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Free webinar

# Enhancing outreach to the LGBTQ+ community

Tips to simplify data collection around sexual orientation and gender identity

**Thursday, Sept. 29 at 2 p.m. ET / 11 a.m. PT**

Register

CareForum 2022

The WellSky® Conference

# Quantifying the impact of SDoH on community health

*Outcomes data from a two-year study by Reading Hospital*

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# Agenda

- Approach to addressing SDoH
- Clinical-community collaboration
- Case Study: Quantifying the impact on patients with a food need who received CHW outreach
- Wrap-up/Lessons learned
- Q&A

# Reading Hospital

- Flagship, Magnet Recognized, acute care hospital of Tower Health
  - West Reading, PA, Berks County
  - 714-bed, large teaching hospital
  - Level 1 Trauma Center
  - Busiest ED in the state
- Serving primarily urban and rural areas
  - High volume of Hispanic and predominantly Spanish speaking patients

# Community Health Needs Assessment

**We are currently in our 4th CHNA cycle.**

**Consistently, the CHNA has highlighted inequities for vulnerable and disparate populations in our community.**


- Primary service area

- Primary sources i.e., stakeholder interviews, focus groups, Electronic Health Records
- Secondary sources i.e., Census, County Health Rankings

- Data-sharing with internal and external stakeholders

- Monitor & improve current programming
- Identify opportunities for new programs

# Addressing social determinants of health (SDoH)

- In 2017, received a $4.5 million cooperative agreement from Centers for Medicare and Medicaid Services to implement the 5–year Accountable Health Communities Model.
  - Can identifying and addressing SDoH through screening, referral, and navigation impact healthcare costs and reduce healthcare utilization?
- Coordinating a consortium
  - Identify and partner with clinical sites and make referrals to community services
  - Coordinate and connect patients to community service providers
  - Align partners to optimize community capacity to address health-related social needs.

# Community Connection Project (CCP)

- Staffing
  - Full-time patient screeners, community navigators/chws, and college interns (per semester) as patient screeners, project coordinator, project manager
- Identify patients with unmet social needs through screening
- Provide resources, referrals, and ongoing follow-up to determine need resolution
- Support to internal teams with SDOH assistance, knowledge and education
- Bi-directional integration (Epic <> WellSky SCC)
  - Patient data in EPIC creates records in WellSky SCC
  - Screening data captured in WellSky sends Community Resource Summaries to Epic
  - Closed-loop referral network (30+ CBOs)
- CCP Consortium
  - Monthly meetings to foster clinical-community linkages

# CCP Performance Outcomes

| CCP Performance Outcomes | N(%) |
|---|---|
| Patients Screened (n=51,327) | |
| High-Risk Patients | 18,895 (36.8) |
| # of Screenings (n=136,469) | |
| # of High-Risk Screenings | 44,154 (32.4) |
| Identified Social Needs (n=37,849) | |
| Housing | 8,931 (23.6) |
| Food | 13,303 (35.2) |
| Transportation | 8,552 (22.6) |
| Safety | 691 (0.02) |
| Utilities | 6,372 (16.8) |
| Core Needs Identified from Navigation (n=14,074) | |
| Resolved | 7,464 (53.0) |

Reporting Periods: SEP 24 18 – NOV 15 21
Source: CMS AHC Data System; CMS DEC 21 Monthly Monitoring Report

# Sustainability: From Project to Program

- Staffing Model
  - CHWs & college interns
  - Training i.e., certifications
- Operationalize workflows
  - Implement a seamless Epic <> WellSky Integration
  - Align CHWs with Population Health for Epic workflows
- Engage Patients
  - Focus groups, surveys
- Maintain/strengthen clinical-community linkages
  - Encourage community partner referral activity
  - Value add to clinical teams i.e., support health/quality outcomes
  - Continue collaborative meetings
- Building a business case $
  - Determine and communicate a return-on-investment
- Communication is 
  - Invest in marketing

# Community connection program workflow

**Staff at RH (including Patient Screeners) conduct SDoH screenings.**
**CHWs conduct targeted outreach and follow-up for patients with needs.**

### SDOH Screening

- Completed in Epic
- Self-screening via MyTowerHealth in Pilot

### Patients with unmet needs

- WellSky sends Epic community resource summaries
- Clinical staff can review screenings with patients
- Physicians can make referrals to CHWs

