American Hospital Association™

Advancing Health in America

Part 2 – Connect: Building bridges from health care to social care

October 26, 2022

Organized by:

ACHI

AHA Community Health Improvement

Sponsored by:

Metro Health

Welcome & Housekeeping

1. Attendees have been **muted**. Please make comments or ask questions in the Chat.

2. Send a chat message **AHA Host** with any technical issues.

3. If desired, you can **indicate your organization or city, state** by hovering your pointer over your video & clicking on the … and selecting “Rename”.

American Hospital Association™

Advancing Health in America

Building a Comprehensive SDOH Screening and Response Model Within a Health System

Part 2 – Connect: Building bridges from health care to social care

Kevin Chagin, Manager, Advanced Analytics & Data Operations

Karen Cook, Director, Healthy Families & Thriving Communities

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Alissa Glenn, Director, Community Health, Nutrition and Measurement, Greater Cleveland Food Bank

MetroHealth

Devoted to Hope, Health, and Humanity

- Serving Greater Cleveland since 1837
- The essential safety-net health system for the most at-risk members of our community
- Open and accessible to all (95% of Cuyahoga County residents live within 10 minutes of MetroHealth care)
- The region's essential public-health leader during times of crisis
- 300,000+ patients making 1.5 million visits annually
- Provide care at four hospitals, four emergency departments, more than 20 health centers and 40 additional sites in Northeast Ohio
- Operate Ohio's top rehabilitation center, the region's most experienced Level I Trauma Center, and Ohio's only adult and pediatric trauma and burn center
- Total Community Benefit: $238.6 million

MetroHealth | Institute for H.O.P.E.™

Identifying and acting on the social drivers of health as an integral component of care, through programs and partnerships for:

- Fresh, healthy food
- Stable, safe housing
- Legal assistance
- Education
- Job training
- Transportation
- Language and literacy
- Digital connectivity
- Connection with others
- Safer neighborhoods
- … And much more

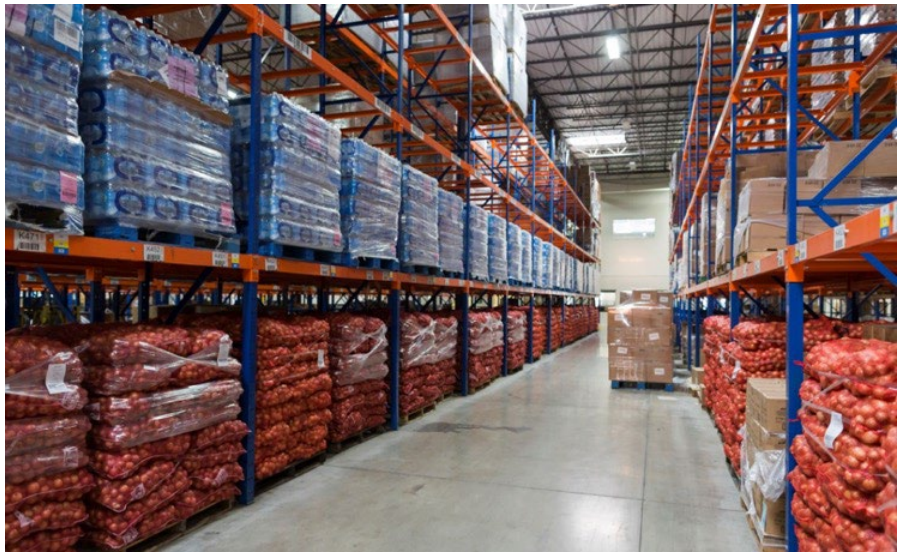
Health, Opportunity, Partnership, Empowerment

Greater Cleveland Food Bank

Greater Cleveland Food Bank

Text Bar

- GCFB mission is to ensure that everyone in our communities has the nutritious food they need every day
- Collect and store food to distribute to smaller hunger relief programs, such as food pantries, hot meal programs, and other child and senior food programs
- We serve 6 counties, including Ashland, Ashtabula, Cuyahoga, Geauga, Lake, and Richland
- In our FY 2021, served 343,000 unique individuals through **emergency feeding** programs, 36,000 children through (CNI) **Children Nutrition Initiative**, submitted 11,000 **SNAP applications** for our neighbors, and distributed over 48 million pounds of food



