CIVITAS
Networks for Health

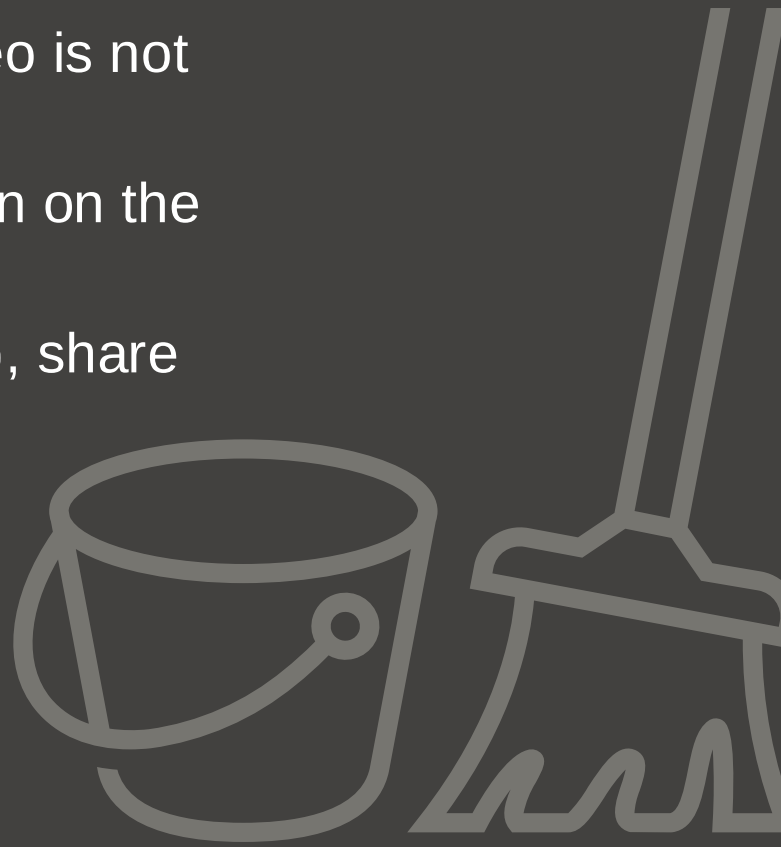
Collaboratives in Action

Bridging Health Care and Community

April 10, 2025

Housekeeping Items

- This is a Zoom webinar.
- All webinar participants are automatically muted, and your video is not displayed.
- If you would like to ask a question, please use the Q&A function on the taskbar.
- Use the chat feature to introduce yourself (name, org, location), share resources, etc.
- We will share slides and the recording after today's event.
- For questions following the webinar, reach out to contact@civitasforhealth.org.



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Agenda

- **Civitas Welcome**
  - **Lisa Bari**, *CEO*
  - **Jolie Ritzo**, *VP of Strategy and Network Engagement*
- **Civitas Introduction and Annual Conference Update**
- **Member Spotlight Presentations:**
  - **Dan Cranshaw,** *Executive Director, KC Health Collaborative*
  - **Jennifer Lundblad**, *President, Stratis Health*
  - **Kathy Miller**, *COO, Bronx RHIO*
- **Q&A**

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Civitas Introduction & Annual Conference Updates

