United Hospital Fund
A Community Control Project for Seniors

Case study prepared by Jenna Hunter-Skidmore[1], Anya Nawrocky[2], Fredda Vladeck[2], Charles E. Sepers, Jr.[1]; and Ithar Hassaballa[1]

[1]Work Group for Community Health and Development at the University of Kansas
[2]United Hospital Fund

PROJECT OVERVIEW

The United Hospital Fund (The Fund) is a New York-based nonprofit research and philanthropic organization devoted to improving healthcare for the people of New York City, particularly its underserved residents. Known for its foresight and innovation, the Fund's research, programming, and policy endeavors aim to meet emerging healthcare needs. Its Together on Diabetes project sought to reach seniors diagnosed with diabetes within underserved neighborhoods and link them to care in order to improve diabetes self-management and quality of life. Targeted outreach strategies and partnerships with hospitals, primary care clinics, and senior-serving organizations created a robust referral network that enrolled more than 1,500 seniors in the program. Senior participants took part in weekly self-management education, support groups, individual coaching, cooking and nutrition classes, and social events for seniors with diabetes. By bringing together and drawing on the strengths of medical providers, community organizations, senior organizations, and seniors themselves, the Fund's Together on Diabetes project provides a unique model of diabetes care for seniors that has been effective in engaging seniors in controlling their diabetes. Additionally, The Fund sought to build a mechanism for reimbursement to assure sustainability of the program's core features.

CONTEXT AND PARTNERS

In New York City, 39% of adults diagnosed with diabetes are over the age of 65. Of the nearly 217,000 seniors diagnosed with diabetes, 31% are African American and 28% are Latino. In Washington Heights/Inwood, where the program was implemented, more than a quarter of seniors have been diagnosed with diabetes. More than 85% of neighborhood residents are Hispanic or Black and 44% of the population receives some form of income support.

This project built upon the Fund's extensive experience in facilitating connections between neighborhood clinics and community service organizations in naturally occurring retirement communities (NORCs). The Fund's NORC Blueprint and associated website serves as a guide to developing and sustaining NORC programs that are based on community strengths and resources, involve a broad range of partners, and are responsive to community needs. Based on this model, the Fund sought to establish an integrated community diabetes control partnership among seniors diagnosed with diabetes, health care providers, and key community organizations both senior-serving (e.g., senior centers) and traditional (e.g., churches, libraries, beauty parlors).

Community partnerships were a central feature of this project and multiple partners representing different segments of the community were engaged to implement this initiative. Core partners included:

- ARC XVI Fort Washington, Inc.

- Center for Adults Living Well at the YMCA
- City Harvest
- Cheng A. Gonjon, MD-Imperial Medical, PC
- Jose Goris, MD
- Isabella Geriatric Center
- NYC Department for the Aging
- NYC Department of Health and Mental Hygiene
- New York-Presbyterian Hospital
- Riverstone Senior Life Services
- Visiting Nurse Service of New York
- Washington Heights and Inwood Council on Aging
- Healthfirst Insurance

ASSESSMENT AND PLANNING

To select the implementation community for its Together on Diabetes project, the United Hospital Fund examined nine neighborhood communities in four of the five New York City boroughs. Eligible communities had strong NORC programs, a high incidence of diabetes among seniors, and predominantly low-income or minority residents. A community assessment collected demographic and diabetes prevalence data as well as information on community resources, capacity, availability of patient-centered medical homes, and existing diabetes programs. Table 1 presents criteria considered in the community selection process. The three leading communities underwent an additional in-depth community analysis, including interviews and meetings with community and health care leaders to gauge interest and support of the initiative.

Table 1: Community scan criteria	
Demographics	Low income, community of color, high percentage of older adults, high rate of diabetes in older adults
Health care	Engaged health partner with sufficient nursing hours, presence of a Patient Centered Medical Home, pharmacy, nursing homes/rehabilitation centers
Aging service providers	NORC program, senior center (preferably designation as innovative), EISEP case management, Meals on Wheels
Nutrition	Healthy foods neighborhood, congregate meal site, access to healthy foods
Diabetes efforts	Diabetes specialty clinic, WE COACH, New York State Health Foundation
Recreational/community resources	Gym, YMCA/YWCA, Churches, community colleges, libraries
Health information technology	Pre-existing Condition Insurance Plan provider penetration or potential, Regional Health Information Organization
History of community activism	Prior experience

Washington Heights/Inwood was selected as the initial implementation community. Washington Heights/Inwood is a neighborhood in the northern part of Manhattan with approximately 190,000 residents. A high incidence of diabetes among seniors, strong capacity among community organizations and health care providers, and a high degree of community cohesion made this community a natural choice for strategic partnership.

