



# Summa Health Equity Center

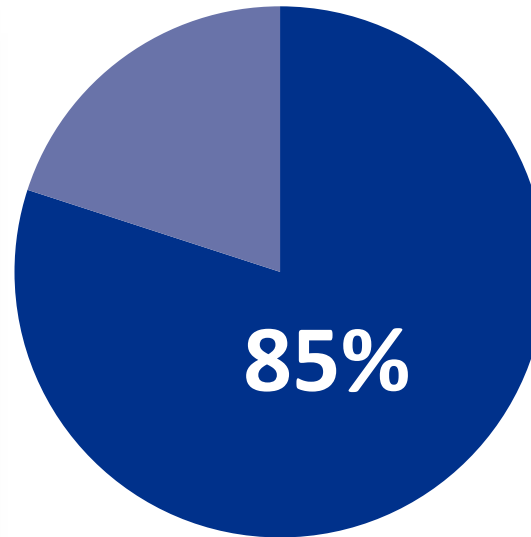
Billi Copeland King, JD  
Director

12/2/2021

Fall 2021

# The Problem

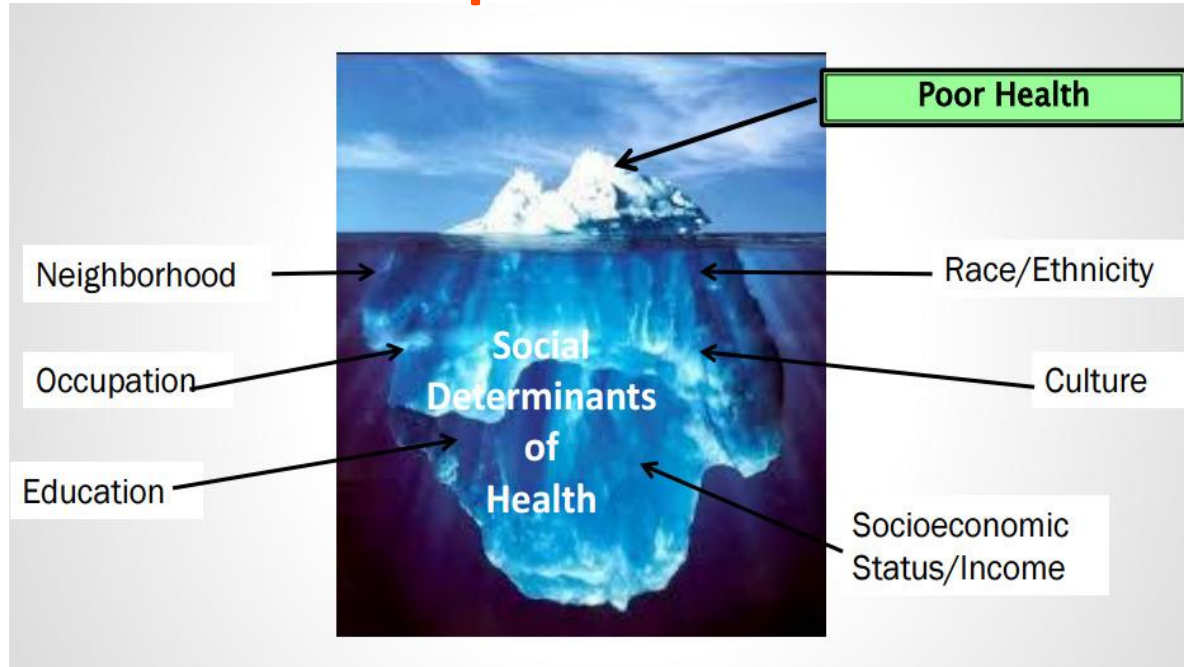
Despite advances in medical care and public health, disadvantaged population groups continue to experience high incidence of chronic diseases and lower life expectancy



