

CASE STUDY

# Collaboration for Community Health

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## BACKGROUND

There is a widespread recognition that we can no longer rely solely on traditional health systems to improve community health. Health systems, community organizations, and governments recognize the need to meaningfully collaborate to address social determinants of health. In the backdrop of federal and state health care reform, many health care and community organizations have sought more effective collaborations in an effort to improve patients' outcomes. Beginning in August 2018, the Arnhold Institute for Global Health began an initiative aiming to apply lessons from abroad to create better processes for health system and community collaboration.

The Arnhold Institute for Global Health (AIGH) is part of the Icahn School of Medicine at Mount Sinai. It is an academic institute that develops and evaluates global health solutions which can be replicated at scale. The institute is focused on global health systems and implementation research, and committed to applying global lessons from developing country contexts to settings in the United States. The institute partners with community-based organizations, health systems, government partners and academic institutions to maximize impact at scale.

In 2017, the Arnhold Institute for Global Health received support from the Robert Wood Johnson Foundation to convene the Task Force for Global Advantage. The task force was comprised of over 50 global and United States health care leaders. Global advantage describes the benefit the United States health care system could gain by applying global lessons to improve community health<sup>1</sup>. One key insight was the need for a closer integration of the health system with the community. This aligned with the efforts of the New York State Delivery System Reform Incentive Program (DSRIP) which began in 2014 as part of the Medicaid Redesign Team. The primary goal of DSRIP was to reduce avoidable hospitalizations by 25 percent over five years<sup>2</sup>. In order to do this, health

systems recognized that it was imperative to collaborate closely with community-based organizations focused on the social determinants of health. A total of 25 Performing Provider Systems (PPS) were established across New York State to implement projects across three domains: system transformation, clinical improvement and population health improvement<sup>3</sup>.



1. Singh et al. "The Task Force on Global Advantage Report." 2018. The Arnhold Institute for Global Health.

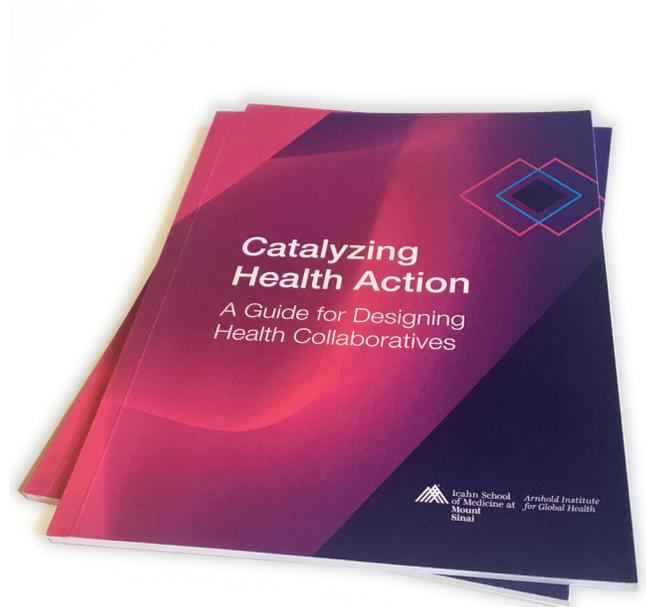
2. "DSRIP Overview." New York State Department of Health. ([www.health.ny.gov/health\\_care/medicaid/redesign/dsrp/overview.htm](http://www.health.ny.gov/health_care/medicaid/redesign/dsrp/overview.htm)). Accessed December 2019.

3. "DSRIP Performing Provider Systems (PPS)". New York State Department of Health. ([www.health.ny.gov/health\\_care/medicaid/redesign/dsrp/pps\\_map/index.htm](http://www.health.ny.gov/health_care/medicaid/redesign/dsrp/pps_map/index.htm)). Accessed December 2019.

This initiative was supported by the Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund, its directors, officers, or staff.

In 2018, AIGH received support from the Commonwealth Fund to build upon the insights of the Task Force on Global Advantage. The goals were two-fold: to develop and operationalize a participatory process to address community health issues in partnership with community-based organizations and to generalize the process and make it accessible to a wider national audience through the Catalyzing Health Action guide. This initiative convened health systems and community organizations to identify a community health need and strategize about possible solutions. This was an opportunity for health systems and community organizations to interact with one another in a less formal environment and explore new possibilities for how to work together. The geographic focus was defined as Central Harlem, located in New York City.

The Arnhold Institute for Global Health served as the convener and facilitator for this initiative. Although the institute is part of the Icahn School of Medicine at Mount Sinai, we intended to serve as an intermediary that was trusted by the health system and we invested in building that trust with community organizations, some of whom we had existing relationships with but many of whom we did not.



