



## AAAs & Hospitals: Partnerships Toward Common Goals Population Health & Individual Patient Health



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*Part of the Aging and Disability Business Institute Series- a collaboration  
of n4a and ASA*



## The “Business Institute”

The mission of the Aging and Disability Business Institute (Business Institute) is to successfully build and strengthen partnerships between community-based organizations (CBOs) and the health care system so older adults and people with disabilities will have access to services and supports that will enable them to live with dignity and independence in their homes and communities as long as possible.

[www.n4a.org/businessinstitute](http://www.n4a.org/businessinstitute)



## Partners and Funders

### Partners:

- National Association of Area Agencies on Aging
- Independent Living Research Utilization/National Center for Aging and Disability
- American Society on Aging
- Partners in Care Foundation
- Elder Services of the Merrimack Valley/Healthy Living Center of Excellence

### Funders:

- Administration for Community Living
- The John A. Hartford Foundation
- The SCAN Foundation
- The Gary and Mary West Foundation
- The Colorado Health Foundation
- The Marin Community Foundation



# AAAs & Hospitals

## Partnerships Toward Common goals

### Simultaneous development on 2 levels...

#### Level 1: Population Health

Discussion: Healthy Berrien Consortium, survey techniques, data-sharing, examples of community initiatives

#### Level 2: Individual Patient Health

Discussion: MIChoice Medicaid waiver, Interagency Care Team



## Healthy Berrien Consortium

est. 1998

**Vision:** To improve the overall health of Berrien County

**Mission:** To work in collaboration with community health organizations to help facilitate improvements in health and wellness of our community

**Purpose:** The Healthy Berrien Consortium has adopted a conscious strategy of pursuing collaboration and integration to continuously improve the health and wellness of the entire community.

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#### Membership

|                                 |                                           |
|---------------------------------|-------------------------------------------|
| Region IV Area Agency on Aging  | InterCare Community Health Network [FQHC] |
| Lakeland Health [hospital]      | Dept. Health & Human Services             |
| Cty Health Department           | Riverwood Mental Health Authority         |
| Cty Medical Society             | United Way                                |
| PACE of Southwest Michigan      | Regional Planning Commission              |
| Cassopolis Family Clinic [FQHC] | Assorted Community Leaders                |
| Hospice At Home                 |                                           |



## Healthy Berrien Consortium

**Characteristics:** data-driven, formal/not legal entity, no cost, CEO membership/buy-in, consensus of priorities, no direct program implementation

### Local Impact/products:

|                                     |                                   |
|-------------------------------------|-----------------------------------|
| Behavioral Risk Surveys             | Smoke Free Berrien campaign       |
| Topical local forums                | PACE of Southwest Michigan formed |
| Established Berrien Health Plan     | Be Healthy Berrien formed         |
| Infant Mortality Reduction campaign | Interagency Care Team formed      |
| Falls Prevention campaign           | Focus on Population Health        |



## Population Health @ Lakeland Health: The Community Health Needs Assessment

**What is a Community Health Needs Assessment (CHNA)?** An appraisal of the health status of a community, and is required of tax-exempt hospitals under the 2010 Patient Protection and Affordable Care Act.

### Purpose:

- To generate information needed to inform Lakeland's ability to effectively meet the health needs of the community it serves.
- To facilitate alignment of the activities among area health care providers and other stakeholders who are responsible for supporting, promoting, and enhancing population health.

### Key elements:

- Must assess needs of "...medically underserved, low-income, or minority populations..."
- Need is defined broadly to include, not only medical/clinical health determinants, but also the *social determinants of health*.



# Population Health

## The Partnership: CHNA Data Collection

**Execution of the CHNA was guided by commitments to the following principles:**

- Inclusive input
- Community voice
- Transparency
- Authentic collaboration
- Social determinants of community health
- Health equity



# Population Health

## The Partnership: CHNA Data Collection

**Who:**

- Community-based organizations/private non-profits (AAA)
- Government (i.e, local, regional and state)
- Business (i.e., small and corporate)
- Health care providers (i.e., Berrien County Health Department, HQFC)
- Public safety
- Faith-based organizations
- Media
- Education (i.e., K-12, higher education)
- Recreation
- Support groups



# Population Health

## The Partnership: CHNA Data Collection

### What:

- Focus Groups (55)
- Key Informant Interviews (56)
- Surveys (742)
- Photovoice (110)

***Total ~ 1300 people throughout the community***



# Population Health

## The Partnership: CHNA Data Collection

### What:

1. *What are the biggest health issues in your community?*
2. *What in your community makes it hard to be healthy?*
3. What are some good things in your community that help you be healthy?
4. In an ideal world, what would a healthy community look like? What would it have? How would it feel?
5. What are your ideas on how to improve health in your community?



# Population Health

## The Partnership: CHNA Data Collection

- Berrien County (Berrien) compares unfavorably to the state and the nation.
- Berrien has census tracts with death rates that are more than twice the county average.
- Berrien has census tracts with death rates that are more than 2.5 times the national average.
- All the census tracts even in the 3rd quartile are worse than the national and state averages



# Population Health

## The Partnership: CHNA Data Collection

### PRIORITY HEALTH NEEDS: HEALTH CONDITIONS



# Population Health

## The Partnership: CHNA Data Collection

### Provider Availability

- “Not enough doctors. I have to use the E.R. for health care.” (Focus Group, Salvation Army Niles)
- “We need better mental health treatment and more psychiatric practitioners.” (Survey Respondent)

### Cost of Care

- “Too many people do not seek treatment because they can’t afford the cost.” (Survey Respondent)
- “Healthy is the new expensive.” (Student, Niles New Tech)