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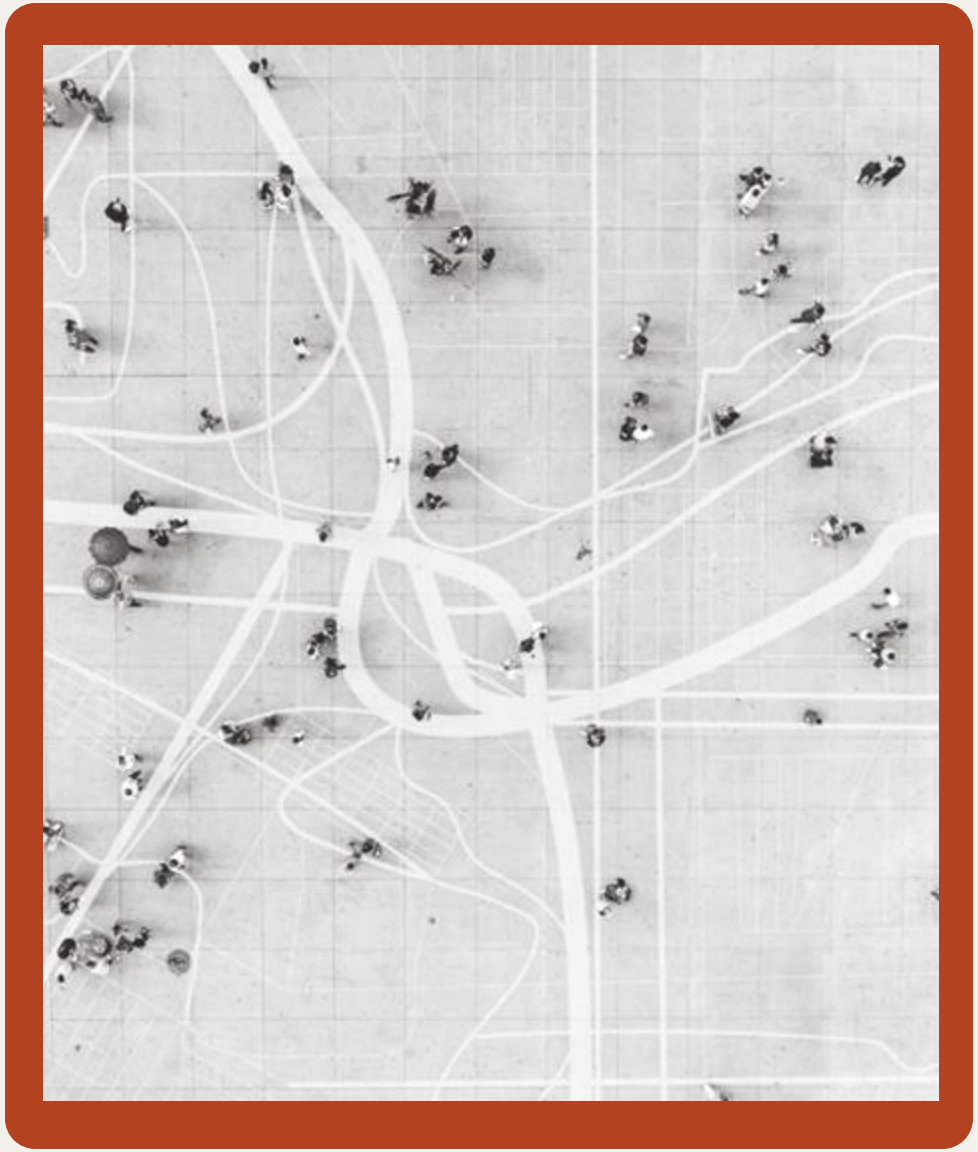

Regional innovation, national impact.

Our vision: Communities across the country are thriving and healthy, realizing the full potential of data-driven, multi-stakeholder, and cross-sector approaches to health information exchange and health improvement.

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Civitas is the Bridge Between...

DATA

DOING

CIVITAS
Networks for Health

Save the Date for the Civitas 2025 Annual Conference – *Bridging Data and Doing*

The Civitas Networks for Health 2025 Annual Conference – *hosted in Partnership with 211 San Diego/CIE and Civitas' California Members* – will take place in Anaheim, CA from September 28-30, 2025. **We are expecting 800+ attendees this year and look forward to seeing you all in Southern California.** Registration will open in early May.

Be sure to browse our Sponsorship Prospectus if your organization is interested in sponsoring the conference. ***Questions?*** Reach out to Kate Kroell (kkroell@civitasforhealth.org) to discuss opportunities.

Thank you to our returning platinum sponsor, InterSystems!