Redesigning how healthcare and community organizations work together to help communities thrive

Screen for SDOH

- Self > MyChart
- Provider > care setting
- CHW > community
- Team > COVID vaccination clinics

CONNECT

Connect to Meet Needs

- Electronic > Unite Ohio platform
- Curate relationships for people needing more assistance
- Design interventions based on identified community needs

RESPOND

Close the Loop in Real Time

- Inform clinical team & CBOs
- Verify patient needs met
- Reduce duplication
- Identify strength & gaps within social service delivery system

EVALUATE

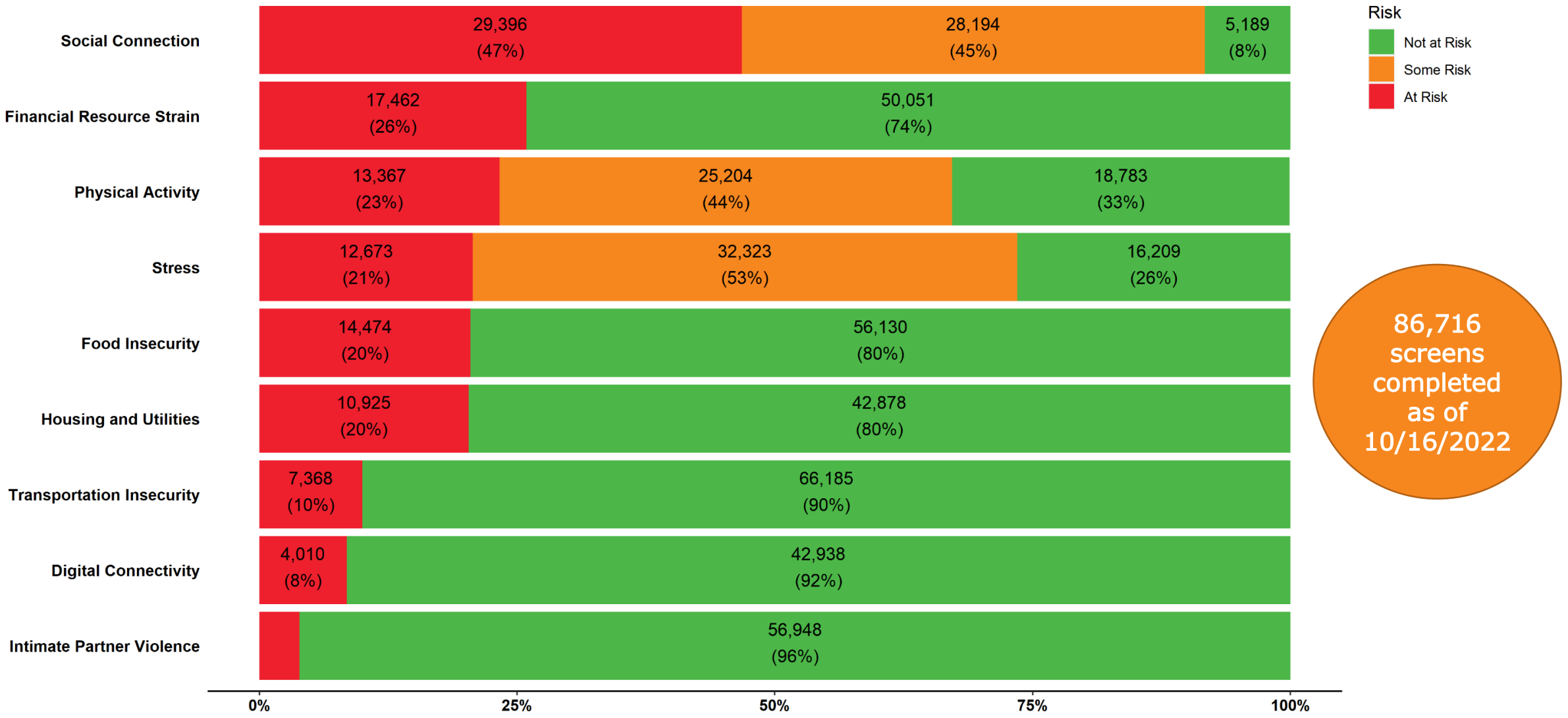
Evaluate Impact

- Track outcomes at individual & community level
- Prove impact, outcomes, & cost-effectiveness
- Supply data & narratives to drive policy change

