



January 2021 Virtual Webinar

Addressing Social Determinants of Health and Their Impacts: Philosophy, Tools and Sustainability

Presentation Background, Takeaways, Q&A for each of the sections

Idaho Health Data Exchange -- Spotlight on Social Needs

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SDoH Screening, Outreach and Delivery on the Ground in Ohio

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Oklahoma Route 66 Consortium -- Mobile Social Needs Screening

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Idaho Health Data Exchange -- Spotlight on Social Needs Presentation Highlights

The Idaho Health Data Exchange (IHDE) utilizes a variety of shared technology services, including ConnectAmerica, Orion Health, 4medica, Lake On FHIR, KPININJA, myhELo, and Aunt Bertha. IHDE is able to bring an advanced technology stack to patients who would not otherwise have access to those capabilities. These tools can support social workers and providers seeking to address patients' social needs, both by identifying appropriate resources and reducing the manual workload. They are essential as an estimated [80%](#) of total health is affected by situations outside of a healthcare delivery setting. To illustrate: at an appointment with a healthcare provider, a patient and social worker completes the [PRAPARE](#) assessment online through [Aunt Bertha](#), a flexible and customizable technology platform designed to facilitate patient referrals to social care providers. PRAPARE is the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences, and it is used nationwide to help health centers and other providers capture relevant information on a patient's social determinants of health. Completing this form helps identify a patient's key social needs, e.g., access to nutritious foods, safe housing, transportation, etc. The Aunt Bertha platform then displays available programs and resources to support the patient's social needs, and the provider or social worker can create the appropriate referrals. The social worker can follow up with the patient and track when the referral is complete within the platform. Aunt Bertha provides an analytics dashboard which allows users to granularly track patients with open needs, referrals in progress, and support provided. Organizations looking for a social needs referral platform like Aunt Bertha should consider how they will seek to expand in the future and how the technology can enable that.

Kootenai Care Network (KCN) has significant experience utilizing tools like Aunt Bertha to create a clinically integrated network including transitional care services. This includes resources that are not typically captured in national databases, such as a local church with a food pantry. Focusing on quality of database, ensuring programs are strong partners. Provided education to optimize the program and highlight favorites. Provides GPS functionality to direct patients to resources. The intention is to have a comprehensive database to streamline the referral process and identify gaps in care. The closed loop referral is a critical component of the process.

See full presentation for additional information.

Q&A

What did the vendor landscape look like for products like Aunt Bertha, i.e. were there a lot of platforms to consider or was Aunt Bertha the gold standard?

- Conducted a wide vendor assessment and initially identified many viable contenders
- The differentiating factor for Aunt Bertha was the maturity of its catalog of community services in the Idaho region
- IDHE had a limited timeline (4 months) for vendor evaluation and implementation

- For external capabilities, many vendors noted an Aunt Bertha integration in place

How have CBOs reacted?

- CBOs have been excited about the tool and referral tracking capabilities, particularly mid-size and large organization
- Tool allows CBOs to add intake forms, adjust information / hours, etc. compared to printed resources and static directories

Can clinics use different social needs screening? Was there a statewide discussion on the assessment to put in there that involved providers?

- Within Aunt Bertha, any assessment can be utilized (not just PRAPARE) or custom created
- PRAPARE was selected through conversations with CMS and the National Association of Community Health Centers
- PRAPARE seems designed primarily for an FQHC population rather than a general population. UC Health's SDoH form (shared in CPC+) seems to be a better general population form.

Currently, what are the top three social needs identified by PRAPARE in Idaho?

- Housing, transportation, food

How does the closed-loop referral include the patient's preferences? Does PRAPARE or Aunt Bertha have a question about desire for assistance (i.e. readiness)?

- Providers are handling the technology, so patients can opt-in or out and provider will update the case appropriately
- Question can be explicitly included in the assessment, though it does not standardly come in the PRAPARE assessment
- Verbal consent is noted in the application

Closing the referral loop: How much effort does it require for CBOs to close the loop? Does it duplicate their internal documentation for clients? Does the documentation of "Done" automatically get documented and linked to the referral in the EHR?

- Light lift, clinics essentially click a button and a referral completion alert is generated
- Community based centers can utilize the tool at varying degrees, i.e. minimally or extensively at their discretion
- Integration with EHRs minimizes the risk of duplicative documentation
- Aunt Bertha can be integrated through HIE (IHDE uses this) or directly integrated into EHR (Kootenai Health uses this)

What is the biggest value-add of Aunt Bertha?

- Ability to share information across providers and community-based organizations and track support status

- Tool can reduce the manual workload associated with dual paperwork, etc.
- Tracking referral completion

SDoH Screening, Outreach and Delivery on the Ground in Ohio Presentation Highlights

The Health Collaborative has a 5-year demonstration project sponsored by CMS in Cincinnati and N. Kentucky, and it has partnered with a number of clinical delivery organizations, including health systems (e.g. UC Health, TriHealth, etc.) and FQHC. Its trusted community partners include CareSource, Molina Healthcare of Ohio, Council on Aging of Southwest Ohio, etc.

