HIGH UTILIZER SUMMIT

June 21, 2017

BACKGROUND

Mile High Health Alliance (MHHA), in collaboration with Center for Health Progress, led a series of webinars throughout 2016 and 2017 that focused on various topics affecting the high utilizer population including legal issues, housing, and data use/data sharing. The webinar series culminated in the 2017 High Utilizer Summit – *Social Determinants of Health: Tools to Action*.

INTRODUCTION

Serving and meeting the needs of high utilizer populations in order to improve their health are common challenges to communities and health systems across Colorado and the nation. The goal of the High Utilizer Summit was to hear from some of the programs that are addressing social determinants of health (SDOH) for these patients as well as provide tools and conversation for participants interested in adapting and implementing these strategies as part of their own work.

PRESENTATIONS & PANELISTS

You can access the presentation slides here.

Mary Carl, Managing Director of Programs, California, Health Leads

> *"We envision a healthcare system that addresses all patients' basic resource needs as a standard part of quality care."* - Health Leads Vision

Health Leads started as volunteer-based program in which physicians wrote prescriptions for social needs such as housing support, and volunteers connected patients to resources. Currently, Health Leads is trying to standardize their process and move beyond volunteers. The presentation summarized the core elements of social needs integration and discussed the current work through a case study of Kaiser Permanente in Southern California. This pilot was based on four key tenants: clinical integration at scale, joint research on value of resource connections, co-development of product innovations, and joint leadership in the sector.

Health Leads developed cold calling methodologies to reach and screen patients, and then tested their work in 2016. The pilot screened 5,000 members, reaching 50% of the target population. Around 50% of those reached had at least one need. 20% were enrolled in navigation support, and these enrolled patients demonstrated improved health and reduced cost outcomes. Health Leads is continuing to refine their work, including the ability to screen and connect their patients to services.

Danielle Varda, Director, Center on Network Science

Danielle Varda's presentation focused on social connectedness as a social determinant of health and the nuances of social networks and relationships that affect a patient's need for support. She highlighted the importance of building evidence about social connectedness and identifying interventions. The UC-Denver Center on Network Science is currently piloting an intervention they developed, the Person Centered Network (PCN) App. Using a mobile device, which can be used in homes, clinics, classrooms, or in the field, the PCN App evaluates social connectedness, levels of dependency on social support, level of trust, and other factors that allow the patient to prioritize in which areas they need the most support. Current pilot sites include a fire department and school. The PCN App seeks to measure social support networks to build adaptable systems around people.

Anne Russell, Integrated Care Supervisor, Southeast Health Group

Southeast Health Group is an integrated care facility serving six counties in the southeast corner of the state. Due to the high number of high utilizers in their community, SE Health Group developed a patient navigation program that focuses on assess to prevention, early detection and integration for primary care, mental health, and substance use for this population. Anne Russell shared the highlights of their work, including developing programs that serve the unique needs of their rural populations and employ people from these communities. The program has six health navigators who utilize motivational interviewing techniques with the goal of increasing patients' self-sufficiency over time. As a result of these efforts, the SE Health Group has seen financial healthcare savings, improved collaboration across agencies, a deep partnership with the local community college, and many patient success stories.

Leslie Scotland-Stewart, Director of Business Development, Meals for Care Transitions, Project Angel Heart

Project Angel Heart delivers medically tailored meals to patients with complex medical needs in Colorado. They believe that food is medicine and important to patients' health. This point was emphasized throughout the presentation: rather than charity, food is medicine. Leslie Scotland-Stewart discussed their Meals for Care Transitions partnership with health care providers statewide, which provides medically tailored meals to support patients as they are discharged from the hospital. Meals are delivered to a patient's home for a specific amount of time, often 30 days, within 48 hours of referral. In the initial pilot with HealthONE, Meals for Care Transitions served 27 patients; 15 remained a part of the pilot for at least 75 percent of the 30-day program. There were zero hospital readmissions in this pilot, along with evidence of cost savings. Looking to the future, it will take advocating together for food to be seen as medicine within health care.

PANELISTS Q&A

Attendees wrote their questions on note cards, which were collected and themed, before being shared in a panelist Q&A discussion. Questions centered on staff (education, training, addressing burnout), costs (price of the PCN app, funding for the programs via grants and

otherwise), and patient engagement (how to address patients who do not want services, marketing, and outreach)

SMALL GROUP DISCUSSIONS

Attendees broke into small groups to discuss some questions about the current work they are doing and key takeaways from the day. The following are the compiled results:

1. **What is one word or phrase that stood out to you from the panel presentations and discussions?** (Listed in order of frequency mentioned)
    - Food as medicine
    - Patient-centered
    - Carrying capacity of resources/non-profits
    - Reframing your mind
    - It's [high-utilizers] not just Medicare and Medicaid problem
    - Term to use other than high utilizers → returning customers
    - Coordinating systems of care
    - Addressing social and developmental needs