IMPROVE

Utilize process and outcome data to drive program evaluation, research and continuous program improvement

Patient SDOH Screening Results

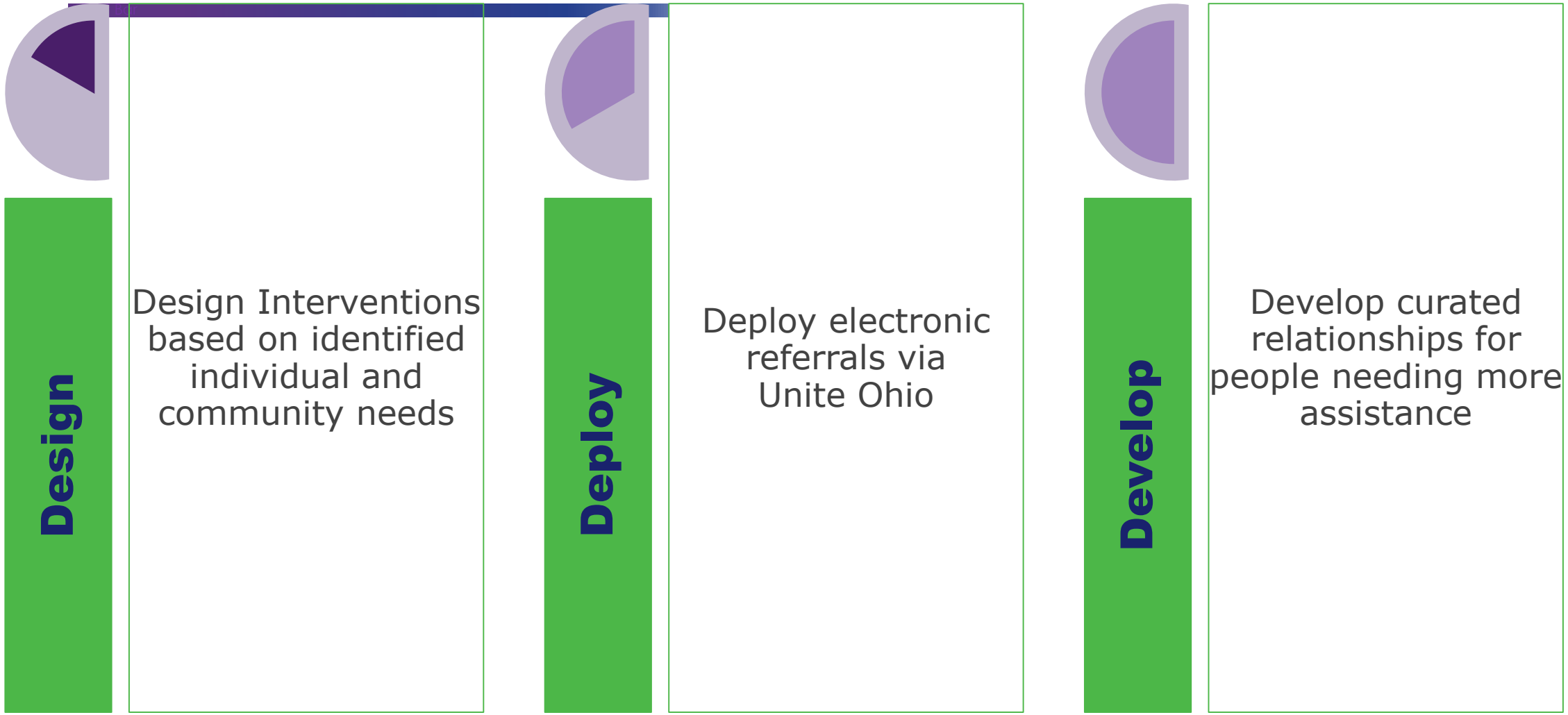


86,716 screens completed as of 10/16/2022

Learning Objectives

- Understand how SDOH screening results can be used to inform and tailor SDOH interventions for patients.
- Identify multiple ways that health systems can connect patients with services and supports to address their health-related social needs, including the use of an e-referral platform, Community Health Workers, and programs with community-based organizations.
- Recognize ways to assess the success of connections between health care and social care.