After the community selection process, the UHF team held a series of meetings with a variety of community stakeholders, key informants, clinical providers, and health organizations to identify and engage partners and gain a more in-depth understanding of the community. A steering committee comprised of local champions and health experts was convened to guide the project throughout the implementation period.

INTERVENTION COMPONENTS

Once the implementation community was selected, four community partner sites (Isabella Geriatric Center, ARC XVI Fort Washington, Inc., Riverstone Senior Life Services, and NYC Department of Health and Mental Hygiene) delivered ToD-NYC's core services and a TOD team consisting of a diabetes educator and onsite coordinators was established. Core elements of the intervention centered around diabetes self-management, social support, and referrals to care. Table 2 below summarizes the main intervention components and specific elements of the Fund's Together on Diabetes project:

INTERVENTION COMPONENTS	SPECIFIC ELEMENTS	MODES OF DELIVERY
Diabetes Self-Management Education	◆ TOD teams established five community partner sites to provide diabetes self-management education classes, support groups and individualized coaching to participants; DSME supports provided in English and Spanish ◆ Nutrition and healthy cooking classes ◆ Regularly scheduled Diabetes Day at partner sites	◆ Diabetes educator ◆ Onsite coordinators ◆ Community partner City Harvest
Support for Managing Diabetes and Distress	◆ Support groups held at partner senior organizations	◆ Diabetes educator
Enhanced Access/Linkage to Care	◆ Participants recruited at common destinations in the community (e.g., grocery stores, pharmacies) through a targeted community activation campaign ◆ Management information system implemented to guide client intake and manage linkages to care ◆ Established dedicated phone number for receiving TOD referrals and developed website to promote and enroll participants ◆ Referral systems implemented at two PCP practices ◆ Awarded capacity building grants to four community sites to enhance programming and improve performance	◆ Street outreach team ◆ Diabetes educator, onsite coordinator

Improve Quality of Care	◆ Implemented standard of care protocol in community-based senior serving agencies ◆ Introduced community practice protocol to enroll, assess, and provide support to seniors ◆ Trained TOD connectors to handle new referrals via hotline or internet	◆ Connectors at Isabella Geriatric Center
Community Organization, Mobilization, and Advocacy	◆ Implemented community activation and marketing campaign to promote the program and recruit participants	◆ Street outreach team ◆ Asociacion de Mujeres Progresistas
Health System and Community Transformation	◆ Established health care utilization and data sharing agreements with New York Presbyterian Hospital ◆ Advocated for policy change to enable new partnerships (e.g., worked with the Department for the Aging (DFTA) to allow TOD intakes to count towards the required number of intakes) ◆ Provided funding and worked with DFTA to pilot diabetes-friendly meals at one of its community sites and the Meals on Wheels vendor for Washington Heights	◆ UHF staff

STORY OF COMMUNITY TRANSFORMATION

Prior to Together on Diabetes NYC, referrals to diabetes services were contingent upon an individual organization's knowledge of available resources. The United Hospital Fund created a centralized referral and resource center to make it easier to connect elderly patients in Washington Heights/Inwood with a full spectrum of diabetes support services in their community. The online center is a web-based data management system and diabetes support enrollment service, accessible at www.togetherondiabetesnyc.org. Now anyone from providers at primary care clinics to staff members at senior centers has access to the same system of diabetes care referral. Not only does the website act as a resource and referral portal, but it is also a diabetes registry that collects rich data on enrollees. These data are in turn used to monitor use and participation and make adjustments as needed. For example, after consulting weekly enrollment data, the team implemented a strategy of weekly reminder calls to improve program participation and relocated the street outreach team to target pockets of low participation in the neighborhood. Creating access to a centralized system of diabetes support has made it easier to bring much needed diabetes support services to elderly residents of the Washington Heights/Inwood community.

EVALUATION RESULTS AND FINDINGS

Data on Project Implementation

From the beginning of the project to its completion (12/2010–05/2014), the results show steady implementation of program components including development activities, changes to the community system, and the delivery of services with community constituents. In all, 2800 senior residents of the Washington Heights/Inwood neighborhood of New York City were referred to the Together on Diabetes NYC program. 1,581 seniors were enrolled. 20 staff members at four community sites were trained to administer the self-management assessment and enroll participants.

