The Schenectady Bridges Project: Using the Bridges Model to Build a Communitywide Health Coalition

by Kellie Valenti

IN 2007 NEW YORK STATE'S hospital closure commission (the Berger Commission) mandated the merger of Schenectady's three hospitals into one. During the ensuing five years, a broad community coalition has used the "Bridges®" (Payne, DeVol, & Dreussi-Smith, 2006) lens to enhance access to healthcare services, leading to measurable improvements in community health and positioning Schenectady as a leader in healthcare innovation.

The forced consolidation of the three hospitals, which was accomplished in less than a year, left Ellis Medicine, the non-profit owner of the single remaining acute-care hospital (and, suddenly, also one of the community's largest primary-care providers) with *de facto* responsibility for the health and wellness of all the county's 150,000 people.

James W. Connolly, the new president and CEO of the newly consolidated hospital (he had interviewed for his job on the day the Berger Commission issued its report), called the recognition of that responsibility "an epiphany." As the only place that the community's substantial uninsured and underinsured population can go for care, Connolly said, "The hospital has two choices. You can wait until people get sick and come to the Emergency Department for very expensive care, or you can get out into the community and promote cost-effective wellness and primary care. Either way, you pay for it." And paying for it was a valid concern in a community where the three hospitals lost a combined $7 million in the year preceding consolidation.

While the hospitals undertook the complex process of merging systems and staffs (and eliminating beds), Ellis commissioned a local college to conduct a telephone survey identifying the community's healthcare concerns. At the top of the list were: (1) access to care for the uninsured, (2) availability of urgent care, and (3) transportation to care.

With these concerns in mind—and faced with the need to stem the flow of red ink that threatened the very existence of the only remaining healthcare resource—hospital and community leaders convened an informal task force to develop a fast response. This led to a three-pronged approach to meeting the community's health needs.

First was a physical modification. One of the former hospitals—located adjacent to the neighborhood with the lowest incomes and highest healthcare needs in the city—was converted to an outpatient facility; the Ellis Health Center (EHC). Patients gained "one stop" access to lab testing, X-rays and imaging, cancer screening, diabetes and asthma education, nutritional counseling, primary care, pediatric care, dental care, and outpatient mental health clinics. The campus' 24/7 Emergency Department (ED) remained open. Going beyond just healthcare services, community partners opened a farmers' market, free income-tax services, a bereavement counseling center, and the school district's new student "welcome center" at EHC. In order to help patients get to the facility, Ellis implemented a free "community shuttle," using an existing van and driver to make stops at seven community sites (including homeless housing providers, soup kitchens, and mental health providers) and then bring patients to EHC. [See "Community Shuttle Volumes" chart at end of article.] After receiving care, patients are given a free bus pass (purchased by the hospital, but at a bulk rate discount provided by the local transit authority) to get back home.

Second came a change in staffing. The hospital and community agencies partnered to place "navigators" at EHC to help patients find their way around the maze of healthcare and community services. Two "health services navigators"—one a nurse employed by the hospital and one a public health nurse under contract from the county Public Health Service—now help patients with healthcare, from selecting a primary care provider to understanding their medications to literally finding their way to an office at EHC. A "community services navigator" (a social worker employed by the local community action agency under a federal grant) helps with non-health services, such as finding housing or transportation. And "facilitated enrollers" from a non-profit health plan assist eligible patients with signing up for Medicaid.

The ***third*** change—affirmatively bringing Schenectady's healthcare, community service, and local government agencies together as a "Bridges Community"—has tied together the participants in a "common language" of effectively coordinated services intended to meet the specific needs of each member of the community. Sparked by Michael Saccocio, executive

director of the Schenectady City Mission, implementation of the "Bridges" model throughout Schenectady rests on four pillars.