InterSystems®
Creative data technology

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Bridging Health Care and Community

Presentations and Insights from Civitas Members KC Health Collaborative, Stratis Health, and Bronx RHIO

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A Hub for Community Care

Collaboratives in Action
Civitas Networks for Health
April 10, 2025

10 YEARS KC HEALTH COLLABORATIVE

“Optimism is its own form of resistance.”

Nikki Giovanni

Who?

The KC Health Collaborative (KCHC) is a multi-sector regional health improvement organization.

Our focus is on addressing health care issues that no one member can achieve on their own.

Put simply, KCHC represents *collective action* directed at:

- Better care
- Healthier people
- Smarter spending

A Collective Force for a Healthier Kansas City

Multisector Membership

Purchasers	IBEW Local 124, JE Dunn
Providers	KC CARE Health Center, Kansas City Medical Society, HealthTeamWorks
Hospitals & Health Systems	Children's Mercy Hospital, The University of KS Health System, North Kansas City Hospital, KC Metropolitan Healthcare Council
Health Plans	Blue KC
Community at Large	BioNexus KC, Clay County Public Health, First Call, Greater Kansas City Chamber of Commerce, Greater Kansas City Coalition to End Homelessness , Harvesters, Jewish Family Services, KC Digital Drive, Lewis and Clark Information Exchange (LACIE), MOHAKCA (Metropolitan Public Health Agencies), Mid-America Regional Council (MARC), Midwest Health Connection, QVIC, United Way of Greater Kansas City, Wyandotte Community Health Council

What?

KCHC creates a trusted common *Community Table* to promote collaboration among members and community partners in support of access to high-quality, affordable, and equitable health care for all.

"[To] become a national leader in bringing a broad and diverse set of stakeholders to a common table that improves the health and well-being of our communities. To accomplish this, we need coordinated action, aligned investment, and strong communication and advocacy for our most vulnerable populations and the agencies supporting them."

In the Beginning…

CDC Grant – SDOH Accelerator Plan

- In partnership with Kansas City, Missouri Health Department
- Members and community partners, including community-based organizations (CBOs) involved in drafting plan

Two Unifying Goals

- Robust closed-loop referral system that linked clinical providers to CBOs
  - Whole-person care
- Develop sustainable financial support for CBOs

“A Journey of 1,000 Miles…”

Step One

- Identify technology partner
- Criteria
  - Technologically nimble
  - Patient/Client-Focused
  - CBO-centered

Community CareLink

- Technology partner of record for many CBOs

Allowed development of hub to come from community rather than hospital systems

"…If You Want to Go Far, Go Together"

Step Two

- Identify community partner
- Criteria
  - Connected to community
  - Trusted

Urban Neighborhood Initiative

- Community development that serves residents in the urban core of Kansas City, Missouri. *"We believe in building communities with purpose on purpose."*
  - Mixed-income housing
  - **Connection to supportive services for families**
  - Steam-based educational services for community youth
  - Convener of community

UNI Service Map

“If at First You Don’t Succeed…”

Step Three

- Re-engage individual neighborhood leaders
- Seek understanding and share context
  - Undue reliance on UNI partnership
  - Unfair leveraging of trusted relationship

Lessons Learned

- Walk alongside partners, not behind
- Trust requires 1:1 relationship
- Every community is unique
- Moving at the speed of trust requires patience

Next Steps

Continue community needs assessments

- Ensures that community members are centered in the work

Engage CBOs

- With authorization from community

Engage Clinical Partners

- Final element of loop

Engage Data Partners

- Potential HIE engagement

Tackle technology

> “It does not matter how slowly you go as long as you do not stop.”

Strengthening Community Partnerships

Civitas Collaboratives in Action

April 10, 2025

Jennifer P. Lundblad, PhD, MBA

President & CEO

StratisHealth

We make lives better.

Stratis Health

Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety and serves as a trusted expert in facilitating improvement for people and communities.

We make lives better!

Community Partnerships: Why and how?

- Health care belatedly caught up with the understanding that community-driven factors significantly contribute to a person's health. (Duh!)
- In health improvement work, a community can be the "unit of action."
- Authentic community partnerships require diverse methods of engagement, such as implementation science, co-design, and Learning and Organizing in Action (LOA).