Making Connections for Patients with Social Needs



Food Security

Why Focus on Food Security?

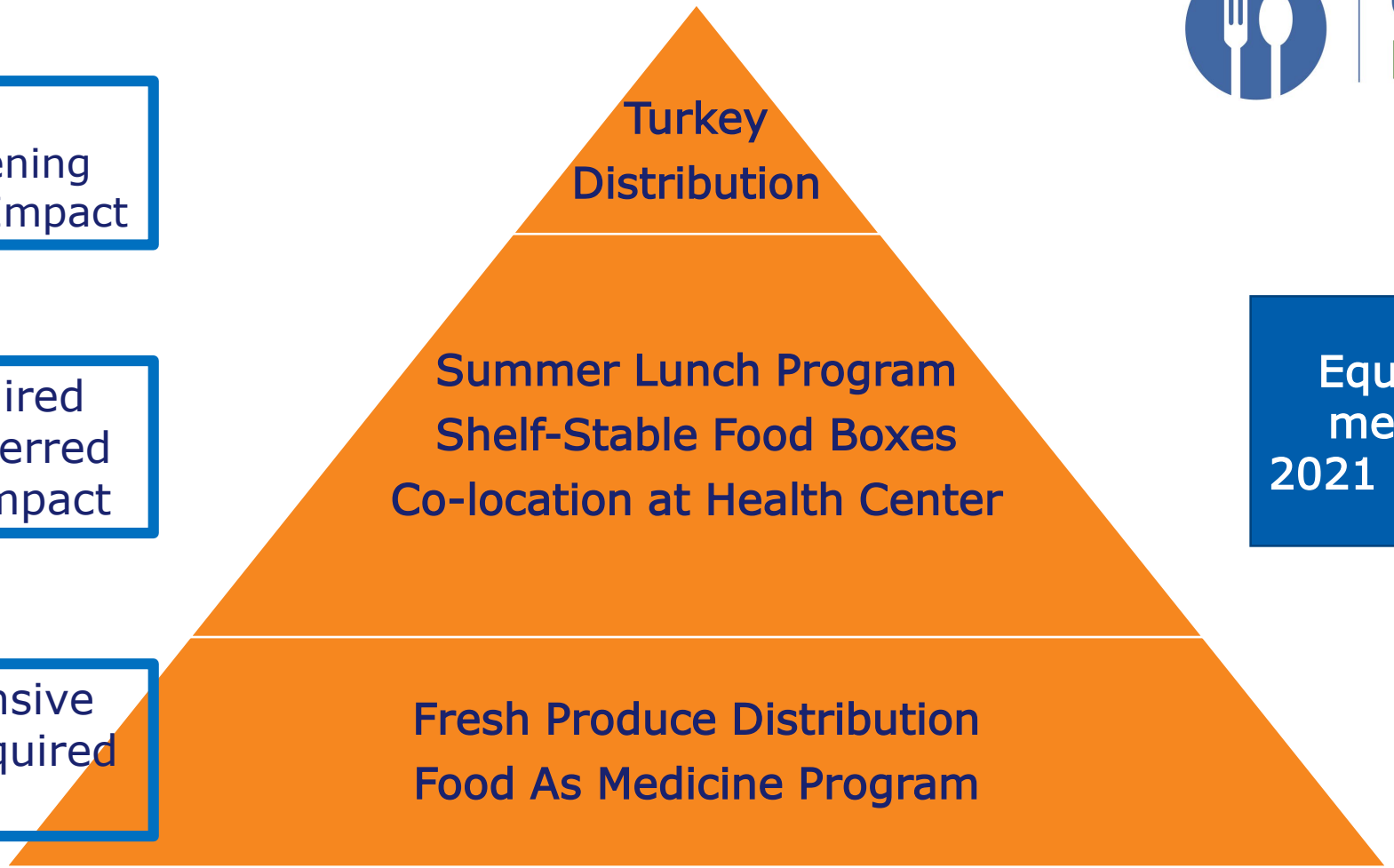
- Food Security is among the highest identified social risks among MetroHealth patients, with 20% of patients screening at-risk
- Strongly correlated with chronic disease:
  - Food insecure individuals are more likely to develop a chronic disease
  - Once a disease is established, food insecurity makes management more difficult
- Many health systems have active programming in this area
- Most communities are served by a food bank

