Embracing community health and health equity in a large, integrated health care system

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Welcome

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Conflict of Interest

Nazleen Bharmal, MD, PhD, MPP

Has no real or apparent conflicts of interest to report.
Agenda

• Overview of Cleveland Clinic Community Health Strategy
• Examples: COVID-19 response and digital equity
• Challenges and Opportunities
Learning Objectives

• Describe the approach to address community health

• Outline how healthcare systems can develop a proactive, outcomes based approach to health equity

• Discuss examples and challenges for technology, narrative, integration, and impact measurement
Population Health & Value

- Focus on outcomes (value) vs. services (volume)
- Focus on prevention
US Federal Budget

1975

Social Security & Healthcare 34%

2017

Social Security & Healthcare 51%
**Big Picture**

- Clinical Care – 20% of population’s health
- Place matters
- Health equity

Healthy People 2020, DHHS
Place matters

- Poverty
- Racial residential segregation
- Prevalence of chronic disease
- Lack of access to fresh foods
- Lead and pollution
- High school graduation rates
- Household with internet access

There is a 23 year difference in life expectancy between these two neighborhoods, less than 2 miles apart.

Municipal boundaries are outlined in white

Community Health

- A multi-sector and multi-disciplinary collaborative enterprise that uses public health science, evidence-based strategies, and other approaches to engage and work with communities, in a culturally appropriate manner, to optimize the health and quality of life of all persons who live, work, or are otherwise active in a defined community or communities.

Centers for Disease Control and Prevention
Steps and Decisions

Principles and Population
- Health equity
- Vulnerable populations
- Community definition

Inventory
- Programs
- Data
- Stakeholders

Priorities
- Community health needs assessment
- Anchor institution
- Partnerships

Governance
- Centralized
- Steering committee
- Advisory team

Outcomes
- 5-year SMART goals
- Regional and institutional

Milestones
- Yearly milestones
- Metrics
- Data sharing
HEAL
• Most Vulnerable Populations
• Focus on Community Health Needs
• Root Causes

HIRE
• Local Youth Education to Workforce Development
• Employee Pipeline

INVEST
• Buy local
• Invest local
• Improve local built environments

Health Equity, Community Voice, Prevention
• Increase our caregiver workforce hired from within the City of Cleveland
• Invest in programs and partnerships that foster job readiness and create an employee pipeline
• Leverage our status as an anchor institution to support local workforce

Hire, Buy, Invest Local
Built Environment
Eliminate Structural Racism
Increase Trust

INFANT HEALTH
CHRONIC DISEASE PREVENTION
MENTAL HEALTH, ACEs
DRUGS AND ALCOHOL
LEAD EXPOSURE

Maternal Health
Food as Medicine
Trauma/Stress/Isolation
Social risk and needs: transportation, utilities
Digital + Health Care Access

Partnerships, Education, Programs, Advocacy, Funding

ANCHOR
YOUTH
ADULT
<table>
<thead>
<tr>
<th>Objective</th>
<th>Partner in our communities to attain the highest levels of health, wellbeing, and health equity utilizing an Anchor approach</th>
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<tr>
<td><strong>Key Results</strong></td>
<td><strong>Measures of Success</strong></td>
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| Enable Lifelong Wellness with Partners | Community Health Needs Assessment priorities  
• Maternal/Infant Health  
• Chronic Disease  
• Behavioral Health |
| Reduce Barriers to Health |  
• Screen and close gaps for social needs  
• Equitable access to virtual platforms |
| Combat Structural Racism | Key Anchor priority areas: Hire, Buy, and Invest Local |
| Streamline and Scale Enterprise Efforts | Centralized governance and database |
| Build Trust & Ensure Shared Mission/Vision | Staff and community partner engagement |
Partnership criteria

- Align with community health priorities
- Health equity focus
- Trusted stakeholder and/or advocate for vulnerable
- Bi-directional partnership
- Report impact
- Work uses evidence-based practices
Community Health COVID Approach

**Connect**
- Local government & public health
- Community-based organizations & stakeholders
- Community members and patients

**Communicate**
- Bi-directional communication
- Virtual forums, including faith-based orgs
- Direct outreach via calls and emails

**Mitigate**
- Determine assets/services delivered and client needs
- Screen for health behaviors & social determinants

Study impact through standard surveys and needs database
COVID Pandemic—Catalyst for Change

inSight: A Community Monitoring Program

**High Risk Chronic Disease**
- Manage chronic disease and reduce preventable ED and inpatient utilization
- Weekly monitoring

**Hospital Discharges / Transitional Care Management**
- Reduce preventable ED and inpatient utilization
- Weekly monitoring

**COVID-19 Home Monitoring**
- Monitor for decompensation
- Daily / every other day monitoring
COVID-19 Community Health Response

COVID-19 and high-risk non-COVID patients
- Physical, mental, social needs screened and addressed
- Reduced inpatient admission by 35%

Referrals
- Ambulatory social work: emotional support and food greatest needs
- Mental health social work: 80% given resources or care

Community residents and organizations
- Including ~1K men of color; 94% identified need
- Trust gained by sharing resources
Testing equity

- Support FHQCs - federally-qualified health centers
  - Reference lab
  - Swab training
  - FIT testing and PPE education
  - Observation of testing sites
  - Mobile team training
  - Community testing website

- Community testing events
  - 6 events in 3 months
  - 600+ people
  - State and national guard partners
Vaccination equity

- Racial/ethnic communities
  - Walk-ins sites in Black and Hispanic neighborhoods
  - Community partners, including Medicaid

- Staff campaign
  - 70% uptake
  - Low uptake: facilities, security, patient support

- Elderly and homebound
  - Direct outreach
  - Home delivery campaign: ~1K
Digital Inclusion Pillars

- Digital skill training
- Connectivity
- Devices
- Digital health skill training
- Tech support

Digital Health Equity
Advance Digital Equity

- Connectivity: Hospital rooftops and grant support for high speed internet

- Established Virtual Health Equity committee
  - Data stratified by key sociodemographic factors
  - Metric development
  - Patient and caregiver engagement

- Participation in regional Digital Equity Coalition
  - Standard screen for digital connectivity
  - Best practices for digital navigators and expand digital spaces
Challenges and Opportunities

1. **Narrative**
   - Value of the organization
   - Executive leadership
   - All levels of caregivers

2. **Integration**
   - Data sources: clinical, public health, employment
   - Interoperability
   - Centralized vs. decentralized

3. **Collective impact measurement**
   - Meaningful metrics
   - Modifiable measures
Questions

• What are other challenges for healthcare systems to embrace community health and health equity? How have you addressed?

• How can we engage payors yet have interventions be applicable to all patients and community residents?
Thank you!

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