### CHW Services

- Patient outreach is documented in Epic
- Close care gaps i.e., PCP appointments
- Assigned patient rosters for care coordination support i.e., missed visits, frequent ED visits

### WellSky SCC Closed-loop Referral Network

- CHWs access WellSky through a link within the patient's chart in EPIC
- CBOs receive and respond to referrals

### SDOH/Care Coordination until case is closed.

- CHWs provide ongoing follow-up to determine need resolutions
- CHWs document results in Epic
- Monthly progress reports are shared with stakeholders

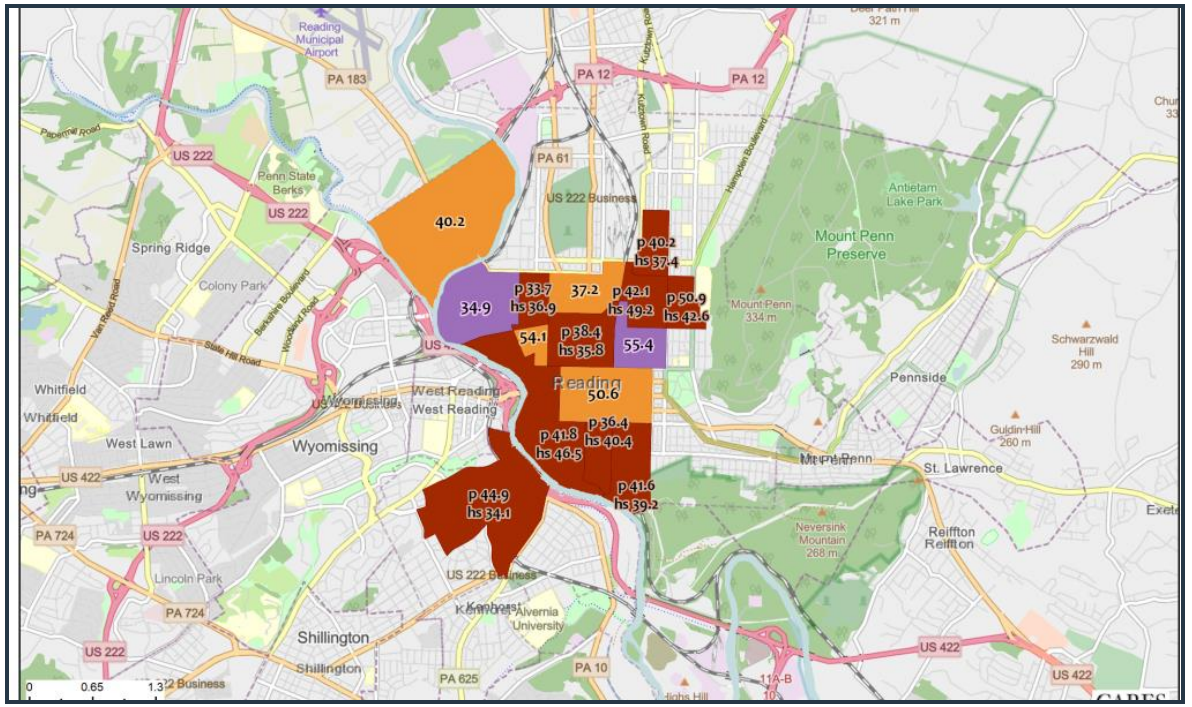
# Clinical-community collaboration

# CCP Consortium

- Clinical delivery sites, local federally-qualified health center, CBOs, PA Office of Medial Assistance Programs, payors
- Established subcommittees
- Completed Memorandums of Understanding
- Monthly meetings
  - Engaged in meaningful discussions
  - Data-sharing
  - Project monitoring and improvement

# Conducting a gap analysis

- Collected baseline data
  - Targeted city of Reading, PA
  - Community statistics: City of Reading vs. PA vs. U.S.A
  - 5 core HRSNs
  - Capacity and potential gaps for existing community services and resources to address HRSNs
- Primary and Secondary data collection
  - Focus groups, window shield - walking study
  - CHNA, census data