One pillar is the commonality of language. "Bridges" concepts are formally taught to hospital staff—including doctors, nurses, and administrators—as well as to staff of the many participating community agencies. Using formal training at many levels, the goal is to hard-wire Bridges thinking throughout Schenectady's healthcare and community service agencies. A hospital staff member completed the formal "train the trainer" program and is now qualified as a Bridges expert. Using the hospital's training facilities, she and other community professionals teach Bridges concepts in a two-day, seven-student course every other month—with the "graduates" continuing to meet monthly to discuss how they are implementing what they learned. In addition, required continuing education for hospital executives includes coursework in the Bridges process. And these executive "trainees" experience what they are learning. After a group of healthcare managers exploring city bus routes missed a connection and had to walk half a mile in the bitter cold, local medical practices suddenly became more tolerant of patients who were a bit late for appointments.

A second pillar is a greater awareness of what makes the local community special—and therefore requires special responses. Schenectady hosts a substantial West Indian community, largely the result of affirmative outreach by a previous mayor who welcomed secondary migration of Guyanese immigrants from New York City. Census data show that this initiative reversed the central city's population decline; the data also project that future growth will enhance Schenectady's diversity, with the "Asian" (the U.S. Census category for West Indians) population growth outpacing any other population group in both absolute numbers and relative share. But the medical community's growing awareness of local population dynamics led to a discovery beyond the demographics: the need for medical care that isn't just culturally appropriate but with particular understanding of population genetics. In this case, research conducted at Ellis identified an unexpectedly high prevalence of diabetes in West Indian men, especially those without such a typical indicator as obesity. The West Indian community mobilized behind community-service and faith-based organizations; the county Public Health Service obtained a federal grant; and medical practitioners are now routinely screening for, and identifying diabetes in, patients who would not previously have been considered candidates for screening.

As a side note, active involvement of the West Indian community with the healthcare system has led to increased interest in, and opportunities for, employment. As of 2012, the workforce at Ellis Medicine is more diverse than the population of its service area (17% people of color vs. 12% for the population), with more than 40% of the minority employees in the "Asian" category.

The third "Bridges" pillar is a new predilection toward cooperation, both within and among communities. The informal group that helped envision the outpatient facility and its staffing model of navigators has become a formal advisory group and "think tank," tying the hospital and a multitude of community groups together. Individual partners have built direct linkages, such as a four-way partnership among two children's service organizations that identify clients needing dental care and two dental clinics (Ellis Medicine and Hometown Health, the federally qualified health center), which provide pediatric dental care based on their specialties and capacities. When New York State offered Medicaid funding for community-based care management programs called "Health Homes," 30 providers and community organizations signed on as partners, and Schenectady was chosen as one of only two upstate communities to participate in the first phase of the Health Homes project. And, when the Medicare Community-based Care Transitions Program (CCTP) solicited applications from large regional coalitions, Schenectady's partnership was the logical leader of what became collaboration among 10 hospitals and six community-based organizations serving 21% of the geography of New York State.

The final pillar is the most important for the future: use of the "Bridges lens" to look at what we do every day. This concept ensures that the community's viewpoint is always "at the table" during the decision-making process so that, just as the chief financial officer (CFO) may express the fiscal viewpoint and the chief nursing officer (CNO) expresses the nursing viewpoint, a designated community-based executive understands and puts forward the views and needs of the community. As a result, the goal is that new programs should be designed to fit everyone's needs—perhaps by ensuring understandable reading materials or by locating new facilities on a convenient bus route. And while the "Bridges lens" is not the ***only*** way of looking at an issue, just as the financial perspective is not the ***only*** way to look at healthcare, having a strong voice for that view substantially increases the potential that the final decision also will benefit the community.

This integration into community thinking is well illustrated by the "aha" moment that took place as a group of hospital administrators were gathered to hear from a national speaker on the Bridges process. During the follow-up discussion, participants talked about transportation issues (some of them had been part of the group that missed the bus and had to walk) and about their efforts to accommodate patients who came late for an appointment. Some of the patients even came on the wrong day or week because of multiple issues—from transportation to childcare to dealing with family crises—which make it difficult to come to a specific place at a specific time. Starting with stories about working medical schedules around patients' appearances (one dental technician routinely "hijacked" dental residents to treat patients without appointments but in obvious pain), the group began to ask why we need appointments at all. Rather than require patients to do what may be difficult or impossible, why not organize the care and treatment process around

what patients can do? This is now leading to several forms of experimentation. Hometown Health sets aside several time slots daily for walk-ins, as do the Ellis clinics, which maintain open slots coinciding with the arrival of the community shuttle van. The Ellis dental clinic is investigating the possibility of dedicating one day a month for open treatment of the parents who accompany their children for pediatric dental care. And the full array of outpatient services at EHC might be made "open access" for some uniform period weekly or monthly so that patients without appointments would know that they can come for any care they need during that open period.