Design Interventions

Low Resource
No SDOH Screening
Low/Unknown Impact

Resource Required
Screening Preferred
Likely Some Impact

Resource Intensive
Screening Required
Health Impact



Equivalent of 80,000 meals distributed in 2021 across all programs

Food As Medicine Clinic

Nutrition Prescription for Good Health

- Nutrition prescription program for patients who are food insecure and have specific chronic disease diagnoses that are impacted by diet
- Adult and pediatric populations are served
- Eligible for healthy food package every 2 weeks for up to one year
- Two clinic locations
- Home delivery and curbside pick-up options available
- Demonstrated outcomes in behavior change (eat more vegetables; reduced fast food consumption); trend of decreased ED visits
- On-going evaluation in process

Deploy Electronic Referrals

Background

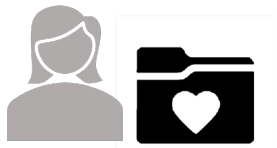
- Aligned with County's Community Health Needs Assessment process
- Multiple vendors assessed, with feedback from community stakeholders
- Key features desired:
  - Free to CBOs
  - Integration with electronic health record
  - Real-time status updates, confirming outcome

- Launched September 2020, with MetroHealth as inaugural sponsor
- Pandemic underscored need for better connections between health and social care
- Greater Cleveland Food Bank as first CBO to join
- All local health systems now on same platform

Community-Wide Resource Referral Platform

MetroHealth partners with community-based social service organizations (CBOs) through Unite Ohio's multi-directional electronic interface to "close the loop" on social needs.

Screening



Patients complete a SDOH questionnaire in MyChart or during their clinic encounter to assess social needs they may have

Referral

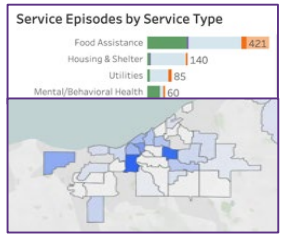
Clinicians and Coordinators note SDOH concerns, obtain consent, and make a UniteOhio referral within the Epic Health Record

The shared technology platform serves as a coordinated care network to connect people to resources

Resource

CBOs in the UniteOhio Network receive referrals and connect patients with resources.

Feedback



Clinicians and Coordinators receive updates on partners working to support patients. Aggregate data used to inform community strategy.

Discover more at https://ohio.uniteus.com

MetroHealth | Institute for H.O.P.E.™

By the Numbers

229 Community Based Organizations

422 Programs

Over 13,300 Referrals Made

On behalf of 7,353 Individuals

By 1,288 Users

Since Inception

- Aligned with CHNA, with leadership from CWRU and CHA
- Review and input from United Way, BHP and others
- MetroHealth Founding Sponsor of Unite Ohio
- Cleveland Clinic, St. Vincent's Charity and UH also active with Unite Ohio
- Local Community Advisory Council formed

Figures from inception through 10/10/2022 for MetroHealth users

MetroHealth and Unite Ohio

- 150 user licenses at MetroHealth across multiple departments
  - Care Coordination
  - Institute for H.O.P.E.™
  - Trauma Recovery Center
  - Cancer Care
  - Opioid Safety
- Care Coordinators, Social Workers and Community Health Workers are primary users
- On-going efforts:
  - Onboarding new users
  - Training all users
  - Network growth
  - Assessing outcomes
  - Integration with screening and evaluation