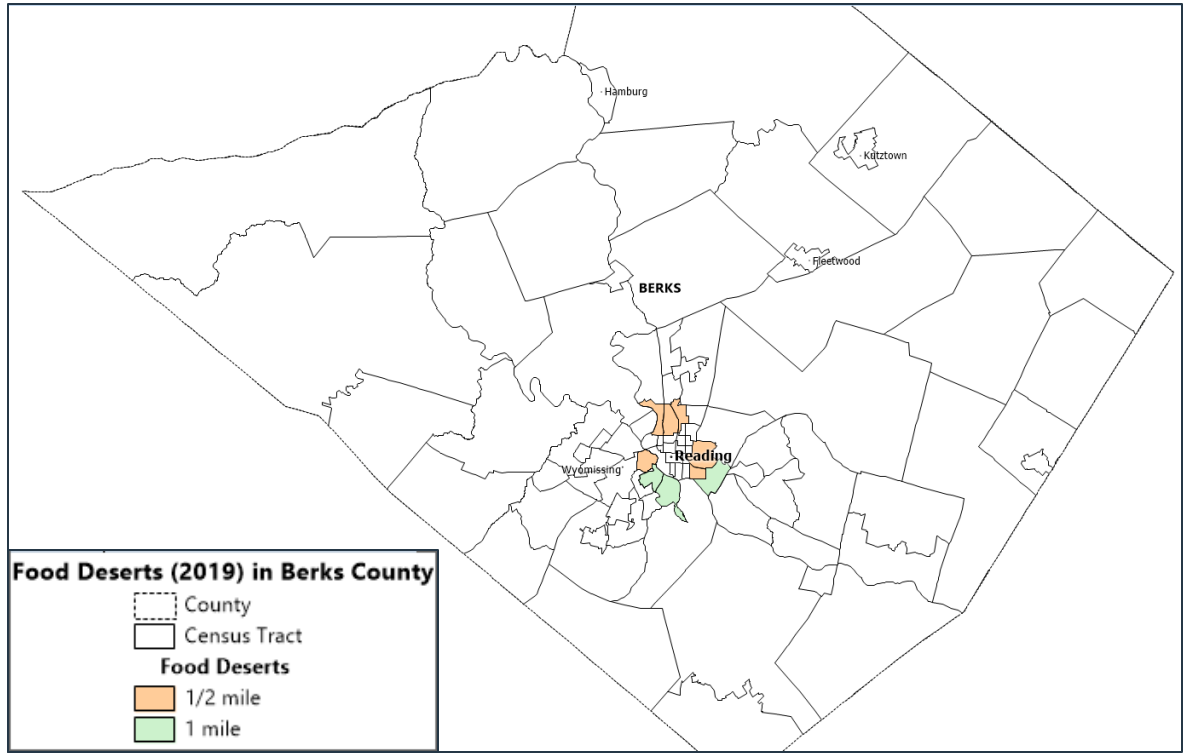



Source: Community Commons Vulnerable Population Footprint
This map displays areas where at least 33% of the population in the census tract is below 100% of federal poverty level (orange) or has less than a high school diploma (purple), or crosses both thresholds (red).

# Stakeholder engagement: data sharing

- **Data sharing, community conversation, and collaborative discussions**
  - Including patient feedback i.e., focus groups, patient stories
  - Share data ahead of meetings
  - Open channels for communication
  - Ask questions for education, knowledge and awareness
- Meaningful Meetings
  - Using visuals to record notes i.e., whiteboards
  - Prepare potential discussion questions
  - Put your Ego to the side, we are in collaboration!

