Enhancing Complex Care Beyond the Walls of a Clinical Setting Series:

Addressing Social Determinants of Health: Connecting People with Complex Needs to Community Resources

September 10, 2018, 2:00-3:30 pm ET

Please standby, today’s webinar will begin shortly.

Made possible with support from the Robert Wood Johnson Foundation
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Questions?

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Agenda

- Welcome and Overview
- Connecting Uninsured Patients to Care and Social Supports—AccessHealth Spartanburg
- Q&A
- Identifying and Addressing SDOH in Complex Populations—Petaluma Health Center
- Reflections and Q&A
About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of low-income Americans
Transforming Complex Care Program Overview

- Multi-site demonstration aimed at **refining and spreading effective care models** that address the complex health and social needs of high-need, high-cost patients

- Made possible with support from the Robert Wood Johnson Foundation
Meet Today’s Presenters

Caitlin Thomas-Henkel, Senior Program Officer, Center for Health Care Strategies

Carey Rothschild, Director, AccessHealth Spartanburg

Summer Tebalt, RN Case Navigator, AccessHealth Spartanburg

Jessica Moore, FNP, Associate Clinical Director and Director of Innovations, Petaluma Health Center

Derek DeLia, PhD, Director of Health Economics and Health Systems Research, MedStar Health Research Institute
What Impacts Health?

- Impact of different factors on risk of premature death

# Social Determinants of Health (SDOH)

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
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<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
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<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
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<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Social engagement</td>
<td>Community engagement</td>
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<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td>Discrimination</td>
<td>Provider availability</td>
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<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td>Community linguistic and cultural competency</td>
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<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
<td></td>
<td>Quality of care</td>
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## Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Strategies for Addressing SDOH in Complex Care Programs

Employing non-traditional workers

» Identify hazards in home
» Connect patients to resources and services
» Mitigate barriers to health care
» Serve as interpreter between patient and health care system

Partnering with community-based organizations and social service providers

» Identify providers serving similar populations with complementary skills
» Establish formal and informal partnerships
Identifying and quantifying patient needs

» Screening for SDOH (e.g., PRAPARE, Health Leads)
» Tracking patient needs over time

Testing the use of technology

» Bridge gaps in geography
» Inventory resources and track referrals (e.g., Healthify, Aunt Bertha)
Care Coordination
for the Uninsured
The AccessHealth Spartanburg Mission:

To improve access to healthcare for the uninsured of Spartanburg County through sustainable health system change that will result in better health outcomes and 100% access to effective, efficient, safe, timely, patient-centered, and equitable healthcare.
Program Strategies/Services:

- Screen for AccessHealth Spartanburg eligibility
- Screen for state, federal, and local assistance
- Assess psychosocial needs
- Collect medical history
- Assign primary medical home
- Serve as bridge between primary and specialty medical services
- Provide transportation as needed
- Provide care navigation and coordination
- Connect to behavioral health and social resources
Community-based Organizations & Relationships

AHS Founding Partners

- Forrester Center for Behavioral Health
- Mary Black Health System
- ReGenesis Health Care (FQHC)
- St. Luke's Free Medical Clinic
- South Carolina DHEC
- Spartanburg County Medical Society
- Spartanburg Area Department of Mental Health
- Spartanburg Regional Healthcare System
- USC Upstate
- Welvista (Rx assistance program)

Outreach & Engagement Strategies

- Shared leadership model
- Dedicated and consistent efforts to engage local media
- Staff participation in a variety of community work groups, projects and boards
- Capitalizing on Serendipity
Added Partners/Collaborations

- Emerge Family Therapy Center & Teaching Clinic
- Middle Tyger Community Center (and free clinic)
- Via Edward College of Osteopathic Medicine (VCOM)
- St Matthew’s Episcopal Church (monthly free clinic)
- Spartanburg County Detention Center
- Miracle Hill Rescue Mission
- Spartanburg County Public Library
- Northside Development Group
- Jumpstart Prison Rehabilitation
Social Determinants of Health

- 83 question assessment
- Topics include:
  - Medical history and needs - primary & specialty care, medications, vision & dental
  - Behavioral Health history and needs - mental health, substance abuse, counseling
  - Social - housing, transportation, education, employment, access to food, connection to church or spiritual community, etc.
- Administered at initial enrollment
- Generates a care plan & goals specific to each client
<table>
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<tr>
<th>Question</th>
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<tr>
<td>Have you applied for social security?</td>
<td>Have you applied for, or are you receiving unemployment?</td>
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<td>Have you been connected to Welvista?</td>
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<td>Have you been diagnosed with any of the following?</td>
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<td>Have you completed annual preventative screenings (reference U.S. Preventative Task Force <a href="http://www.uspreventativetaskforce.org/adultrec.htm">http://www.uspreventativetaskforce.org/adultrec.htm</a>)?</td>
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<td>Have you ever been treated for a mental health disorder?</td>
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<td>Have you ever been treated for substance abuse?</td>
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<td>Have you ever served in the military?</td>
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<td>Have you had a flu shot within the past 12 months?</td>
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<td>Have you had a pneumonia shot within the past 12 months?</td>
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<td>Have you recently been hospitalized or had surgery?</td>
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<td>How many are living in your household?</td>
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<td>How often do you need to have someone help you when you read instructions, pamphlets, or other written materials?</td>
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<td>How would you rate your ability to read?</td>
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<td>What are your current living arrangements?</td>
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<td>What dental needs do you have?</td>
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<td>What is the combined annual income of everyone in your household?</td>
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<td>What is the combined monthly income of everyone living in your household?</td>
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<td>What is the last grade you completed in school?</td>
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<td>What is the last grade you completed in school?</td>
<td>What is your plan for managing your condition?</td>
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<td>What is your plan for managing your condition?</td>
<td>What kind of birth control are you using?</td>
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<td>What kind of birth control are you using?</td>
<td>When was the last time you saw a dentist?</td>
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<td>When was the last time you saw a dentist?</td>
<td>When was the last time you saw an eye doctor?</td>
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<tr>
<td>When was the last time you saw an eye doctor?</td>
<td>When was the last time you visited the emergency room and how often are the visits?</td>
</tr>
<tr>
<td>When was the last time you visited the emergency room and how often are the visits?</td>
<td>What are you most proud of?</td>
</tr>
</tbody>
</table>
- Needs are prioritized
- Information and education provided
- Referrals generated to community partners
- Ongoing client/care navigator relationship to follow up on referrals
- Education continues
AHS Unique Partnerships