Stratis Health Strategies

Co-design system changes that connect health care and community organizations to improve health.	Advance a safe and compassionate health care environment for those receiving and those providing care.	Accelerate evidence-informed and culturally responsive care and services.

With these strategies, we prioritize improvement efforts that empower those who have been historically marginalized. In implementation, we work in ways that are inclusive, systems oriented, and centered on equity. Our work is broad and inclusive, while highlighting:

- People who are age 65 and older.
- People living in rural places.
- People experiencing substance use disorders.
- People experiencing health disparities.

Community Partnership Examples

- QIN-QIO Coordination of Care Communities
- Community-Based Palliative Care
- Co-Creating a Shared Approach to Social Needs Resource Referrals

Coordination of Care Through Community Coalitions

- **Why:** To improve the coordination of clinical decisions.
- **Who:** Ten collaboratives in Minnesota, comprising 28 clinics, 77 hospitals, 131 nursing homes, 65 pharmacists, 71 home health agencies, 21 assisted living facilities, and 35 community organizations and local government groups.
- **What:** Stratis Health convened these community partners, facilitated root cause analyses, offered mentorship to community leaders, provided data and analytical support, guided strategies for improvement, and assisted communities in measuring their impact.

Community-Based Palliative Care

- **Why:** To build capacity to deliver whole-person care for individuals with serious or advanced illnesses.
- **Who:** More than 50 communities in six states (and growing), each comprising health care, faith-based, and community partners.
- **What:** Stratis Health led three cohorts in Minnesota, through which we developed and refined a model and implementation processes. We are now replicating this effort through state-based partners, utilizing a train-the-trainer approach to localize resources and facilitate community engagement.

Co-Creating a Shared Approach to Social Needs Resource Referrals

- **Why:** To design a sustainable, shared solution for connecting people with needed and culturally responsive community resources.
- **Who:** A statewide initiative in Minnesota represented by a Guiding Council composed of 13 CBOs, eight health care organizations, and five payers, informed by intermediaries (EHR vendors, social needs e-referral platforms, HIEs, and resource directories).
- **What:** Stratis Health facilitated a discovery and engagement phase, a planning and design phase with broad engagement through workgroups, and a strategy endorsement process, and is now implementing five interrelated strategies.

Lessons Learned

Strengthening Community Partnerships

- Health care alone is not enough to achieve whole-person health.
- Community organizations possess expertise and established relationships with individuals seeking health and social care resources.
  - Creating trust and building relationships with community organizations is paramount to success and requires time and intentionality.
  - Meet community partners where they are and align other incentives and resources when possible, e.g., Medicaid waivers and investments from philanthropy, employers, and others.
- Actions and solutions must be comprehensive and integrated…and clinical medicine and technology are necessary, not sufficient.
- Utilize engagement methods that equitably distribute voice, power, and influence among all partners.

For More Information:

Jennifer P. Lundblad, PhD, MBA
President & CEO
jlundblad@stratishealth.org
952-853-8523
3001 Metro Drive, Suite 280
Bloomington, MN 55425

Learn more about Stratis Health at www.stratishealth.org

BronxRHIO

Connecting for Better Health

Civitas Collaboratives in Action

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Who We Are

A non-profit regional health information exchange organization established in 2005

Founded and lead by a consortium of healthcare institutions and providers

Established the Bronx Regional Informatics Center (BRIC) in 2012 to provide analytic/pop health services

Expertise in clinical informatics, data quality, data aggregation & analysis, data visualization, intervention support, reporting

Certified by NY State DOH as a Health Information Exchange/Qualified Entity (HIE/QE)

