Creating Alliances for a Healthy Community

A look at how one collaborative project is providing healthcare to uninsured populations.

Public Health Solutions' Population Overview

- Local Health Department covering Saline, Gage, Jefferson, Thayer, and Fillmore counties.
- The LHD serves roughly 58,000 people.
- Similar to other rural areas in the state:
  - Losing population, getting older, losing market share and workforce to urban area, overall poverty levels higher than state average, and lower educational attainment levels (particularly in Jefferson and Saline Counties.)
  - Rapidly increasing minority population in Saline county.

Public Health Solutions' Population Overview

- Saline county is about 23% Hispanic, with a large portion of Guatemalan Native populations.
  - Average Hispanic rate in Nebraska is 9.15%; the national average is 16.35%
- Health disparities, especially for uninsured immigrant and local population.
  - Less likely to be able to access health care
  - Less likely to have a medical home or use preventive services (screenings for cancer, metabolic and cardiovascular disease)
  - Less likely to follow recommended nutritional and physical activity guidelines.
  - Lack of transportation to the closest FQHC (Bluestem Health) is a significant barrier to care.

Public Health Solutions' District Statistics

Health Indicators	Nebraska	Fillmore	Gage	Jefferson	Saline	Thayer
Diabetes Prevalence	9%	10%	11%	12%	9%	10%
Adult Obesity	30%	33%	34%	36%	33%	30%
Physical Inactivity	22%	26%	27%	28%	31%	27%
Access to Exercise Opportunities	80%	49%	52%	32%	54%	34%
Uninsured	11%	10%	9%	11%	14%	10%
Poor or fair health	13%	12%	12%	13%	14%	12%
PCP Ratio	1,330:1	1,130:1	1,350:1	1,470:1	1,780:1	1,310:1
Mental Health Provider Ratio	440:1	940:1	730:1	2,420:1	1,790:1	2,580:1
Health Factors Ranking (out of 93)		28	67	54	51	31

A Shared Vision

- A local champion shared our desire to break down barriers to care
- Met several times to devise a plan and structure
- Champion recruited other stakeholders
- Shared responsibility

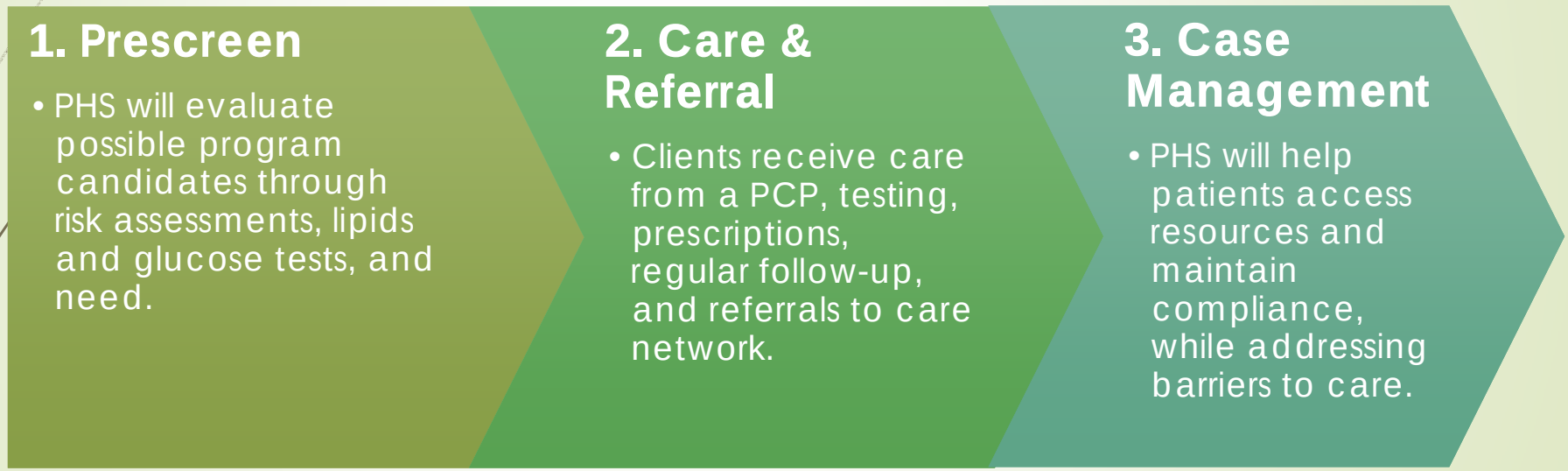
A Shared Vision

- **“Healthy Community Alliance”**
- **Goal**: Provide healthcare services for uninsured/underinsured community members with chronic illness in an effort to decrease barriers to care, promote the use of primary and preventive care, and maintain a healthier community.