Chronic conditions account for 85% of every healthcare dollar

Robert Wood Johnson Foundation, 2012

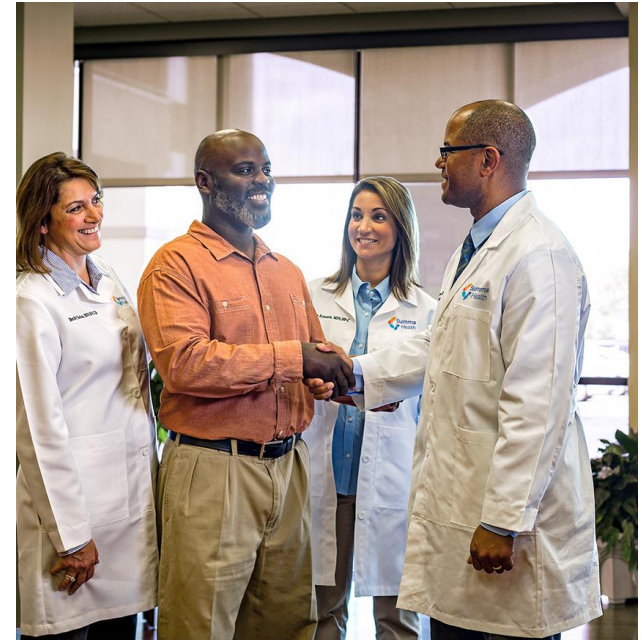
# The Problem Runs Deep



- **Social determinants of health** combined with fragmented delivery systems result in failure to integrate the patient into the care process
- Poor cultural competency IQ and poor healthcare interactions
- Social/behavioral challenges cause communities to struggle with chronic health conditions
- Underserved patients experience barriers to healthcare resulting in undiagnosed and untreated chronic conditions

# The Solution: Summa Health Equity Center

- The Center is a unique health delivery model focused on wellness, disease prevention, chronic disease management, and self-managed care for underserved and minority populations
- The Center opened in 2012 as a collaborative partnership between Summa Health, House of the Lord, Testa Companies (local developer) and Neighborhood Development Corporation
- **Vision:** healthy people living in healthy communities
- **Mission:** to understand, reduce and eventually eliminate health disparities in Summit County in collaboration with the community



*A free nutrition class in the community room demonstration kitchen at the Center*

# Goals

- **Improve access to health services for underserved populations** focused on wellness strategies and chronic disease management, prevention and acute care
- **Empower patients to guide their health** destiny through education, counseling and program activities
- **Initiate population-based research** that results in reducing health disparities
- **Reduce inappropriate use of emergency rooms** and urgent care clinics
- **Provide a rich learning environment** for medical students and health professions