GCFB Experience with Unite Ohio

Greater Cleveland Food Bank

- Among CBOs, GCFB had relatively robust capacity to manage referrals
- Initially "shared" responsibility across staff, but found it beneficial to have 1 dedicated staff member to manage referrals
  - Form productive relationships with those submitting referrals
  - Gain institutional knowledge
  - Notice patterns among referrals, leading to ideas for programmatic improvements/better service
- Unite Ohio platform is user friendly and intuitive; we do request modifications and customization when needed
- Regular training for healthcare partners sending referrals is critical
  - Understand services we offer
  - Make sure referrals are entered correctly
- Focus on quality vs quantity

Referral Status

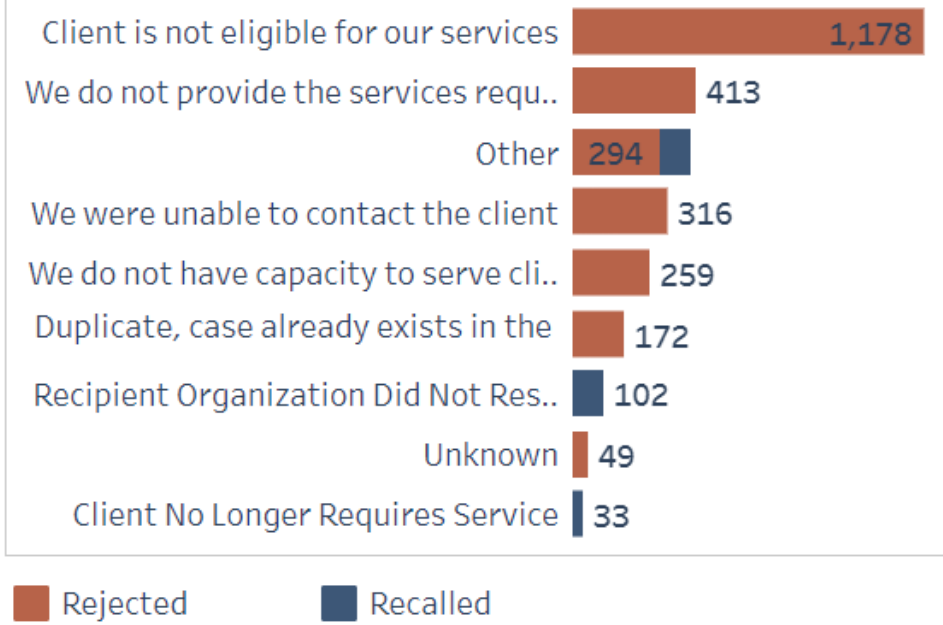
	Accepted	Rejected	Sent	Recalled	Forwarded	In Review
Benefits Navigation	688	117	24	13	17	7
Clothing & Household Goods	108	119	18	20	5	
Education	797	56	46	6	1	
Employment	365	69	27	34	8	7
Entrepreneurship	3	2	3		1	
Food Assistance	3,524	819	79	35	56	38
Housing & Shelter	824	618	105	24	62	8
Income Support	99	57	11	6	11	
Individual & Family Support	873	159	56	20	12	6
Legal	36	18	2	2		
Mental/Behavioral Health	830	91	42	28		4
Money Management	241	27	2			

Managed Cases by Outcome

Show Service Type: Show

Food Assistance	Received Services	10,281
	Other	1,771
	Unable to Contact Client	1,675
	Referred Out of Network	1,240
	Applied	508
	Client Self-Resolved	312
	Refused Services	174
	Enrolled	106
	Duplicate Record	45
	Denied / Ineligible	33
	Did Not Receive Services	17
	Services Not Available	7
Utilities	Received Services	3,515
	Other	487

Referral Rejection / Recall Reason



Develop Curated Relationships: Community Health Workers

Community Health Workers (CHWs) are lay members of communities who work in association with local health care delivery systems as front-line public health workers who are trusted members of or have a close understanding of the community being served. CHWs often share ethnicity, language, culture, socioeconomic status and/or life experience with the people or community they serve.

