VITAL2023
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CALL FOR ABSTRACTS SAMPLE SUBMISSIONS, BY TRACK

SAMPLE SUBMISSION #1

Submission Title: Utilizing Mobile Units to Meet Health and Social Needs of the Community

Track: Improving Social and Environmental Determinants of Health (formally Improving Population Health)

Key Takeaways

1. Identify novel ways for health systems to use mobile units to meet health and social needs of underserved communities
2. Provide key tools, such as site checklists, to enable successful community partnerships to deliver mobile care
3. Describe the evolving evidence-based landscape of delivering care in non-traditional community settings

Abstract | 300 word maximum (50-word minimum)
Research demonstrates that Social Determinants of Health (SDOH) not only impact health outcomes but also place limitations on access to healthcare services. The MetroHealth System has closed access gaps and improved health care outcomes for their patients by taking health services into the community where their patients live, work, and play. As the county hospital system and an essential healthcare system providing care to all community members regardless of ability to pay, MetroHealth has capitalized on population health and community assessment data to guide mobile unit deployment and meet both health and social needs of the community.

The System's mobile units are deployed with a focus on health equity to meet the needs of the county's most vulnerable populations. Mobile units are used to connect individuals with financial counseling to enroll in insurance/Medicaid/Medicare. The School Health Program's mobile units provide access to health care at schools and have improved both health and education outcomes, including increased attendance and decreased emergency department utilization. During COVID, MetroHealth expanded its reach with mobile units to serve the local homeless Continuum of Care by providing COVID19 testing and vaccinations. The System's Office of Opioid Safety serves the community by having mobile needle exchange programs, Narcan distribution, and COVID resources. This fall, under the System's public entity FQHC Look-Alike, primary care services will be provided to patients in partnership with community organizations including homeless shelters, social service organizations, and city recreation centers. This transition to FQHC-Look-Alike will assist with program sustainability.

This session will include a brief overview of the different MetroHealth programs that provide care via a mobile clinic; discuss successes and challenges in using mobile units as a model of care; and provide data on the health and social outcomes of their programs.

SAMPLE SUBMISSION #2

Submission Title: One Health

Track: Innovations in Health Care

Key Takeaways

1. The learner will have examples of data analysis methodology for identifying medically and socially complex super utilizers at their institutions
2. The learner will understand the value of using similar evaluation and management tools used by the social service agencies for measuring baseline and improvements in domains outside of healthcare
3. The learner will be given examples of process improvement opportunities inside and outside of the health system

Abstract | 300 word maximum (50-word minimum)
One Health was designed as a population health strategy to reduce the human and financial burdens of serving our uninsured super utilizers of healthcare. Super utilizers are defined as persons who have 10+ ED visits and/or 4+ inpatient admissions. We serve as both payer and provider which creates an opportunity to design a system based on value not volume. Super utilizers are often both medically and socially complex and are among our most vulnerable patients.

We partnered with the Camden Coalition to build a complex care program for our most vulnerable. Program planning included data analysis, community asset mapping, and co-design of clinical and community solutions.

The program is built on forming authentic healing relationships with the patient. A root cause analysis is performed, a face to face meeting occurs, the Arizona Self Sufficiency matrix is administered, and a care plan is initiated with the patient to address what matters most from the patient's point of view. Interventions occur in 14 domains, many outside of health care, and our community partners play a pivotal role in addressing the whole person. Most participants are active in the program for 90-180 days but are also followed post-graduation.

- Outcomes (7-month intervention data) 96 people enrolled
- 77.6% reduction in costs equaling $1,721,311 costs avoided
- 44% reduction in emergency department visits, 151 visits avoided 85% reduction in inpatient admissions, 72 admissions avoided 92% reduction in inpatient days, 747 days avoided
- $175,430 collected from payers equals net revenue improvement 14 enrolled with a payer
- 15 homeless enrollees now have permanent housing, additional 15 enrollees have been prequalified for homes
- 9 enrollees have been referred for job placement; 2 have full-time jobs

Based on interim outcomes, a strategic plan for taking the program to scale all payers is in progress.