What is the “Healthy Community Alliance”?

- Partnership to provide a medical home for those who do not have access to care.
- Criteria to be considered a patient:
  - Adults only
  - Uninsured or underinsured: Medicare part A only
  - Income at or below 138% of Federal Poverty Level
  - Does not have a PCP
  - Chronic conditions

Model of Care & Network



Model of Care & Network

- Clients can be referred by medical offices and through PHS screenings events.
  - Screenings test for lipids, glucose, A1Cs, BMI, health risks, barriers to care, and need.
  - PHS chooses patients based on criteria and availability of resources
- Clients know their rights and responsibilities
- Clients receive care, lab tests, prescriptions, and regular follow-up
- Clients receive case management in order to access resources and maintain compliance

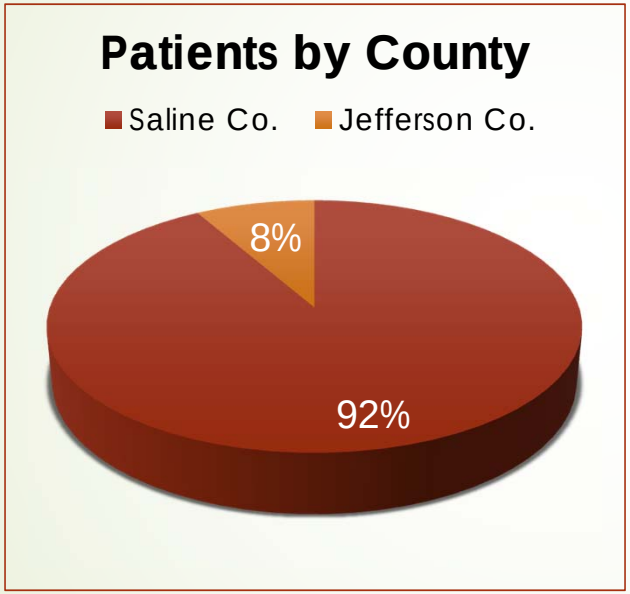
Model of Care & Network

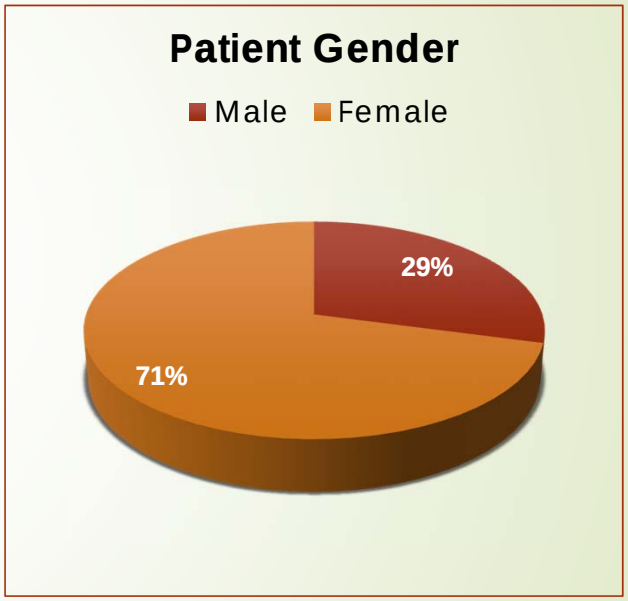
- Current participants in referral network include:
  - Bessler Eye Care (Saline)
  - Diabetic Educator (Jefferson, Gage, Saline)
  - Bluestem (FQHC in Lincoln)
  - Saline Medical Specialties (Saline)
  - Crete Physical Therapy (Saline)
  - Nebraska Health Imaging (Omaha)

Goals

- **Goals:**
  - Reduce hemoglobin A1c results in diabetic patients
  - Bring hypertensive patients under control
  - Improve cholesterol levels
  - Improved depression scores
  - Avoid emergency room visits for chronic illness