HITRUST Certified

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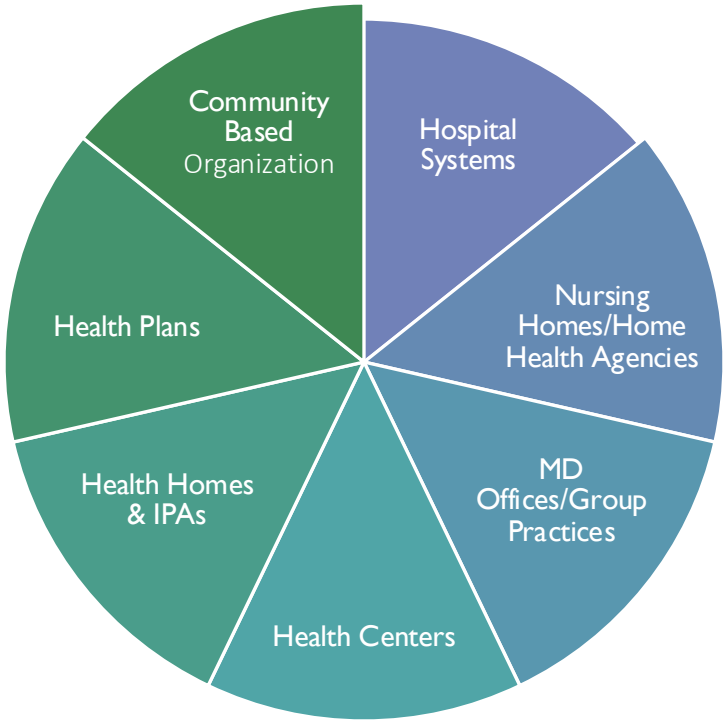
Connecting for Better Health

Membership & Data Providers



Bronx RHIO's membership includes over 400 data provider organizations.

BronxRHIO
Connecting for Better Health

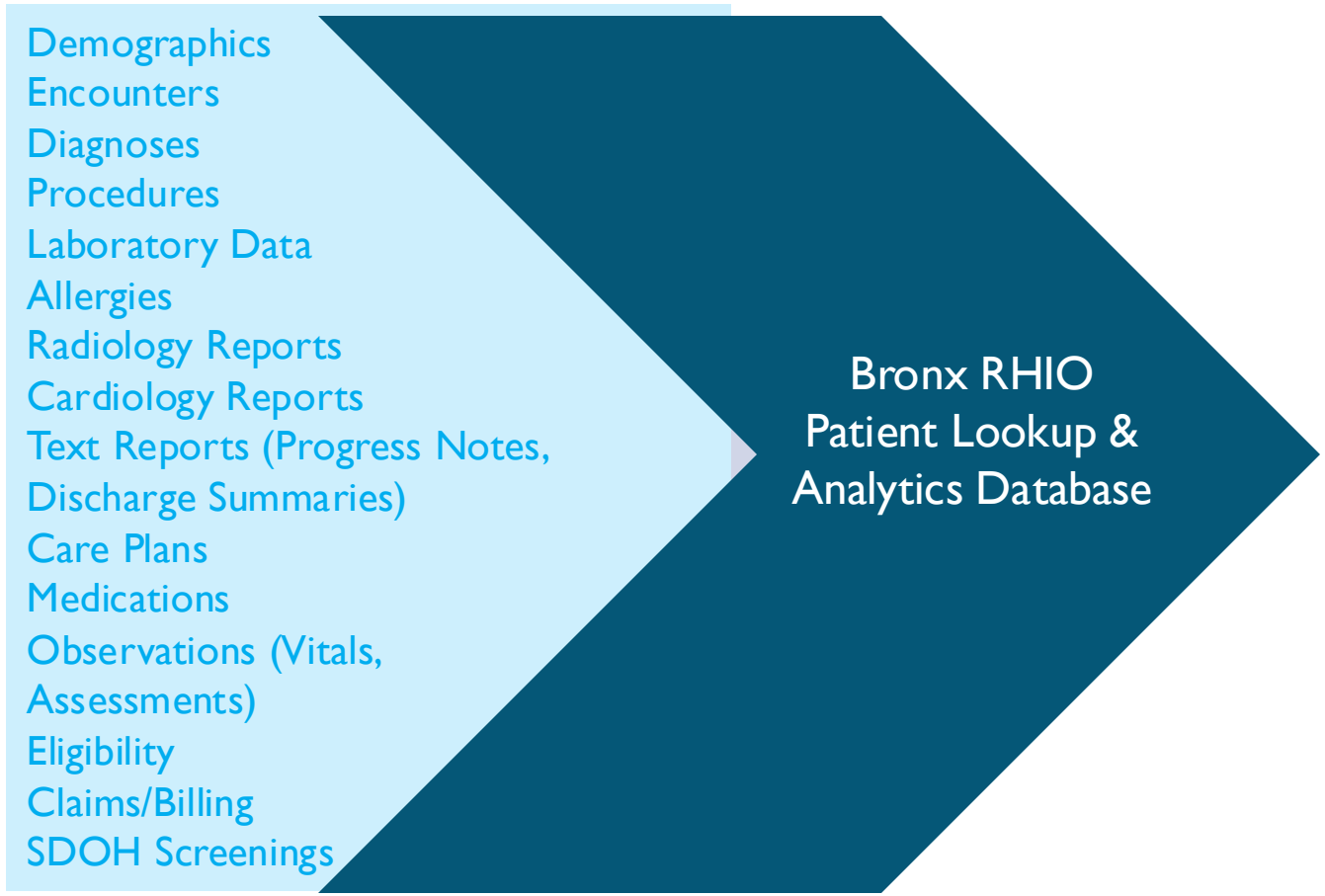
Full List: Participants Directory | Bronx RHIO