• Complimentary Medicine (chiropractic, acupuncture)
• Corner of Hope (furniture donations)
• City of Spartanburg- SPARTA
• Hub City Farmer’s Market (meet & greet)
• Hub Cycle Program
• Spartanburg County Detention Center
• SRHS Heart Resource Center (screening clinic)
• DHEC (flu shot clinic at AHS)
• Free Little Library
• Partnership between United Way of the Piedmont & Exel Logistics
• Low-cost membership to any non-profit organization
• Weekly visits to the warehouse
• Household items – paper products, cleaning supplies, household items, hygiene products
• Used to provide assistance as well as incentives
Questions?

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Identifying and Addressing SDOH in Complex Populations
Petaluma Health Center

- **Location:** Petaluma and Rohnert Park, CA
- **EHR Used:** eCW
- **Unique Patients:** ≈30,000
- **Population:** 50% Medi-Cal, 15% Medicare
  - ≈40% Monolingual Spanish speaking
- **Screening Tool Used:** PRAPARE
Initial Observations

- SDOH impact patients’ health
- Addressing SDOH can help
- We can’t help if we don’t know
- Helping takes time
The Problem

- Community resource information not widely available
- No standard screening
- Fear of overwhelm
The Solution?

Physical Binder  →  Virtual Binder
Platforms

• Healthify
• Purple Binder
• One Degree
• Aunt Bertha
Screening: PRAPARE

WHAT IS PRAPARE?
Protocol for Responding to & Assessing Patients’ Assets, Risks & Experiences:

A national standardized patient risk assessment protocol designed to engage patients in assessing & addressing social determinants of health (SDH).

PRAPARE = SDH screening tool + implementation/action process

Customizable Implementation and Action Approach

Assess Needs → Respond to Needs
At the Patient and Population Level

- UDS SDH Domains
  1. Race
  2. Ethnicity
  3. Veteran Status
  4. Farmworker Status
  5. English Proficiency
  6. Income
  7. Insurance
  8. Neighborhood
  9. Housing

- Non-UDS SDH Domains
  9. Education
  10. Employment
  11. Material Security
  12. Social Integration
  13. Stress

- Non-UDS SDH Domains
  1. Incarceration History
  2. Transportation
  3. Refugee Status
  4. Country of Origin

PRAPARE asks 15 questions to assess 14 core SDH domains.

- 9 questions already asked for UDS reporting
- 5 non-UDS questions informed by MU3

PRAPARE has 6 optional domains.
Screening Strategy

Care Gaps
- Due for PRAPARE
  *Recommended Intervention: Give Patient PRAPARE Screening Today*
- Not Web-Enabled
  *Recommended Intervention: Web Enable Patient Today*
- Due for Colorectal Cancer Screening
  *Recommended Intervention: Order Colonoscopy or Fit Kit Today*
- Due for Mammogram
  *Recommended Intervention: Order Mammogram*
- Due for Hepatitis C Screening
  *Recommended Intervention: Order Hep C Screening Lab Today*
- Overdue for cervical cancer screening (F24-64 excludes hysterectomy)
  *Recommended Intervention: Urge Patient to get PAP TODAY*

- Part of clinical decision support
- Risk score ≥ 3
- Diagnosis of diabetes or depression
Using Data to Inform Partnerships

Food insecurity nationally

Nationally, 1 in 6 adults have inadequate access to enough food.

The U.S. population

83.33 percent

16.66 percent

EFFECTS OF LONG-TERM UNEMPLOYMENT

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEPRESSION</td>
<td>&gt; 52 weeks</td>
</tr>
<tr>
<td>Obesity Rate</td>
<td>&gt; 52 weeks</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>&gt; 27 weeks</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>&gt; 27 weeks</td>
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BERCHAM KAMBER  THE DAILY ILLINI
SOURCE U.S. DEPARTMENT OF AGRICULTURE
Food First

Petaluma Bounty

Redwood Empire Food Bank
Employment and Skills

Sonoma County Job Link

Petaluma Adult School
Lessons Learned

• You don’t know until you ask. This goes for screening patients as well as mutually beneficial partnerships.

• Front-line staff who are doing the work need to be at the table from the beginning.

• Engaged leadership will help you move this work forward faster. Evaluate priorities before launching.

• Look for opportunities for pilots and seed funding, lots of energy and interest in this field.

• Partnerships take time.

• This is community building work.

• Get outside of your clinics!
Reaction: Derek DeLia, MHRI

- Links to health care payment & delivery reform
- SDOH & the “health-wealth gradient”
- Matching supply & demand for community resources
- Redefining health system boundaries
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Relevant Resources

- BRIEF - Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations

- PROFILE - AccessHealth Spartanburg: Wrap-Around Community Support for South Carolina’s Most Vulnerable Patients
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