Figure 1 below displays the unfolding of development activities from project onset through the duration of the planning phase (during the period of 12/2010-7/2012). Development activities that prepared the project for implementation included the formation of committees, developing community selection criteria, in-depth community assessments and resource mapping, meetings with key community leaders, selection of the implementation community, focus groups and surveys of seniors living with diabetes in the selected community to assess support services and health care utilization patterns, and ongoing partnership building to develop referral relationships and systems.

Figure 1: Development Activities Over Time for the United Health Fund's Together on Diabetes NYC Project

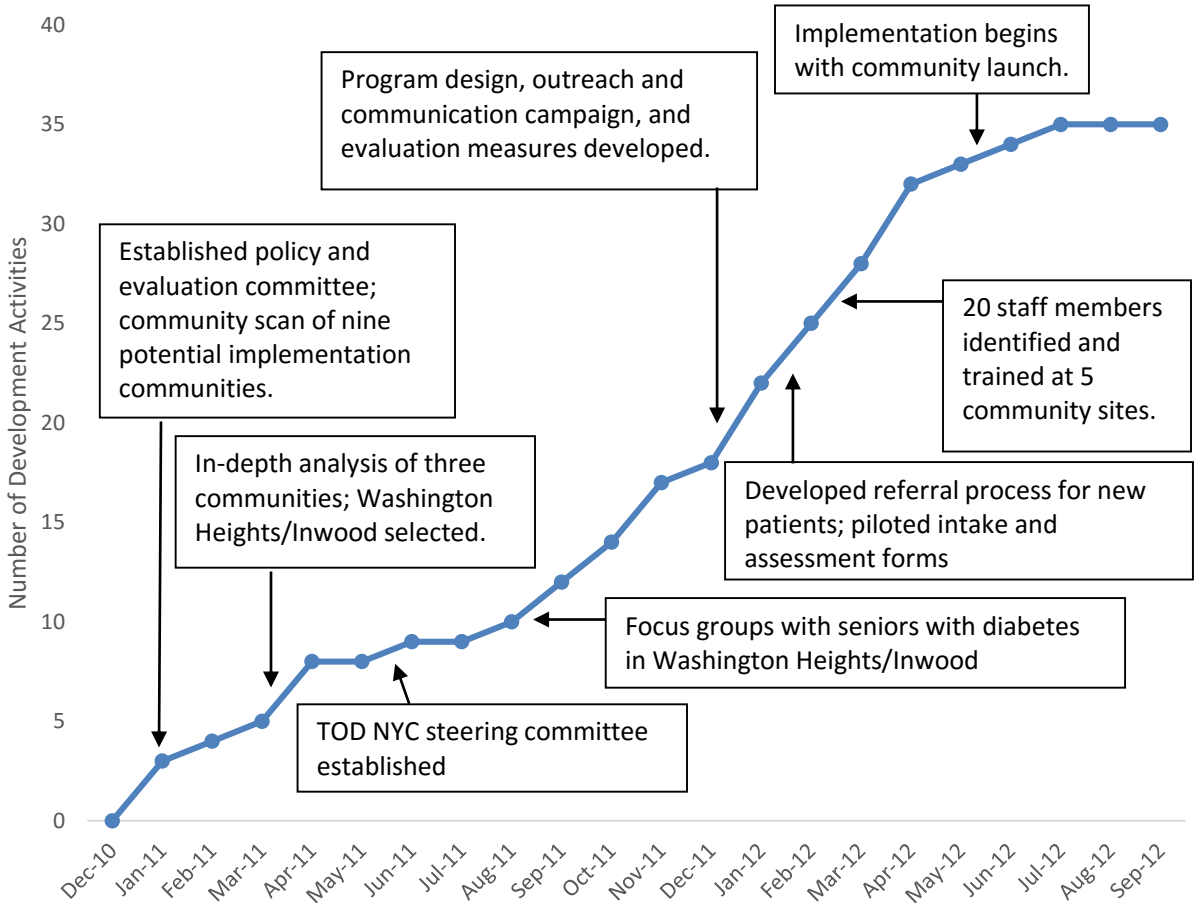
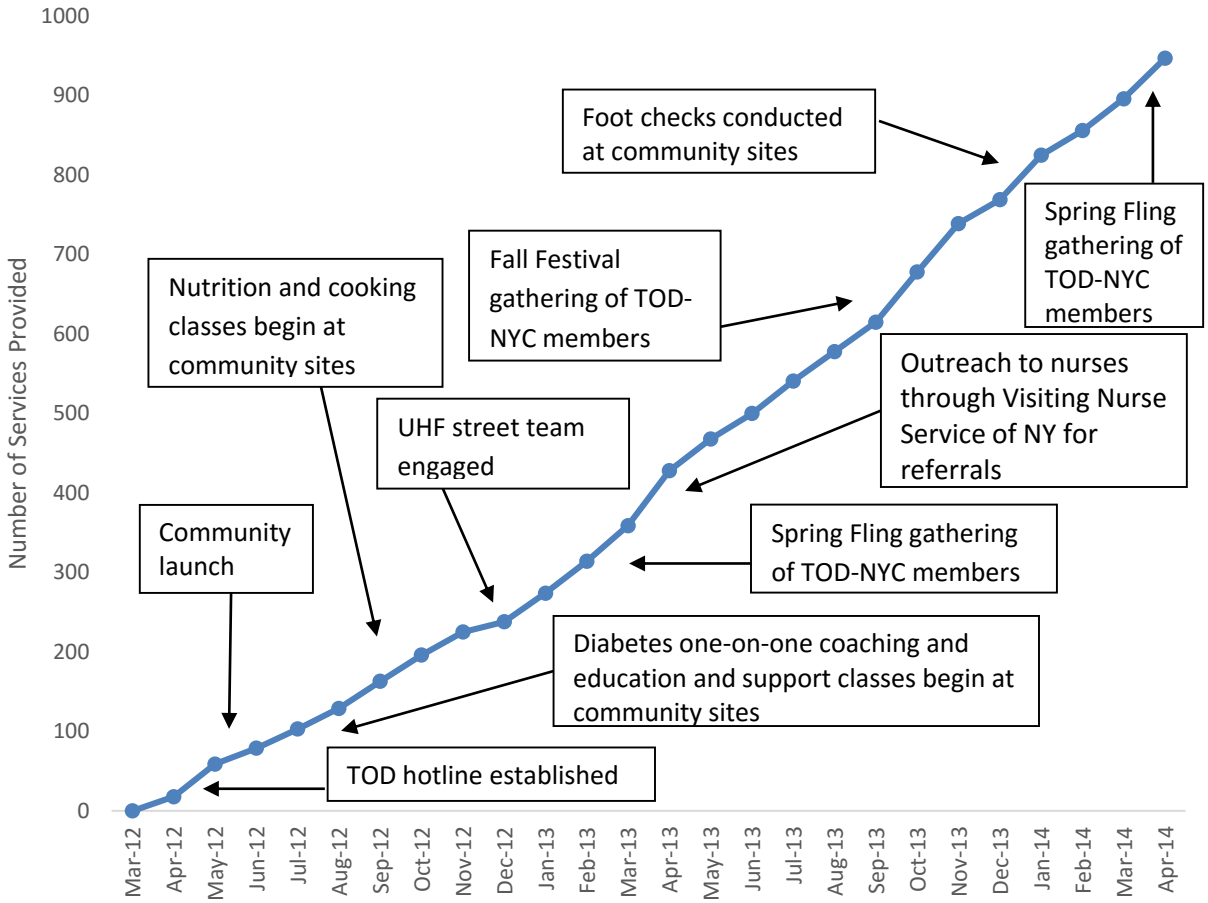