Available Data

Data in the Bronx RHIO is constantly growing, expanding and improving*

Data flows in real time to the VHR and analytics

* 10+ million people in Master Patient Index



Bronx RHIO Services

Data Management

- Data Integration and Normalization
- Data Quality Monitoring
- Patient Identity and Consent Management
- User Permissions

Core Services

- Virtual Health Record
  - Statewide Patient Record Lookup
  - Data Availability Flags
  - Single Sign-On
  - Care Team Tracking
- Alerts
  - Emergency Room Visits
  - Inpatient Visits
  - Clinical Events
  - Incarceration
- Direct Messaging

Reporting & Analytics

- Reports
- Patient Stratification
- Research & Quality Improvement
- Foundation BI Data*
- Analysis Support

***Data Warehousing Vertical**

BronxRHIO
Connecting for Better Health

CBO Face Sheet Background

NY is an HIE Opt-In Model: People consent to share their data with their service sites

- Bronx RHIO's CBO Sites are required to take HIPPA training and attest to following those rules

Social services site staff can operate more efficiently with access to data through the RHIO.

- RHIO data can speed client intake by providing demographics
- RHIO data can support care transitions and care management by providing history
- RHIO data can inform supportive services needed by clients.

Face Sheet concept is to create a program-specific set of data to be provided to the CBO on patient registration or on demand.

- Has ONLY the data the program staff need to know (minimum necessary)
- Organizes the data to be readily consumed by staff
- Eliminates need for staff to access the RHIO Portal to look up information on the patient
- Feeds the information into their system in structured data or PDF

Face Sheet Work Flow

Bronx RHIO and a Settlement House developed the Face Sheet Concept

- CBO supplies client roster to identify their clients enrolled in specific programs
- CBO has real time registration feed to Bronx RHIO to identify new clients
- CBO Programs identify the specific and limited set of data elements needed by the program
- Bronx RHIO develops program-specific Face Sheet
- Real time query is run by Bronx RHIO when a new registration is received
- If client is known a Face Sheet is returned to the program electronically as data or PDF