It should be noted that implementation of a new way of thinking did not come painlessly to Schenectady, nor is the Schenectady experience always directly applicable to other communities.

The "crisis" that brought the community together—closure of two hospitals—was resisted at the time—and the succeeding steps would not have happened without the outside intervention of the state's hospital closure commission. But once the hospital closures actually occurred, the Schenectady response/model of integrated care has spread rapidly in the region: The two hospitals in Amsterdam, immediately to the west of Schenectady, merged in 2009; and three hospital systems in Albany and Troy, to the east, are now in the process of merging. Those communities are using many of Schenectady's strategies as they move forward with their new realities.

Although Schenectady's size (the city's population is about 60,000, the county's is about 150,000, and the county is geographically the second smallest upstate) limited the number of competing social services and healthcare agencies to begin with, the creation of the single hospital's "monopoly" (combined with the "monopoly" of the county Department of Social Services as the sole Medicaid payor) was a factor in inducing organizations to work together. Here again, cooperation seems contagious; the "Health Home" partnership includes a number of large, regionally based agencies that are working closely with each other and with smaller Schenectady-based groups.

So far, management efficiencies and economies of scale resulting from the hospital consolidation have helped to pay for many of the direct costs of the community-based services. Ellis receives no insurance or government reimbursement for such costs as the salaries of the navigators or the expenses of the community shuttle van. This may not be viable for the long haul; however, continuing cuts in both Medicare and Medicaid reimbursement levels are substantially reducing funds available to the hospital for investment in the community. Increasingly, the hospital and community coalitions are working together to submit combined grant applications, but to date they have limited experience and results.

There is positive experience in Schenectady with measureable outcomes from the overall changes in the community's approach to healthcare. The nationally recognized "County Health Rankings" proj-

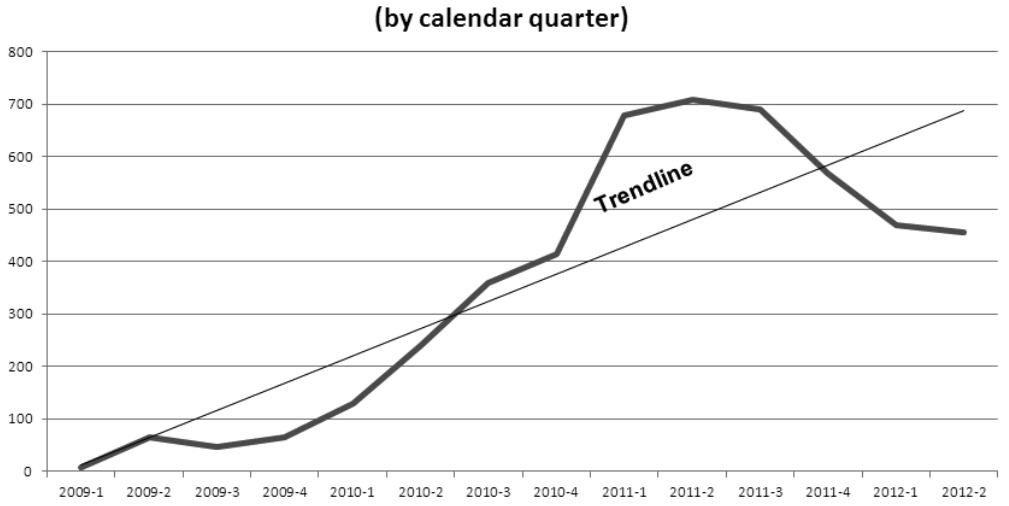
ect funded by the Robert Wood Johnson Foundation shows Schenectady's steady progression of improved health outcomes over the three years (2010–12) that the rankings have been published. In the first year, Schenectady ranked 37th healthiest among New York's 62 counties, moved up to 34th in 2010, and continued up to 30th for 2012. Other more specific measures also show progress. For example, the percentage of uninsured patients treated at the EHC ED declined from 20% to 18%, indicating that more patients are enrolling in Medicaid. The number of patients receiving primary care in the community has increased—with a 25% increase in patient volume at the Ellis primary care clinics between 2009 and 2011. Further, a process in which ED discharge nurses directly make follow-up appointments at the EHC clinic for ED patients who don't have a primary-care physician has led more than 300 people to establish primary care for the first time. [See "Cumulative Ellis Health Center Emergency Department Referrals to Family Health Center" chart.]

