: psychiatric provider shortage, insurance coverage, lack of beds, alignment of many existing efforts

• Opportunity: transitions of care, improved communications among providers

• Opportunity: empowering primary care physicians to meet mild behavioral health care needs (with psychiatrist support)

• Partners are willing to share their distinct data to help best identify areas of need.
Collaborative Approach
Next Steps

- Additional data analysis and environmental scan
- Conduct behavioral health listening tours
- Research successful community collaboratives
- Convene health leaders to share summary of interviews and prioritize next steps
TOOLS AND RESOURCES
Population Health Tools and Resources

- Ongoing Data Analysis
- CottageData2Go.org
- Population Health Learning Lab
- Population Health Workshop Series
- Outreach Inventory
- Environmental Scan
- Evaluation Support
- Population Health Consultations
Population Health Research Projects

- Factors Associated with Primary Healthcare Avoidance Among Homeless Adults
- Gestational Diabetes Education Pilot Study: Improving Health Outcomes for Hispanic Women and Their Infants Through an Education and Care Curriculum
- Surveillance Analysis of Hospital-Acquired Versus Non Hospital-Acquired Clostridium Difficile Infection
Cottage Health Data Party

- Pose a formative research question and hypothesis
- Behavioral health strengths or challenges
- CottageData2Go.org
- Data Party Review Committee rates posters, plus one people’s choice
- 5 poster proposals receive grants of $10,000 each
- Create videos of their results
Urgent Need
Providing care to our patients in a mass casualty event

Immediate Need
Ability to get our staff to work

Long Term Need
Disaster Recovery
Cottage Health’s Role in Disaster Recovery

- How We Heal Presentation and Panel
- Expanded Employee Assistance Program
- Long-Term Recovery Group
- Case management services
- Support groups for adult, adolescent, and children
QUESTIONS

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