COMMUNITY HEALTH CARE ASSOCIATION of New York State
chcanys.org

COMMUNITY HEALTH CENTER FQHC QUALITY

SOCIAL DETERMINANTS OF HEALTH

LUNCH &LEARN series

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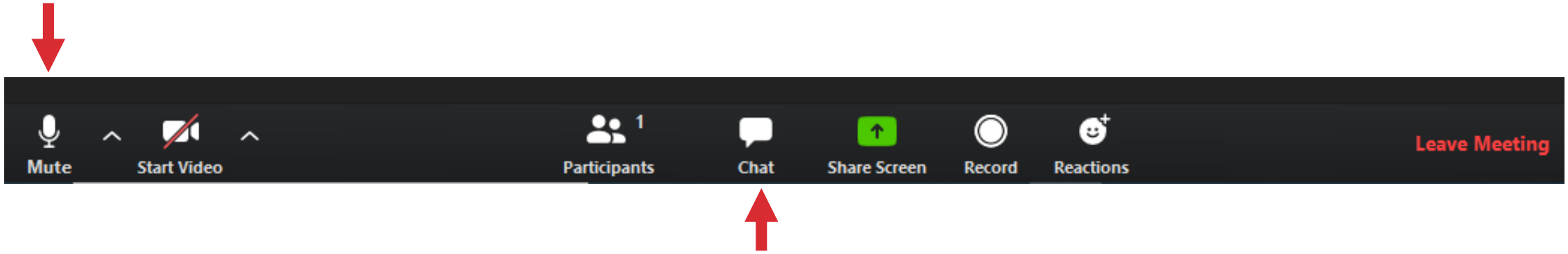
Housekeeping

- Phones have been muted to prevent background noise
- Use the chat box to type questions during the webinar
- This webinar is being recorded and will soon be available to all participants
- Tell us how we did in the evaluation, at the end of each session, and a follow-up evaluation will be sent 3 months from today

Zoom Meeting Controls

1. Manage your audio:
    - Dial ***6** to mute your phone, if your phone does not have a "Mute" button. Dial ***6** again to unmute.
    - Tap the "Mute" button on your phone or computer. Tap the "Mute" button again to unmute when you want to speak.



2. Use the chat box throughout the webinar

COMMUNITY HEALTH CARE ASSOCIATION of New York State

Part III
Promising Practices to Address Social Determinants Of Health for Patients with Chronic Diseases

