ALLIANCE FOR THE DETERMINANTS OF HEALTH

2019 Alliance Update

In 2019 the Alliance for the Determinants of Health focused on implementing and improving workflows based on the three-pronged Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities Model of awareness, assistance, and alignment. The following are some examples of how each component has been put into action and highlights from the past year.

Click here to visit CMS website.

MEASURES OF SUCCESS

AWARENESS: A Parents as Teachers Program is working closely with a pediatric office to create warm hand-offs for patients being screened for Social Determinants of Health (SDoH). This enhanced communication between providers means more children being getting connected to services, and entering services at an earlier age, which is crucial for development. The two-way link means families benefit from the coordination of expert intervention from both healthcare and social care providers.

Visit Parents as Teachers Program.

ASSISTANCE: A Federally Qualified Health Center (FQHC) patient was screened and referred to a Community Health Worker (CHW) for assistance with clothing and food. During the screening assessment, it was noted that this participant had long-standing dental needs which he had avoided due to severe anxiety about going to the dentist. The CHW shared the barrier during a coordination meeting and the FQHC arranged for a behavioral health provider to accompany this participant to his dental visit for support. The participant had a positive experience and established a trusting relationship with the dentist which resulted in a follow up appointment.

ALIGNMENT: As screening workflows were implemented, participating organizations collectively decided the next step of improvement was engaging the hardest to reach members. One metric to measure success was CHWs completing a full PRAPARE with participants. Each organization then adopted goals to improve their specific workflow process for engagement. For example, one organization focused on warm hand-offs to CHWs by notifying them when high-risk members had upcoming appointments.

AWARENESS

Evidence-based screenings for social needs

Using claims data, risk stratified lists of SelectHealth Community Care (Medicaid) members are created based on 3 or more emergency department visits in the last 12 months. These lists of high-risk members are shared monthly with FQHC, Local Mental Health Authorities, and Intermountain Clinics based on the members attributed to their clinics. In addition, flags built into Intermountain's electronic health record alert emergency departments and ACCESS Centers (dedicated behavioral health centers) when these members are admitted.

Lesson Learned: Screening for social determinants of health SDoH in a clinical setting provides opportunities to identify non-medical contributors to overall health and well-being and to build bridges between healthcare and social service providers. Community organizations can offer expertise and resources to clinics that identify a participant with a social need such as shelter from domestic violence or winter clothing to stay warm. These resources can drastically improve health in ways that could not be impacted with a diagnostic test or prescription. Similarly, healthcare providers can help identify participants who need social care but may not be aware of available resources.

ASSISTANCE

Coordination between healthcare, behavioral health, and social service organizations to address SDoH and provide care for all aspects of life

When social needs are identified through screening, participants are provided with information on community resources or assisted with coordination of resources with the support of an Alliance CHW who works in conjunction with the clinic's care management team. CHWs work as a mobile team providing motivational interviewing, home visits, and self-management goal setting to empower participants in addressing barriers beyond the walls of healthcare.

Lesson Learned. Multi-agency teams are convening to provide updates on shared cases and seeing remarkable progress. These meetings provide insight into participants' care—ranging from bus passes to specialty care—and allow teams to share notes and eliminate duplicative efforts. Team meetings also provide a forum to strategize how and where to find the hardest-to-reach members. An excellent example is the recent detective work that went into finding a high utilizer who had suddenly stopped coming to the emergency department. An on-line search by an astute care manager found that this participant had been booked in the county jail. This discovery provided the Alliance with the opportunity to finally engage the participant in a meaningful way.

ALIGNMENT

Resourcing gaps in social need and coordination between healthcare and social services, sharing workflows and metrics, building organizational capacity to meet social needs, and addressing policy concerns

Alignment is demonstrated by community organizations working across siloed borders that have traditionally separated health and social care. Paving new avenues of collaboration involves consultation with policy and legal experts, implementing a shared technology platform, sharing data, making collective funding decisions, and care coordination that allows different organizations to huddle as one team.

Lesson Learned. Alliance organizations that are screening for SDoH created a collective dashboard to align their key performance indicators and outcomes. These metrics are tracked through shared data and are reviewed during regular huddles where continuous improvement strategies are implemented. The use of discretionary funds is one such metric being tracked. These funds allow CHWs to cover one-time costs for participants that are not covered by Medicaid or other social service providers. Associated costs are often under $200 but can have a positive impact on a participant's life. Examples of how funds have been used include transportation from jail to a homeless shelter that helped ensure a participant's road to sobriety, a pair of diabetic shoes that allowed a participant to continue working, and late charge on a utility bill that caused a participant to rely on a space heater during winter.

"I've learned that my problem patients are just patients with problems."

—Steve Clark, D.O., Intermountain Family Medicine

LAUNCHING THE CONNECT US NETWORK

Connect Us went live in Washington and Weber counties in August with plans to expand to other communities including Utah County in the immediate future. Connect Us is a coordinated network of healthcare and social service providers working together on a web-based platform. The shared technology provides the ability to connect people to services and follow the outcomes. For example, a patient discloses to a physician that he has food insecurity and needs assistance. The clinic notifies the foodbank through the platform, and the foodbank responds by reaching out to the patient explaining what info is needed for assistance. The patient arrives on the appropriate day with the correct documentation and receives a food box. The foodbank reports the service episode successfully completed and the clinic can track the updates. The network can also track metrics around what service types are most utilized in the community and identify gaps in resources. You can read more at the Connect Us website.

Click here to visit Connect Us website.

UNDERSTANDING COMMUNITY NEEDS

The Alliance provides a data-driven understanding of community needs. There are two versions of the PRAPARE screening tool that are being implemented and tracked for outcomes. The abbreviated version, PRAPARE Lite, is administered in the clinical setting to establish a baseline of SDoH need, and just as important, to begin a dialogue about what barriers the participants are facing outside the clinic walls. Participants who report moderate to severe social need are offered the support of a CHW who then administers a full PRAPARE screening which is a more-thorough assessment. The screening tool guides the prioritization of next steps as the CHW and participant make a game plan and set goals. In September the Alliance hit a milestone by screening the hundredth participant with the full PRAPARE tool.

Both screening tools have identified the top needs in the Alliance geographies as transportation, food insecurity, housing, and dental care. Thus far the CHWs have made more than 300 referrals to community services on behalf of 110 unique participants through the Connect Us network.

These connections to services range from signing up a participant living in a rural area for prescription delivery to helping a person experiencing homelessness complete the paperwork to secure permanent housing.