The organizations also have been successful in leveraging their partnerships and combined resources for successful grant applications. The Health Home project will bring new capitated Medicaid payments to at least a half-dozen agencies that are directly delivering care management services. The federal REACH (Racial and Ethnic Approaches to Community Health) grant to the Schenectady County Public Health Service is supporting substantial research and outreach by multiple community members of the West Indian Diabetes Coalition, and it's forming the basis for other research grant applications. Too, the Medicare CCTP could generate $6 million over five years to support care transitions services by the six community-based organizations and 10 hospitals.

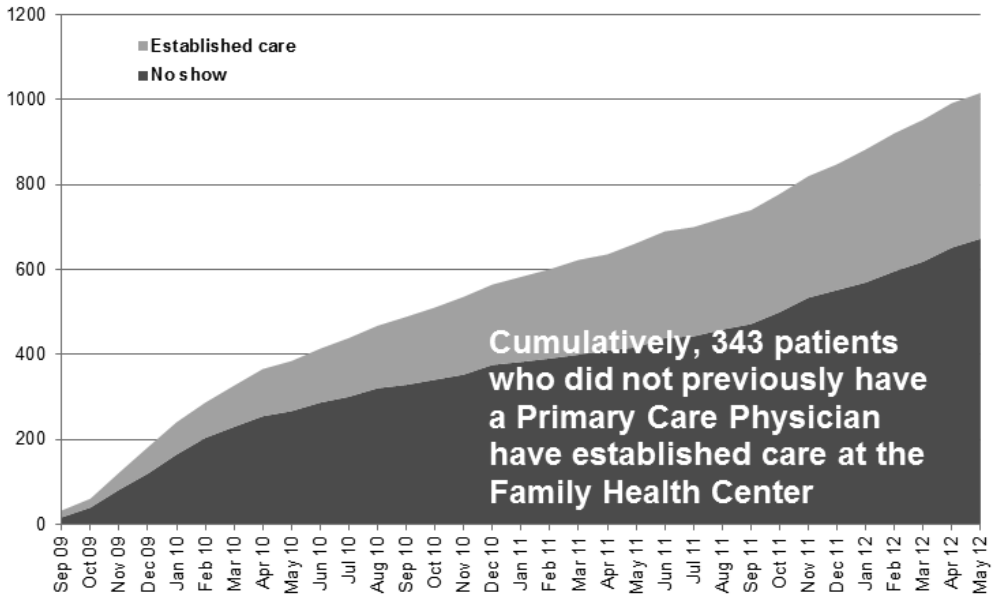
There is a great deal of opportunity in healthcare to do things differently. Pretty much everybody in the system—or who observes the system—says that major elements of healthcare are "broken." And this means that there is relatively little risk in trying new things. The worst that can happen is that the system will remain "broken," while any improvement is a step in the right direction. The goal and the lesson of this initiative, of which Bridges concepts have been key elements, have been the value of understanding the needs of the community, using a comprehensive and consistent "lens" to ensure that those needs are always considered, and always including representatives of the community as voices "at the table" in the course of everyday business.

As a result, those of us who live and work in the Schectady area are better able to meet the healthcare and community service needs of the diverse array of people in our community.

Community Shuttle Volumes



Cumulative Ellis Health Center ED Referrals to Family Health Center



Reference

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