May 21, 2021

Agenda

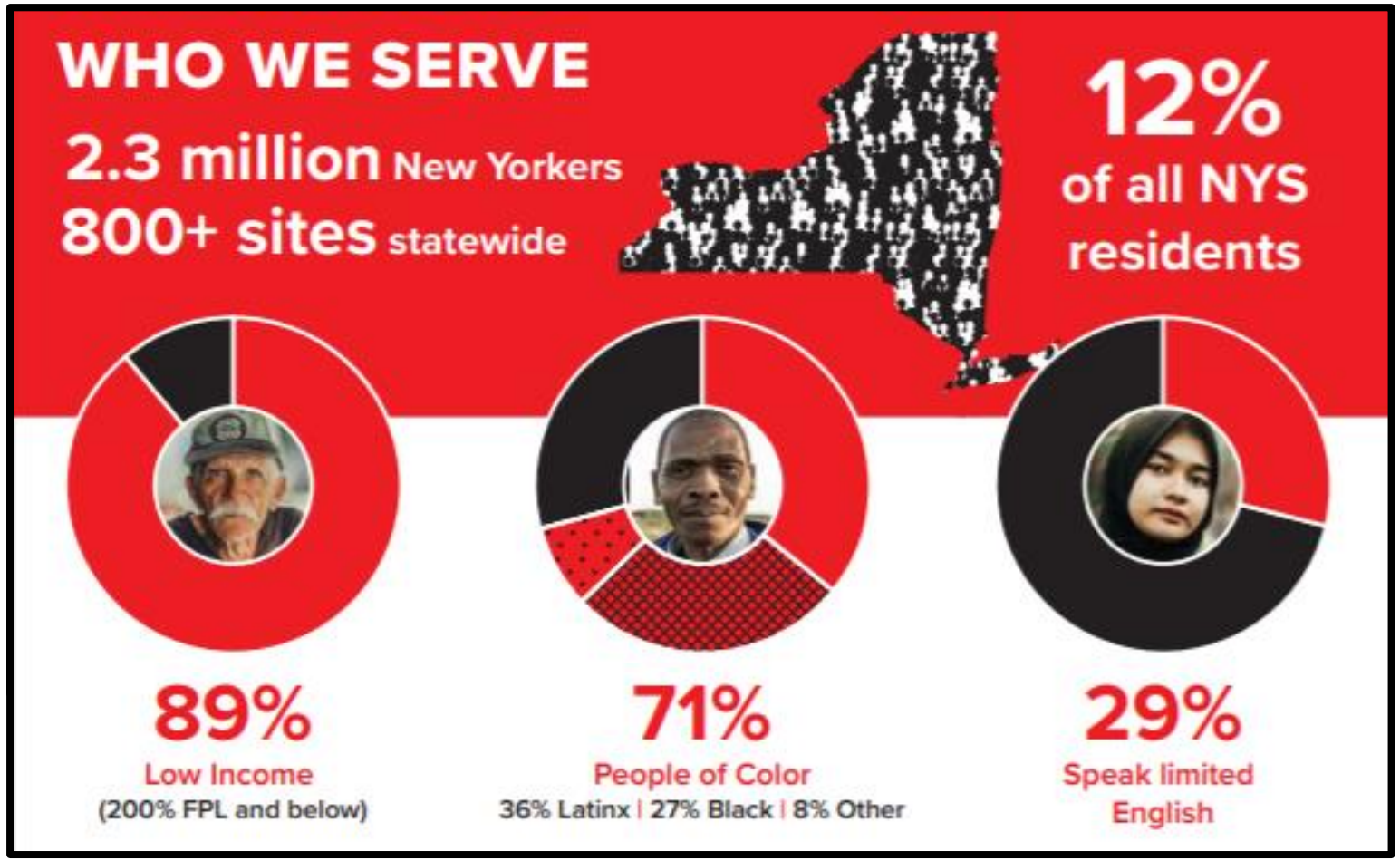
I. Welcome

II. Presenter: Laurie Levasseur at Hometown Health Centers

III. Questions & Answers

IV. Closing Remarks

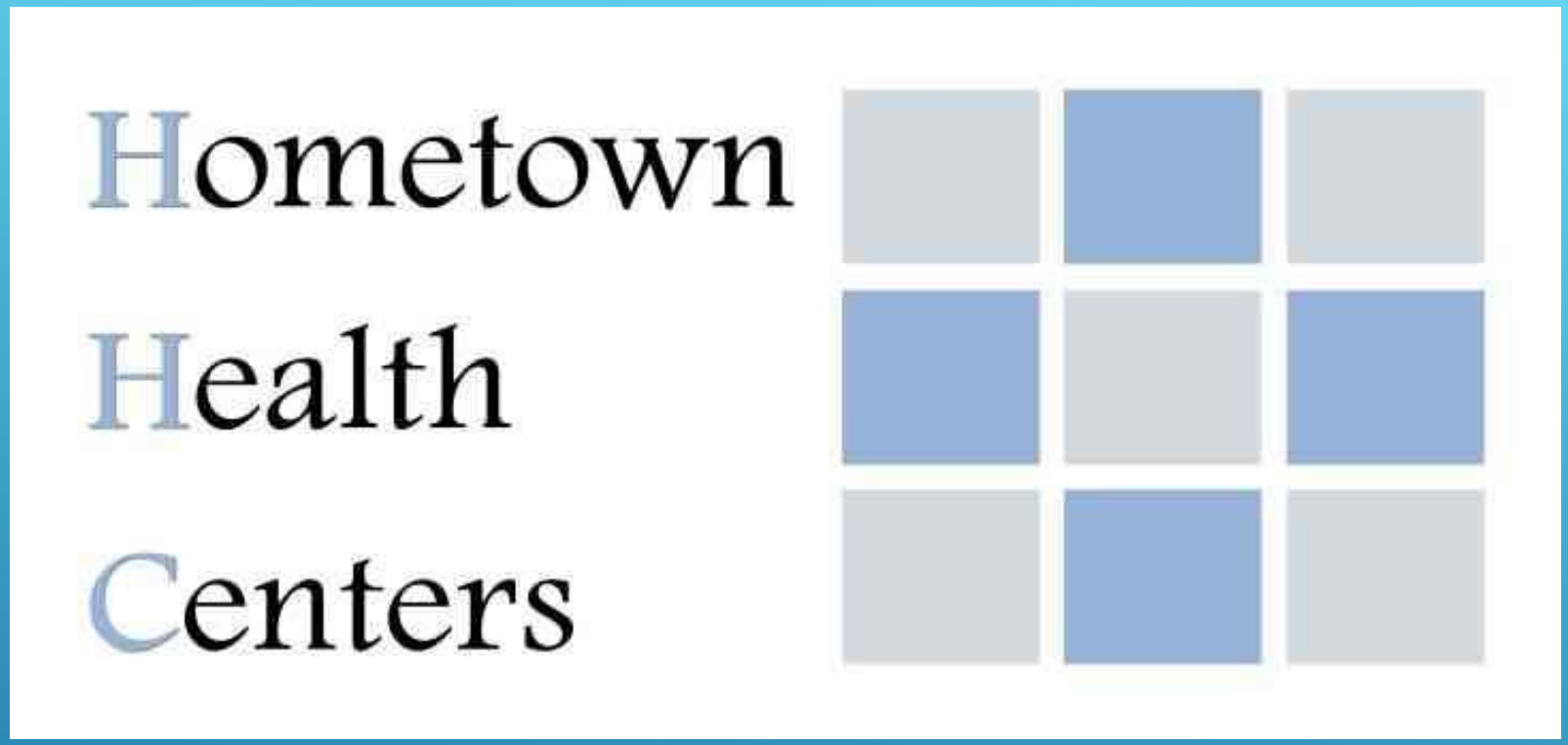
New York Community Health Centers: Facts 2021



