3-minute case study: Building a bridge to pop health

By Lia Novotny | March 21, 2018

What drives success in healthcare? Here's a tactic from a leading community health center.

The problem

Suburban towns can struggle to find the funding and expertise to solve chronic health issues in their populations. In central Massachusetts, four communities with high rates of tobacco use, hypertension, asthma, and falls among older adults banded together in 2014 to find resources to improve the health of their residents.

The solution

The Massachusetts towns of Hudson, Marlborough, Framingham and Northborough formed the MetroWest Prevention and Wellness Partnership. Together, they applied for a grant through the Massachusetts Prevention and Wellness Trust Fund to reduce pediatric asthma, hypertension, tobacco use, and older-adult fall risk by referring eligible patients to evidence-based prevention and wellness services in their region.

After identifying organizations capable of supporting the mission, and formalizing the relationships between them and the towns, clinical partners began screening and referring patients to community partners.

Pediatric asthma patients seen at the Edward M. Kennedy Community Health Center, for example, are referred for home visits by trained municipal health department staff to review action plans and assess triggers in the home. Hypertension patients are referred to the MetroWest YMCA for a 6-week program to learn to take an active role in managing their condition.

Community health workers manage communication between partners via a simple HIPAA-compliant online

communications system. "It's basically an online form for clinical partners to fill out, and the community partners receive it on the other end and start contacting patients," explains the system's creator, Sam Wong, Ph.D., director of public health services for the city of Framingham.

The community health workers also update each patient's electronic health record. The system enables the partnership to process the thousands of referrals without phone calls or faxes.

The bi-directionality of the system is the key to its success, says Alexandra DePalo, program manager for the Hudson Board of Health, especially given that the project "is incredibly communication-heavy at the level of the community health worker."

The outcomes

To date, the partnership has referred more than 1,700 patients to community programs. Sixty-one percent of eligible patients have been referred to services – exceeding the set goal of 50 percent – and 57 percent of those have completed the program to which they were referred. The completion rate for 2018 is on target to be as high as 70 percent.

Initial data on clinical outcomes is encouraging, including significant increases in hypertension screenings, drops in average blood pressure across all demographics, more than 900 fewer falls among older adults, and declining rates of pediatric asthma. Overall, the partnership projects savings of $11 million in healthcare costs over five years.

Beyond those outcomes, the partnership reveals value that community health workers bring to population health, says DePalo. Thanks to them, clinical partners "cannot believe how much they're learning about their patients and about the context and environment in which they live," she says.

Lia Novotny is a frequent contributor to athenaInsight.

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