2. **What is one thing that your organization is already doing that relates to today's presentations and discussions?**
    - Meeting patients where they are at
    - Ensure clinicians are aware of resources
    - Working beyond 1-on-1 care → scale (strategy)
    - Care coordination (social workers, patient navigator, primary care, etc.)
    - Sub-groups within high utilizers
        - Increased screening
        - Integrated behavioral health into primary care units
        - Patient navigation
    - Food is medicin
    - Motivational interviewing
    - Starting to make connections to key needs (i.e. housing and food insecurity)

3. **What is one thing you learned today that you want to apply to your work moving forward?** (Listed in order of the frequency mentioned)
    - What is the carrying capacity of non-profits/service organizations? It's important to understand the need for these services.
    - All the apps mentioned
    - Asking about the qualities of individual supports
    - Using motivational interviewing
    - Cold calling is complex and should be piloted
    - Rebranding the term "charity"
    - Patient navigator training licensure
    - Potential to improve 211 with map
    - Great way of community and health needs assessment
    - Moving beyond a fragmented health system

Speaker Biographies

Mary Carl, Managing Director of Programs, California, Health Leads

Mary has provided leadership for the Health Leads since the inception in 2014 of California's programs for design, development, implementation and operations throughout the state. Prior to launching the California team, Mary acted as Director of Programs for Building Opportunities for Self-Sufficiency, a San Francisco East Bay nonprofit, to provide a safety net for the wellness of homeless families and individuals. Her integrative approach builds interdisciplinary teamwork that is sensitive to diverse perspectives and population needs. Mary's empowerment tactics focus on implementing social justice and equity strategies at ground level for consumer-centeredness. Volunteer efforts include participation in a UCSF study on the health impacts of homelessness on aging adults, and supporting development of a program for adolescent girls. She completed her undergraduate work at the State University of New York at Buffalo and her Master in Public Health at University of North Carolina. An avid runner and the mother of two toddlers, she is found on the trails running with her family.

Contact Info: info@healthleadsusa.org
Website: www.healthleadsusa.org

Jeremy Long, MD MPH, Director of LEADS Track Program, University of Colorado

Jeremy is an assistant professor and Director for LEADS Track Program. Through monthly seminars from community-based healthcare advocates, case studies and small group sessions, help students develop advocacy skills necessary to better serve vulnerable and underserved populations. His focus has been on researching and teaching professionalism and civic engagement of the medical profession. Dr. Long received his medical degree from the Wake Forest University School of Medicine in Winston-Salem, N.C., and also received his Master of Public Health in Behavior and Health Education from University of North Carolina at Chapel Hill - Chapel Hill, NC.

Leslie Scotland-Stewart, Director of Business Development, Project Angel Heart

Leslie is the Director of Business Development for Project Angel Heart's Meals for Care Transitions program. She worked in sales and marketing for a variety of Fortune 500 companies before deciding to focus her career on health and wellness. After helping build a startup company that helps executives become healthier leaders, she joined Project Angel Heart in a business development role. She has a passion for all things health, including nutrition, exercise, and mindfulness. Leslie has her MBA from the University of Denver and teaches fitness classes on the side.

Contact Info: lscotlandstewart@projectangelheart.org
Website: https://www.projectangelheart.org/

Anne Russell, **Integrated Care Supervisor, Southeast Health Group**

Anne has been a native to Southeast Colorado with exception of about 10 years when she attended the University of Northern Colorado and completed a degree in Psychology, and then worked in Denver where she developed a love for working in healthcare. After missing living in a rural community, she returned to her roots in La Junta and continued working in healthcare. She is currently the Integrated Care Supervisor at Southeast Health Group (SHG) in La Junta. Experience working in many areas of healthcare such as long-term care, acute care, emergency care and community health has led her to enjoy her current work in heading a team of Health Navigators and Lifestyle Coaches who work in the community to help members better understand how to utilize the healthcare system to become healthier people. She has a passion for finding alternative ways to engage people in understanding the importance of their healthcare. With this, she completed a Master's degree in Health Communication from the University of Illinois in 2014 and continues to utilize the skills acquired from that program daily. One of the accomplishments Anne has been proud of was being fortunate to take part in the development of the Health Navigation program and curriculum at Otero Junior College in La Junta as an adjunct instructor in 2012. This program is one of the first to be offered in Colorado. It has been very enjoyable to continue to be involved as the Advisory Committee Chair and be able to see how it continues to thrive and evolve to serve more interested students.

Website: http://www.southeasthealthgroup.org/home

Danielle M. Varda, PhD, **Director of the Center on Network Science, University of Colorado Denver**

Dr. Varda is a published researcher, entrepreneur, and teacher – working to translate network science to questions of how to build, manage, and evaluate effective community partnerships. She and her team strive to build tools and resources that can help to build capacity of people and whole communities to strengthen their collaborative endeavors to solve our most pressing social and economic issues, focusing specifically on measures of social connectedness and social support. She is the author of the PARTNER (www.partnertool.net) tool and the Patient-Centered Network App – two tools that help to make visible the complex web of social networks that we are all embedded in, as a way to identify gaps, leverage strengths, and develop strategies to strengthen them.

Contact Info: danielle.varda@ucdenver.edu
Website: www.center-networkscience.net
www.networkleader.org