CHCs are a “one-stop shop” for health care, providing high quality primary and preventive care and support services to all New Yorkers, regardless of their immigration status, insurance coverage, or ability to pay.

Key Factors for Success

- UNDERSTAND THE WHY
- STANDARDIZED SDOH SCREENING PROCCESS
- TEAM-BASED CARE APPROACH
- DOCUMENT AND MONITOR PERFORMANCE
- SOCIAL INTERVENTIONS & CLOSE THE LOOP
- DEVELOP A DATA STRATEGY
- ACT: Use SDOH data to drive practice transformation



HOMETOWN HEALTH CENTER'S SCHENECTADY, NEW YORK

WHO ARE WE?

- Services offered: Medical Care, OB/GYN Care, Newborn/Pediatric Care, Behavioral Health/Substance Abuse Services, Triage Nursing Team, Telehealth/Telehealth Home Visits (for homebound patient/those who lack internet access) Dental, and Ophthalmology, Case Management and Social Work, STD clinic (weekly)Outreach and Enrollment, SDOH Screening, Pharmacy and lab service on premises.
- 2020 UDS reports: Serving 17,000 patients. Populations served include: Black or African American, Spanish, Guianese, Arabic, Asian, Asian Indian.
- Two Locations: Schenectady NY Clinic is the main location.
- Amsterdam NY is our second clinic location that primarily serves a large Spanish speaking population.

SOCIAL DETERMINANTS OF HEALTH MANAGEMENT

Telehealth Home Visit Program

Outreach and Enrollment Program

Primary Care (Clinic)

HOW DID WE BEGIN?

- Covid-19 Strategy to see patients who did not have the capability for web enablement.
- March 20, 2020 Telehealth Home Visits were designed to see patients who could not be seen using a telehealth app., home bound status or over the age of 65. (High risk patients).
- Social Determinants of Health (SDOH) assessment completed in ECW with each patient Telehealth Home Visit. (evaluate safety of home environment, food needs, etc.) Initially started with Prepare Tool and switched to Health Leads.
- Referral would be made to Case Manager for any patient who was identified as having a SDOH need.

HOW DID WE BEGIN/WORKFLOW?

