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2016-06-27

Linking Health Across the Systems

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Repository Citation
Cherala S, Kennedy T. (2016). Linking Health Across the Systems. Commonwealth Medicine Publications. https://doi.org/10.13028/nqb3-0h61. Retrieved from https://escholarship.umassmed.edu/commed_pubs/170

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Linking Health across the Systems:
Worcester Prevention Wellness Trust Fund

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PREVENTION & WELLNESS TRUST FUND | WORCESTER PARTNERSHIP

Public Health Prevent. Promote. Protect.

INTRODUCTION

Healthcare Crisis: Prevention vs. Treatment

- An individual's heath 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:
  - 88% 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 (WDPH) 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, client 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 the project were analyzed.
- Focus on portion of city (105,742 residents).

DISCLOSURES & ACKNOWLEDGMENTS

The authors have no financial disclosures. Special thanks to all partners on Worcester PWTF Partnership.

RESULTS

- Implementation is active at: Asthma (n=9), HTN (n=4), Falls (n=5) sites
- Community Health Workers (N=23) serving as clinical-community linkage
- 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 (SMBP) for around 203 uncontrolled hypertensive patients

Figure 1. Worcester PWTF Partners

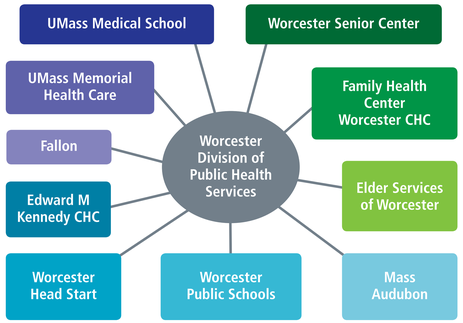

Table 1. Percent of Patients Seen From Total Population of Interest (June-December 2015)

Condition	Baseline
Pediatric Asthma	50.3%
Hypertension	71.4%
Senior Falls	15.2%

Figure 2. PWTF Intervention Activities

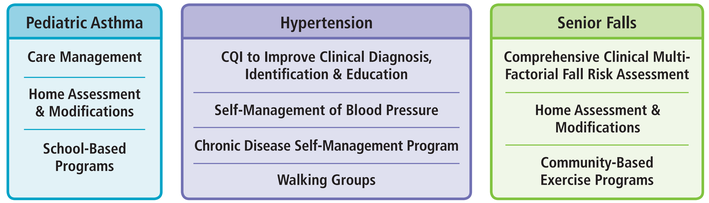

Figure 3. Comparison of Clinical Data across Worcester and Other PWTF sites

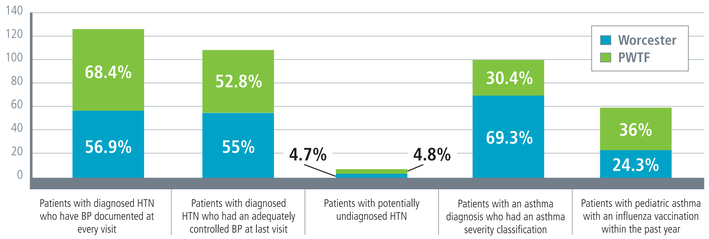

Table 2. Comparison of Community Data across Worcester and Other PWTF sites

Enrollees and Referrals	Worcester	PWTF
PWTF referrals who enrolled in asthma Home Assessment program	100%	36%
Enrolled PWTF referrals who completed the asthma Home Assessment program	80%	32.9%
PWTF referrals who enrolled in CDSMP program for HTN	50.6%	42.4%
PWTF referrals who enrolled in SMBP program for HTN	42.1%	56.9%
PWTF referrals who completed the CDSMP program for HTN	22.7%	52.3%
Enrolled PWTF referrals who completed the SMBP program	50%	27.4%
PWTF referrals who enrolled in the exercise program for senior falls	15.4%	43.4%
PWTF referrals who enrolled in the Home Visit for senior falls	80%	52.2%
Enrolled PWTF referrals who completed the exercise program for senior falls	100%	53.8%
Enrolled PWTF referrals who completed the Home Visit for senior falls	100%	56.7%

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

Importance of:

- Engaged leadership
- Stakeholder involvement and buy-in from community
- Organizational capacity in critical infrastructure elements for clinical and community systems
- Coordination of efforts both within the initiative and across other initiatives

Opportunites

- 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

- Communications across different systems
- Evaluation and ROI – short period to demonstrate health improvement
- Infrastructure 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

CONCLUSIONS

Our vision is to extend care into the community through:

- CHW as new care team members
- Clinical and Community Linkages
- Bi-directional information to track patient progress
- Expanding to other health conditions to help bend the cost curve

IMPLICATIONS FOR POLICY AND PRACTICE

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

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