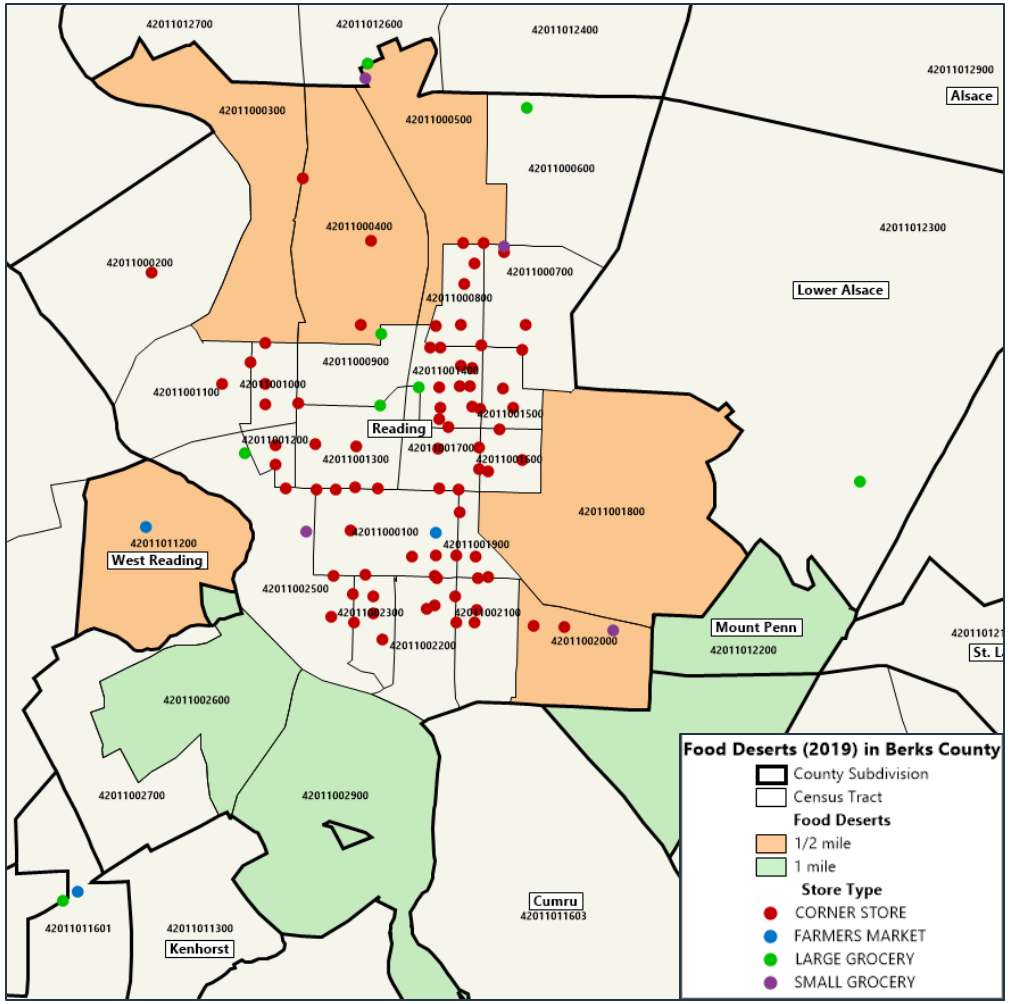
# Food as a top priority




Source: USDA Economic Research Service, Food Access Research Atlas, 2019 Low Income & Low Access Layers, last updated April 2021. Census tract data, 2020 Census

- Large food bank operation, generable amount of area food pantries
- Lack of awareness, coordination, and communication of services/information
- Nine (9) tracts in Berks County, clustered in and around the City of Reading, that are identified as food deserts by the USDA.
- Adult Obesity rate, 32%
- Economic (working-poor)
- Households with children or age 65+
- Limited reliable transportation

# Access to fresh and affordable food




- Map displays corner stores, large and small grocery stores, and farmer markets proximate to food deserts
  - Food desert areas do not have many proximate sources of food
- Numerous corner stores
  - Inconsistent availability of fresh food

Source: USDA Economic Research Service, Food Access Research Atlas, 2019 Low Income & Low Access Layers, last updated April 2021. Census tract data, 2020 Census. Food retailers are obtained from the January 14, 2022, SNAP retailer locator data, and then grouped into categories of store.

Note: Convenience stores, pharmacies and specialty food stores are excluded from the map.

# Shared AIM and measures

- Aim: Enhance Food Access for Vulnerable Populations in Berks County, PA by April 2022
  - Increasing awareness of access to fresh/healthy food in the community
  - Determining specific underlying issues faced by food insecure households
  - Identify resources and interventions to mitigate downfalls of the community's capacity to address the food need including but, not limited to improving coordination of food services.

# Implementing a quality improvement plan

- Keep the food bank engaged and central
  - We need to approach the food system with a spirit of collaboration!
- Identify CBO champion, New Journey Community Outreach
  - Co-lead initiative
  - Actively utilizing WellSky SCC
  - Communicate benefits
- Identify resources to assist with QI activities
  - Leadership Berks
- Determine smaller areas where QI activities can be piloted
  - Oakbrook Area (food desert)

# QI Activities

- Patient Focus groups and surveys
  - "Standing in lines at food pantries were exhausting and anxiety-provoking."
  - Pantries are used based on the relationship patients develop with pantry staff
- Interviews, observations, and Journey Mapping with Food Pantry Operators
  - 80% of food pantry operators were volunteers, and pantries were understaffed
- Collaborate with Food Bank to convene Oakbrook area food pantry operators
  - Identified ways Food Bank can support
- Disseminate Findings
  - Presented findings of actional recommendations to Food Bank and Consortium
  - Case Study with Healthify (now WellSky)
- Increase coordination through WellSky SCC closed-loop referral network