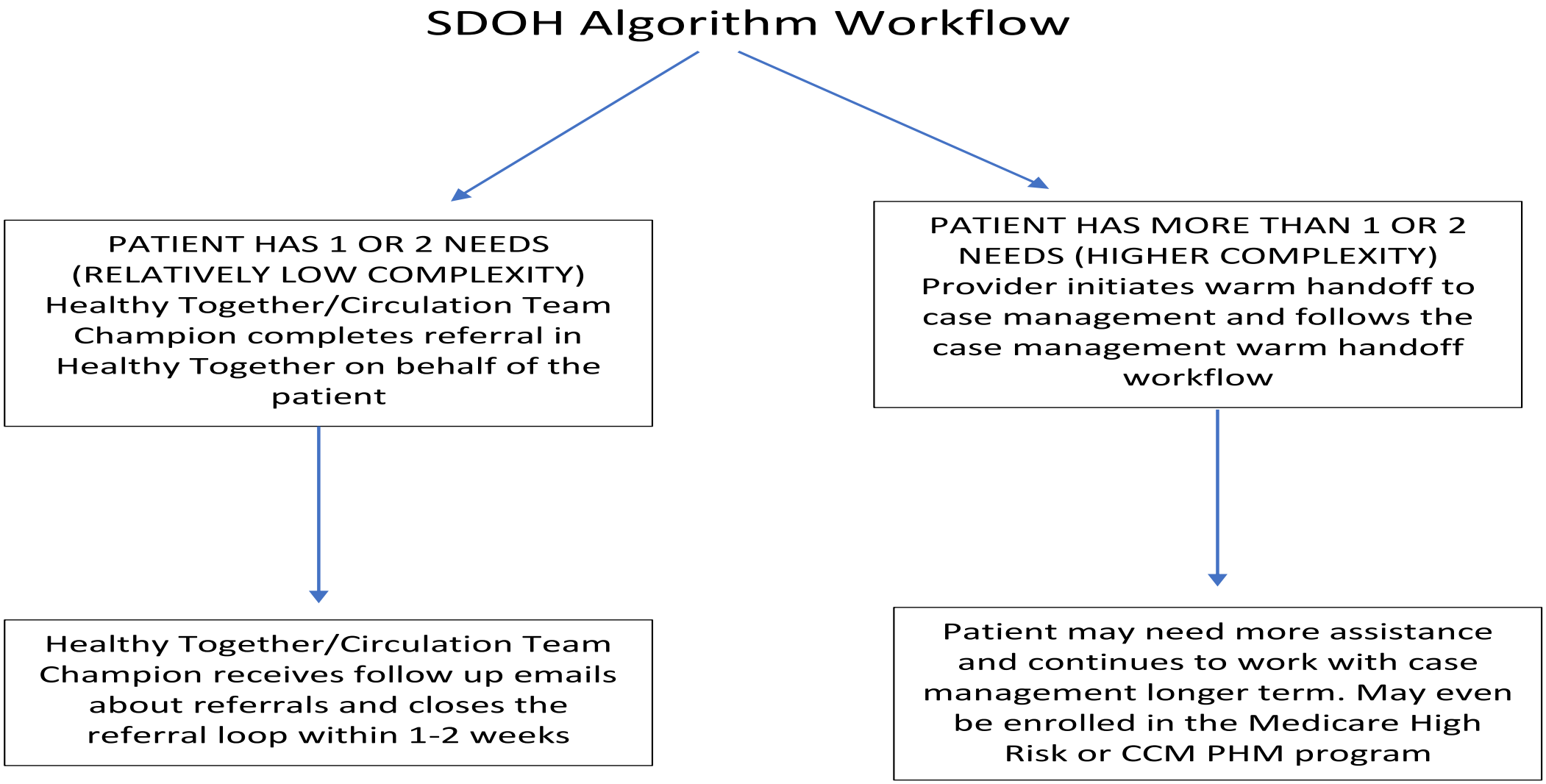
- A new Outreach and Enrollment representative on-boarded with our team in June 2020. Outreach and Enrollment job description re-designed to reflect SDOH assessment to be completed for every person in need of health insurance or not able to afford health insurance.
- Outreach and Enrollment trained to Unite Us/Healthy Together Platform. Any SDOH needs identified, the person is referred to Unite Us/Healthy together to meet their needs. If more than two needs identified; Case Management is notified.
- Nursing performing Health Leads Assessment while rooming patients in clinic. Nursing and Provider huddle to discuss SDOH needs identified. A referral is made to Unite Us/Healthy together based on needs. More than two needs identified is referred to Case Management. Patient is assessed for SDOH with each visit due to COVID-19 and an increase in SDOH needs statistically in the Capital District. (Pilot for one month).

- Any patients who are showing signs of increased anxiety or express increased anxiety/COVID support. A Social Worker at the time of the visit will meet with patient in real-time, to evaluate need for counseling and assist patient with coping needs.

POLL QUESTION #1

At your respective health center, does your Outreach & Enrollment team screen patients for social needs using a standardized assessment tool such as PRAPARE, Health Leads, etc.? **Please select one**

- Yes
- No



SDOH INITIAL WORKFLOW: 10/14/20

Today's date: _____

Patient Name: _____

Patient Date of Birth: _____

Hometown Health Centers

In order to provide comprehensive healthcare to our patients and address all of the needs that affect their health, please provide answers to the questions below:

	In the last 12 months, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Yes	No
	In the last 12 months, has your **utility company shut off your service** for not paying the bills?	Yes	No
	Are you worried that in the next 2 months, you **may not have stable housing**?	Yes	No
	Do problems getting **child care make it difficult for you to work** or study? (leave blank if you do not have children)	Yes	No
	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Yes	No
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	Yes	No
	Do you ever need help **reading hospital materials?**	Yes	No
	Are you **afraid you might be hurt** in your apartment building or house?	Yes	No
	In the last 12 months, have you ever had to go **without access to a phone**?	Yes	No
	If you checked YES to any boxes above, **would you like to receive assistance** with any of those needs?	Yes	No
	**Are any of your needs urgent?** For example: I don't have food tonight, I don't have a place to sleep tonight	Yes	No

HEALTH LEADS SCREENING TOOL

WHAT IS UNITE US/HEALTHY TOGETHER

- Unite Us/Healthy together is a platform used in partnership with Alliance for Better Health, IPA partnership. Hometown and the IPA have a shared governance towards its mission in “making a difference”/ “collaborating with other community organizations” related to SDOH/community needs for healthy outcomes (Health Improvement for patients/whole patient approach).
- Hometown Partnered with Alliance to educate staff to SDOH/Unite Us/Healthy Together Platform.
- Education, food, shelter, clothing, utilities, employment, legal needs (to name a few) are referral options for patients in need.
- The platform has the capability to share documentation so all involved with the patients plan are able to communicate.
- Health Leads Assessment tool is used to assess SDOH. We have assessed a total of 1,261 patients for 2020.