Patient Demographics





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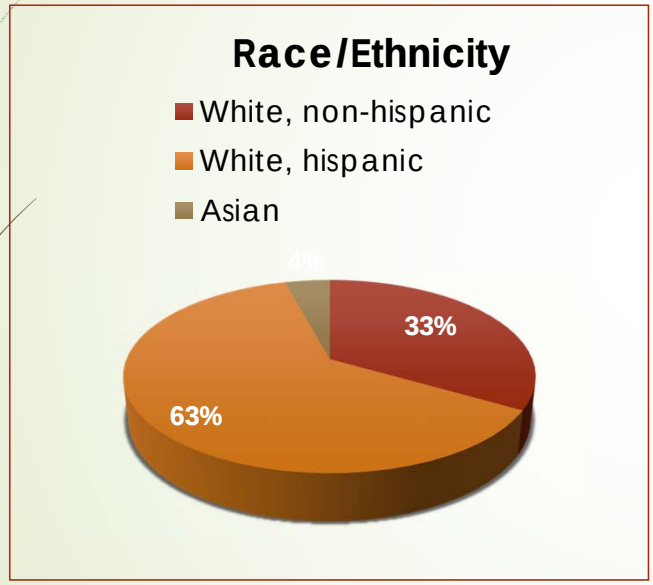
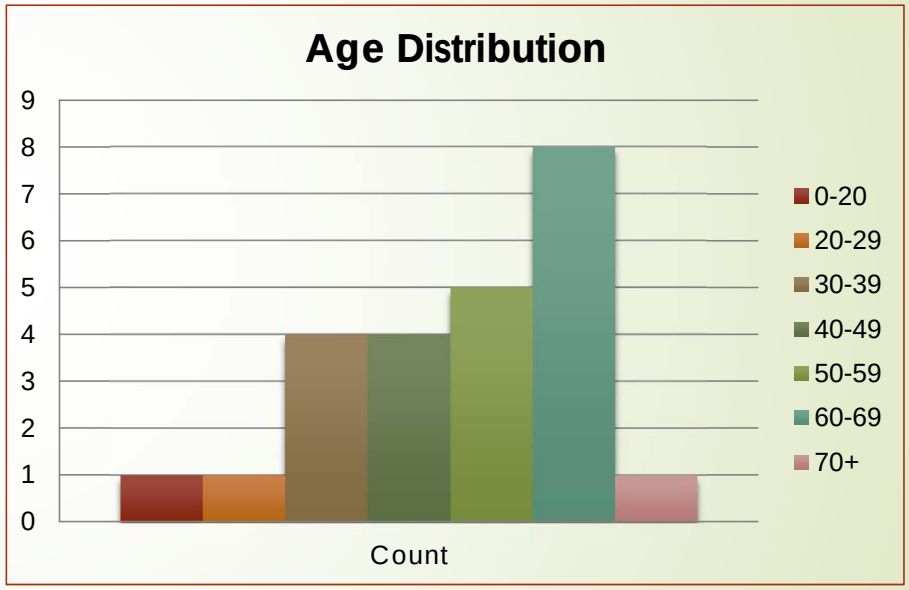
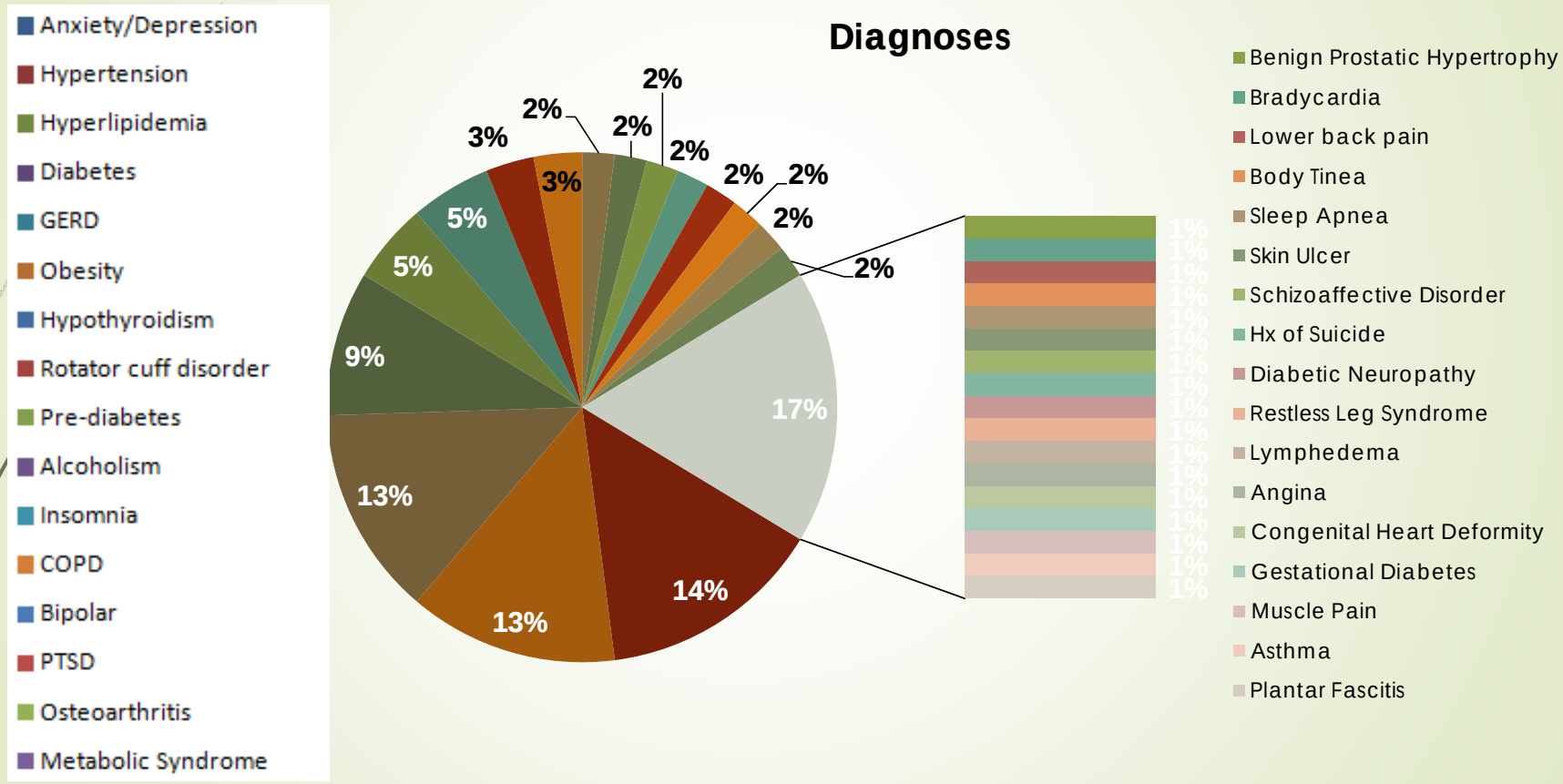