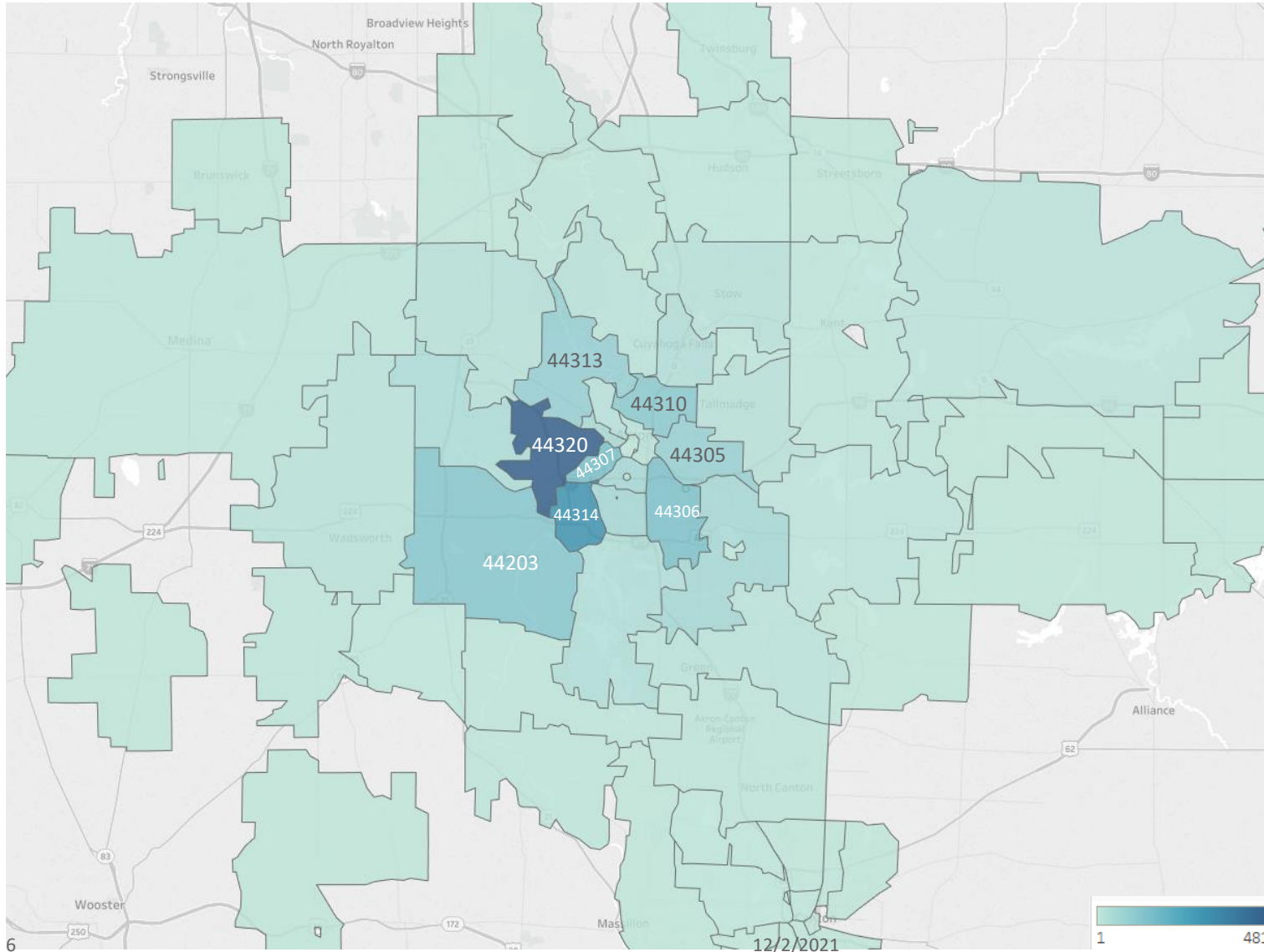


**A New Model of Care**

12/2/2021

# Summa Center for Health Equity

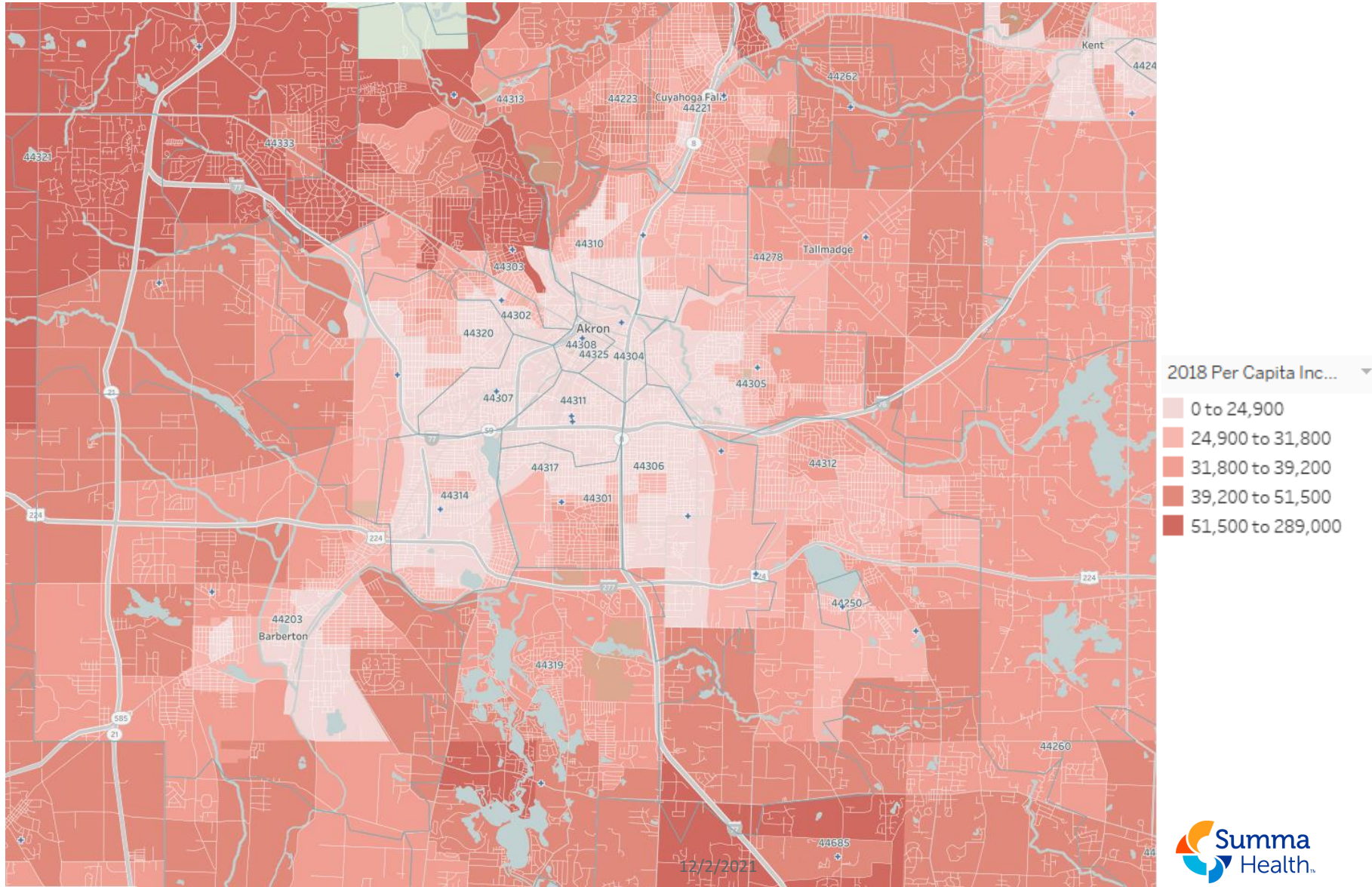
## Patient Locations by Zip Code





# Summa Center for Health Equity

## Patient Zip Codes by Per Capita Income

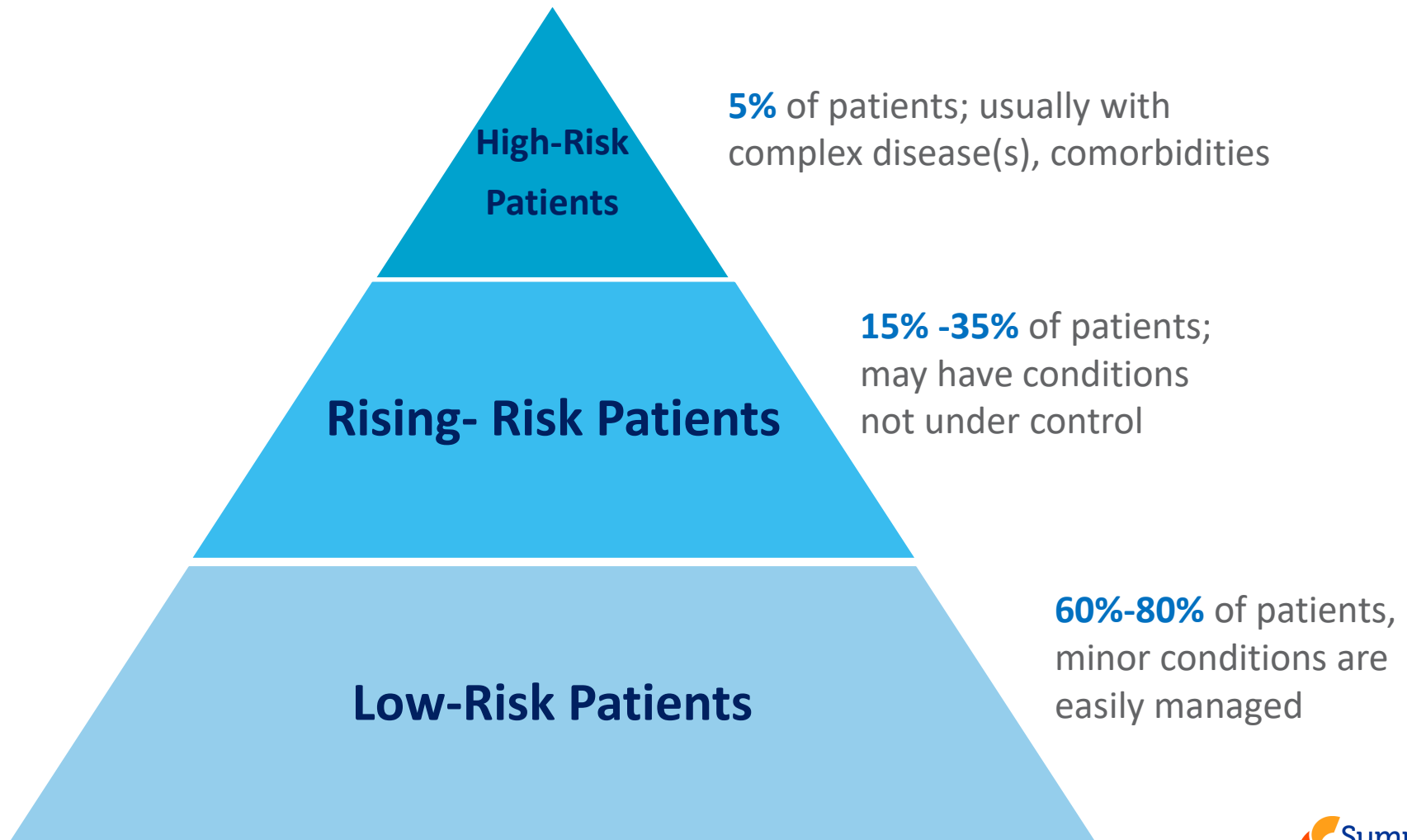