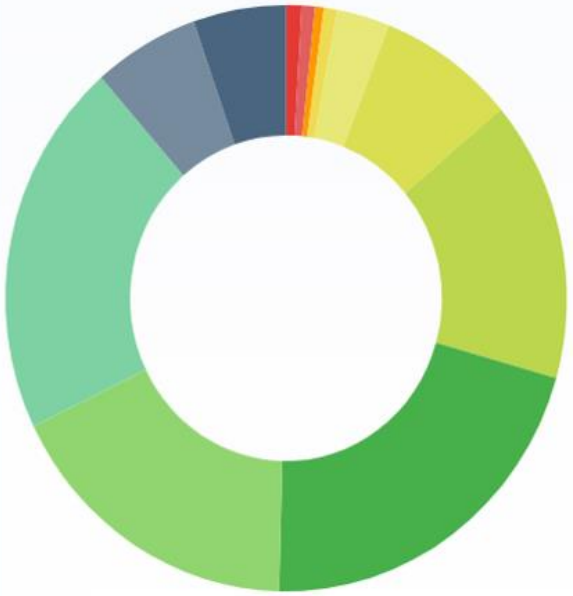
DATA/HISTORY

- Telehealth Home Visit Program has had 273 patient visits from March 1, 2020 to November 14, 2020. SDOH screening was also conducted.
- Pilot began mid October 2020 in our OB clinic (one team at a time) 96 referrals opened and closed for SDOH. **(OB patient answered Yes to all questions, engaged staff to the need for SDOH screening)**
- Unite Us/Healthy Together Platform: 29 users on boarded. Goal Met: All staff educated and performing SDOH assessment in clinic by Mid December 2020 (adding10 more users/4 Teams).
- 786 total patient referrals to Unite Us/Healthy Together (includes: BH, CM).
- In the past 30 days 96 referrals had been placed and closed related to SDOH.
- Outreach and Enrollment increased patient capacity to 48 internal referrals for uninsured populations with SDOH screening from 10/1/20-11/11/20.
- Total of 1,261 SDOH screens conducted for year 2020.

Gender

Gender		
Female	397	(51%)
Male	282	(36%)
Non-Binary	0	(0%)
Other	0	(0%)
Undisclosed	107	(14%)
Total	786	

Age



Age		
0-5 Years	7	(1%)
6-10 Years	6	(1%)
11-15 Years	4	(1%)
16-17 Years	6	(1%)
18-20 Years	24	(3%)
21-25 Years	62	(8%)
26-34 Years	122	(16%)
35-44 Years	165	(21%)
45-54 Years	137	(17%)
55-64 Years	163	(21%)
65-74 Years	48	(6%)
75+ Years	42	(5%
Total	786	

UNITE US/HEALTHY TOGETHER DATA COLLECTION: 3/2020-11/2020.

RECENT CHALLENGES

- Limited Staffing
- Patients requiring more needs/referrals due to COVID pandemic impact.
- Staff overwhelmed as a result
- This resulted in incomplete referral details for the Coordination Center, making it difficult for the Coordination Center to assist the patient.
- Frequent discussions with Alliance for Better Health (IPA)/Coordination Center to address challenges. (Continuous Collaboration). Alliance support/coaching, working with Hometown Team to meet our goals/measures/outcomes, based on real-time data review.