SAMPLE SUBMISSION #3

Submission Title: The Institutional Path to Health Equity

Track: Executive Leadership Lessons

Key Takeaways

1. This session will chronicle the first 120 days of an inaugural Chief Health Equity Officer. It will provide an in depth look at vision and strategy planning that is key to the success of setting up a new office
2. Explores how to identify and collect data on health equity. Data is available in many places and this session will provide an exploration and pathway to how to identify and collect the data. In addition, to ensure data integrity is in place.
3. Once the data integrity' is ensured, data is available, now there is a need to analyze and present the data. Presentation of data based off the strategic plan for the system. Aligning data with the institutional strategy is key.

Abstract | 300 word maximum (50-word minimum)
Chief health equity officer is a new position for many health systems aiming to eradicate health inequities and mitigate disparities in care delivery. This role is a great addition to many C-suites but requires thoughtful preparation to implement. This session will chronicle the steps for setting up a new health equity office to:

- expand the value proposition of health equity to an organization's vision, mission, culture, and strategy;
- demonstrate a significant and quantifiable impact on patient care and clinical outcomes; and
- enable operational and fiscal sustainability.

Additionally, this session will offer practical and tactical insights into establishing an advisory council, integrating data from various sources, developing a strategic plan, and disseminating key messaging from the health equity office.

SAMPLE SUBMISSION #4

Submission Title: Leveraging Medicaid Financing to Transform Population Health

Track: Policy and Finance

Key Takeaways

1. Stronger, together coalitions are the critical infrastructure for working in complex, multistakeholder population health transformation efforts. Coalitions grow through wins - a yes strategy identifies pathways to gain institutional and political support, and regulatory approval.
2. Find your champions - Policy champions build, sustain the coalition while executive champions are necessary to maintain organization focus and priorities.
3. Accomplishing the coalitions purpose requires successful implementation - designing incentives that align quality improvement strategies, internally and externally, builds clinical focus and guides implementation. CMS and Departments of Medicaid/Health and Human Services are amenable to such initiatives and strong coalitions and implementation plans show you're serious and transforming how care is delivered.

Abstract | 300 word maximum (50-word minimum)
Safety net health systems are positioned to improve their financial positions and usher in a new era of healthcare delivery if they are willing to work in coalition, adopt the health transformation strategy of state policymakers, and collectively implement clinical change.

Many safety-net health systems desire to be a part of their states health transformation efforts by systematically changing the way health care is delivered because they recognize the positive impact on high-risk, high-needs patients. Safety-net health systems are also well positioned to lead healthcare transformation because of their focus on outpatient care and the strength of their community programs, and many run Medicaid ACOs or MCOs and county public health functions. Unfortunately, these systems aren't positioned to make the necessary investments. Inadequate revenue and fragmented and siloed quality improvement efforts block efforts for systematic change, resulting in uncoordinated and higher-cost care. Supplemental professional payment programs, a unique arm of Medicaid financing, offer opportunities for safety-net health systems to overcome these challenges and change healthcare delivery in ways that improve population health.

This session will share the story of how four, Ohio-based safety-net health systems came to form a coalition, focused on transforming health in Ohio through delivery-system changes in exchange for the opportunity to gain Medicaid supplemental payments. The session will include critical insights into the Coalitions political and clinical implementation strategy, the commitments made to improve care for those at risk of or living with opioid or other substance abuse disorders, as well as a review of the value-based payment arrangement, leveraged by the Medicaid supplemental payment opportunity.

By sharing the Ohio Coalitions story, insights, and lessons learned, the session will help spur creative thinking and approaches to aligning revenue-maximization strategies with the public policy goals of states. The alignment allows states and safety-net health systems to win.