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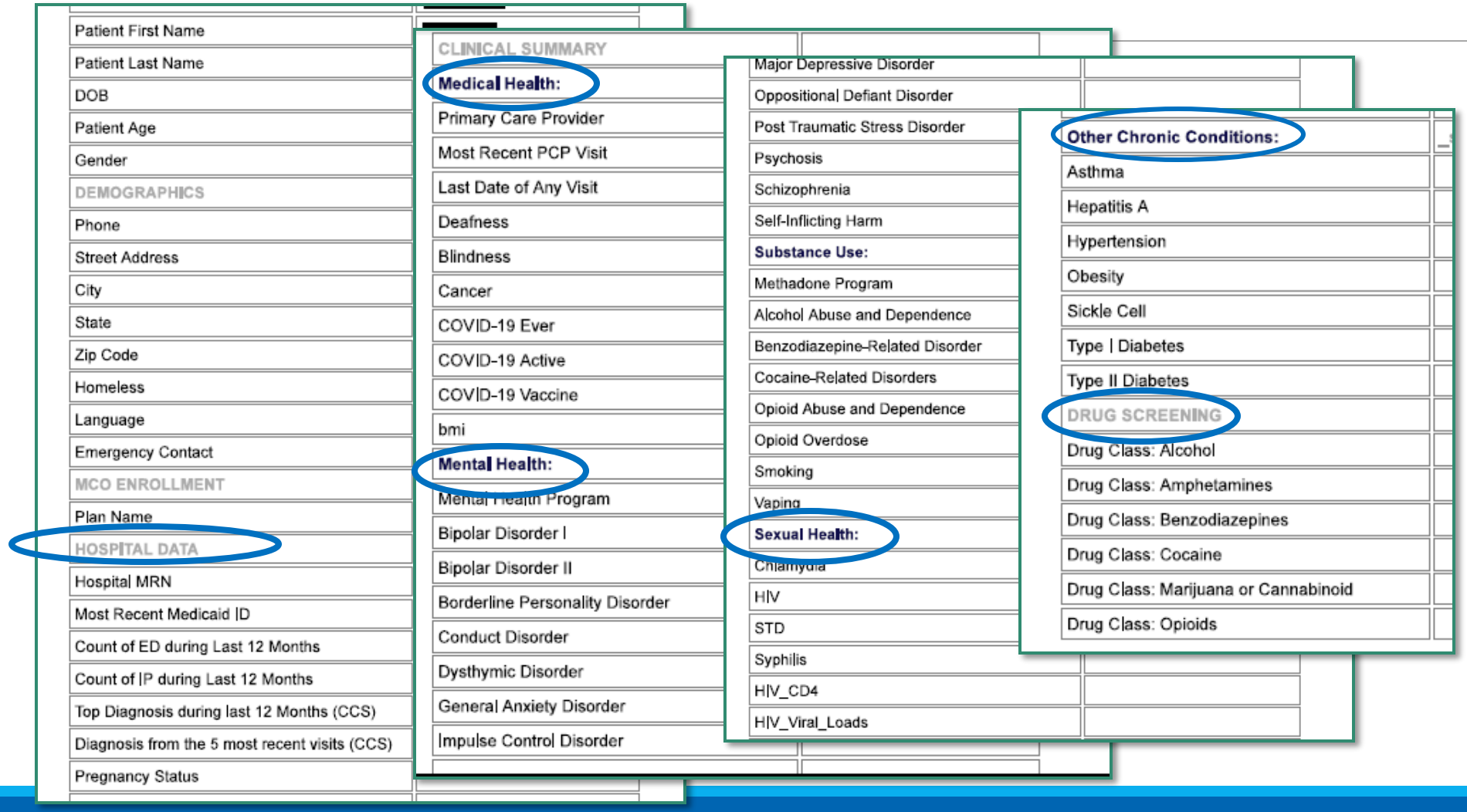
Reporting | Patient Face Sheet

Output Format- PDF

Delivery- Self Service or integrated w/ EMR



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Patient Stratification

Output Format: Risk Score in Face Sheet, Worklists

Unplanned Readmission in 30 days:

Outcome: Predicts if patient will have unplanned Inpatient utilization in 30 days after discharged from the hospital.