# Population Served

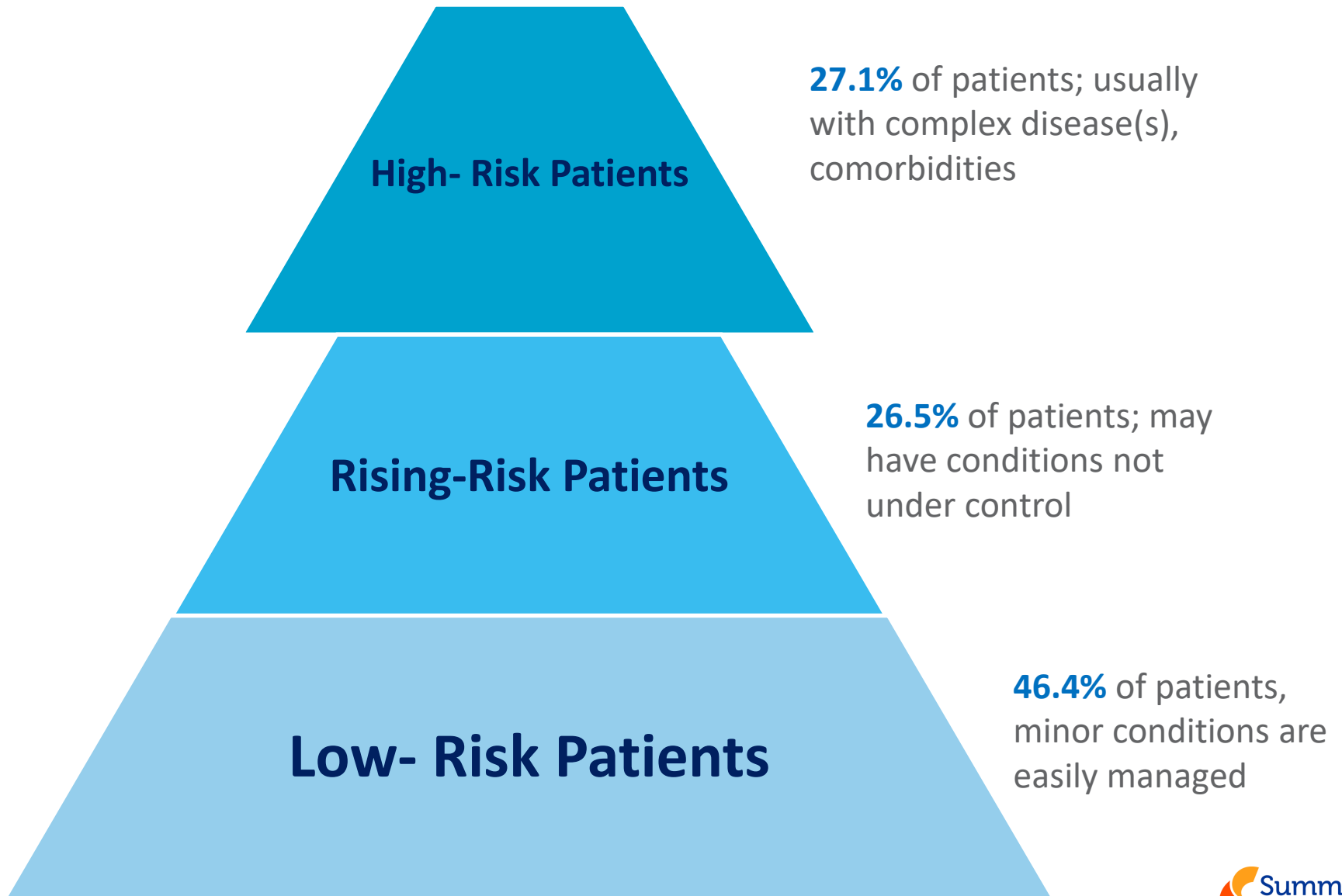
- **Nearly 70 percent of patients** served at the Summa Health Equity Center **meet the criteria for low to moderate income**
- Primarily serves people living in ZIP codes 44307 (84% African-American) and 44320 (72% African-American) as well as 44314 (18% African-American)
- Nearly half of all the patients served are African-American
- Over 80% of the patients have Medicaid, Medicare or are self-pay; 18% have private medical insurance
- The population served is at risk for chronic disease
  - Incidence of diabetes is 17% (10% in Ohio, 8% national)
  - 65 % are overweight or obese