Catalyzing Health Action. A Guide for Designing Health Collaboratives



# Catalyzing Health Action

## A Guide for Designing Health Collaboratives



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## THE PROCESS

### ***Recruitment: Leveraging Existing Connections***

We reached out to community organizations to learn more about their work and to see if they were interested in participating. Advisors and already recruited stakeholders played a significant role in connecting us with well-respected leadership from community-based organizations. They had extensive experience in Central Harlem and therefore were easily able to identify stakeholders who would be strong prospective partners and willing to participate in a collaborative forum. In addition, we reviewed the organizations that the Mount Sinai PPS had identified. In order to determine who to invite to participate, AIGH developed criteria that included: diversity of population served, interest in developing best practice collaboration between health systems and community partners, and experience with collaborations. After numerous meetings with community organizations, we successfully recruited representatives from health care and community-based organizations that serve Central Harlem. These included two community health worker organizations, AIRnyc and City Health Works, the Mount Sinai PPS, New York Common Pantry, and clinical and administrative leadership from Mount Sinai Saint Luke's Hospital.

One challenge was determining what seniority level of staff was most appropriate to participate in the collaborative. We found that having leaders with decision-making power who were peers was effective.

### ***Site Visits & Meetings: Building Trust***

Even after completing recruitment, there was still much time spent in smaller groups and as a collaborative on identifying and building trust. The AIGH team conducted a number of one-on-one meetings and site visits. This not only demonstrated to stakeholders that we were eager for their commitment, but allowed us to learn more about the services they offered, their interactions with the Central Harlem community and health systems, and what they had learned from their work and previous collaboration experiences. These visits were not only essential in the early phases of the initiative, but would continue to be a vital part of the process.



In-person visit to a stakeholder organization. Photo by Patrick Kolts

## Workshops: Designing Convenings

As a group, the collaborative met in nearly monthly workshops that included thoughtfully curated exercises informed by design principles. Human-centered design can improve collaboration and convening experiences by creating convenings and processes with the potential to build trust, shift relational dynamics and mindsets, and improve collaborative practice.

In this initiative, we acted as both a convener and facilitator for this complex process, devoting intention to each detail of the convenings. The result was a fresh experience for stakeholders within which they were able to discover new insights and approach existing institutional relationships with a different and more interpersonal lens. Many people in the collaborative hadn't met each other in person before. Face-to-face, stakeholders were able to move past their organization-level misunderstandings and connect as individuals. Bringing the stakeholders' commonalities to the center helped break down barriers.

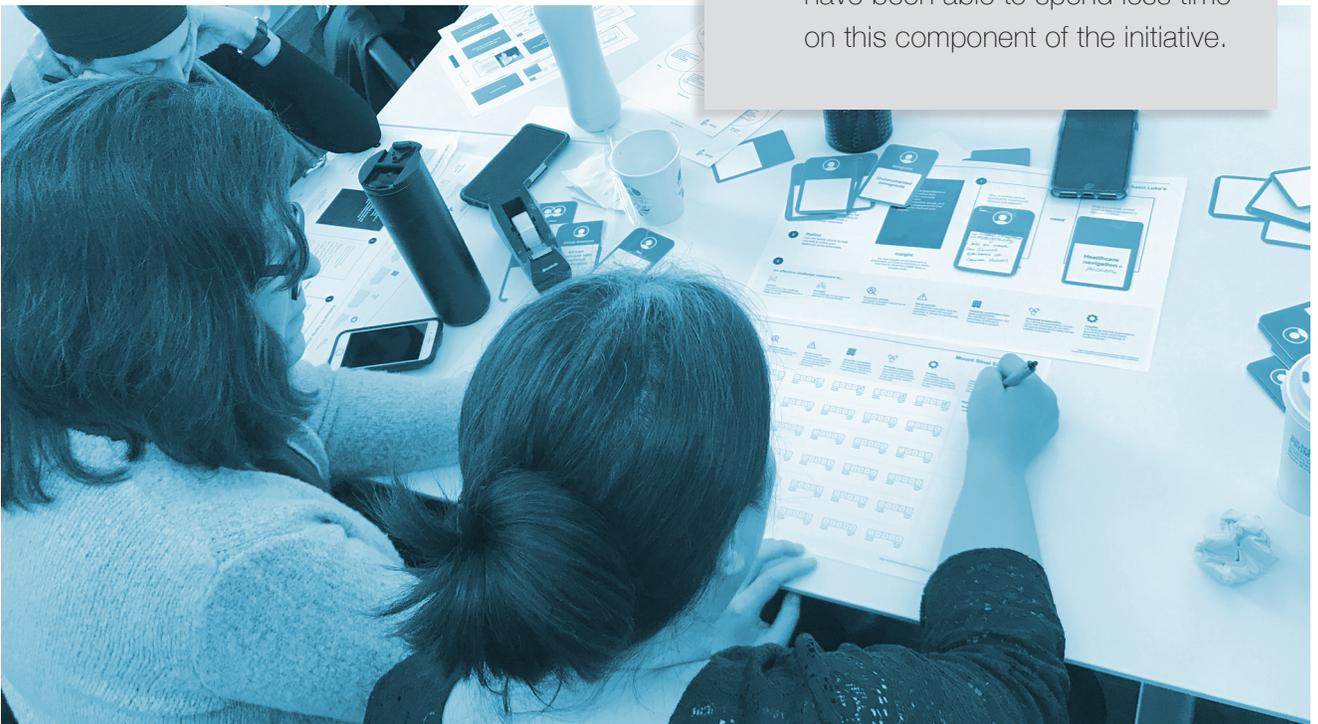
More details about the workshops and specific exercises can be found in the guide, "[Catalyzing Health Action: A Guide for Designing Health Collaboratives](#)" that we developed based on these experiences. Three aspects of the workshop arc - two challenges and one success - are further elaborated below.

