COACH

Collaborative Opportunities to Advance Community Health

COACH brings together diverse regional partners to address unmet health needs of vulnerable communities in southeastern Pennsylvania

WHO WE ARE

7 HEALTH SYSTEMS

Representing 18 hospitals in the region

16 PARTNERS

Public health, community, and insurer partners in the region

WHY WE WORK TOGETHER

Many challenging health problems arise from social issues that cannot be effectively addressed by one stakeholder alone. Through a collective impact approach, COACH gives participants an opportunity to make real progress together in addressing the underlying social needs that give rise to poor health.

COACH's ultimate goal is to achieve measurable improvements in the population health of vulnerable local communities, thereby reducing the incidence of preventable medical interventions—such as hospital readmissions—caused in part by patients' social circumstances.

COACH participants identified improving access to healthy food as an effective way to help at-risk patients and families prevent or better manage chronic disease

TARGETING FOOD INSECURITY

Food insecurity is the lack of consistent access to sufficient nutritious food necessary to lead a healthy life

Nationally. 12.7% of households are affected by food insecurity.

In Philadelphia, 21.7% of residents, including 22.4% of children are affected.

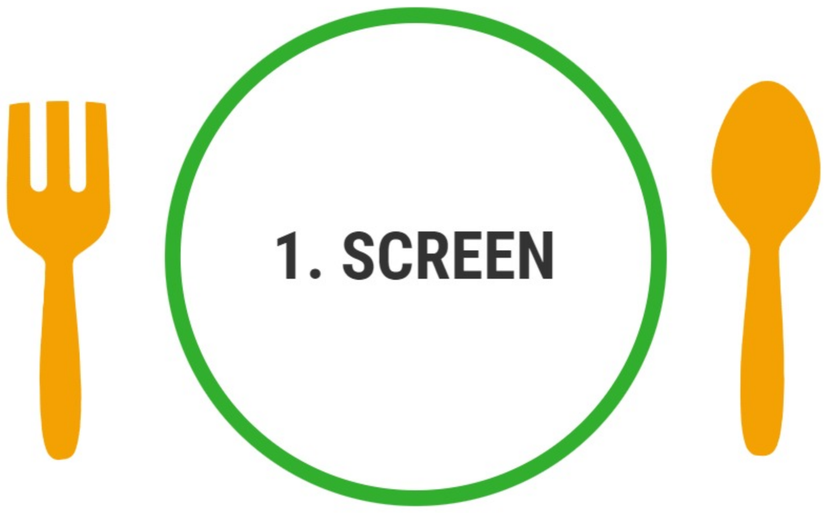
Food insecurity is associated with:

HEALTHY FOOD ACCESS PILOT

COACH participants agreed to a collective food insecurity screening and intervention effort to reach a large number of patients and community members in need

WHAT WE'RE DOING

Participating hospitals have implemented pilots in settings as varied as primary care offices, inpatient units, a post-discharge call center, and emergency departments to:



Screen patients for food insecurity using a research-validated two-question screening tool

Connect patients who are food insecure to healthy food resources and programs

HOW WE INTERVENE

- Engage care teams: community health, social workers, case managers, nurses, and physicians
- Develop comprehensive resource lists and "warm handoffs" to community resources and enrollment assistance with public benefits
- Explore partnerships with grocery stores, food banks, food buying clubs, social service agencies, and anti-hunger organizations

HOW WE EVALUATE

We are tracking measures such as:

- Number of patients screened and positive screens
- Number of referrals made to community resources
- Number of patients referred for SNAP benefits
- Number of SNAP applications submitted
- Number of patients whose needs were met

SPONSOR

The Hospital + Healthsystem Association of Pennsylvania

www.haponline.org

COACH PARTNERS

Children's Hospital of Philadelphia
Einstein Healthcare Network
Holy Redeemer Health System
Jefferson Health (including Abington Jefferson Health and Jefferson Northeast)
Mercy Health System
Temple University Health System
University of Pennsylvania Health System
Montgomery County Health Department
Pennsylvania Department of Health
Philadelphia Department of Public Health
U.S. Department of Health and Human Services, Region III
Benefits Data Trust
Center for Hunger-Free Communities, Drexel University
Coalition Against Hunger
Delaware Valley Regional Planning Commission
The Food Trust
Health Federation of Philadelphia
Health Partners Plans
Keystone First
Philabundance
Philadelphia Association of Community Development Corporations
Share Food Program
United Way of Greater Philadelphia and Southern New Jersey

FACILITATOR

THE HEALTH CARE IMPROVEMENT FOUNDATION
Building Partnerships For Better Health Care

www.hcifonline.org

March 2018