

Minneapolls/
Sr Paul i-94:

3 miles could
add up to 13
year life span
difference

New Orleans:

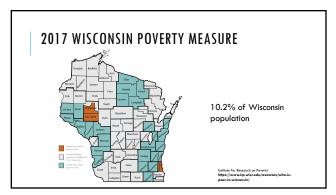
Life span
varies by 25
years across
neighborhoods
just a few miles
apart

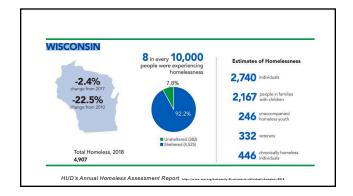
Chicago: 16 year difference in life
expectancy between Washington Park
and the Loop

MAKING THE CONNECTIONS: OUR CITY, OUR SOCIETY, OUR—
HEALTH

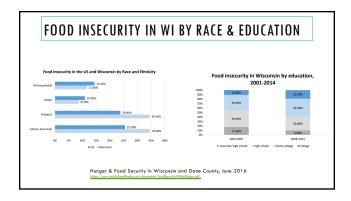
https://www.voutube.com/watch?v=a-3mUJGióbA&feature=voutu.be



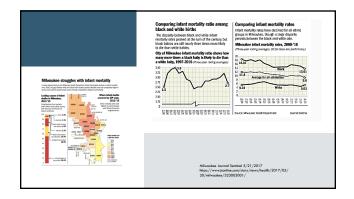


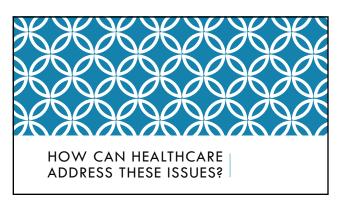












### HEALTHCARE ANCHOR NETWORK

The long-term goal is to reach a critical mass of health systems adopting as an institutional priority to improve community health and well-being by leveraging all their assets, including hiring, purchosing, and investment for equitable, local economic impact. By doing so, we can powerfully impact the upstream determinants of health and help build inclusive and sustainable local economies

Community Partnerships

45 Health Systems nationwide

## HOUSING EXAMPLES Bon Secous Bollimore – helped build more than 800 usins of affordable housing using Low-Income Housing Tax Credits. \*\*Investing to the forest to support for forest healthy affordable housing using Low-Income Housing Tax Credits. \*\*Investing to the forest to be about your forest and investing to the forest forest to the about your forest and the forest forest to the about your forest and the forest forest to the about your forest and the forest forest to the about your forest and forest to the about your forest and forest fore

# GUNDERSEN HEALTH SYSTEM HOUSING PROJECTS Count Brewery Lofts - 8.5 with housing (68 offordable) Gundersen provided the land and building to a private developer who used Low-income Housing Tax Credit and Hattoric Lax Credit Resident housing in Neighborhood \*\*Dis Arcontines for Employees who live in the neighborhood OHabitat homes in the Neighborhood \*\*Project BRNEW \*\*La Crosse Collaborative to End Homelessness



### DETROIT — ASTHMA AND LEAD POISONING PROJECT

The Healthy Homes and Asthma Program addresses lead hazards, asthma and allergy triggers, and home safety for Detroit families who have children five years old or younger with diagnosed asthma.

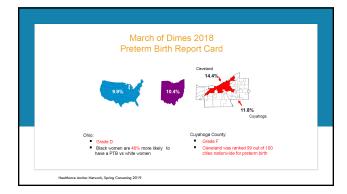
with auginosed astinut.

The asthma prevalence rate for children in Detroit is approximately 30%, three times the national average; and asthma is the leading chronic condition causing school absenteeism and preventable hospitalization for children under 18

- 1. Case manager identifies hazards and provides education
- 2. Family Action Plan is customized, listing products to reduce triggers, etc
- 3. Referral to partner agencies

Work with Community Based Development Corporation (CBDG) for help with funding programs

https://clear corps detroit.org/programs/healthy-homes-detroit/







### TRANSPORTATION

- No Show rate 5-30% or more
- Lyft and Hitch Health (tech company) conducted a pilot study at Hennepin Healthcare in Minneapolis and were able to reduce no-shows by 27% in previous patients with no-shows (2018)
  ♦ Used texting technology to offer Lyft rides to patients in need.
- ❖Increased revenue by \$270,000 (297% ROI)
- ♦ Uber Health allows healthcare providers, clinics, and hospitals assign rides for their patients from a centralized dashboard without requiring the patient have the Uber app or smartphone
  ♦ Boston Medical Center reported \$500,000 in transportation savings by using Uber Health



### Community Hubs – Pathways Model

- Understand the interplay of measured risk and measured health outcomes
- Hubs situated between community health workers (CHW's) and the health care system- public, provider, payer, government
- Find those in need in a community
- Assess elements of risk: modifiable and social risk properly weighted
- CHW's/community navigators who know the community and the clinical aspects

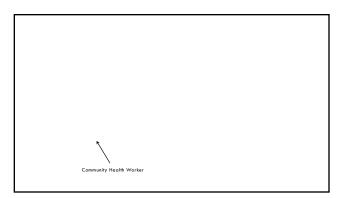
   Create connections to services

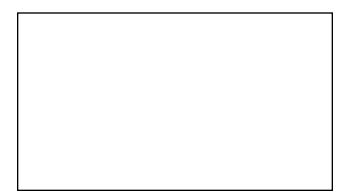
   Mitigate risk directly/indirectly

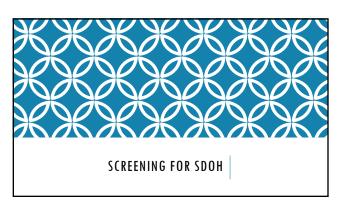
   Educate

   Connect to care



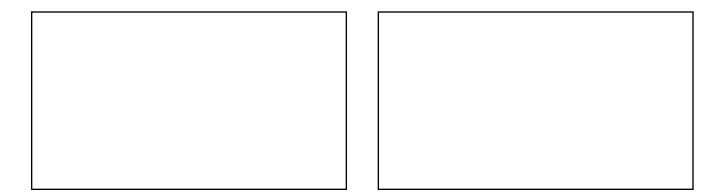


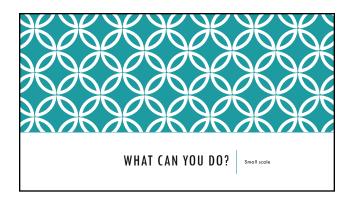




SCREENING FOR SDOH
One person's data is another person's difficult life experience.

### SCREENING FOR SDOH 1. Screening for SDOH Practices should consider the social determinants prevalent in the population they serve and whether those SDOH needs are issues that the practice can assess and refer for within their workflow constraints 2. Referral to Community-Based Organizations What organizations can handle referrols? Know where your patients live to make referrals convenient for them. 3. Get Patients the Needed Services Making sure the patient follows through an referrals. 4. Closing the Communication Loop





### OTHER WAYS TO HELP YOUR PATIENT

- 1 Pick a tonic
- 2. Don't wait for perfection or system solutions.

Refer your patients.

Empower your staff to refer.

Use your local community resource listings — 211

3. Get involved in systemic issues in your community

Habitat, food pantries, Boys & Girls, Salvation Army, United Way

Your presence provides credibility & power