# Risk Stratification



# Risk Stratification – Summa Center for Health Equity



# The Model of Care

Prevention and Wellness	Education and Technology	Community Based Participatory Research	Community Benefit
<ul style="list-style-type: none"> <li>•Increase frequency/diversity of low (no) cost maintenance programs to sustain gains achieved in lowering blood pressure, BMI, etc. These include nutrition education, cooking classes, exercise promotion, weight management and smoking cessation</li> <li>•Implement shared medical appointment programs like Centering Pregnancy and additional chronic disease groups</li> <li>•Increase programs focused on obesity and weight management incorporating children and families into the care process</li> </ul>	<ul style="list-style-type: none"> <li>•Expand/ increase frequency of community based diabetes education and support group sessions</li> <li>•Implement shared medical appointment program for patients with pre-diabetes or newly diagnosed</li> <li>•Promote awareness and self responsibility through culturally competent web-based tools and forums</li> </ul>	<ul style="list-style-type: none"> <li>•Ensure accurate, consistent data collection to provide foundation from which outcomes can be measured and programs can be evaluated</li> <li>•Create partnerships with local universities to develop northeastern Ohio as a hub for health equity research</li> <li>•Create a learning collaborative and annual symposium that helps disseminate research and results in Northeast Ohio</li> </ul>	<ul style="list-style-type: none"> <li>•Emphasize cultural competency through provision of staff and provider education</li> <li>•Financial assistance to help patients succeed with treatment and care plans, i.e. procurement of medication, supplies, patient incentives.</li> <li>•Expand the numbers of community health workers</li> </ul>

## Strategy Examples

Summa Health Equity Center shares a commitment to building strong communities. We address **health disparities** by identifying the **social determinants of health** to achieve **health equity**:

400 Reclamation Project: Address SDoH using Community Health Workers (CHWs) to navigate the healthcare system and address resource deficits utilizing Pathways HUB Care Coordination System and scripted discussions.

High-Risk: Address of highest risk patients using CHWs, existing prevention and wellness programs, develop new chronic disease initiatives, and effectively track outcomes to replicate programs with positive results.

# Community Programming

We reduce health disparities by engaging in collaborative and innovative care delivery strategies and research for minority and underserved populations offering data driven solutions and interventions



# Infant Mortality: An Example of Success

Infant mortality is the death of an infant before his or her first birthday



# Ohio Infant Mortality Rates

- Ohio ranks 38th out of 50 states in infant mortality at 6.8 deaths per 1,000 live births (2014)
- Two zip codes surrounding the Summa Health Equity Center have the worst infant mortality rate in Ohio

**About three infants die each day in Ohio**



## Centering Pregnancy Program

Summa Health received a grant from the Medicaid Advantage Plans to implement the program Centering Pregnancy at the Summa Health Equity Center, aimed at reducing infant mortality, improving the health of the newborns and reducing admissions to the neonatal intensive care unit

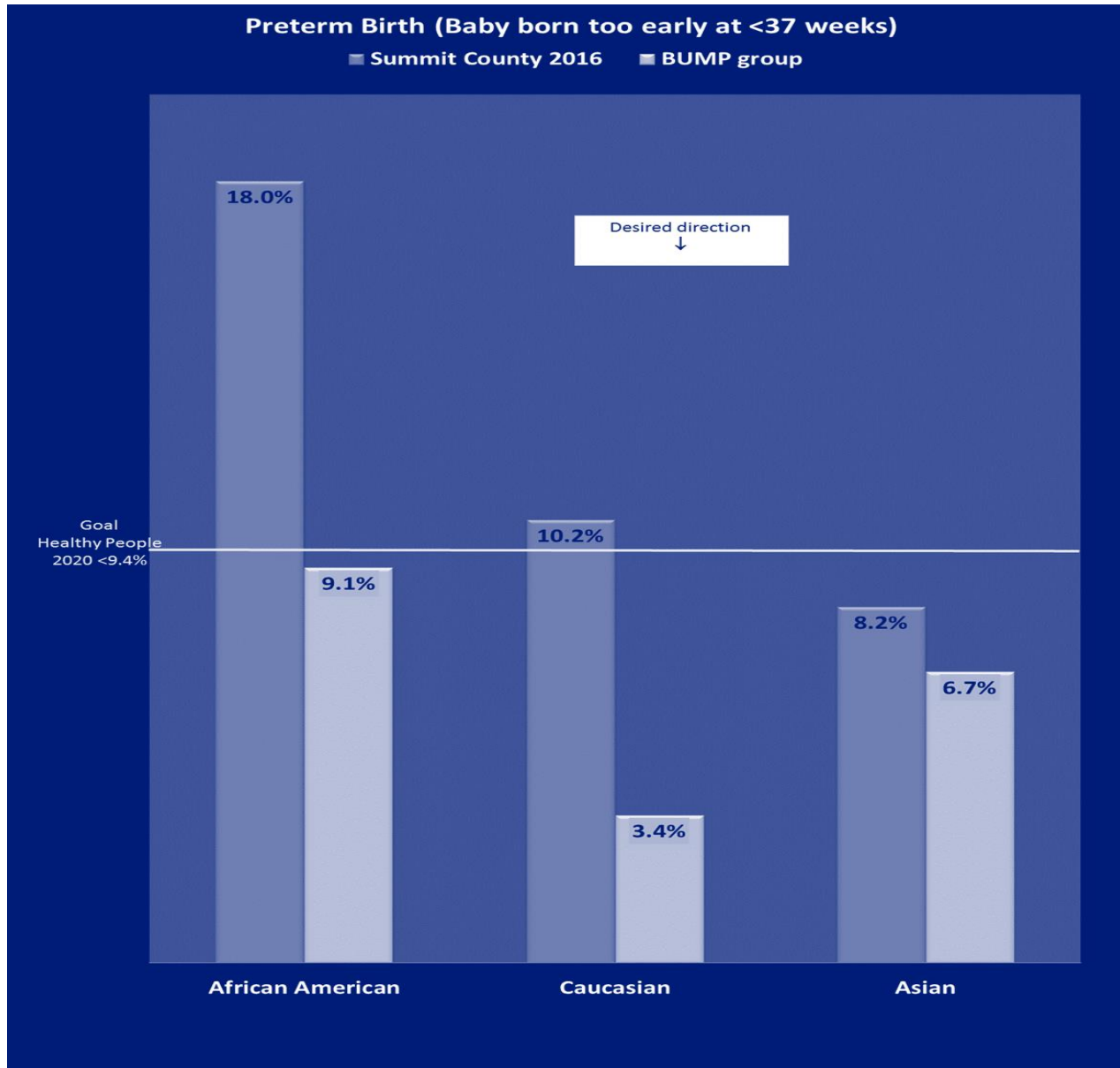
\$1.5 million opioid settlement funding public/private