CHWs within the **Institute for H.O.P.E.™** engage with patients in a variety of ways:

- Navigation, advocacy and support to address health-related social needs
- Brief interventions to connect patients with social services
- Longer-term support for patients with multiple and complex needs
- Assisting patients to gain digital access
- Engaging patients in specialty programs like Food As Medicine
- Home deliveries of food
- Addressing wider needs of people served by Economic Opportunity Center
- Connecting families with the School Health Program
- Navigation support for smoking cessation
- Pathways HUB participation

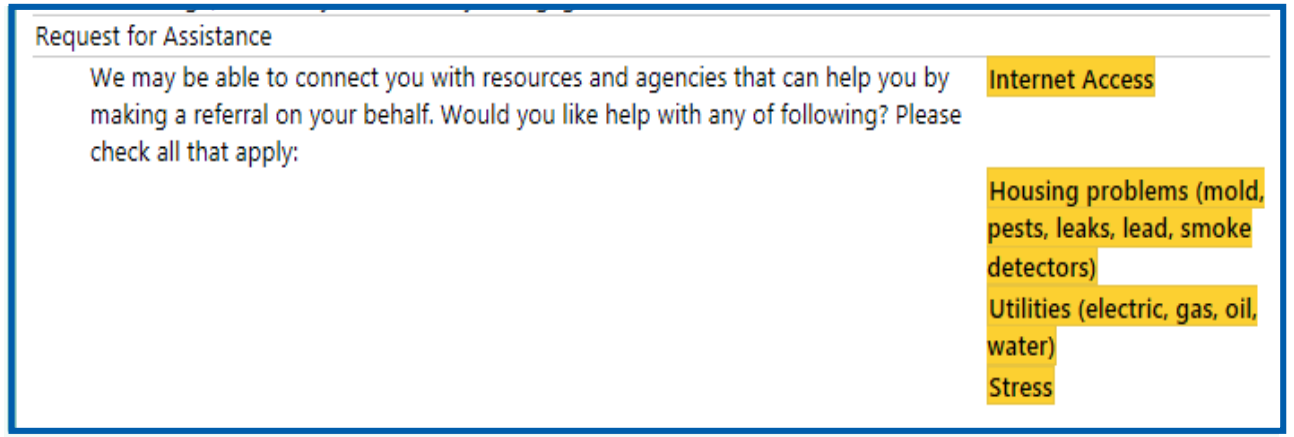
Workflows To Address Social Needs

ROLE	Patient Population and Link to SDOH Screening	KEY FEATURES
MyChart Navigator	**Screened on MyChart** Have social needs Request assistance	• High volume • Brief intervention • Immediate response • Social service referrals
Pathways HUB	**Multiple high-risk social needs** Chronic conditions Rising risk No care management	• Dedicated caseload • On-going support • Social service referrals • Addressing care gaps
Food As Medicine (FAM)	**Eligible for FAM program/food insecure**	• Outreach, enrollment and scheduling • Home delivery of food • Other social service referrals
Opportunity Center	**Screen at risk for Financial Strain** Have education or employment needs	• Linked to broader services of Opportunity Center • Brief intervention or on-going support
School Health Program	**Screened on Pre-Visit call for Well-Child**	• Social service referrals • Connection with School Health Team and care team