### Health Education and Information

- “It is hard to be healthy in our community because people don’t fully understand what it means to be mentally, physically, emotionally and financially healthy.” (Survey Respondent)
- “People are fearful or too intimidated to ask questions because they don’t think they have enough education to discuss their condition or even know what questions to ask.” (Focus Group, Benton Harbor)



# Population Health

## The Partnership: CHNA Data Collection

### Food Environment

- “There are 16 fast-food restaurants on 11th Street called ‘Fast Food Alley or Temptation Road’ by many young adults.” (Student, Niles New Tech Center)
- “The food that isn’t good for us is cheap whereas healthy food is way expensive.” (Survey Respondent)
- “In rural areas, its difficult to find healthy food nearby. (Survey Respondent)

### Health Behaviors

- “...this person is smoking, trying to hide the cigarette... people are isolated from others [when they] smoke.” (Student, Niles New Tech Center)
- “If healthier [affordable] appealing options were available in the same al a carte form of snack foods, perhaps healthier eating habits would be established.” (Student, Berrien Springs High School.)





## Other Population Health Initiatives

### **Be Healthy Berrien** - [www.behealthyberrien.org](http://www.behealthyberrien.org)

A collective impact model working to reduce and prevent obesity in Berrien County through policy, systems, and environmental changes

### **Livable Communities** – [www.drivegreatness.com](http://www.drivegreatness.com)

Imbedded as a Quality of Life initiative in a larger effort, a campaign to raise awareness of livability indicators that promote active, interdependent lifestyles

### **Blue Zones** – [www.bluezones.com](http://www.bluezones.com)

Initiation of community wide discussion regarding local manifestations of key Blue Zone concepts



## Individual Patient Health

### **Example 1: MIChoice Waiver**

Background: Region IV AAA is a PAHP [Prepaid Ambulatory Health Program] serving adults 18 and older under Michigan's Medicaid HCBS waiver program in the southwest Michigan counties of Berrien, Cass and VanBuren.

Lakeland Health is the dominant hospital in the region and the sole system located in Berrien County, the region's most populous area. Root cause of hospital admissions has pointed to social determinants of care.

Social determinants and stabilization of daily living in the home comprises AAA's core competency.



## Individual Patient Health

### Example 1: MIChoice Waiver

#### Linkages

- AAA has access to Lakeland EHRs for all AAA MIChoice clients, enhancing collaboration to assure care plan monitoring and adjustment as needed
- AAA is listed in individual patient files as a member of Lakeland's care team for all MIChoice clientele in case of Emergency Dept or hospital admission
- AAA and hospital CM staff share/utilize direct dial connectivity
- Discussions are underway to expand PCP/MIChoice connections to create PACE-like comprehensiveness



## Individual Patient Health

### Example 2: Interagency Care Team [ICT]

Background: Through Healthy Berrien Consortium, a Community Roadmap was developed which created consensus understanding that multiple entities provide critical services to the same person without recognizing the interdependence of their efforts. A model for meaningful exchange when a high risk person is served by multiple agencies was lacking.

#### ICT Purpose

**Goal #1:** Improve health outcomes and reduce costs;

**Goal #2:** Facilitate access to services, community resources and other supports to reduce barriers

*\*\* Multi-year demonstration funded by private and community foundations with goal of fund source sustainability and scalability by the end of 2017*



## Individual Patient Health

### Example 2: Interagency Care Team [ICT]

Project basics:

- Selection Committee identifies ICT potential patients based on set criteria including hospital history, co-morbidities and likelihood of ICT impact
- Working w/ case management staff and PCPs from different entities serving the same individuals to achieve better outcomes
- Creation of ICT to link medical & HCBS providers; capability to shift lead across agencies; HIPAA communication tool



## Individual Patient Health

### Example 2: Interagency Care Team [ICT]

Who: AAA, FQHC, Hospital, Health Dept.  
Designed to expand to other entities on Community Roadmap

Why: AAA – transitions coaching; linkage to HCBS; ongoing Care Management  
FQHC – PCP; care coordination  
Hospital – Identification of all initial patients; coordination w/ hospitalists, other physician groups  
Health Dept. – outcome analysis; data tracking



## Individual Patient Health

### Example 2: Interagency Care Team [ICT]

#### Value Expectations

- Reduction of ED use & hospitalizations; cost reductions
- Better health outcomes for targeted high risk patients
- Less duplication & fragmentation of effort
- Creation of payment model for scalability/replication
- Consumer education/empowerment



## Individual Patient Health

### Example 2: Interagency Care Team [ICT]

#### Evaluation Design

**Berrien County Health Department** - oversight & management

#### **Evaluation Components**

- 1) Patient Surveys – pre and post (every 6 mo.)
- 2) Systemic Changes
  - a) Process changes within ICT member agencies
  - b) Common patient education tools: CHF, Diabetes, COPD
- 3) Patient Outcomes
  - a) specific health markers
  - b) evidence of self-management/elimination of barriers/stabilization
- 4) Cost Reduction



## Questions & Answers: Please Submit Using the “Questions” Box



## Please join us for future webinars in the Aging and Disability Business Institute Series

**Leadership and Change Management for Community-Based  
Organizations – Nov. 16**

**Is My Organization Ready? Assessing CBO Capacity to  
Partner with Health Care Entities – Dec. 13**

**Learn more and pre-register here:**

<http://www.asaging.org/series/109/aging-and-disability-business-institute-series>



# Questions about the Aging and Disability Business Institute?

Email us:

**[BusinessInstitute@n4a.org](mailto:BusinessInstitute@n4a.org)**