Funding is urgently needed to continue the program and expand it to serve more women

# Centering Pregnancy Addresses Infant Mortality

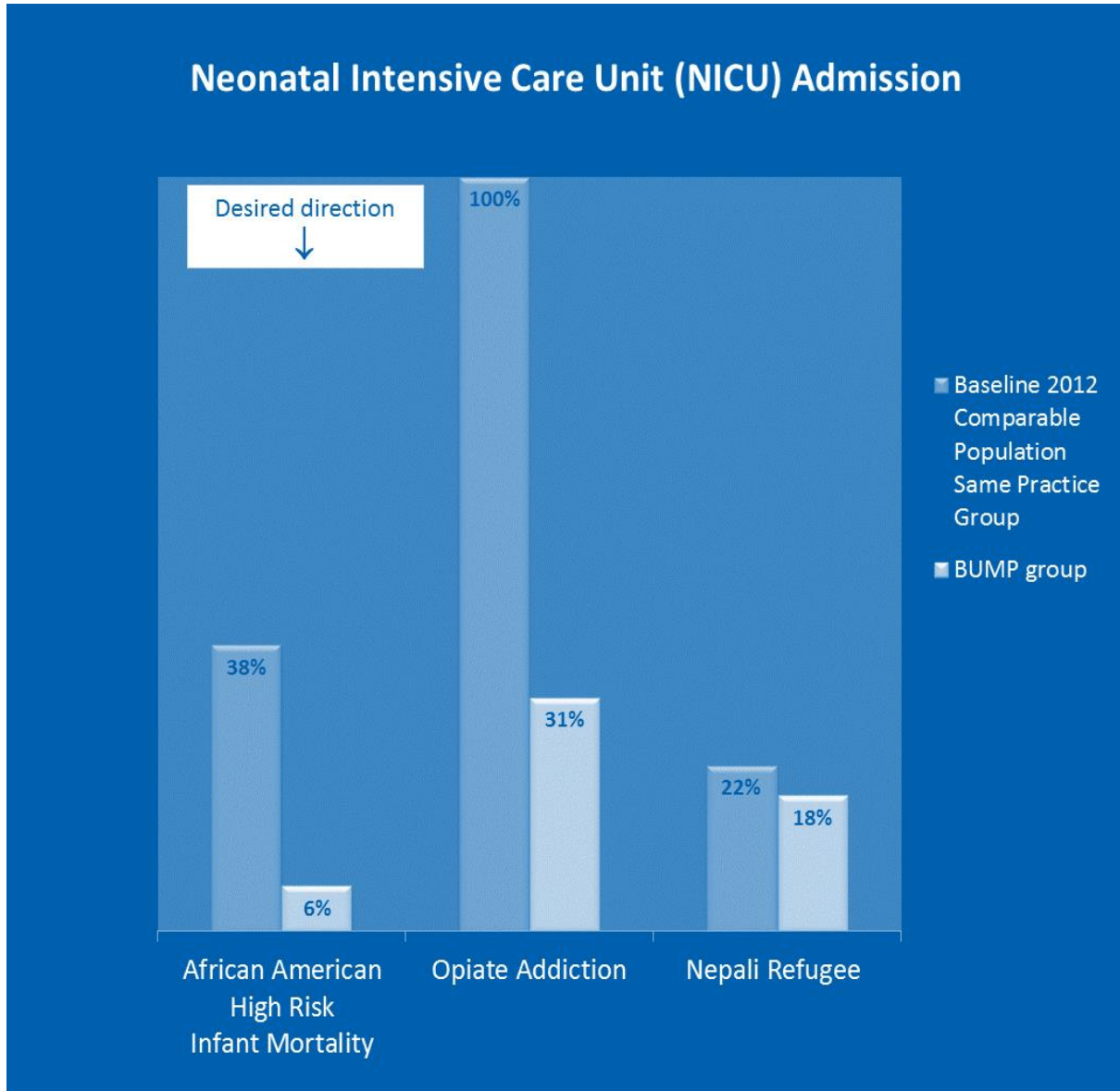
- **Centering Pregnancy is a group model of care** that brings 8-10 women all due at the same time together for their prenatal visits.
- **Visits are 90 minutes-** giving women 10 x more time with the doctor
- **Moms engage in their care** by taking their own weight and blood pressure and recording their own health data
- **Moms and providers relax** and get to know each other on a much deeper and meaningful level, forming lasting friendships not possible in traditional care
- **The provider and support staff "circle-up"** with moms. They lead facilitative discussion and interactive activities designed to address important and timely health topics while leaving room to discuss what is important to the group.
- **Centering materials** help educate moms on everything from nutrition, common discomforts, stress management, labor and delivery, breastfeeding, and infant care