Patient Diagnoses



Results and Lessons Learned

- Hypertensive patients: 80% showed improvement
- Diabetic patients: 50% reduced A1c levels and 13% showed no improvement but remained under control (63% total)
- Depression- not enough data at this point
- Cholesterol- not enough data at this point
- Only two patients under our care have visited the ER:
  - Dental abscess and accident

Results and Lessons Learned

- Having a champion creates a snowball effect
  - Able to work with non-traditional partners
  - Leverage for more funding (private donations, presentations to local groups, foundations, in-kind donations)
  - Possibility of new partnerships not available before
- Necessary improvements:
  - Better promotion of our success

Success Stories: Patient A

- Patient A is grandmother taking care of her three grandkids
- She came to our clinic without insurance and chronic illness that was not well controlled.
- With our help, she has made several improvements in her lifestyle that have controlled her nerve pain and improved her overall health.

Success Stories: Patient B

- Patient B is a mother of two with uncontrolled high blood pressure.
- After participating in our program, her blood pressure is well controlled and her risk of heart attack reduced,
- She can enjoy a more fulfilling life now that she has less headaches that prevented her from participating in activities with her children

Success Stories: Patient C

- Patient is a newer patient.
- She is uninsured and had a high A1C level.
- She has been able to decrease her levels by almost half, making her a healthier person at a decreased risk of a multitude of illnesses caused by diabetes.

Activity

- What is one project and/or goal your community needs?
- List at least three possible community champions that would address this community project/need
- What resources can this community champion connect you to in order to help your population and/or program? List ones that you would not have access to without their help.
- What is something you can provide for your possible community champion that will get them on board?

Q & A