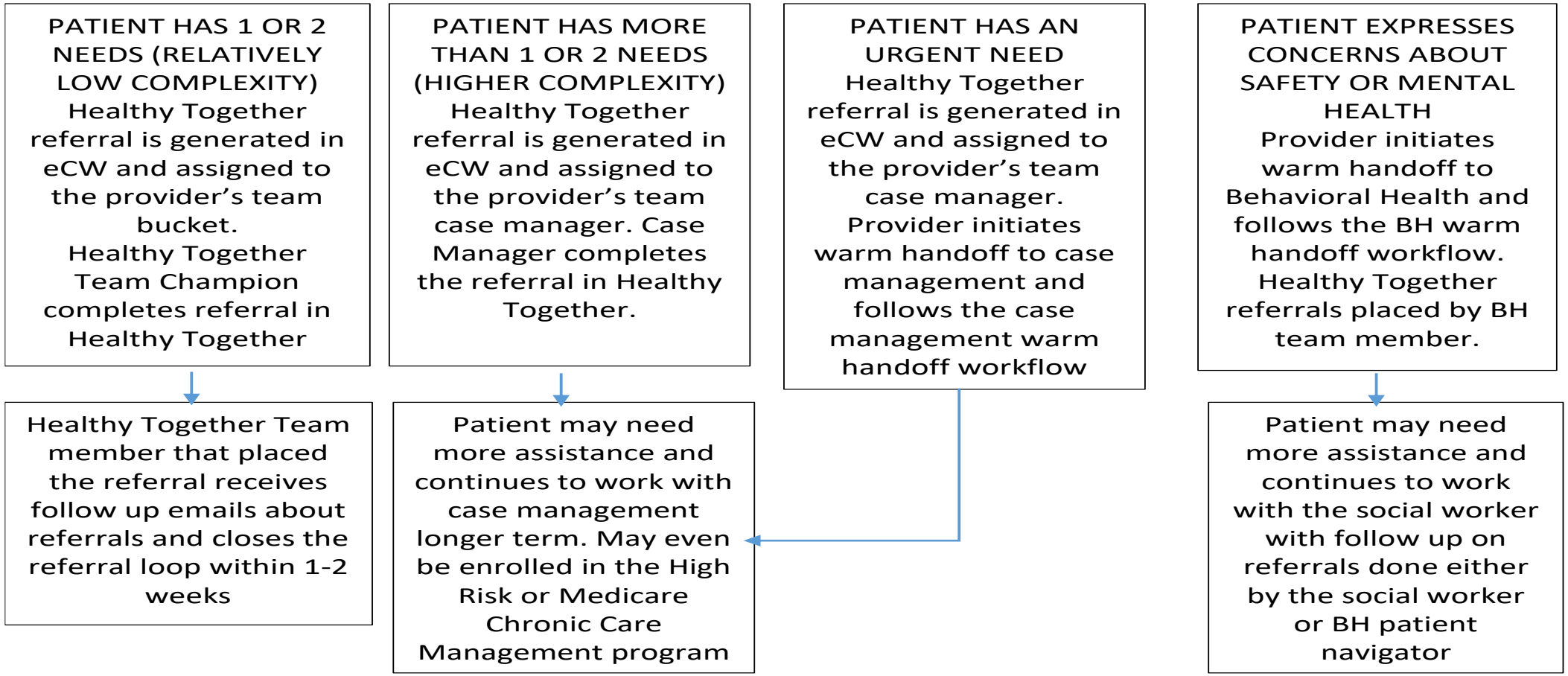
POLL QUESTION #2

What challenges has your organization encountered, if any, in supporting health centers in implementing patient-level SDOH screening and addressing their unmet social needs? **Select all that apply:**

- Challenges asking sensitive SDOH questions
- Lack of sufficient training and guidance to facilitate member implementation
- Frequent staff turn over
- No clear strategy for supporting SDOH work
- Too many competing initiatives
- Lack of reimbursement to sustain this work
- Challenges in bringing our SDOH screener(s) to scale across health centers
- Lack of community partners or resources to address social risk needs for health centers
- Challenges sharing data with community partners (e.g., for closed loop referral tracking)
- We have not experienced any challenges

WORKFLOW CHANGES/EDUCATION

- Registration staff provides patient SDOH screening tool for patient to complete while waiting for appointment. If patient requires assistance with the tool, assistance will be provided.
- SDOH Team Champions chosen as facilitators to the model
- Champions will place referrals and ensure referrals are closed out (closing the loop).
- All employees at Hometown Health Centers will be educated to SDOH.
  - **Goal**: engaging all staff to the SDOH needs of our patient.
  - **Goal:** patients to have improve outcomes to health/compliance with chronic health needs.
- Behavioral Health now using Health Leads Tool to screen more frequently
- Dental staff educated to SDOH screening
- Patients being seen by the Eye Doctor will be screened



REVISED: SDOH WORKFLOW ALGORITHM (4/2021)

CLINICAL METRICS OUTCOMES

- Diabetes Type 2: Patient answering "Yes" to SDOH: 79. Out of 79 patients, all but 13 patients were noted to have improved HGB A1C by ensuring SDOH needs were also met. (11/20-2/2021)
- Patient examples:
- HGB A1C 15.5 on 4/27/20 and repeated on 8/7/20: 11.8 = 23.87% improvement value.
- HGB A1C: 8.7 on 10/28/20 and improved 1/21/21: HGB A1C was 4.8 = 44.83% improvement value.
- Blood Pressure Control: 49 patient screened "yes" for SDOH. Out of 49 patient, 26 patients were improved and controlled in our hypertension program. (11/20-3/2021)

POLL QUESTION #3

How frequently does the health center care team screen & review the SDOH/social risk factor data with patients? **Please select one**
E.g., SDOH data part of the pre-visit planning/patient triage, care team connects patients with resources, review/addition of ICD-10 Z codes in the patients' chart, etc.