Figure 2 below displays the unfolding of services provided—a measure of program implementation—to the program's participants over time following the project's planning phase. (Note: In a cumulative chart, each new activity is added to all prior activities.) These services included outreach activities conducted by the street team, diabetes support services for seniors including educational sessions, group and individual support sessions, nutrition and cooking classes, training of new partners on referral processes, and community events to gather TOD-NYC participants. The data show steady implementation of services provided throughout the course of the grant period, indicating successful outreach and implementation strategies. Increased rates of services provided (beginning around March 2013) were associated with the introduction of street teams to conduct reminder calls and directly recruit seniors at community sites including pharmacies, supermarkets, churches, and social service agencies. Project implementation concluded in April 2014.

Figure 2: Services Provided Over Time for the United Health Fund's Together on Diabetes NYC Project



Data on Behavioral and Clinical Outcomes

The results show improvement in multiple self-care practices and quality of life indicators. Among eligible participants (n=263), the number of people reporting engagement in exercise at least three days per week increased from 24% to 59% and the number of participants reporting confidence in controlling their diabetes increased from 74% to 94%.

An analysis of health care utilization yielded no significant change in inpatient or emergency room utilization among program participants.

WHAT WE ARE LEARNING

United Hospital Fund TOD-NYC staff identified several important learnings throughout the duration of the project. Facilitating factors that appeared to have contributed to the program's success included:

- Timely adjustment of recruitment strategies. Participant recruitment was initially slower than anticipated so they conceptualized a street team outreach approach to recruit seniors face-to-face. Representatives from the project and community members formed a street team that directly recruited seniors in the community at venues where seniors tend to frequent – e.g., pharmacies, supermarkets, churches, social service agencies and legal assistance agencies. This direct recruitment strategy was very successful in

increasing participation in the program; by June 2013, the street team was directly responsible for 1,100 of the 1,500 referrals.

- Strategic engagement with key agencies to minimize policy barriers to participation. UHF experienced initial resistance to participation from community service sites and found that the sites were overburdened and reluctant to take on the additional work of identifying and enrolling seniors. They eliminated this barrier by working with the Department for the Aging to allow TOD intakes to count toward the total required number of units of service.
- Establishing effective outreach and referral relationships with the right partners. Some partners may be more or less willing to adjust their internal processes, so identifying partners flexible and able to meaningfully partner with your project is critical. Referrals from physicians were much more modest than anticipated, so they turned their efforts toward engaging new referral partners such as the Visiting Nurse Service of New York (VNSNY) and a major Medicare Advantage plan provider.
- Strategic marketing of services. To increase participation in services being provided at the senior centers, UHF reframed the services as "clubs" rather than "classes". The word and idea of a formal class was a barrier to participation for many seniors so reframing the services as a set of activities and supports increased participation.
- Attracting third party payers with evidence of success. Evidence of a new program's successes is an important precursor for attracting new partners and payers who may be reluctant to engage and adopt new processes.

Restraining factors or challenges that made it difficult to successfully implement the project included:

- Lack of efficient and useable health information technology. UHF had to develop their own web-based management information system to track referrals, enroll seniors, document self-care practices, track use of support services and share information with physicians.
- Lack of capacity at community sites to provide adequate and consistent diabetes education programming. To overcome this challenge, UHF provided capacity building grants to train community site staff and enhance programming in exercise, social events and healthy eating.
- Forging new inter-sectoral relationships takes time. Linking health care providers with community-based service providers to work together on a common issue is a process that requires time in order to adequately develop relationships and build a foundation of success.

MOVING FORWARD AND PLANS FOR SUSTAINABILITY

Table 3 below outlines UHF's plans for sustaining the TOD-NYC project.

Table 3: Strategies for Sustaining the Work

TACTICS OF SUSTAINABILITY	SPECIFIC EXAMPLES OF TACTIC
Incorporate activities into another organization	UHF continues to partner with the Isabella Geriatric Center and New York Presbyterian Hospital to explore ways to sustain program services. NYP is considering applying community benefit resources to TOD-NYC.
Apply for grants	UHF partners are pursuing multiple grant opportunities.

Tap into available personnel resources	UHF has committed staff support to continue TOD-NYC beyond the funding period.
Pursue third party funding	UHF partners are pursuing funding from multiple foundations. Established a reimbursement mechanism through Healthfirst, a third-part insurer serving Northern Manhattan.
Acquire public funding	UHF is seeking discretionary funding from the New York City Council.

PROJECT PUBLICATIONS AND MATERIALS

– Blueprint (Spring, 2015). https://www.uhfnyc.org/publications/881044

–

PROJECT CONTACT INFORMATION

Anya Nawrocky, Project Director
United Hospital Fund
Email: anawrocky@uhfnyc.org
Phone: 212.494.0700

Fredda Vladeck, Director
United Hospital Fund
Email: fvladeck@uhfnyc.org
Phone: 212.494.0700

EVALUATION CONTACT INFORMATION

This case study was prepared by the Work Group for Community Health and Development team (Jenna Hunter-Skidmore, Ithar Hassaballa, and Charles E. Sepers, Jr.) at the University of Kansas http://communityhealth.ku.edu, in collaboration with the United Hospital Fund, and as part of the evaluation of the BMSF's Together on Diabetes Program.

Jerry Schultz, Co-Director
Work Group for Community Health and Development, University of Kansas
Email: jschultz@ku.edu
Phone: 785-864-0533

Charles E Sepers, Together on Diabetes Evaluation Coordinator
Work Group for Community Health and Development, University of Kansas
Email: jmhunter@ku.edu
Phone: 785-864-0533