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CBOs Test New Tools to Support Seniors' Health

Community-based organizations play a key role in helping older New Yorkers live at home. But their health and wellness efforts are typically reactive and ad hoc, rather than data-driven and results-oriented—two essentials of meeting health care's triple aim.

UHF's Health Indicators–Performance Improvement project is making it easier for community organizations—senior centers and other groups offering case management, health promotion programs, exercise classes, meals, and other supportive services—to identify their client populations' specific health risks, target interventions, and measure results. This methodical approach enables them to know the extent to which they are making a difference, something which health care providers are increasingly looking for from their community partners.

Supported by a grant from the Altman Foundation, the project's data collection and performance improvement tools are being tested by three community organizations—JASA, the Carter Burden Center, and Neighborhood SHOPP—at six sites in low-income communities of Brooklyn, the Lower East Side, East Harlem, and the South Bronx. Each has received a small capacity-building grant from UHF.

"Once specific health risks are identified among a CBO's clients using the Health Indicators survey data, a more detailed picture can be gathered using our newly developed analytic tool," says Fredda Vladeck, director of UHF's Aging in Place Initiative. "This 'registry generator' makes it possible to learn what other things clients with, for example, diabetes are dealing with—such as hypertension, obesity, possible depression, and lack of exercise—so the CBOs can target those who are most at risk. That's a game changer."

The initial survey explores not only common chronic conditions of seniors but also access to health care, use of preventive and screening services, and social isolation. A performance improvement component of the project utilizes health modules—on topics such as diabetes management and clinical screenings and preventive services—that include a range of suggested interventions, measures, and tracking tools, along with how-to guidance, that organizations with different levels of resources can use.

"The registry generator is giving us the data we need to target interventions," says JASA's Arielle Basch.

"This is a really important development for us," says Arielle Basch, JASA's director of program development. "We were aware, for example, that seniors in Bushwick had high rates of diabetes, but we were short on data. This has allowed us to verify that—and, in fact, to see those high rates among younger clients; we're also seeing that hypertension among that group is rampant. So we're working with UHF to develop an evidence-based program of blood pressure screening and a diabetes self-management program. The ability to target interventions and demonstrate their impact is very significant, not only in meeting client needs but also in strengthening and formalizing ties with our health system partners."