- At each visit
- Every 3 visits
- Quarterly
- Semiannually
- Annually
- Not conducting SDOH screening at this time

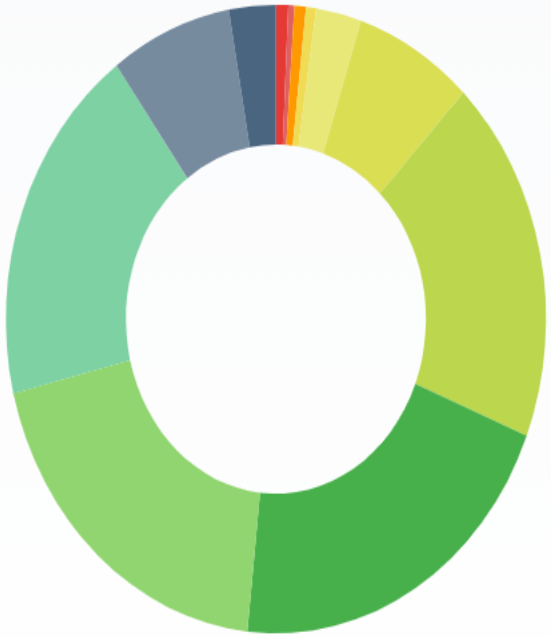
Unite NY (ADK Wellness Connections, CNYCares Referral Network, Healthy Together)

Showing data from 1/7/2021 to 4/7/2021

Population | Services | Network Performance

Last 90 Days

Gender		
Female	1139	(46%)
Male	895	(36%)
Non-Binary	1	(0%)
Other	0	(0%)
Undisclosed	434	(18%)
Total	2469	



Age		
0-5 Years	18	(1%)
6-10 Years	9	(0%)
11-15 Years	17	(1%)
16-17 Years	15	(1%)
18-20 Years	67	(3%)
21-25 Years	175	(7%)
26-34 Years	466	(19%)
35-44 Years	509	(21%)
45-54 Years	482	(20%)
55-64 Years	463	(19%)
65-74 Years	179	(7%)
75+ Years	69	(3%)
Total	2469	

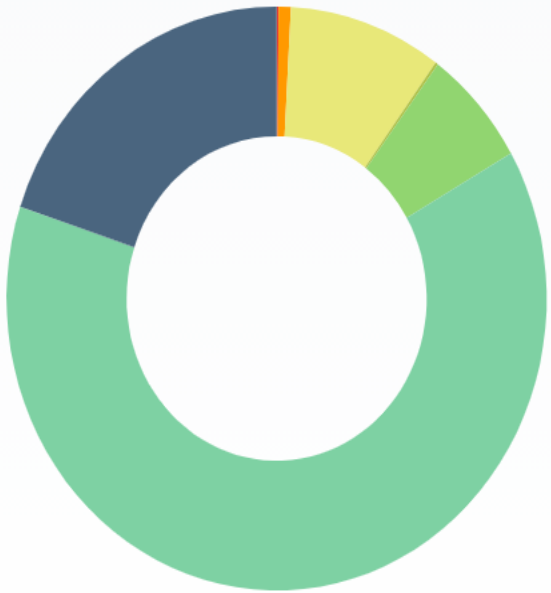
Unite NY (ADK Wellness Connections, CNYCares Referral Network, Healthy Together)

Showing data from 1/13/2021 to 4/13/2021

Population Services Network Performance

Last 90 Days

Race



Race		
American Indian or Alaska Native	3	(0%)
Asian	19	(1%)
Black/African American	239	(9%)
Native Hawaiian or Pacific Islander	4	(0%)
Other Race	170	(7%)
Undisclosed	1650	(63%)
White	518	(20%)
Total	**2603**	

Ethnicity

Ethnicity		
Hispanic or Latino	133	(5%)
Not Hispanic or Latino	727	(28%)
Undisclosed	1743	(67%)
Total	**2603**	

HOMETOWN HEALTH CENTER TEAM

- Schenectady NY/Amsterdam NY Clinics: It takes a committed team to meet/establish positive health outcomes for the patients and community we serve. (Shout Out/Well done)!!
- Administrative/Senior Management/Management Team
- Compliance/Ethical Team
- HR Team
- IT Team
- Registration Team
- Nursing/Provider Team (Medical, OB, Peds)
- Case Management Team
- Behavioral Health Team
- Dental Team
- Ophthalmology Team
- Outreach and Enrollment Team
- Medical Records
- Quality Management
- Credentialing
- Maintenance Team

COMMUNITY PARTNERSHIPS

- Alliance for Better Health, IPA
- MVP Partnership (Telehealth Home Visit Program and Hypertension Program)
- HRSA Hypertension Grant Program
- Schenectady County Public Health: Maternal Health Focus with Schenectady Families Services Program. STD clinic. Primary Care Referrals for COVID positive patients.
- Social Determinates of Health Program
- Ultimate Goal: Mobile Health Clinic: Use of data mapping to serve high risk populations in the community and meet health disparity goals.