Patient cohort classified into:

Critical Risk – Top 5%

Rising Risk - Top 6-10%

Medium Risk – Top 11-20%

Low Risk – Rest

ED High Utilizer in 6 months:

Outcome: Predicts if patient will remain a high utilizer in 6 months

Patient cohort classified into:

Super Utilizer– Top 5%

High Utilizer - Top 6-10%

Medium Utilizer – Top 11-20%

Low Utilizer– Rest

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Contact Information

Kathy Miller
Chief Operating Officer
917-968-7408
kmiller@bronxrhio.org
www.bronxrhio.org

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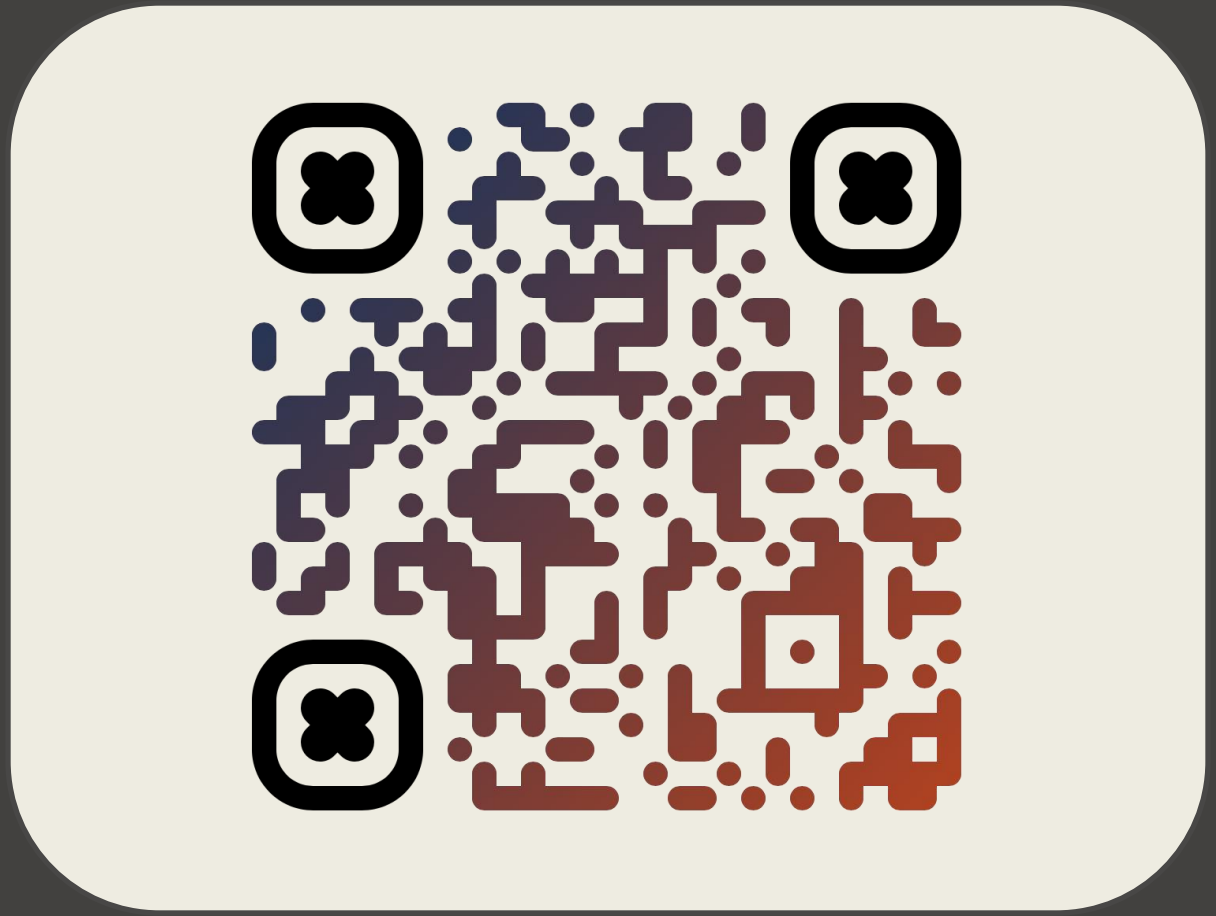
Stay In Touch with the Civitas Team



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