## Defining a Shared Challenge Statement

A main part of the initiative was identifying a shared community health challenge statement. We defined this statement as something which identified a population and a community health need. Refining and achieving consensus on the challenge statement was the most difficult part of the initiative. It took nearly all the workshops to narrow it down to a specific population and health focus. All stakeholders were concerned about the lack of timely access to trusted and culturally appropriate health services to vulnerable populations. This concern about mistrust and stigma played a significant role in developing the challenge statement since it is what made the population vulnerable. The final challenge statement states the following: older adults with multiple chronic conditions need knowledge, skills, and confidence to better self-manage, navigate, and problem-solve.



In hindsight, as facilitators we may have been too myopic about the structure of the challenge statement. If we had had better defined parameters about the group focus beforehand, or had not divided population and needs, we may have been able to spend less time on this component of the initiative.



Stakeholders working on Challenge Statement Generation and Evaluation exercise

### Adapting Global Case Studies

As we were still trying to achieve consensus on the challenge statement, we identified and introduced a global case study to the collaborative. Given that the initial idea of this work was that it would be inspired by global best practices in community health, we hoped that being introduced to solutions from abroad could help to catalyze a different way of approaching local challenges. However, we soon realized there is much complexity and many decisions to be made when identifying global case studies. From the outset, decisions need to be made about aims. Is the priority to introduce and apply global lessons, or to be responsive to local needs? If the latter, the first challenge is to thoroughly understand the challenges that communities face and determine what the group will focus upon. After that, groups must determine which aspects of a global innovation to prioritize. We used Bhattacharyya et al's (2017) criteria scoring system to assess global case studies to share with the collaborative which was very helpful<sup>1</sup>. But there were still a number of decisions to be made: From which regions will you source innovations and why? Are there any geographic parameters from where you will source innovations? Should the United States be included? Which aspects of an innovation will you prioritize? For example, evidence-based, novelty, or the similarity of the context? Will you be willing to take significant liberties with regard to adaptation?

1. Bhattacharyya et al. "Criteria to assess potential reverse innovations: opportunities for shared learning between high- and low-income countries." 2017. Globalization and Health.

Another obstacle is identifying global solutions with sufficient amounts of relevant information available. Many well-regarded innovations do not include sufficient operational information to assess the potential for or to design a replication effort. Often times site visits or conversations with people who have designed and implemented these solutions are necessary in order to have sufficient information to design a replication effort. For many groups, committing this level of time and resources to learn and adapt another model is unfeasible.



It is difficult to know when is best to introduce global solutions in a collaborative process. If you do it too early, you can risk shattering the fragile sense of group identity and distracting from identifying and scoping the local challenge the group would like to focus on. However if you wait until the local issues and solutions are well scoped, you may miss the opportunity to catalyze paradigm shifting ideas.

### Human-centered design

We leveraged the following human-centered design-informed elements, each unique to the typical convening approach in health care:

- **Participatory methods:** design encourages participation beyond conversation through interactive elements (i.e. workshop activities, worksheets, case studies, etc.)
- **Facilitation:** skilled facilitation helps encourage safe conversation and efficient use of time toward said goals
- **Visualization:** design surfaces collective wisdom by visually mapping information and interpreting patterns

In healthcare, human-centered design can push us towards true patient-centeredness, putting the person at the center. In convening, human-centered design can improve the collaborative process, reshape power dynamics, and build sustainable partnerships by approaching relationship building as a step-by-step process.



