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Linking Health Across the Systems

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INTRODUCTION

Healthcare Crisis: Prevention vs. Treatment

• An individual’s health status is determined by social determinants including:
  – 50% lifestyle choices and available options and only 10% by access to health care
  – Americans’ health dollars are spent: 48% on access to care and treatment and only 4% on lifestyle choices and options
• In 2012, the Massachusetts Legislature acted on this mismatch by passing Chapter 224 and led to the creation of the Prevention & Wellness Trust Fund (PWTF)

OBJECTIVES

In 2014, the Worcester Division of Public Health (MDPH) received a PWTF grant from the Massachusetts Department of Public Health (MDPH), to improve care in regards to: senior falls, pediatric asthma and hypertension (HTN) in 26 census tracts of City of Worcester

Primary Objective:
The aim of Worcester PWTF project is to improve health outcomes by linking clinically prescribed activities to the home and community based resources through the engagement of Community Health Workers (CHWs).

METHODS

• This is a mixed method study using EMR data from clinical partners, clinic level intervention based data from community based services providers groups.
  • The clinical based EMR measures include: blood pressure control; asthma action plans; appropriate medications; screening seniors for risk of falls.
  • The community based intervention includes the number of home assessments for falls and asthma; number of participants completing chronic disease self-management programs; number of missed school days.
• The reported data from October 2014 to December 2015, the first year of chronic disease self-management programs; number of missed school days.
• Focus on portion of city (105,742 residents).

RESULTS

• Implementation is active at: Asthma (n=9), HTN (n=4), Falls (n=5) sites
  • Community Health Workers (N=23) serving as home and community based resources
  • Asthma template is live and conducted by all sites; completed 181 home assessments
  • Completed falls assessment tool; completed 89 home visits
• Provided Chronic Disease Self-Management program (CDSMP) and Self-Management of Blood Pressure (SBMP) for around 203 uncontrolled hypertensive patients

Figure 1. Worcester PWTF Partners

|-------------------------|---------------|--------------------------|-------------------------------|----------------------------|---------------------------|---------------------|----------------------|--------------------------------|----------------|-------------------|---------------------------------------------|

DISCUSSION

• In the first year, Worcester PWTF has shown improvement in screening patients for these three disease conditions.
• Community-based groups have shown improvement in services provided to high-risk individuals.

LESSONS LEARNED

• Learning opportunities with other eight partnerships
  – Building infrastructure to address health inequities in the community
  – Developing evaluation and reporting tools for community and clinical groups
  – Potential to connect and use e-referral as a standard tool

Challenges:
• Communication across different systems
  – Evaluation and ROI — short period to demonstrate health improvement
  – Information needed to support this work is just being developed now (assessments, systems, databases)
• Data systems in use are siloed and it is expensive and difficult to connect

IMPLICATIONS FOR POLICY AND PRACTICE

CONCLUSIONS

Our vision is to extend care into the community through:
• CMW as new care team members
  – Clinical and Community Links
  – Bi-directional information to track patient progress
  – Expanding to other health conditions to help bend the cost curve

These lessons can inform the next generation of payment system reform initiatives and change health culture to impact population health.