The model to address social determinants of health includes screening, referral, navigation, and alignment. The screening was developed by the National Academy of Medicine and focuses on food insecurity, housing, transportation, utilities, and interpersonal violence. At the alignment stage, the Health Collaborative coordinates clinical and community services. The Collaborative utilizes the [Healthify](#) platform to identify health-related social needs and direct resources based on patient risk (e.g. greater than or less than 2 emergency department visits per year). The resources consolidated into a referral summary with navigation and usual care information.

See full presentation for additional information.

Q&A

What work was conducted with the Food Policy Council?

- First step was to identify gaps and food deserts by comparing internal data with Food Policy Council data to develop a community strategy to ensure resources are available at large
- Overlaying transportation data to food data is critical to understanding

How is the loop closed once the referral is made? How does this get documented in the EHR?

- Through Healthify, the user or navigator can track that a client's needs are resolved and add informational notes related to completion, success of treatment or challenges encountered, etc.
- Currently working on integration with EHR

How do you contact patients? Do you do home visits?

- Yes, prior to COVID-19 and will continue when safe to do so
- Health Collaborative makes 3 attempts to contact the patient, typically beginning with a phone call and then (if a patient has not responded) a home visit

How do you obtain consent from patients to make referrals and share data for care coordination?

- Consent and data sharing permission is embedded in the screening tool
- Patients can also separately consent for navigation services (i.e. someone following up over phone, etc.)

How is Healthify similar or different Aunt Bertha? What is a bridge organization?

- The bridge organization can be a non-profit, a health system, etc. that facilitates connections among organizations
- Healthify and Aunt Bertha appear to have the same core functionality. Healthify has a closed loop for navigators, and over 600 community resources for navigators to reference

Do patients demonstrate any resistance or reluctance to participating in social needs assessments?

- No hesitation regarding privacy but some patients want fewer phone calls, appointment reminders, etc.
- Materials are available in different languages
- Employ cultural competency to ensure an inclusive approach to minority and ethnic populations

Is screening driven by providers or social workers?

- Both providers and CBO workers can conduct the screening though providers may have limited bandwidth. CBO workers / social workers may be more appropriate users

How do you incorporate race and ethnicity into measuring program effectiveness?

- Ivory is an expert on race and ethnicity inclusive data collection
- Race and ethnicity council meets monthly to routinely evaluate program

Is this integrated into the state HIE?

- Yes. Healthify allows navigator to auto populate patient information based on HIE data

Is there a way to use Healthify for care management/care coordination? i.e. to see who is involved with the patient and to reduce duplication for services. Can the CBO enter patient needs?

- Yes. Platform generally facilitates the referral process and care management.
- CBOs using the Healthify platform can update directly in the system but otherwise the navigator at the bridge organization will receive communications from the CBO and make updates

Oklahoma Route 66 Consortium -- Mobile Social Needs Screening

Presentation Highlights

[MyHealth](#) is a nonprofit coalition of OK health providers who use technology to connect providers, exchange information, and improve care delivery. CMS released a funding opportunity announcement to test the Accountable Health Communities model. MyHealth formed the AHC Route 66 Consortium to apply for the cooperative agreement as a bridge organization with CMS. This project is in the 4th year of its 5-year duration. The bridge organization responsibilities include: provide screenings to assess social needs, minimize burden on clinics, measure study outcomes, provide community resource summaries to patients based on needs, refer high risk patients to Tulsa and OK City Health Departments, and build relationships with community resource agencies. Screening occurs via text messaging upon entry into a variety of provider settings (e.g. ERs, clinics, hospital specialty units, etc.). Screening questions include the privacy and consent notices, and CMS qualifying questions, social needs identifiers, and demographic information. Patients receive a standardized referral summary. The objective is to align CBOs, governmental health agencies, etc. to improve health outcomes for individuals.

Recently CMS announced a new E/M coding change. If a social need is detected for a patient, the provider can upcode in the billing by a level. This can motivate healthcare delivery systems to add this assessment to the usual course of care, as they can benefit financially.

See full presentation for additional information.

Q&A

What percentage of patients complete the assessment?

- 18%. System also captures partially completed assessments

What are other options for screening for patients without cell phones?

- In-person tool available which uses SurveyMonkey. Assessment can also be emailed
- 90% of patients have a cell phone

Are you screening in the outpatient clinics only or also inpatients?

- Screen in outpatient clinics, ERs, hospital units, care coordination sites, etc.
- Starting a partnership with Meals on Wheels to do in-home screenings

Has your analysis demonstrated that patient response rates and identified needs have increased correlated to COVID related unemployment in your region?

- Analysis underway to understand this but needs are observed to be higher among people who are completing responses
- Social needs are integrated into EHR, so insights can be generated by connecting the social needs to other clinical diagnoses made, medications, etc.