# Centering Outcomes – Reduced Preterm Births





# Centering Outcomes – Reduced NICU Admissions



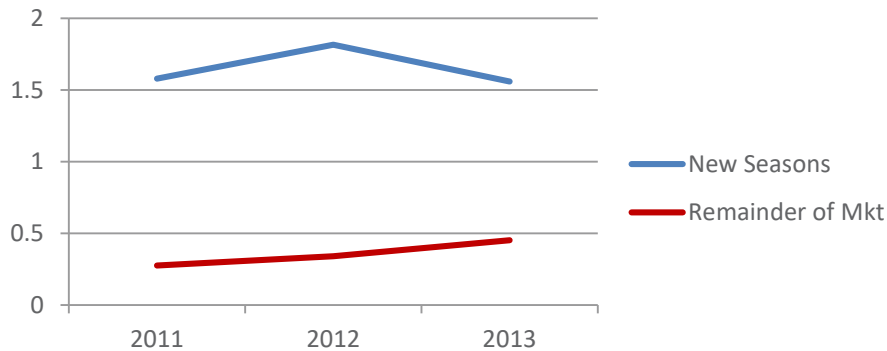
# The SWEET Life Program - Example of Success

- **Culturally relevant diabetes risk reduction program**
- **Carried out in three phases over a 15-week time period.** The three phases are based on the Health Belief Model, and aim to increase participants' belief in the benefit of lifestyle change, help participants learn practical ways to overcome barriers to developing healthy behaviors, and increase feelings of self-efficacy.
- **Participants are over 18, at risk for developing diabetes** (pre-diabetic, family history of diabetes, overweight, etc), and who are willing to make small life style changes are eligible to participate. During the 15-week program, participants learn to make small, healthy lifestyle changes through hands-on lessons with a nutritionist, fitness specialist, psychologist, and health educator.

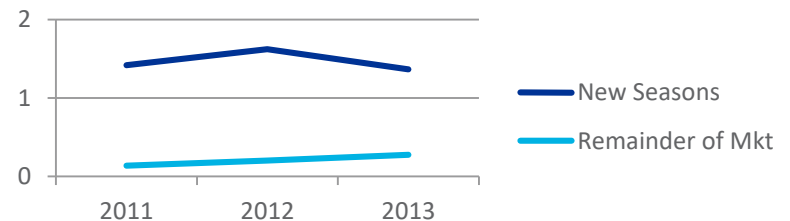
# The SWEET Life Program Positive Results

- Statistically significant **reduction in blood pressure, A1C (diabetes) and waste circumference** for program participants
- Overall improvement in the mean scores for quality of life.
- Emergency room visits for diabetes and hypertension beginning to show a downward trend.

ED Encounters for Diabetes  
per 1,000 population



ED Encounters for Hypertension  
per 1,000 population



## COVID-19 Response

1. March 11, 2020-Centering Programs moved to virtual platform.
2. Increased televisits for patients with chronic disease
3. Launched reclamation project to connect resources and provide COVID-19 information
4. Launched high-risk project to address resources and provide COVID-19 education
5. Vital Vax mobile health unit
6. Facilitated testing sites for Minority Communities with SCHD
7. Maintain virtual fitness classes to facilitate healthy behaviors

# Policy and System Level Approaches

1. Population health-based program development
2. Practice Optimization
3. Research Infrastructure
4. CHWs as trusted advisors to bridge the community and the clinical experience
5. Health equity in all policies



**Thank you!**

Questions?