*Hypothetical Patient Journey Mapping*

In order to shift the workshops towards solutions, we conducted a journey mapping exercise. The facilitators created a fictitious, but plausible scenario where an older adult, “Mrs. Jones”, had endured a health crisis and was admitted and preparing to be discharged from the hospital. Each organization described how they would hypothetically interact with an older adult with multiple chronic conditions from admitting to discharge. In addition, each organization described how they would likely interact with one another during the transition post hospitalization. Throughout this exercise, much of the burden for managing care was falling on Mrs. Jones. When it was mapped out, it was more clear that there was a lot of duplication of efforts and potential for miscommunication between the health care system and community-based organizations, as well as among community-based organizations. Many processes were ad hoc rather than systematic. We documented all the interactions and the stakeholders identified small and specific changes or actions each organization could make with each other to substantially improve the care of an adult with multiple chronic conditions.

Through this exercise, we collectively created a visual representation of the process, which highlighted that the food pantry, NY Common Pantry, was on the periphery of the interactions, whereas a patient with limited income would probably think first about their access to food. This highlighted that some services may be critical to a patient yet are not really part of the “system,” potentially leaving patients’ priorities and vital needs unaddressed. This highlighted that some services may be critical to a patient yet are not really part of the “system,” potentially leaving patients’ priorities and vital needs unaddressed.

The stakeholders identified three potential interventions during the mapping exercise. The first intervention was to create a list of all those involved in Mrs. Jones’s care. This includes all physicians, case managers, social workers, and family members or other caregivers. When there are so many different organizations and people interacting with a single person, it can be difficult to understand who is responsible for what and which information needs to be shared across the system. The second intervention was to understand patients’ priorities by asking them directly and to create a list documenting them. Many times healthcare providers or case managers give a “to-do” list to patients, with certain items requiring greater priority. However, this list does not necessarily take into account the patients’ priorities, such as childcare and employment responsibilities or access to food. The group believed a list that combines the priorities of patients with that of the health systems has the potential to improve social and health outcomes. The final intervention was to conduct a gap analysis on behalf of vulnerable patients. The case managers should help to identify needs and connect patients to these services. All these interventions are intended to decrease the burden on patients through improved coordination amongst community organizations and health systems.

 One of our big takeaways from this process was that when we could shift the focus of the group to the people they serve, real or hypothetical, it was a powerful motivator for thinking beyond organizational identities and into a collective mandate to serve.



Example of completed Simulation Mapping exercise from our initiative

## FURTHER ACTION

The initiative's participatory process culminated in a local symposium. Following this event, stakeholders continue to engage in the relationships they established through the initiative. Mount Sinai St. Luke's intends to expand the initiative's Central Harlem work, and the Mount Sinai Health System is broadly exploring how to improve collaboration with community-based organizations.

### *Local Symposium*

At the end of the series of workshops, we convened a symposium in August 2019 to expand the conversations to a broader group of stakeholders primarily comprised of Mount Sinai clinical and administrative leadership, New York City-based community organizations and philanthropic representatives. These stakeholders had a robust discussion about effectively collaborating and there was a unanimous commitment to deepen and improve collaboration to better serve patients. The symposium helped catalyze conversations among funders and senior Mount Sinai leadership about how to support this type of work. To that end, the guide, "[Catalyzing Health Action: A Guide for Designing Health Collaboratives](#)", was well received, with multiple participants indicating they will use it and adapt aspects for their organizations.



Local Symposium, held in August 2019.

### *Stakeholder Engagement*

At the end of the initiative, there were no concrete next steps. Stakeholders remained interested and engaged, open to a continued opportunity to work together, which demonstrates the initiative's success in creating an honest and valuable space. The individual relationships formed in that space continue to bear fruit through improved collaborations and increased efficiency working across their organizations. For example, airNYC and Institute for Family Health have pursued multiple collaborations.



Stakeholders panel, held in August 2019.

### ***Continued work in Central Harlem led by Mount Sinai St. Luke's***

In Harlem, Mount Sinai St. Luke's Hospital - a represented stakeholder in our initiative - is continuing the work of this initiative and its DSRIP PPS by reinitiating its Hub, which aims to "create and empower a network of providers and community based organizations in a particular geography to optimize patient care by coordinating services and minimizing the impact of non-clinical barriers to receiving care." The Mount Sinai St. Luke's Hub will be a prototype for the system, informing the next iterations of community health and collaborative approaches in New York City.

### ***Continued work across Mount Sinai Health System***

Mount Sinai Health System broadly is eager to leverage the learnings and momentum created by this initiative. At a system level, the Mount Sinai Health System Social Determinants of Health Committee guides the system-wide strategy on identifying and addressing patients' social determinants of health. Through this committee, the learnings of this initiative catalyzed conversations and informed strategy. There is a greater recognition of the complex historical relationships and the importance of building shared value between community groups and the health system.



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