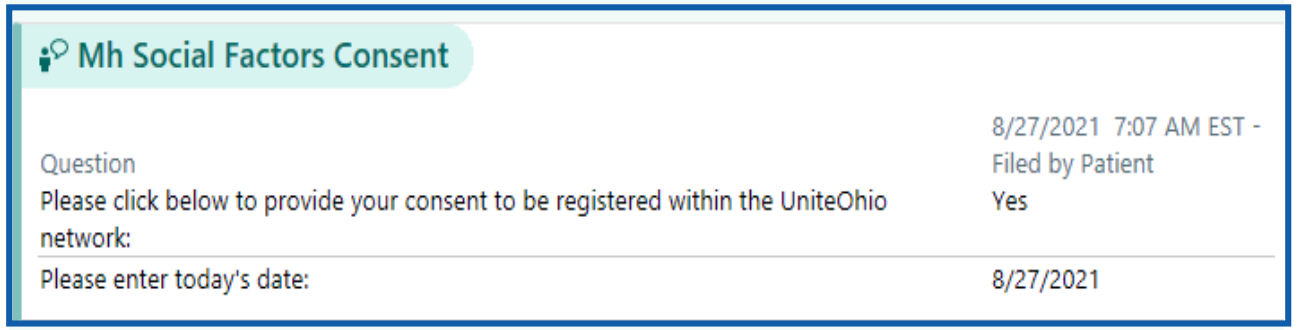
Making the Connection

Responding to Requests for Assistance

- Screening results instantly populate into an Inbasket that the CHW reviews for outreach
- Focused outreach based on screening outcome by specialized team
  - For example, patients at risk for Intimate Personal Violence are contacted by our Trauma Recovery Center
- Outreach focused on connecting patients to resources and education
- Resources deployed by use of our e-referral platform
- Outreach interventions documented within EMR to be visible for the patient's care team



Request for Assistance	
We may be able to connect you with resources and agencies that can help you by making a referral on your behalf. Would you like help with any of following? Please check all that apply:	Internet Access Housing problems (mold, pests, leaks, lead, smoke detectors) Utilities (electric, gas, oil, water) Stress



Mh Social Factors Consent

	8/27/2021 7:07 AM EST - Filed by Patient
Question	
Please click below to provide your consent to be registered within the UniteOhio network:	Yes
Please enter today's date:	8/27/2021

Assessing Connections Made

METHOD	CONFIRMATION of CONNECTION
Direct Programming	Varies by program/service: • Track volumes • EMR documentation
Electronic Referral	• Real-time updates on referral status • Data dashboards
Community Health Worker	Varies: • Outreach encounters documented in EMR • Pathways HUB
Emmi Educational Content	Reporting from vendor: • Number modules distributed • Number opened • Number completed • Customer survey

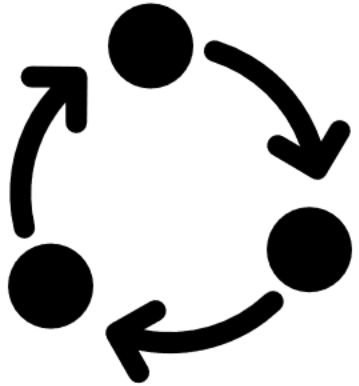
Continuing Our Efforts: Emerging Projects

Text Box

- Text outreach campaign to increase SNAP enrollment among MetroHealth patients
- Food at discharge offered to all food insecure patients with an inpatient stay
- Food as Medicine Clinic expansion to additional patient populations and locations

SNAP Supplemental Nutrition Assistance Program

Lessons Learned and Recommendations



Making the Connection from Screening to Services

- Use screening results to drive actions
- Ask patients if they want assistance, and for what
- Identify multiple ways to engage and connect patients with services and resources
- Communicate with patients about these connections and what to expect
- Leverage existing programs with community-based partners
- Assess the level(s) at which you want to intervene
- Dedicate time to build and nurture relationships
- Assess along all points of continuum: Identify, Connect, Close, Resolve

Thank you!

For more information:
InstituteForHOPE@metrohealth.org

Upcoming Webinar

- Wednesday, November 16, 10:30-11:30am CT
  Part 3–Assess: Building a Data Process for Reporting, Research and More

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Exploring Multi-Sector Collaboration: A Playbook for New Rural Healthcare Models of Investment

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Build Healthy Places Network

Wednesday, November 9, 2022 | 12:00 p.m. - 1:00 p.m. CST

Samantha Borow
Program Manager, Population Health
American Hospital Association

Colleen Flynn
Senior Director of National Programs
Build Healthy Places Network

Ashley Hernandez
Research and Product Manager
Build Healthy Places Network

Rebecca Lemmons
Regional Director of Community Health & Well-Being
Saint Alphonsus Health Syste

ACCELERATING HEALTH EQUITY
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TOGETHER ON THE QUEST FOR HEALTHY ECOSYSTEMS

MAY 16-18, 2023 | MINNEAPOLIS

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