# Case Study: Quantifying the impact on patients with a food need who received CHW outreach

# Patient Cohort (n=1,032)

- Patients with an unmet food and received CHW outreach (6/18-2/20)
- 37% of patients also had Housing and Transportation needs
- Food HRSN Resolution Status
  - 74% resolved their food need
    - 61% stated by the patient
    - 13% by a successful CBO referral
- WellSky SCC Referrals, n=3,146
  - 59% Service Completed

| Demographics | |
|---|---|
| Average Age | 43.1 years |
| Sex | |
| Female | 698 |
| Male | 334 |
| Ethnicity | |
| Hispanic or Latino | 586 |
| Not Hispanic or Latino | 439 |
| Patient Refused | 1 |
| Unknown | 6 |
| Race | |
| American Indian/Alaska Native | 5 |
| Black or African American | 113 |
| Native Hawaiian/Other Pacific Islander | 2 |
| Other | 454 |
| Other Asian | 2 |
| Unknown | 6 |
| White or Caucasian | 450 |

# Health measures of patient cohort Pre-CCP

- Healthcare utilization
  - Frequent ED visits n=4,955
  - Only 21% of ED visits transitioned to Hospital Admissions
  - Low volume of PCP visits
- Chronic Disease
  - 26% of patients were on the Diabetes Registry

# Determine value for audiences

**Healthcare**

- Hospitals/Payors
  - Healthcare Utilization i.e., Emergency Visits, hospital admissions, readmissions
  - Care gaps i.e., preventative care with primary care physician visits
  - Chronic disease management
  - Healthcare costs

**Community**

- CBOs and Boards
  - Community-level change and impact
  - Partnerships
  - Funding/resources
- Patients/Consumers/Clients
  - Telling the story/voices are heard
  - Trust and support

# Communicating Impact

| | |
|---|---|
| Must communicate the whole story | • Collaboration of cross-sector partnerships<br>• Identification of root causes<br>• Improvement of coordination |
| Highlight all stakeholders especially the CBOs | • CBOs bring much value to addressing health-related social needs |
| Leveraging data and technology | • Linkages powered by WellSky<br>• Data to quantify success |

# Impact on healthcare

- Pre/post study
- For patients on the diabetes registry, A1C rates decreased by an average of 2.2%
- Analyzed patients with resolved food needs n=747
  - ED Visits decreased by 34%
  - Admissions decreased by 32%
  - Readmissions decreased by 29%
  - Total hospital costs decreased by 31%

# Wrap-up/lessons learned

# Pursuing health equity

**Being intentional about investing in Health Equity strategies and continuing cross-sector collaboration.**

### Expand CHW Outreach

- Close care gaps for PCP appointments, preventative screenings
- Target populations contributing to health/quality metrics i.e., missed visits, ED visits

### Convene Health Equity Council

- Hospital staff
- Identify health disparities
- Ensure internal capacity to address health disparities

### Convene Health Equity Community Collaborative

- Leverages CCP Consortium members
- Manages clinical-community linkages in WellSky SCC
- Ensures community capacity to address needs
- Advisory to HE initiatives
- Focus on quantifying value for CBO reimbursement

### Communication and Marketing

- Flyers
- Social Media

### Engage Patients

- Focus groups
- Surveys
- Leverage technology
- Committee memberships

# Best Practices/Recommendations

- Gaining buy-in from all stakeholders
  - Staff need to be skilled/trained, engaged, empowered and consistently monitored for performance improvement
  - Leadership needs the ROI, decision-makers need to be at the table
  - Elevate the patient's voice, gain trust
- Community Collaboration
  - Discussions to identify root causes
  - Partnerships/relationships rooted in trust
- Data-sharing/Communication
  - CHNAs/gap analyses
  - Meaningful conversations and comprehension
  - Highlight wins/success
  - Disseminate findings consistently
- Technology
  - Investing in interoperable, innovative software to breakdown silos, barriers, and foster communication

# Q&A

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# Thank you.

**Contact us:**

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# WellSky Social Care Coordination

## Discover how the nation's largest network of healthcare and social care providers can help you address SDoH

WellSky