Question and Answer

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Practice Administrator
Hometown Health Center
1044 State Street
Schenectady, NY 12307
Phone: 518-370-1441 ext. 4295
Email: llevasseur@hhchc.org

THANK YOU!!

Announcement: Last Chance!

PRAPARE Smart Form Subsidy for eClinicalWorks Users:

CHCANYS has a limited-time opportunity expiring in *June 2021* to support health centers' systematic collection and response to patients' social needs by subsidizing the PRAPARE smart form in eClinicalWorks for a limited number of health centers.

If your health center is interested, please contact Gabriela Gonzalez at ggonzalez@chcanys.org.

Join the Diabetes and CVD Prevention and Control Initiative

- Cohort III Kicks off July 2021 through June 2022
- Primary Focus Areas Include:
  - Maximizing HIT
    - Stratification by health disparities
  - Referrals to evidence-based community programs
    - DPP/DSME
  - Health education and nutrition counseling
    - SMBP
  - Practice transformation and process Improvement
- Project Evaluation
- Interest Form: https://bit.ly/3c28Byf

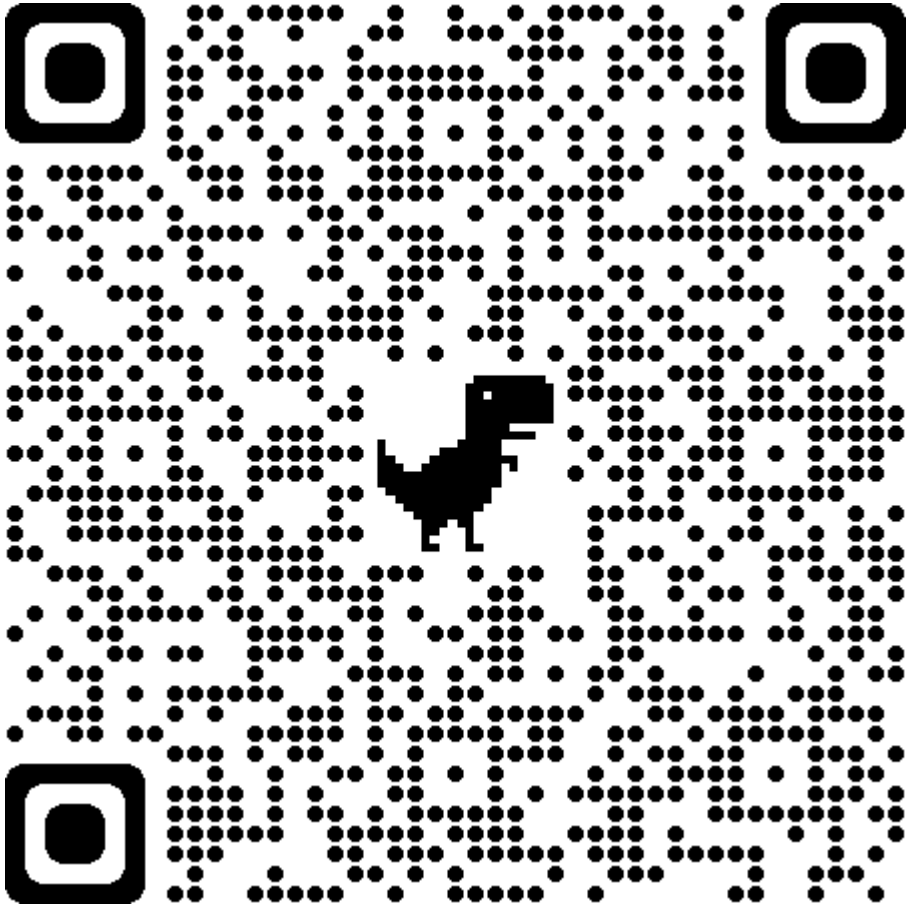
SCAN ME

Fill Out an Interest Form

Webinar Evaluation:

- Today's Presenter: Laurie Levasseur MSN/MHA, Practice Administrator at Hometown Health Centers
- Mercy Mbogori, Assistant Director
  - E: mmbogori@CHCANYS.ORG
- Gabriela Gonzalez, Program Manager
  - E: ggonzalez@CHCANYS.ORG

Link: https://bit.ly/3wC5rcn



Please fill out an evaluation

Social Determinants of Health Resources

- CHCANYS' Social Determinants of Health Webpage
- NACHC Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
- Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. https://health.gov/healthypeople/objectives-and-data/social-determinants-health
- Research on Integrating Social & Medical Care | SIREN https://sirenetwork.ucsf.edu/
- The Gravity Project | A consensus-driven standards on Social Determinants of Health https://confluence.hl7.org/display/GRAV/The+Gravity+Project


thank you
danke
謝謝
merci
gracias
obrigado
dziękuję
bedankt
go raibh maith agat
sukriya
kop khun krap
terima kasih
ngiyabonga
teşekkür ederim
dank je
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